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# MACRA

CMS has announced that it plans to implement a new payment program for Medicare providers under the Part B physician fee schedule beginning in 2019. This program is a result of the Medicare Access and CHIP Reauthorization Act which repealed the sustainable growth rate formula and will replace the current programs that influence reimbursement including PQRS, the EHR incentive program, and the value based payment modifier. While the new program is set to begin on Jan. 1, 2019, provider performance reporting which will determine 2019 payment rates will begin in 2017.

The program will apply only to physicians, PAs, NPs, clinical nurse specialists, and CRNAs for at least the first two years. CMS is considering additional eligible clinicians to include PTs, OTs, SLPs, audiologists, CNMs, CSWs, psychologists, and dieticians for participation in 2019. Providers will elect to follow one of two tracks. The first track is the Merit-Based Incentive Payment System (MIPS) under which Medicare reimbursement for services will be increased or decreased based on the providers' performance relative to their peers. The second track is the Advanced Alternative Payment Model (APM) under which a 5% lump sum bonus will be available annually and participants will be exempt from the MIPS reporting requirements.

The payment adjustment under MIPS will be determined using a composite score from four components:

- Quality Performance (50%)
  Must report on six quality measures and three population measures derived from claims
- Advancing Care Information (25%)
  Requires the use of a certified EHR and to perform annual security risk assessment
- Clinical Practice Improvement Activities (15%)
  Select from a list of 90+ activities focusing on care coordination, beneficiary engagement, and patient safety with accommodations for small, rural, and non-patient facing providers
- Resource Use (10%)
  Cost data to be extracted from claims and compared to CMS benchmarks

The weights of the various components will be adjusted over time with more weight attributed to resource use and less to quality in subsequent years. Reporting requirements for MIPS are offered to both groups and individuals. These options include claims, qualified clinical data registries (QCR), qualified registries, EHR, and attestation. For groups consisting of 25+ eligible clinicians the CMS web interface reporting option is also available. The deadline for reporting is generally no later than March 31st of the year following the performance year.

There will be exemptions from MIPS participation for those providers in their first year in Medicare Part B and also those who do not achieve at least $10,000 in Medicare billing charges and see 100 or fewer Medicare patients in the reporting period.

Based on the composite score from performance in 2017 relative to their peers, a Medicare provider could experience up to a +/- 4% adjustment in their fee for service reimbursement in 2019. This swing increases to 5% in 2020, 7% in 2021 and 9% in 2022 and beyond. Providers who fall below the mean composite will receive a penalty and those who exceed this threshold will receive a positive adjustment to their FFS reimbursement. These adjustments will follow a bell curve distribution and will be budget neutral meaning that the cumulative increases will be entirely offset by the cumulative decreases. However, there will also be a pool of funds up to $500 million annually for years 2019-2024 that will be available as an additional incentive for those providers who exceed the performance threshold by more than 25%. This incentive is capped at 10% for eligible providers and is not impacted by the budget neutrality requirement.

Clinicians who participate in certain advanced alternative payment models are exempt from MIPS participation. The APMs are defined as those models which link payment to quality, make use of certified EHRs, and bear more than a nominal amount of financial risk. Current models that meet these criteria include track 2 and 3 ACOs, next generation ACOs, CPC+ program, most comprehensive ERSD care organizations, and oncology care model track 2. CMS is considering adding the Comprehensive Care for Joint Replacement and Cardiac Care mandatory bundles as additional APMs.

Participants in these models must meet MACRA thresholds for revenue (25%) generated through the APM and patients (20%) receiving care through the APM to qualify for an annual 5% lump sum bonus in 2019. These thresholds are scheduled to increase in subsequent years to 75% for revenue and 50% for patient volumes for 2023 and beyond.

MACRA legislation requires CMS to release the final rule no later than November 1, 2016.

*If you have any questions or want additional information, please contact your consultant:*

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