Executive Summary: CMS MACRA Proposed Rule

Key Financial and Operational Impacts from the Proposed Rule to Implement MACRA:

The proposed rule implementing Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was made available on May 9, 2016. A detailed summary of the rule is now available on the HFMA web site.

Physician Fee Schedule Update Impact: The physician fee schedule will be updated by the amounts below in the relevant years.

1) 2016 – 2019: .5%
2) 2020 – 2025: 0%
3) 2026 and Beyond:
    a. Eligible professional (EP) in an Advanced Alternative Payment Model (APM): .75%
    b. All other providers: .25%

Impact on Quality Reporting/P4P Programs:

1) MACRA combines the Physician Quality Reporting System (PQRS), Value Modifier (VM) and Meaningful Use programs into the Merit Based Incentive Payment System (MIPS).

2) MIPS has four components – Quality, Resource Use, Clinical Practice Improvement Activities (CPIAs), and Advancing Care Information.

3) To whom does MIPS apply?
    a. In years one and two (2019 & 2020) it only applies to physicians (MD/DO and DMD/DDS), physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists.
    b. In years three (2021) and beyond, the HHS Secretary may broaden the definition of eligible clinicians to include physical or occupational therapists, speech-language pathologists, audiologists, nurse midwives, clinical social workers, clinical psychologists, dietitians/nutritional professionals, as well as those providers/clinicians described above.
    c. There are three groups that MIPS will not apply to:
        i. Providers/clinicians in their first year of Medicare Part B Participation
        ii. Providers/clinicians who do not exceed a low-volume threshold (Medicare billing charges of $10,000 or less, and provides care for 100 or fewer Medicare patients in a given year).
        iii. Qualifying or partially qualifying APM participants (see APM section for further discussion)

4) While the MIPS program is budget neutral, it will penalize low performers and pay bonuses to high performers.
    a. The adjustment is +/- 4% in 2019, +/- 5% in 2020, +/- 7% in 2021, and +/- 9% in 2022 and thereafter.
    b. Due to a scaling factor to maintain budget neutrality, the actual bonuses paid out in a given year could be up to three times higher than the maximum payout listed above.

The scaling factor is necessary as it is anticipated that a significant number of providers/clinicians will not meet reporting requirements, and will therefore, receive the maximum penalty.

c. An additional bonus (not to exceed 10%) will be applied to payments to eligible clinicians with exceptional performance where the composite performance score (CPS, calculation discussed below) is equal to or greater than an "additional performance threshold," defined as the 25th percentile of possible values above the CPS performance threshold.
d. A CPS above the performance threshold will result in neutral or positive payment adjustment; a CPS below the performance threshold will result in a negative adjustment.
    i. A CPS at or below the bottom quartile (worst performers) will yield the maximum negative adjustment.
e. Not reporting will result in the maximum negative adjustment.

5) There is a one year lag between the MIPS performance period and the period to which the payment adjustment is applied. For example, for the first payment year of the program (2019), the performance period is 2017.

6) Each of the MIPS performance categories (quality, resource use, CPIA, and advancing care information) is weighted differently, has its own submission mechanisms, and activity requirements. Tables I and II in the appendix provide specifics for each of the performance categories.

Bonus for Participating in an Advanced Alternative Payment Model (APM)

1) Beyond the additional .5% PFS payment update factor starting in 2026 for participating in an advanced APM, qualifying professionals will receive a 5% bonus payment based on their prior year's allowable Part B payments during the years from 2019 to 2024.

2) An alternative payment model as defined by MACRA includes models:
    a. Developed under:
        i. CMMI under section 1115a of the SSA (excluding Health Care Innovation Awards)
        ii. Medicare Shared Savings Program (MSSP)
        iii. Demonstration under the Health Care Quality Demonstration Program
        iv. Demonstration required by federal law
    b. That meet the following criteria:
        i. Requires the use of certified electronic heath record technology (CEHRT)
            1. With the exception of MSSPs, at least 50% of eligible clinicians in the APM entity must use CEHRT in the first year; 75% must use it in the second and subsequent years.
        ii. Bases payment on quality measures comparable to those found in MIPS

iii. The APM either requires the APM entity to bear more than nominal financial risk for monetary losses, or is a Medical Home Model expanded under CMMI authority.

