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MACRA Quality Payment Program Final Rule provides a more definitive path for transformed Medicare payments

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On October 14, 2016, the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) issued a final rule on the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Quality Payment Program (the "Final Rule"). The Final Rule intends to simplify quality reporting requirements for clinicians, including physicians, physician assistants, nurse practitioners, clinical nurse specialists and certified registered nurse anesthetists, as well as to incentivize participation in alternative payment models (APMs). Attempting to heed calls for simplicity and flexibility, CMS made certain changes to the April 2016 proposed rule. CMS anticipates that the Final Rule's Quality Payment Program will eventually transform Medicare reimbursement for over 600,000 clinicians.

As previously reported (http://www.nixonpeabody.com/CMS-releases-MACRA-proposed-rule), MACRA repealed the Sustainable Growth Rate formula and created two quality-based programs: the Merit-Based Incentive Payment System (MIPS) and the Advanced APMs. MIPS incentivizes clinicians by measuring performance in four categories: quality, resource use, clinical practice improvement activities and meaningful use of certified electronic health records (EHR) technology. MACRA also provides that clinicians participating in certain Center for Medicare and Medicaid Innovation payment models, certain Medicare Shared Savings Programs (MSSP) or other federal demonstration projects qualify for incentive payments under the Advanced APM structure.

MIPS

The Final Rule modifies MIPS by allowing clinicians to choose between four options for 2017 data reporting:

- Declining to participate, which would mean a negative four percent payment adjustment;
- Submitting a minimum amount of 2017 data (for example, addressing one quality measure or one improvement activity), which will result in no payment adjustment, positive or negative;
- Submitting data covering 90 days in 2017, which will result in either no payment

adjustment or a small positive payment adjustment; or

- Submitting data for the entire 2017 year, which will provide the opportunity to earn a moderate positive payment adjustment.

For the third and fourth options, payment adjustment amounts vary based on a clinician's quality results.

Advanced APMs

For the 2017 and 2018 reporting years, clinicians who receive at least 25 percent of their Medicare payments through an Advanced APM, or who see at least 20 percent of their Medicare patients through an Advanced APM, can earn a five percent Medicare payment increase in 2019 and 2020, respectively. CMS states that it will publish a final list of Advanced APMs for the 2017 performance year prior to January 1, 2017.

CMS has expressed its goal of increasing opportunities to join Advanced APMs. Responding to criticism on the limited Advanced APMs available to clinicians, CMS indicated that it is considering expansion of the care models that are deemed to be Advanced APMs, including a new accountable care organization Track 1+ model. At this time, CMS has identified the following Advanced APMs for 2017: CPC Plus, MSSP Tracks 2 and 3, Next Generation ACO and the Comprehensive End Stage Renal Dialysis Care Model with two-sided risk. CMS has indicated that it will publish a final list of Advanced APMs before January 1, 2017. It also may "reopen" certain existing APMs to allow more clinicians to apply to join these arrangements. CMS anticipates that about 25 percent of eligible clinicians will participate in the Quality Payment Program through the APM track in 2018.

In response to many comments received regarding MACRA's impact on small medical practices, the Final Rule attempts to address the challenges facing small practices in several ways. First, it increases the low-volume threshold under which a clinician or a group is exempt from complying with the regulations. Clinicians or groups with less than or equal to $30,000 in Medicare Part B allowed charges (increased from $10,000 in the proposed rule) or that provide care for 100 or fewer unique Part B-enrolled Medicare patients per year are exempt from complying with the requirements of the Final Rule. This is less burdensome than what CMS originally proposed, which required clinicians and groups to meet *both* the dollar value of Medicare billing charges *and* the number of Medicare Part B beneficiaries cared for during a performance period. CMS stated that it intends to provide clinicians a National Provider Identifier level lookup feature before or soon after the start of the performance period for clinicians to determine whether they fall under the low-volume threshold and therefore are excluded from complying with MIPS. Further, clinicians who are new Medicare enrollees in 2017 also are exempt from reporting for calendar year 2017. CMS also indicated that it will continue to pursue the option for solo clinicians and small practices to join together in "virtual groups" to submit combined data for MIPS reporting. CMS intends to publish further guidance on the requirements for these "virtual groups."

The commentary to the Final Rule also references $20 million in annual MACRA funding for the next five years to provide MIPS-eligible clinicians in practices of 15 clinicians or less and those providing services in rural or underserved areas with technical assistance and training to comply with the requirements of the Final Rule. This funding also will be available to practices with low MIPS final scores or those transitioning from MIPS to APM.

Although the Final Rule takes effect on January 1, 2017, clinicians are not required to submit calendar year 2017 data to CMS until March 31, 2018. Clinicians may begin collecting data anytime

between January 1, 2017, and October 2, 2017. Data collected in 2017 will be analyzed for payment adjustments that take effect on January 1, 2019.

In conjunction with the Final Rule, CMS also announced a Quality Payment Program website (http://qpp.cms.gov) to help clinicians and other stakeholders better understand the regulations.

CMS indicated that it welcomes feedback and will accept comments until 60 days following the release of the Final Rule.

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