



## **MACRA and You**

### **What is MACRA, and what does it mean for rural providers and patients?**

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) attempts to realign physician payments under Medicare from volume to value. MACRA offers providers that participate in Medicare Part B two options to demonstrate value: the Merit-based Incentive Payment System (MIPS) or Advanced Alternative Payment Models (AAPMs). MIPS is a new program that streamlines the existing Physician Quality Reporting System (PQRS), Value Modifier (VM) and Meaningful Use (MU) with new clinical practice improvement measures into a single composite score. Based upon that score, clinicians can receive positive or negative adjustments to their payments through the physician fee schedule. AAPMs, new payment systems that shift to value and/or quality from the volume-based fee for service system, encompass very few alternative payment models because of the strict requirements set out in law and regulations.

There is no longer a need for a so-called “doc fix” where Congress had to find a way each year to stop an ever-increasing reduction to Physician Fee Schedule (PFS) payments to eligible practitioners. There were 17 temporary doc fixes between 1997 and 2015 that delayed implementation of the sustainable growth rate (SGR). MACRA is the permanent doc fix legislation passed on April 16, 2015. The SGR was an ill-conceived and ultimately ill-fated attempt by Congress to keep the rising cost of health care down by capping how Medicare pays physicians.

MIPS will require all clinicians receiving payment under the physician fee schedule (Medicare Part B) to participate in quality reporting, clinical practice improvement activities, use of electronic medical records, and consider resource use. There are some exemptions from MIPS participation that are described below. Keep in mind that these exemptions are retrospective only after quality reporting is performed in real time. In short, the exemption is from the potential consequences of reporting, not from the reporting itself.

### **Who must participate in MACRA?**

In short, clinicians, which initially include physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse anesthetists that receive payments through the Medicare Physician Fee Schedule, unless otherwise exempted must participate. This includes physicians practicing at a Critical Access Hospital (CAH) billing under Method I or if an eligible clinician has assigned their Medicare Part B billing to a CAH through Method II regulations.

Here is a list of important exemptions that may impact certain rural providers:

- (1) First year participating in Part B,

(2) Medicare PFS Part B charges less than or equal to \$30,000 **or** provides care for 100 or fewer Medicare patients in one year. For providers at a CAH, only, the portion of the charges paid under the Medicare physician fee schedule counts toward the \$30,000 threshold, not the facility payment to the CAH.

(3) Participants in a Qualified Advanced Alternative Payment Model (APM) – more details on what this means below.

#### Rural Health Clinics and Federally Qualified Health Centers:

Clinicians practicing at a Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) are exempted from reporting data to the Quality Payment Program (QPP) and from any payment adjustments that might result. Claims from RHCs or FQHCs billed under the Medicare Physician Fee Schedule are subject to the QPP and any payment adjustments that would be appropriate based on the data reported. For example, claims for rounding on patients in hospital or procedures performed at a hospital or other outpatient facility.

MACRA provisions call for RHC and FQHC claims submitted to Medicare Part A to be able to report QPP data voluntarily, and there will be no payment adjustments for claims submitted under these provisions. Again, any service at a RHC or FQHC paid through the Medicare Physician Fee Schedule is subject to QPP reporting and possible payment adjustments related thereto. If these Physician Fee Schedule charges are more than \$30,000 and these services are provided to more than 100 Medicare patients, the provider will be required to participate for care involving those payments. Unfortunately, you will only know retrospectively if the volume thresholds will apply for a particular reporting year.

Everyone should plan to participate.

Finally, it must be noted that the non-RHC/FQHC providers that are exempt are not relieved of their need to report. The first-year exemption is designed to provide an on ramp for new providers to understand where they fall and give them some opportunity to make improvement. For the other exemptions, they are not determined until the end of the reporting year, meaning a provider will not know for sure they are exempt until after the reporting period is over. In that case, mistakenly believing you are exempt would result in a MIPS score of zero and the resulting negative payment adjustment.

#### **What is MIPS?**

The Merit-based Incentive Payment System is a new program that combines the existing Physician Quality Reporting System (PQRS), Value Modifier (VM) and Meaningful Use (MU) with new clinical practice improvement measures. MIPS is intended to be a streamlining of these existing programs into a single composite score based on:

60%<sup>1</sup> Quality (replacing PQRS) – A choice of six measures from a range of options (options are designed to cover a variety of specialties and practice types).

0%<sup>2</sup> Resource Use (replacing VM) – This uses claims data and doesn't require additional reporting.

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<sup>1</sup> Percentages are for the first year.

<sup>2</sup> This information will be reported to providers, but will not be a part of the score initially.

25% Advanced Care Information (replacing EHR MU) – This is not all or nothing like Meaningful Use and will instead be based on reporting based on measurement options with a focus on interoperability and information exchange.

15% clinical practice improvement – There are 90 options. Of these 90 options, rural providers must attest to two (instead of the generally required three) high-rated practice improvements. Accredited Patient Centered Medical Homes (PCMH) automatically received full credit in this category. Rural practices participating in APMs automatically receive half of the required credit and are only required to attest to one high-value practice improvement.

