



# Medicare Access and CHIP Reauthorization Act (MACRA)

## Quality Payment Program Final Rule

The Medicare Access and CHIP Reauthorization Act (MACRA) was signed into law on April 16, 2015. This bipartisan legislation permanently repeals the sustainable growth rate formula. Medicine strongly supported this bill.

On April 27, 2016, the Centers for Medicare & Medicaid Services (CMS) released the proposed rule to implement MACRA's Merit-based Incentive Payment System (MIPS) and advanced alternative payment models (advanced APMs). Throughout the regulatory process, the AMA conducted significant advocacy efforts to simplify many of CMS' proposals and reduce the reporting burden for physicians.

On Oct. 14, 2016, CMS released the final MIPS and advanced APM rule with comment period. In the final rule, CMS adopted numerous AMA recommendations and made significant improvements over both the proposed rule and the previous reporting program requirements.

Without the passage of MACRA, physicians could have been subjected to negative payment adjustments of 11 percent or more in 2019 as a result of the Meaningful Use (MU), Physician Quality Reporting System (PQRS), and value based modifier (VBM) reporting programs—with even greater penalties in future years. In contrast, under MACRA, the largest penalty a physician can experience in 2019 is 4 percent. MACRA also provides incentives for physicians to develop and participate in different models of health care delivery and payment through advanced APMs.

Collectively, the MIPS and advanced APM programs are part of what CMS now calls the Quality Payment Program (QPP). The MIPS program consolidates and better aligns the MU, PQRS and VBM reporting programs to simplify them and reduce physicians' administrative burdens. It also adds a new improvement activities component to help physicians achieve a higher score. Physicians with annual Medicare billing charges less than or equal to \$30,000 or physicians who provide care for 100 or fewer Part B-enrolled Medicare beneficiaries (the low-volume threshold) are exempt from MIPS.

The AMA will continue to pursue every opportunity to work with CMS to further improve the QPP and develop practical tools to help physicians succeed under the program. For 2017, CMS is implementing a transition year where physicians have the opportunity to "pick their pace" (see 2017 pick your pace document).

### Overarching Improvements in QPP Final Rule

- Shortened performance period and transition year in 2017
- Simplified reporting burden and improved chances of success by creating more opportunities for partial credit and fewer required measures
- Lower financial risk standards for advanced APMs
- Additional flexibility for solo physicians and small group practices, including an increased low-volume threshold which exempts more physicians
- Modified performance threshold formula that allows more physicians to succeed

### MIPS program structure

- The following four components are scored individually and then combined to create a composite score. Each physician's score will result in a positive, negative or neutral payment adjustment.
  - **Quality**—60 percent of score in the first year (replaces PQRS and some components of VBM)
  - **Cost**—0 percent of score in the first year (replaces the cost component of the VBM)
  - **Improvement activities**—15 percent of score in the first year
  - **Advancing care information**—25 percent of score in the first year (replaces MU)

## APMs

- Qualifying physicians in advanced APMs are eligible for a 5 percent bonus and are exempt from MIPS.
- MIPS APM participants—that is, those APM participants who do not qualify for the 5 percent bonus and report to MIPS—receive adjusted MIPS scoring that recognizes the ongoing quality and practice improvement activities of the APM.

## AMA resources

- The AMA will continue to develop and revise resources and tools to help physicians succeed in the **QPP program**, so please visit our QPP resource and AMA **STEPS Forward™ practice improvement strategies** web pages often.
- Check out the AMA **Payment Model Evaluator** to help decide which path your practice should take to maximize success.



## Quality (replaces the “Physician Quality Reporting System”)

- Physicians are required to report on six quality measures, or report on a specialty measure set. Of the measures a physician reports on, however, one must be an outcome measure or, if no outcome measures are available, a high-priority measure. A high-priority measure is defined as a measure related to appropriate use, patient safety, efficiency, patient experience or care coordination. The Centers for Medicare & Medicaid Services (CMS) eliminated the requirement that all physicians must report on one cross-cutting measure.
- Groups of 16 or more physicians with at least 200 attributed cases will be subject to an all-cause hospital readmissions measure. The measure will be calculated based on administrative claims data with no reporting required from the physician practice.
- In 2017 any physician who reports on one quality measure for at least one patient will receive at least three points on the measure, thereby avoiding a negative payment adjustment in 2019.
- In 2017 physicians have to report on a measure successfully on 50 percent of patients, and in 2018, physicians have to report on a measure successfully on 60 percent of patients in order to potentially receive an incentive payment. CMS intends to increase the measure thresholds over time. If a physician is only avoiding a negative payment adjustment and not attempting to earn an incentive, they are only required to report on one patient in 2017.
- Sixty percent of the final score will be based on the quality performance category in 2017, due to the reduction of the cost performance category weight to 0 percent. Fifty percent of the final score will be based on the quality performance category in 2018. In 2019 and beyond, 30 percent of the final score will be based on the quality performance category.
- Recognizing the cost to report through electronic sources, CMS provides a bonus of up to 10 percent of the denominator of the quality performance category score to physicians who report quality measures through an electronic health record, qualified registry, qualified clinical data registry (QCDR) or web-interface. Reporting through the QCDR will also assist with satisfying the improvement activities category.
- If a physician reports on additional high-priority quality measures beyond the one required high-priority/outcome measure, they have the potential to receive up to a 10 percent bonus.