3) In addition to meeting specific risk criteria, for a medical home model to qualify as an advanced APM, it must have the following features:
   a. Include primary care practices or multi-specialty practices that include PCPs.
   b. Empanels each patient to a PCP
   c. Performs at least four of the following activities:
      i. Planned coordination of chronic and preventive care
      ii. Patient access and continuity of care
      iii. Risk-stratified care management
      iv. Coordination of care across the medical neighborhood
      v. Patient and caregiver engagement
      vi. Shared decision-making
      vii. Payment arrangements in addition to, or substituting for, fee-for-service payments

4) To qualify as an advanced APM, an APM must require one of the following if actual expenditures exceed targeted expenditures:
   a. Requires direct repayment from the APM entity to the purchaser
   b. The purchaser reduces payment rates to the APM entity or participating clinicians
   c. The purchaser withholds payment from the APM entity or participating clinicians

5) In addition to meeting the repayment standard (discussed above) an APM must meet the nominal risk standard which requires that an advanced APM must include in its design that the APM entity:
   a. Bear total risk of 4% of expected expenditures
   b. Bear marginal risk of at least 30%
   c. Be subject to a minimum loss ratio of no more than 4%

6) Table 29 from the proposed rule (reproduced below) provides examples of shared savings arrangements that do and do not qualify.

	Benchmark	Actual	Marginal Risk Sharing Rate	Stop Loss	Amount Owed	Is Financial Risk Criterion Met?
Example 1	$1,000,000	$1,100,000	50%	15%	$50,000	Yes
Example 2	$1,000,000	$1,100,000	60%	10%	$60,000	Yes
Example 3	$1,000,000	$1,100,000	40%	3%	$30,000	No
Example 4	$1,000,000	$1,100,000	100%	5%	$50,000	Yes
Example 5	$1,000,000	$1,100,000	25%	10%	$25,000	No

7) For a medical home model to meet the requirements of an advanced APM, one of the following must occur if the APM entity fails to meet the proscribed performance standard:
    a. APM entity makes a direct repayment to the purchaser
    b. The purchaser reduces payment rates to the APM entity or eligible clinicians
    c. The purchaser withholds payment to the APM entity or eligible clinicians
    d. The purchaser reduces an otherwise guaranteed payment.

8) The nominal risk standard for medical homes escalates over time as shown in the table below:

Proposed Medical Home Model Nominal Risk Standard Total Risk Amounts	
Performance (Calendar) Year	Amount (% of the APM entity's total Parts A and B revenue)
2017	2.5%
2018	3.0%
2019	4.0%
2020 and beyond	5.0%

9) Only a limited number of APMs will qualify as advanced in 2017 which is the performance year on which the 2019 bonus payment will be based:
    a. MSSP Tracks 2 and 3
    b. Next Generation Accountable Care Organization Model
    c. Comprehensive End Stage Renal Disease Care
    d. Comprehensive Primary Care Plus
    e. Oncology Care Model

10) To become a qualifying advanced APM participant (and receive the 5% bonus payment) it must either have a certain percentage of its revenue flow through the APM or a certain percentage of its patients attributed to the APM (using the APM's specific attribution model).
    a. In 2019 and 2020, the targets are Medicare specific (see Tables III and IV in the Appendix).
    b. In 2021 and thereafter, there is a qualifying threshold that allows it to qualify on a Medicare only basis or an all payer basis (see Tables V and VI in the Appendix).

11) For the first payment year (2019) the timeline for determining whether or not a APM entity is a qualified participant in an Advanced APM is detailed below. The timing will be the same in subsequent years:
    a. 2017 – QP performance year for 2019 payment year to determine if the APM entity satisfies either the payment or volume threshold.
    b. 2018 – Add up qualifying Part B payments made to the APM entity to determine the base on which the bonus is calculated.
    c. 2019 – A lump sum payment is made to the APM entity or qualifying professional during the 2019 calendar year. CMS estimates that it will take approximately six months to determine the appropriate amount and make payment.

