

November 28, 2016

MACRA Final Rule and Post-Election Questions

The Medicare Access and CHIP Reauthorization Act of 2015 (**MACRA**) and the October 14, 2016 [final rule](#) from the Centers for Medicare & Medicaid Services (**CMS**) that implemented it (the **Rule**) brought a clear end to the plagued Medicare Sustainable Growth Rate methodology that brought uncertainty each year as to the next year's Physician Fee Schedule. MACRA did away with the threat of catastrophic fee schedule cuts and fundamentally shifted how Medicare will pay physicians and other clinicians in the future, incorporating quality measurement and reporting into payments, and encouraging participation in value-based payment arrangements.

Of concern, however, is that even if the new administration and Congress do not make any modifications to MACRA, curtailment of the value-based programs and projects that are a key feature of the Affordable Care Act (the **ACA**) could result in the inability of physicians to participate in programs that would qualify them under MACRA for full fee schedule increases, and MACRA, in turn, would lose at least some of its ability to incentivize clinicians to transition away from fee-for-service payment.

This alert summarizes CMS's final rule implementing MACRA, and offers considerations on what implications the election results bring.

Overview

Building on CMS's proposed rule issued in April 2016 (the **Proposed Rule**) and effectuating the ambitious goals of MACRA, the Rule establishes the parameters of the "Quality Payment Program," that consist of two payment tracks: the Merit-based Incentive Payment System (**MIPS**), based primarily on data tracking and reporting, and the Advanced Alternate Payment Models (**APMs**), based on participation in certain CMS-administered value-based payment programs or federal demonstration projects. Compared to the Proposed Rule, the Rule reflects CMS's recognition that the Quality Payment Program will represent a shift for many clinicians, especially solo and small practices, with greater focus on reimbursement based on quality reporting and patient outcomes. For this reason, the Rule treats the first performance reporting period, calendar year (**CY**) 2017, as a "transition year," which will allow for a gradual transition for clinicians into the Quality Payment Program. Clinicians must begin to submit certain, limited performance data to CMS in CY 2017, with reimbursement adjustments reflecting the CY 2017 data taking effect in CY 2019.

Clinicians Subject to MACRA

The Quality Payment Program applies to physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists—all whether in solo practice or in groups. However, clinicians and groups with annual Medicare Part B allowed charges below \$30,000, or providing care for 100 or fewer Part B-enrolled Medicare beneficiaries, are excluded from participation in the Quality Payment Program.

Clinicians subject to MACRA may report data to CMS on an individual or group basis. Clinicians reporting on an individual basis (defined as a single National Provider Identifier (**NPI**) tied to a single Tax Identification Number (**TIN**)) will get a payment adjustment on the basis of their individual performance. Clinicians reporting on a group basis (with multiple NPIs sharing a common TIN) will get one payment adjustment based on the group's performance. Clinicians wishing to register as a group for CY 2017 must do so no later than June 30, 2017.

Possibly anticipating alignment of individual or small groups of clinicians by contract in response to other value-based health care initiatives (such as the Bundled Payments for Care Improvement Initiative and the Comprehensive Care for Joint Replacement Model), CMS contemplates the formation of “virtual groups” composed of individual clinicians and small groups (not to exceed ten individual MIPS-eligible clinicians) for reporting and payment adjustment purposes. Unlike clinicians reporting on an actual group basis, virtual groups would not be required to share a single TIN.

MIPS

MIPS replaces components of three existing Medicare programs: the Physician Quality Reporting System, the Physician Value-based Payment Modifier, and the Medicare Electronic Health Record Incentive Program for Eligible Professionals (commonly known as Meaningful Use). In place of these programs, MACRA establishes four performance categories under the single reporting framework of MIPS. The four categories are: Quality (evidence-based, specialty-specific standards); Improvement Activities (practice-based standards); Advancing Care Information (measuring the use of certified electronic health record technology (**CEHRT**)); and Cost.

For CY 2017, MIPS-participating clinicians who wish to be eligible to receive the maximum positive payment adjustment in CY 2019 (set at 4%) must report, at a minimum, the following data:

- **Quality** – Clinicians must report at least six quality measures or one specialty-specific or subspecialty-specific quality measure set. CMS has identified hundreds of quality measures (*e.g.*, percentage of patients aged 18 years and older who required an anastomotic leak intervention following gastric bypass or colectomy surgery, percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period, and percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period) and anticipates updating the quality measures on an annual basis.
- **Improvement Activities** – Clinicians must engage in at least four improvement activities. CMS has identified nearly 100 improvement activities (*e.g.*, seeing new and follow-up Medicaid patients in a timely manner, participation in the Consumer Assessment of Healthcare Providers and Systems Survey or other supplemental questionnaire items, and annual registration by the eligible clinician or group in the prescription drug monitoring program of the state where they practice) and anticipates updating the improvement activities from time to time.
- **Advancing Care Information** – Clinician must report five required measures: security risk analysis; e-prescribing; providing patient access; sending summary of care; and requesting/accepting summary of care.
- **Cost** – Clinicians will automatically report the required cost information by submitting claims for adjudication, as such information will be derived by CMS without clinician involvement. Cost will begin to be factored into provider payment adjustments during the CY 2018 reporting period.