Based upon the resulting composite score (for all four components of MIPS), future payments will be either positively or negatively adjusted based on how your score compares to other providers. Reporting can be done individually or as part of a group. The legislation included the ability for providers in small or rural practices to form virtual groups. However, CMS has not developed this option yet. The MIPS program is required to be cost neutral; any money provided to high-value providers must come from reducing payments to low-value providers. The potential payment adjustments will increase each year, +/- 4% for 2019, +/- 5% for 2020, +/-7% for 2021, until they stabilize at +/- 9% for 2022 and beyond. Payment adjustments will be based on performance two years prior to the adjustment, so 2018 reporting will impact 2020 payments.

Though many rural providers were not necessarily a part of PQRS, VM, and MU; many of the penalties for these programs were set to go into effect and had potentially larger cumulative penalties at stake.

### **Are you ready for MIPS?**

For 2017, CMS has provided options for providers, offering the opportunity to test out the program before being subject to payment adjustments. It should be noted that any payment adjustments based on 2017 data will be applied to 2019 payments.

- **First Option: Test the Quality Payment Program**
  - To avoid negative payment adjustment, this only requires you submit some data to the program from after Jan. 1. This allows you to ensure your (and their) system is working and give you an idea where you are.
- **Second Option: Partial participation**
  - This gives you the chance to receive a small positive payment adjustment (up to 4% for 2019 Part B payments) for submitting some MIPS data (more than one measure) from the list of quality measures and improvement activities for at least a continuous 90-day performance period beginning after Jan. 1.
- **Third Option: Participate for the full calendar year**
  - This gives you the chance to receive a modest positive payment adjustment (up to 4% for 2019 Part B payments) for submitting all MIPS data from the list of quality measures and improvement activities for at least a 90-day continuous performance period beginning Jan. 1.

- **Fourth Option: Participate in an Advanced Alternative Payment Model in 2017**
  - As is always an option, you may participate in an advanced alternative payment model (which requires two-sided risk) such as the Medicare Shared Savings track 2 or 3. This also includes a 5% positive adjustment to Part B payments (a bonus that was included in the MACRA legislation).

Regardless of which of these options you choose, the more you report, the better you will understand your current performance, both cost and quality, and potential areas for future improvement. With this information, you can make changes to improve your future score and chance for positive payment adjustments.

### **What opportunities are there for assistance for small rural practices?**

Congress provided \$20 million a year for technical assistance to practices with 15 or fewer eligible clinicians participating in MIPS. This technical assistance is intended to assist small practices in succeeding within the new MIPS system, a particular concern since many rural practices have not participated in the precursor programs such as PQRS and VM. Rural practices, especially those in health professional shortage areas (HPSAs) and medically underserved areas, are to be given priority in receiving the technical assistance.

Additionally, for those not receiving technical assistance, the [Transforming Clinical Practice Initiative \(TCPI\)](#), launched in September 2015, was created to assist practices in transitioning to alternative payment models. Practice Transformation Networks (PTNs) are available across the country to provide coaching, resources and tools to help practices prepare for value-based payment models.

### **What are Advanced Alternative Payment Models (AAPMs)?**

The idea of alternative payment models (APMs), new payment systems that shift to value and/or quality from the volume-based fee for service system, is nothing new. Advanced alternative payment models (AAPMs) are simply APMs that meet the extensive requirements set out in MACRA law and regulations. Not all APMs qualify under MACRA as AAPMs. In fact, only a very limited number of APMs meet the criteria set out in law and regulations. To be considered as an advanced alternative payment model, the APM must be under Medicare demonstration authority, CMMI, Medicare shared savings program or demonstrations required by law. Additionally, the APM must require the use of a certified EHR, utilize quality measurements comparable to MIPS, and require risk taking “above a nominal amount.” CMS has interpreted the requirement of taking risk above a nominal amount to require taking on two-sided risk (meaning you could both gain or lose money depending on performance). Those participating in AAPMs qualify for the 5% advanced APM bonus under MACRA. Currently, only six APMs qualify:

- Comprehensive Primary Care Plus (CPC+)
- Medicare Shared Saving Track 2
- Medicare Shared Saving Track 3
- Next Generation ACO Model
- Oncology Care Model two-sided risk arrangement
- Comprehensive ESRD Care LDO Arrangement

Participation in an advanced APM must make up 25% of Medicare revenues in 2019-20, then in 2021-22 50% of Medicare revenues (or 50% all payer revenue with at least 25% of Medicare revenues), and from 2023 and beyond, 75% of Medicare revenues (or 75% all payer revenue with at least 25% of Medicare revenues). Additionally, though you cannot get the 5% bonus, you can choose to participate in MIPS (and be eligible for positive or negative payment adjustments), or you can opt out of MIPS and receive no payment adjustments.

### **What is the National Rural Health Association doing to help me?**

NRHA has been participating in the process since the inception of MACRA to ensure rural practices were considered, working with lawmakers and regulators to vigorously advocate for rural providers. We will continue to provide information about the law and its implementation moving forward to assist rural providers in understanding the way quality and value are measured under MIPS. NRHA will continue to provide additional guidance and advocacy opportunities through webinars and other educational opportunities.

NRHA continues to advocate for:

- A rural cohort for comparison, or alternatively comparison of similarly sized practices
- Rural-specific measures and methodologies
- Consideration of sociodemographic risk to ensure rural providers are not penalized for providing excellent care to a vulnerable population that is known to be older, sicker and poorer than urban counterparts
- Minimizing reporting requirements and providing timely feedback