



Executive Summary: CMS MACRA Final Rule

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

The final rule implementing the Medicare Access and CHIP Reauthorization Act (MACRA) was made available on October 14, 2016. A detailed summary of the rule will be available on [HFMA's Regulatory Resources](#) page.

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 participant (EP) in an advanced Alternative Payment Model (APM): .75%
 - b. All other providers: .25%

Participation Options:

As part of its transitional policy, CMS is offering four Merit-Based Incentive Payment System (MIPS) participation tracks for the CY19 payment year (2017 performance year).

1. *Option 1: Test the Quality Payment Program*
In 2017, submit at least 90 days' worth of data one quality measure or Clinical practice improvement activity or submit data for the Advancing Care Information "Base Measure" category. Providers who do this will receive no payment adjustment regardless of whether or not the quality data submitted (if that's what's submitted) fails to meet the minimum volumes required to be complete.
2. *Option 2: Participate for Part of the Calendar Year*
In 2017, submit at least 90 days' worth of data that meets the requirements discussed below for each of the three weighted categories for CY19. Participants will not receive a downward adjustment and could receive a positive adjustment.
3. *Option 3: Participate for the Full Calendar Year*
In 2017 submit 12 months' worth of data that meets the requirements discussed below for each of the three weighted categories for CY19. Participants will not receive a downward adjustment and will likely receive a positive adjustment.
4. *Option 4: Participate in an Advanced APM Model*
In 2017, meet the volume and payment model requirements discussed below to receive a 5% bonus payment based on a clinician or group's Part B allowable amount.



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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 (CPIA), 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), PAs, NPs, clinical nurse specialists, certified registered nurse anesthetists or groups that include such physicians.
 - b. In years three (2021) and beyond, the 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 \$30,000 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. For 2019 – 2024, a clinician or group with a final MIPS score above the “additional performance threshold is eligible to receive a bonus payment of up to 10%. Additional MIPS payments for exceptional performance shall not exceed \$500 million annually.
 - d. Not reporting will result in the maximum negative adjustment.
 - e. A MIPS 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. As part of its transitional MIPS policy, CMS will set the performance threshold for the 2019 payment year at three points. The table below translates final MIPS point totals to potential payment adjustments based on both data submitted and actual performance:



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Points Achieved	Adjustment
0-0.75	Negative 4% – Comprised mostly of practices that don’t submit any data.
0.76-2.9	Negative MIPS payment adjustment > negative 4% and < 0% on a linear sliding scale. Based on CMS projections, few practices will fall in this range.
3	0% adjustment.
3.1-69.9	Positive MIPS payment adjustment ranging from > 0 percent to 4 percent × a scaling factor to preserve budget neutrality, on a linear sliding scale.
70.0-100	Positive MIPS payment adjustment of up to 4% AND additional MIPS payment adjustment for exceptional performance. Additional MIPS payment adjustment starting at 0.5% and increasing on a linear sliding scale to 10%, multiplied by a scaling factor.

- 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. For the quality performance category, CMS will use data from CY15 to set performance benchmarks.
- 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 .75% physician fee schedule 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 APM as defined by MACRA includes models:
 - a. Developed under:
 - i. Center for Medicare and Medicaid Innovation (CMMI) under section 1115a of the SSA (excluding Health Care Innovation Awards)
 - ii. 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 health record (EHR) technology
 1. With the exception of Medicare Shared Savings Programs (MSSPs), at least 50% of eligible clinicians in the APM entity must use certified electronic health record technology in the first year; 50% must use it in the second and subsequent years.



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- 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 primary care physicians (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) **Medicare APM Nominal Risk:** In addition to meeting the repayment standard (discussed above) a Medicare APM must meet the nominal risk standard which requires that an advanced APM must include in its design that the APM entity meets either the “Revenue” or “Benchmark” standards described below:
 - a. **Revenue Standard: 8% or more** of the APM Entity’s average Parts A and B revenue must be at risk in performance years 2017 and 2018.
 - i. Example: *The providers have \$1m in Medicare allowable payments. They must be at risk of paying back losses of at least \$80k.*
 - b. **Benchmark Standard: 3% or more** of the expected expenditures for which an APM entity is responsible for. Applies to all performance periods.
 - i. Example: *A joint replacement episode target price is \$20k. The orthopedic surgeon must be at risk of paying back losses of at least \$6k.*
- 6) **Other Payer Nominal Risk:** In addition to meeting the repayment standard (discussed above) an “Other Payer” 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 3% of expected expenditures
 - b. bear marginal risk of at least 30%
 - c. be subject to a minimum loss ratio (MLR) of no more than 4%



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7) Table 29 from the proposed rule (reproduced below) provides examples of shared savings arrangements that do and do not qualify under the “Other Payer” nominal risk standard.

	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

8) 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:

- APM entity makes a direct repayment to the purchaser.
- The purchaser reduces payment rates to the APM entity or eligible clinicians.
- The purchaser withholds payment to the APM entity or eligible clinicians.
- The purchaser reduces an otherwise guaranteed payment.