Furthermore, because CY 2017 is a transition year, CMS has provided three options within MIPS to mitigate the potential for a negative payment adjustment in CY 2019:

- **Option One** – Clinicians that report the full required data set forth above for at least a 90-day consecutive period during CY 2017.
- **Option Two** – Clinicians that report more than one Quality measure, more than one Improvement Activity or the five required Advancing Care Information measures for at least a 90-day consecutive period during CY 2017.

- **Option Three** – Clinicians that report one Quality measure, one Improvement Activity, or the five required Advancing Care Measures for any period of time during CY 2017.

Clinicians that fail to report even one measure or activity in CY 2017 will receive the full negative 4% payment adjustment in CY 2019.

Advanced APM Participation

As noted above, clinicians that otherwise would be eligible for MIPS can elect to participate in an Advanced APM instead. APMs include Center for Medicare and Medicaid Innovation (the **CMMI**) models, Shared Savings Program tracks or certain other federal demonstration projects. For an APM to be an Advanced APM it must also (1) require participants to use CEHRT; (2) provide payment for covered professional services based on quality measures comparable to those in the Quality category under MIPS; and (3) require that participating APM entities bear risk for monetary losses of more than a nominal amount (or be a Medical Home Model).

While CMS has not yet determined the specific qualifying Advanced APMs for CY 2017, it anticipates that at least the following models will qualify: Comprehensive End Stage Renal Disease Care Model (two-sided risk), Comprehensive Primary Care Plus (CPC+), Next Generation (**Next Gen**) ACOs, and Medicare Shared Savings Program (**MSSP**) Tracks 2 & 3.

Clinicians who are qualified Advanced APM participants (**QPs**) during the CY 2017 reporting period will receive a 5% incentive payment during the CY 2019 payment period, which is 1% higher than the maximum *possible* payment adjustment of 4% under MIPS. However, in order for clinicians to become QPs, and, thus, not be required to participate in and report under MIPS, the clinicians must either (1) receive at least 25% of their Medicare Part B covered professional service payments through an Advanced APM, or (2) receive at least 20% of their Medicare Part B patients through an Advanced APM. Clinicians should be aware that these thresholds will increase to 50% and 35% respectively for the CY 2019 reporting period; however, beginning in the CY 2019 performance reporting period, CMS leaves open the possibility that clinicians may satisfy these patient threshold requirements for Advanced APMs by also serving non-Medicare patients through a qualifying model.

Continued Evolution

CMS recognizes that the implementation of MACRA will be an iterative process that will continue to be shaped by stakeholder input. CMS has launched a new website, qpp.cms.gov, to educate clinicians about the Quality Payment Program and welcomes additional feedback from all health care stakeholders. Despite the Rule being issued in final form, CMS will continue to accept public comments on the Rule until December 19, 2016.

Impact of the Election on MACRA

With the election of Donald Trump and with Republican control of both houses of Congress, the Rule's stability, as with other programs implementing health care reform, has been cast into question. Although there are reasons to expect that MACRA itself will not undergo significant revisions—unlike the ACA, MACRA was a bipartisan piece of legislation that was supported by 91% of Congress—any repeal of the ACA or retrenchment from administrative rulemaking could have a significant impact for clinicians looking to take part in Advanced APMs.

Specifically, one possible change may involve the CMMI and MSSP ACOs, which, as indicated above, were both established under the ACA. The CMMI is a testing center for innovative payment and service deliver models aimed at reducing Medicare and Medicaid expenditures while enhancing quality of care. The ACA gave CMS fairly broad authority to expand the scope and duration of a payment model being tested. Some of these CMMI models will qualify as Advanced APMs under the Rule, including Next Gen ACOs. In fact, all Advanced APMs cited in the Rule were initiated through the CMMI or established by the ACA. Through a repeal and replacement of the ACA, Congress may opt to assert more control over new payment models and either limit CMMI's authority or do away

with it all together. In fact, by way of a recent letter dated September 29, 2016, 179 members of Congress criticized many of the mandatory CMMI demonstration projects, and these concerns may carry over into future legislative initiatives. Any resulting statutory change to CMMI would thus reduce the number of Advanced APMs open for clinician participation and warrant further changes to the Rule—even if a larger transition from a fee-for-service system to a value-based payment system enjoys broad support on both sides of the aisle.

Ropes & Gray will continue to monitor regulatory developments in this area. If you have any questions, please contact any member of Ropes & Gray's [health care](#) practice or your usual Ropes & Gray advisor.