Table I: MIPS Measure Performance Category Details

Performance Category	Category Details	First Year Weighting	Scoring	Maximum Possible Points Per Performance Category
Quality	• Report six self-selected measures that are relevant to the practice (as opposed to 9 in PQRS) • Must include one cross-cutting measure and one outcome measure or other high priority measure of an outcome measure isn't available • Select from individual measures or specialty measure set (lists included in tables at the end of the proposed rule) • Population based measures automatically calculated	50%	• Each measure 1-10 points compared to historical benchmark (if available) • 0 points for a measure that is not reported • Bonus for reporting outcomes, patient experience, appropriate use, patient safety and EHR reporting • Measures are averaged to get a score for the category	80 to 90 points depending on group size
Advancing Care Information	• Base score requires submitting data for each of the six objectives below: o Protect patient health information (yes/no – yes required for base score) o E-prescribing (numerator/denominator) o Patient Electronic Access to Health Information (numerator/denominator) o Coordination of Care through Patient Engagement (numerator/ denominator)	25%	• Base score of 50 points is achieved by reporting at least one use case for each available measure • Performance score provides up to 80	100 points

	○ Health Information Exchange (numerator/ denominator) ○ Public Health and Clinical Data Registry Reporting (yes/no – yes required for base score) • In addition to responding no to the protecting PHI or participating in an immunization registry (public health), failure to report data in any base score category will result in 0 points awarded • The performance score encompasses three areas ○ Patient Electronic Access ○ Coordination of Care through Patient Engagement ○ Health Information Exchange objectives		points based on physician/clinician reporting • Total cap of 100 percentage points available	
CPIA*	• Minimum selection of one CPIA from list of 90 possible activities with additional credit given for more activities • Full credit for participation in patient-centered medical home • 50% credit for participating in an APM	15%	• Each activity worth 10 points; double weight for "high" value activities; sum of activity points compared to a target	60 points
Resource Use	• Assessed under all available resource use measures as applicable to the clinician • Calculated based on claims so no additional data submissions are required • Adding more than 40 episode specific measures to create reporting avenues for more specialties	10%	• Similar to quality	Average score of all cost measures that can be attributed

*Clinicians in small practices (15 or fewer professionals, a rural or health professional shortage area, or a non-patient facing professional are only required to report on two CPIAs to receive the full score. Reporting of one CPIA (medium or high weight) would result in 50 percent of the highest potential score (30 points) and reporting of two CPIAs would result in the maximum score of 60 points.

Table II: MIPS Measure Submission Mechanism*

Performance Category	Individual Reporting	Group Reporting
Quality	• Claims • QCDR • Qualified Registry • EHR Vendor • Administrative Claims (no submission required)	• QCDR • Qualified Registry • EHR Vendor • CMS web Interface (groups of 25 or more) • Administrative Claims (no submission required)
Resource Use	• Administrative Claims (no submission required)	• Administrative Claims (no submission required)
Advancing Care Information	• Attestation • QCDR • Qualified Registry • EHR Vendor	• Attestation • QCDR • Qualified Registry • EHR Vendor • CMS web Interface (groups of 25 or more) •
CPIA	• Attestation • QCDR • Qualified Registry • EHR Vendor • Administrative Claims (no submission required)	• Attestation • QCDR • Qualified Registry • EHR Vendor • CMS web Interface (groups of 25 or more)

*While providers can use different reporting mechanisms for different performance categories, they must, with limited exception, use the same reporting mechanism within a category.

Table III: Medicare Option – Payment Method

Payment Year	2019	2020	2021	2022	2023	2024+
QP Threshold Payment Amount	25%	25%	50%	50%	75%	75%
Partial QP Threshold Payment Amount	20%	20%	40%	40%	50%	50%

Table IV: Medicare Option – Patient Count Method

Payment Year	2019	2020	2021	2022	2023	2024+
QP Threshold Patient Count	20%	20%	35%	35%	50%	50%
Partial QP Threshold Patient Count	10%	10%	25%	25%	35%	35%

Table V: Other Payer Combination Option – Payment Method

All-Payer Combination Option – Payment Amount Method										
Payment Year	**2019**	**2020**	**2021**		**2022**		**2023**		**2024 and later**	
QP Payment Amount	N/A	N/A	50%	25%	50%	25%	75%	25%	75%	25%
Partial QP Payment Amount	N/A	N/A	40%	20%	40%	20%	50%	20%	50%	20%
			Total	Medicare	Total	Medicare	Total	Medicare	Total	Medicare

Table VI: Other Payer Combination Option – Patient Count Method

All-Payer Combination Option – Patient Count Method										
Payment Year	**2019**	**2020**	**2021**		**2022**		**2023**		**2024 and later**	
QP Patient Count Threshold	N/A	N/A	35%	20%	35%	20%	50%	35%	50%	35%
Partial QP Patient Count Threshold	N/A	N/A	25%	10%	25%	10%	35%	25%	35%	25%
			Total	Medicare	Total	Medicare	Total	Medicare	Total	Medicare