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

Final 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%

10) Only a limited number of APMs will qualify as advanced in 2017 and 2018 which are the performance years on which the 2019 and 2020 bonus payments will be based:

- Comprehensive Primary Care Plus*
- MSSP Tracks 2 and 3
- Next Generation ACO Model
- Comprehensive End-Stage Renal Disease Care
- Oncology Care Model**
- Comprehensive Care for Joint Replacement (CJR) (2018)
- ACO Track 1+ (2018)***
- New Voluntary Bundled Payment Model (2018)***

*Practices of No More than 50 Providers Under the Corporate Umbrella After 2017

**Two-sided Risk Only

***Details TBD



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- 11) To become a qualifying Advanced APM participant (and receive the 5% bonus payment) you must either have a certain percentage of your revenue flow through the APM or a certain percentage of your 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 you to qualify on a Medicare only basis or an all payer basis (see Tables V and VI in the Appendix).

- 12) 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 – Qualifying APM Participant (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.



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Table I: MIPS Measure Performance Category Details

Performance Category	Category Details	First Year Weighting	Scoring	Maximum Possible Points Per Performance Category
Quality	<ul style="list-style-type: none"> • Report six self-selected measures that are relevant to the practice for at least 90 days during the performance year (CY17)* • Must include one cross-cutting measure and one outcome measure or other high priority measure if an outcome measure isn't available • Select from individual measures or specialty measure set (lists included in tables at the end of the final rule). https://qpp.cms.gov/docs/CMS-5517-FC.pdf • Population based measures automatically calculated 	60%	<ul style="list-style-type: none"> • 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 	60 points
Advancing Care Information	<ul style="list-style-type: none"> • Base score requires submitting data for each of the objectives below: <ul style="list-style-type: none"> ○ Protect patient health information (yes/no – yes required for base score) ○ E-prescribing (numerator/denominator) ○ Patient Electronic Access to Health Information (numerator/denominator) ○ Coordination of Care through Patient Engagement (numerator/ denominator) ○ 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 will result in 0 points awarded • The number of measures a clinician has the ability to earn performance score credit increased to nine in this final policy 	25%	<ul style="list-style-type: none"> • Base score of 50 points is achieved by reporting at least one use case for each available measure • Performance score provides up to 90 points based on physician/clinician reporting • Total cap of 100 percentage points available 	100 points



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	<ul style="list-style-type: none"> Clinicians can choose which of these measures to focus on for their performance score allowing clinicians to customize their reporting and score 			
CPIA**	<ul style="list-style-type: none"> 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%	<ul style="list-style-type: none"> Each activity worth 10 points; double weight for “high” value activities; sum of activity points compared to a target 	40 points
Resource Use	<ul style="list-style-type: none"> Only calculated on Medicare Spend Per Beneficiary and Medicare Per Capita Spend Calculated based on claims so no additional data submissions are required Adding more than 10 episode specific measures to create reporting avenues for more specialties 	0%	<ul style="list-style-type: none"> Will not be incorporated into the MIPS performance score for payment year 2019. However, results for select measures will be provided as feedback Will count for 10% of the score in CY20 payment year 	Feedback Only in CY19

*Clinicians that report just one measure can avoid a downward adjustment.

**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.



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Table II: MIPS Measure Submission Mechanism*

Performance Category	Individual Reporting	Group Reporting
Quality	<ul style="list-style-type: none"> • Claims • QCDR • Qualified Registry • EHR Vendor 	<ul style="list-style-type: none"> • QCDR • Qualified Registry • EHR Vendor • CAHPS Vendor • CMS Web Interface* • Administrative Claims
Resource Use	<ul style="list-style-type: none"> • Administrative Claims 	<ul style="list-style-type: none"> • Administrative Claims
Advancing Care Information	<ul style="list-style-type: none"> • Attestation • QCDR • Qualified Registry • EHR Vendor 	<ul style="list-style-type: none"> • Attestation • QCDR • Qualified Registry • EHR Vendor • CMS Web Interface*
CPIA	<ul style="list-style-type: none"> • Attestation • QCDR • Qualified Registry • EHR Vendor 	<ul style="list-style-type: none"> • Attestation • QCDR • Qualified Registry • EHR Vendor • CMS Web Interface*

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



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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 Threshold	N/A	N/A	50%	25%	50%	25%	75%	25%	75%	25%
Partial QP Payment Amount Threshold	N/A	N/A	40%	20%	40%	20%	50%	20%	50%	20%
			Total	Medicare	Total	Medicare	Total	Medicare	Total	Medicare



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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%	20%	50%	20%
Partial QP Patient Count Threshold	N/A	N/A	25%	10%	25%	10%	35%	10%	35%	10%
			Total	Medicare	Total	Medicare	Total	Medicare	Total	Medicare