# Improvement activities (formerly “Clinical practice improvement activities”)

- Physicians must select activities from a list of more than 90 possible improvement activities to receive credit under the Merit-based Incentive Performance System (MIPS). Activities that count for improvement activities credit include:
  - Completion of the American Medical Association **STEPSForward™ practice improvement strategies** program
  - Hiring diabetes educators
  - Participation in a qualified clinical data registry, also known as QCDR\*
- Improvement activities must be performed for at least 90 consecutive days during the performance period.
- Physicians must attest to two 20-point, high-weighted activities; four 10-point, medium-weighted activities; or another combination of high- and medium-weighted activities equaling 40 points or more to achieve full credit in the improvement activities category.
- Small, rural, health professional shortage areas (HPSA), and non-patient facing physician practices need only report two medium-weighted or one high-weighted improvement activity to receive full credit.
- Participants that have received certification or accreditation as a patient-centered medical home (PCMH), or comparable specialty practices, including those certified by a national, regional or state program, private payer or other body that administers PCMH accreditation and certifies 500 or more practices for PCMH accreditation or comparable specialty practice certification will receive full credit in the improvement activities category.
- Alternative payment model (APM) entities participating in the 2017 MIPS APMs receive a full score for the improvement activities in 2017. The eligible MIPS APMs are subject to change in future years. Other APMs are eligible for at least half-credit.
- As proposed, physicians will report improvement activities generally through attestation. CMS will provide physicians with more information about documentation expectations and reporting processes through sub-regulatory guidance.
- Physicians may receive preferential scoring in the advancing care information category by using certified EHR technology to perform one or more of 18 designated improvement activities.

\* We are seeking clarification from CMS on how physicians can successfully implement these activities.



## Cost (replaces “Resource use”)

- In 2017 the Centers for Medicare & Medicaid Services (CMS) will not include cost measures in the final Merit-based Incentive Performance System (MIPS) score. However, physicians will be able to look up quality and resource use reports (QRUR) that outline their cost measure performance. This will help physicians prepare for 2018.
- Starting in 2018, CMS will include performance on up to 12 measures in the cost category of the MIPS final score. In 2018 the cost category will count for 10 percent of the MIPS final score that affects payment in 2020.
- MIPS cost measures:
  - a. Total per capita cost measure if the physician has 20 or more attributed patients
  - b. Total Medicare spending for hospitalized patients during a 30-day window following a hospitalization (the Medicare spending per beneficiary (MSPB) measure) if the physician has 35 or more attributed hospitalizations
  - c. Ten episode groups for physicians who have 20 or more attributed episodes: (1) mastectomy, (2) aortic/mitral valve surgery, (3) coronary artery bypass surgery, (4) hip/femur fracture or dislocation treatment, (5) cholecystectomy and common duct exploration, (6) colonoscopy and biopsy, (7) transurethral resection of the prostate for benign prostatic hyperplasia, (8) lens and cataract procedures, (9) hip replacement or repair, and (10) knee arthroplasty (replacement).
- CMS will develop a national benchmark for each cost measure based on performance during the performance period. CMS will distribute the benchmark into deciles and assign points (one to 10) to each cost measure based on a physician’s performance compared to the benchmark. CMS will equally weight the points for each available measure to determine a physician’s cost category score.

