CARLTON FIELDS

MACRA: Top 10 FAQs

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Significant changes to the Medicare payment system are underway. *The Medicare Access & CHIP Reauthorization Act of 2015* (MACRA) is set to take effect January 1, 2017. MACRA represents a deliberate departure by the Centers for Medicare and Medicaid Services (CMS) from the traditional, volume-based, fee-for-service business model. By way of MACRA, CMS demands providers assume greater risk for outcomes and rewards high quality and efficient care, rather than volume. Although the final rule is set to be unveiled next month, CMS recently announced that providers will have the flexibility to choose their pace for the first performance year (beginning January 1, 2017). As providers contemplate which pace is best, this article answers 10 frequently asked questions on the topic. **1. What is MACRA?** MACRA repealed and replaced the Sustainable Growth Rate (SGR) formula with a new method for controlling Medicare costs. Whereas the SGR set payment rates through a formula based on economic growth, MACRA links Medicare reimbursement to quality metrics, rewarding providers for value-based, quality care. **2. What is the reimbursement model under MACRA?** Under MACRA, eligible providers can choose to be paid on a fee-for-service basis with pay-for-performance incentives and penalties via the Merit-Based Incentive Payment System (MIPS), or receive a financial incentive for participation in an Advanced Payment Model (APM). These two options form the framework for MACRA's value-based reimbursement plan, the Quality Payment Program (QPP). Medicare payments will vary among providers, with some potentially receiving 27 percent more than others based on higher performance. So, providers will want to contemplate their selection of a path carefully. **3. Who is affected by MACRA?** Beginning in 2017, MACRA will apply to Medicare Part B physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and their associated groups. CMS anticipates expanding MIPS in the future to include other clinicians such as physical or occupational therapists, speech-language pathologists, audiologists, nurse midwives, clinical social workers, clinical psychologists, dieticians, and nutritional professionals. MACRA will also affect the provider and hospital partners with whom eligible providers do business. Hospitals should consider whether they will support employed physicians in meeting advanced APM and MIPS requirements and whether they will provide a compatible infrastructure for affiliated physicians. **4. What is the difference between MIPS and APMs?** MIPS is the consolidation of three existing CMS programs: the Physician Quality Reporting System (PQRS), the Physician Value-Based Payment Modifier (VM) and the Medicare Electronic Health Record (EHR) Incentive Program. Providers selecting the MIPS track will report data across four performance categories and will receive a composite score from 1-100. Medicare

payments will then be negatively or positively adjusted based on composite scores. Clinicians choosing to participate in APMs are exempt from MIPS payment adjustments and instead qualify for a 5 percent Medicare Part B incentive payment. However, only two-sided risk programs qualify as APMs and clinicians must receive enough of their payments or see enough of their patients through Advanced APMs to meet the APM exception. The list of approved APMs currently includes:

- Comprehensive End-Stage Renal Disease Care;
- Comprehensive Primary Care Plus;
- Medicare Shared Savings Program Tracks 2 and 3;
- Next Generation ACO; and,
- Oncology Care Model with two-sided risk, (available in 2018).

CMS will update the list of qualifying APMs annually to add new payment models, and beginning in 2019, clinicians may qualify for incentive payments based on participation in APMs developed by non-Medicare payers. **5. What kind of reporting does MACRA require?** The first year, all providers participating in MIPS and APMs must report either individually or as a group. Providers may report via qualified registries, health IT vendors or CMS-approved survey vendors on the following four performance categories:

1. Quality (**50 percent of total score in Year 1**)
2. Resource Use (**10 percent of total score in Year 1**)
3. Clinical Practice Improvement Activities (**15 percent of total score in Year 1**)
4. Advancing Care Information / Meaningful Use of Certified EHR Technology (**25 percent of total score in Year 1**)

In an effort to enhance transparency and engage beneficiaries, CMS will make QPP results available to the public on the Physician Compare website. **6. Do reporting requirements account for differences between specialties?** Providers may choose their own reporting measures across all four performance areas from CMS options that accommodate unique specialty and practice considerations. **7. How will providers be paid?** MIPS composite performance scores will result in positive, negative, or neutral adjustments to Medicare Part B payments. In the first year, there will be no negative adjustments under MIPS. Thereafter, the maximum MIPS payment adjustment will increase until 2022, when it will level off at 9 percent. An additional bonus, up to 10 percent higher than the respective positive payment, is also permitted for exceptionally high performers in the first five years of the MIPS program. APM participating providers are eligible to receive a lump-sum incentive payment of 5 percent of Medicare revenue per year and will not face additional downside risk within the QPP. **8. When do I have to be ready for this change?** MACRA will take effect January 1,

2017 with the first performance period lasting from January 1, 2017 through December 31, 2017. Payments based on the 2017 performance year will be made in 2019. Beginning January 1, 2017, providers have four participation options from which to choose to ensure no negative payment adjustment in 2019:

1. **Test the Quality Payment Program:** As long as a provider submits "some data" to the quality payment program, he/she will avoid a negative payment adjustment;
2. **Participate in Part of the Calendar Year:** Providers can begin participation later than January 1, 2017 and the practice can still qualify for a small, positive payment adjustment;
3. **Participate for the Full Calendar Year:** Those participating for the full calendar year (beginning January 1, 2017), will qualify for a modest, positive payment adjustment; and,
4. **Participate in an Advanced Alternative Payment Model** (as of January 1, 2017), those who participate in an APM will quality for up to a 5 percent incentive payment in 2019.

9. Is there any option for providers to continue on a fee for service model? Medicare Part B clinicians will be exempt from the payment adjustment under MIPS if they (1) are newly enrolled in Medicare; (2) have less than or equal to $10,000 in Medicare charges and less than or equal to 100 Medicare patients; or, (3) are significantly participating in an APM. Medicare Part B clinicians who choose not to participate in MIPS and APMs may continue to see Medicare patients. They will receive Medicare fee-for-service based payments for treating their patients, and will experience a reduction in Medicare payments two years later. These payments will be reduced by the amount of the maximum MIPS penalty. In 2019, the maximum penalty will be 4 percent. It will increase to 9 percent in 2021. **10. How do I prepare?** Start now. Familiarize yourself with the legislation and pick your pace for January 1, 2017. As you choose which criteria your practice will report, consider implementing clinical practice improvement activities, ensuring adequate use of electronic health records, tracking internal costs and implementing quality improvement initiatives. If you have additional questions about how MACRA will affect you and your practice, you should contact a qualified health care attorney or your billing provider.

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