MACRA Update

Like it or not, MACRA is the law, and the final implementation rule for the Quality Payment Program (all 2398 pages of it) is in place. **The program starts on January 01, 2017, and the results will impact reimbursement for Medicare beginning in 2019.** It hasn't been delayed; it essentially hasn't been changed; **the only reprieve is a fourth pathway that is referred to as "Test" status, and it only applies for the first performance year, which is 2017.**

If you choose to **do nothing in 2017**, there will be an **automatic 4% reduction** in Medicare reimbursement applied to all services supplied and billed to CMS in 2019.

The only **exceptions** are **1) if 2017 is your first year of participation in Medicare** or **2) if you supply services to fewer than 100 Medicare beneficiaries, or the total billed services are less than $30,000.**

If you do not qualify for an exception, you have 2 categories of participation to choose from.

The first category is participation in an Advanced Alternative Payment Model (AAPM); an Alternative Payment Model (APM) is an arrangement that involves a potential for shared savings as well as shared losses; an AAPM is advanced because the potential for loss is "more than nominal"…which is probably going to be about 15% of the total of Medicare Part A and Part B revenue. The exact status of Certified PCMHs is not clear, but they will probably be accorded some consideration; an "expanded" PCMH is considered an AAPM…but none of the PCMHs meet the criteria as expanded yet. There are no AAPMs available in our area at this time.

The second category is participation in the Merit-based Incentive Payment System (MIPS), and this is where most of us are going to fall. MIPS combines the Physician Quality Reporting System (PQRS), Meaningful Use (MU), and Value Based Payment Modifier (VBPM or VBM), **and adds a new measurement area, Clinical Practice Improvement Activities (CPIA**) to produce an overall score that will be used as a surrogate marker for "Value". **The four components of MIPS are now: Quality, Advancing Care Information (ACI), Clinical Practice Improvement Activities (CPIAs), and Resource Use/ Cost**. All Eligible Clinicians (ECs) will be given a score in each measurement area. For 2017, the Resource Use/Cost will not be counted, but scores will be computed and available for review; it will be phased in starting in 2018, and eventually will represent 30% of the composite MIPS score. **So for 2017, Quality will count fort 60% of the MIPS composite, CPIAs 15%, and ACI 25%.** Within each area, individual measures, activities, or components will be awarded points, and the points multiplied by the weight of the area will give the area score, and the area scores will be added to arrive at the MIPS composite score. **The achievable range is 0-100, although there will be an opportunity for "bonuses" in some areas, so in a perfect world, you may achieve a score over 100, but that is really unlikely.**

There are **271 Quality Measures to choose from**; there are **93 CPIAs to choose from**; and there are **5 core measures in ACI that must be reported**, and a couple of optional measures.

Within MIPS, there are now 3 pathways: **"Test", "Partial Year", and "Full Year":**

	Quality Measures		CPIAs		ACI	TIME
Test	**1**	**OR**	**1**	**OR**	**5**	**Any ?**
Partial	**>1**	**OR**	**>1**	**OR**	**>5**	**1 quarter**
Full	**6**	**AND**	**4**	**AND**	**5**	**4 quarters**

If you do nothing, you get an automatic -4% adjustment to 2019 payments for all of your Medicare billings. If you participate at "Test" level, you get a zero adjustment; "Partial", you get a zero downward and possibly a minimal upward adjustment (+2%); "Full", you get no downward, and possibly a substantial upward adjustment (+4%). Out of that 100 points, "Test" will get you 3; if you report "Full", and score 70 or greater points, you will get additional upward adjustment as an "Exceptional" provider. Bear in mind that **this program by law is "budget neutral", which means that any upward adjustments to any providers must be paid for out of downward adjustments to other providers.** There is a separate funding source set aside by CMS for the "Exceptional" category**. The system is designed to be competitive**, and as time passes, the competition will stiffen. Also, **the adjustment increases from +/-4% in 2019 to +/-9% by 2022.**

Reporting the data to CMS can be done using a number of mechanisms that include claims (like we do for PQRS), EHR reporting, use of a Qualified Clinical Data Registry or other Qualified Registry (these are offered by your Medical Specialty Organizations or other IT organizations), Administrative Claims (these are done by CMS), and in some cases Attestation directly to CMS. Ideally, you would do it through your EHR vendor in all categories. The exception will be when the Resource Utilization/Cost area is phased in in 2018, CMS will calculate that.

Practically speaking, to avoid the automatic -4% reduction for doing nothing, you can pick one Quality Measure and report it by claims using the PQRS suffixes for 3 consecutive months. You'll need to report for at least 80% of the patients who qualify for that measure during the reporting time. If you want a shot at a possible +2% adjustment, report 2 Quality Measures using the claims suffixes…but you'll need to perform well on both of them. If you want to get brave, add a CPIA or report the 5 core ACI measures…but you can't report either CPIA or ACI by claims suffix; you'll need to use one of the other mechanisms, ideally your EHR…and you'll have to start by October of 2017 to get a full 90 days reporting in. If you really want to impress Big Brother, do 6 Quality Measures, 4 CPIAs, and the 5 core ACI measures…but you'll have to start with January 01 to get in all 4 quarters.