What you can do now to get ready for Medicare’s evaluation of your costs:

- Obtain your 2015 QRURs and supplemental QRURs that Medicare has created for each medical group and solo practice, as identified by their Medicare-enrolled tax identification number (TIN).
- The QRURs identify the patients attributed to your TIN for the total per capita cost measure and the MSPB measure so you can:
  - Identify your most costly patient population conditions and diagnoses
  - Identify the lead clinician for each attributed patient for each measure
- The supplemental QRURs provide information on 41 episode cost measures, including the 10 that Medicare will include in the 2018 MIPS cost category. Use these reports to:
  - Identify the episode of care cost measures that are relevant to your practice
  - Identify the lead clinician for the patients attributed to each episode cost measure



# Advancing care information (replaces “Meaningful Use”)

- Physicians must report on all required advancing care information (ACI) measures in the base score with up to an additional nine optional measures in the performance score, for which physicians may receive additional percentage points.
  - The base score measures are met by reporting one unique patient or attestation to a “yes” option. Physicians must report on the required measures to receive any ACI score.
  - The performance score measures are eligible for additional credit and do not have thresholds.
- In 2017 and 2018, physicians must report the ACI measures for a minimum of 90 days to potentially qualify for a positive incentive payment (in 2019 and 2020, respectively).
- The clinical decision support (CDS) and computerized physician order entry (CPOE) measures from the Meaningful Use program, as well as the clinical quality measures, have been eliminated from the ACI category.
- Group data submission and performance may be assessed as a group (as opposed to the individual clinician). Physicians may submit data for the first time through qualified clinical data registries, known as QCDRs.
- The Centers for Medicare & Medicaid Services (CMS) will provide bonus percentage points to physicians who demonstrate active engagement with immunization registries, and will provide bonus points to physicians who demonstrate active engagement with one or more public health or clinical data registries.
- Physicians can earn a bonus score in the ACI performance category by using CEHRT to complete certain activities in the improvement activities performance category.
- Physicians may use 2014 or 2015 (or a combination thereof) CEHRT in 2017.
  - Physicians must use 2015 edition CEHRT in 2018. The shortened reporting period in 2018 allows physicians time to upgrade their systems without interfering with ACI reporting.
  - CMS will continue to monitor physician and vendor readiness and availability of 2015 edition technology.



# Advanced alternative payment models (APMs)

- In 2019 and 2020, a physician can become a qualifying participant (QP) through advanced Medicare APM participation (based on 2017 and 2018 performance).
- From 2021 through 2024, QP status can also be reached by combining Medicare advanced APM with other payer advanced APM participation.
- During 2019–2024, QPs can be excluded from the Merit-based Incentive Payment System (MIPS) and receive a lump sum payment of 5 percent of prior year’s payments for Part B professional services. Beginning in 2026, QPs will receive a higher annual fee schedule update than non-QPs.
- **Advanced APM criteria:** 50 percent of participants are required to use certified EHR technology (CEHRT) in 2017 and 2018, use measures that are comparable to MIPS quality measures, and bear risk for more than nominal monetary losses or be part of an expanded medical home.
  - **CEHRT criteria:** An advanced APM must require at least 50 percent of eligible clinicians in each APM entity to use CEHRT to document and communicate clinical care with patients and other health care professionals. The APM may use 2014 edition CEHRT, 2015 edition CEHRT or any combination thereof in 2017. In subsequent years, the APM must use 2015 edition CEHRT.
  - **Quality criteria:** Measures must be evidenced-based, reliable and valid, one measure must be an outcome measure (unless there is no outcome measure relevant to the APM on the list), and measures that are not endorsed by the National Quality Forum (NQF) or on the MIPS measure list would undergo review through an internal Centers for Medicare & Medicaid (CMS) innovation process.
- **Amount of risk:** An APM will qualify as an advanced APM in 2019 and 2020 if the APM entity is either (1) at risk of losing 8 percent of its own revenues when Medicare expenditures are higher than expected, or (2) at risk of repaying CMS up to 3 percent of total Medicare expenditures, whichever is lower. CMS states that it plans to increase the risk standard to 10 or 15 percent of revenues in future years.
- Beginning in the performance year 2018, medical homes with fewer than 50 eligible clinicians have different risk standards from advanced APMs (2.5–5 percent total Medicare revenue). If CMS expands a medical home it will be exempt from either risk standards.
- CMS acknowledged the need to expand the number of APMs quickly in the final rule. CMS indicates that it plans to modify existing programs, such as the Bundled Payments for Care Improvement initiative, so they meet the advanced APM requirements. It also plans to develop a new Medicare Shared Savings Program accountable care organization (ACO) Track 1 + that requires less downside risk than current Track 2 and Track 3 ACOs, but sufficient risk to meet the advanced APM standards.
- By Jan. 1, 2017 CMS will post an initial list of advanced APMs.