What is MACRA?

On October 14, 2016, CMS released the final rule for one of the most bipartisan and significant legislative changes to Medicare in a generation, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). MACRA repeals the Medicare Part B Sustainable Growth Rate (SGR) reimbursement formula and replaces it with a new value-based reimbursement system called the Quality Payment Program (QPP). The QPP consists of two major tracks:

- The Merit-based Incentive Payment System (MIPS)
  - MIPS consolidates and strengthens the financial impacts of Meaningful Use (MU), the Physician Quality Reporting System (PQRS), and the Value-Based Modifier (VBM) programs, while leveraging their respective performance measures which have become increasingly familiar to clinicians over the last few years.
  - CMS predicts that 600,000 Part B clinicians will be subject to MIPS, as MIPS is effectively the “new default” for Part B where few clinicians are exempt from MIPS except under a few conditions.
  - A MIPS provider’s reimbursement will be increased or lowered based on performance compared to other MIPS providers. CMS expects around 90 percent of provider’s subject to MACRA to participate in MIPS.

- Advanced Alternative Payment Models (APMs)
  - An APM is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.
  - Advanced APMs are a subset of APMs, and let practices earn more for taking on some risk related to their patients’ outcomes. You may earn a 5% incentive payment by going further in improving patient care and taking on risk through an Advanced APM.

Who is Affected by MIPS?

The merit-based incentive payment system (MIPS) applies to eligible clinicians that bill over $30,000 Medicare Part B claims AND provides care for a minimum of 100 Medicare patients each year.

A MIPS Eligible Clinician is defined in the Federal register (42 C.F.R. §414.1305) as a:

- physician, including: (1) a doctor of medicine or osteopathy; (2) a doctor of dental surgery or of dental medicine; (3) a doctor of podiatric medicine; (4) a doctor of optometry; and (5) a chiropractor;
- physician assistant, a nurse practitioner, and clinical nurse specialist;
- certified registered nurse anesthetist; or
- group that includes at least one of the clinicians above.

Which Clinicians are Excluded from MIPS?

Clinicians are excluded from participation in MIPS as outlined in the federal register (42 C.F.R. §414.1310(b) & (c)) because the MIPS Eligible Clinician:

- is a qualifying advanced alternative payment model (APM) participant;
- is a partial qualifying APM Participant that does not report on applicable measures and activities that are required to be reported under MIPS for any given performance period in a year;

This information was created from the CMS Quality Payment Program website. Additional information can be found at qpp.cms.gov.
How Does MIPS work?

Clinicians earn a payment adjustment based on evidence-based and practice-specific quality data. You show you provided high quality, efficient care supported by technology by sending in information in the following categories that comprise a composite score: 1) Quality (60%), 2) Improvement Activities (15%), 3) Advancing Care (25%) and 4) Cost.

1) **Quality** (Replaces the Physician Quality Reporting System (PQRS))
   - **Most participants**: Report up to 6 quality measures, including an outcome measure, for a minimum of 90 days. Groups using the web interface: Report 15 quality measures for a full year. Groups in APMs qualifying for special scoring under MIPS, such as Shared Savings Track 1 APM or the Oncology Care Model (OCM) one-sided risk APM: Report quality measures through your APM. You do not need to do anything additional for MIPS quality.

2) **Improvement Activities**
   - Groups with fewer than 15 participants or if you are in a rural or health professional shortage area: Attest that you completed up to 2 activities for a minimum of 90 days.
   - Participants in certified patient-centered medical homes, comparable specialty practices, or an APM designated as a Medical Home Model: You will automatically earn full credit.
   - Participants in certain APMs under the APM scoring standard, such as Shared Savings Program Track 1 or OCM: You will automatically receive points based on the requirements of participating in the APM. For all current APMs under the APM scoring standard, this assigned score will be full credit. For all future APMs under the APM scoring standard, the assigned score will be at least half credit.
   - The IAC QI tool or the IAC MOC Activity qualify in this category.

3) **Advancing Care Information**: Replaces the Medicare EHR Incentive Program, also known as Meaningful Use
   - Fulfill the required measures for a minimum of 90 days:
     - Security Risk Analysis
     - e-Prescribing
     - Provide Patient Access
     - Send Summary of Care
     - Request/Accept Summary of Care
     - Choose to submit up to 9 measures for a minimum of 90 days for additional credit.
   - **For bonus credit, you can**:
     - Report Public Health and Clinical Data Registry Reporting measures
     - Use certified EHR technology to complete certain improvement activities in the improvement activities performance category
   - **OR**
     - You may not need to submit advancing care information if these measures do not apply to you.

4) **Cost** (Replaces Value-Based Modifier)
   - No data submission required. Calculated from adjudicated claims.

What are Advanced Alternative Payment Models (APMs)?

Under MACRA, the merit-based incentive payment system (MIPS) automatically applies to an eligible clinician except in certain circumstances. One of the circumstances in which an eligible clinician is excluded from MIPS is when the clinician participates in an advanced alternative payment model (APM) that meets certain operational, risk and patient/payment volume requirements.
Notably, a participant in a qualifying advanced APM receives a 5 percent annual bonus payment from 2019-2024. A participant in an advanced APM who does not meet the patient/payment threshold requirements may still be exempt from MIPS adjustments (although such a partial qualifying advanced APM participant may choose to participate in MIPS) but will not receive the advanced APM bonus.

In 2017, the following models are Advanced APMs:

- Comprehensive ESRD Care (CEC) - Two-Sided Risk
- Comprehensive Primary Care Plus (CPC+)
- Next Generation ACO Model
- Shared Savings Program - Track 2
- Shared Savings Program - Track 3
- Oncology Care Model (OCM) - Two-Sided Risk
- Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1- CEHRT)
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)

**What is the CMS Timeline to Submit the Measures?**

Under MACRA, the merit-based incentive payment system (MIPS) automatically applies to eligible clinicians and most clinicians who treat Medicare patients are expected to be included in MIPS. CMS’s final MACRA rule confirms that implementation begins Jan. 1, 2017.

The 2017 year is being treated as a transitional year. During this year, clinicians may start reporting data used for MIPS determinations (including advanced alternative payment system (APM) qualification). In its final rule, during the 2017 transition year CMS creates five options for clinicians who are not excluded from MIPS:

Importantly, these transition year options only apply to 2017. In 2018, full-year reporting in all categories, including cost performance (which is weighted 0 percent in the 2017 transition year) will be necessary unless CMS expands the transitional period. CMS thinks the transition may take longer than one year and anticipates making proposals for 2018 during the 2017 transition year.

Given the options above, every clinician should try to achieve at least the minimal reporting requirement to avoid the negative payment adjustment in 2019. If possible, it is likely the best strategy to seek full reporting during 2017 so that clinicians are prepared for later years – the 2017 transition year will allow clinicians to try out various measures to see which are best and to obtain feedback from CMS. The experience and feedback obtained by clinicians reporting in 2017 are likely to help position these clinicians to achieve greater positive payment adjustments in later years.

IAC is here to help.

For further questions about IAC accreditation and MACRA, please contact us at 800.838.2110.