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CMS Issues Proposed Rule to Implement MACRA

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The Centers for Medicare and Medicaid Services ("CMS") recently issued a final rule establishing key guidelines for the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA"). Congress enacted MACRA to replace the inefficient Medicare Sustainable Growth Rate framework because its rate schedules yielded regular fee declines and required frequent legislative adjustments to remedy.

MACRA includes two reforms that change how physicians receive pay. First, MACRA increases physician fees by 0.5 percent per year from 2016 to 2019. Second, MACRA creates the Quality Payment Program, a payment model beginning in January 1, 2019 that emphasizes compensating clinicians based on the *value of care received by patients*, rather than the *volume of services provided by physicians*. The Quality Payment Program includes two paths: 1) the Merit-based Incentive Payment System ("MIPS") and 2) the Advanced Alterative Payment Models ("Advanced APMs"). This article discusses each below.

Merit-based Incentive Payment System

The first pathway, MIPS, determines a physician's pay by considering several performance measures reported to the CMS. Specifically, MIPS compresses the Physician Quality Reporting System ("PQRS"), the Value Modifier ("VM"), and the Medicare Electronic Health Record ("EHR") incentive programs into a single system, evaluates clinicians across four categories, and provides a single score. CMS then uses the score output to determine whether a clinician receives a fee increase, a fee reduction, or no change at all. The MIPS categories include:

1. **Quality** accounts for 50 percent of a clinician's score in the first year. Clinicians choose to report six quality measures, which provides the option to accommodate differences in specialties and practice areas.

2. **Cost** (also called "**Resource Use**") represents 10 percent of a clinician's score in the first year. The score is based on Medicare claims, which means no reporting requirement for clinicians. This category uses more than 40 episode-specific measures to account for differences among specialties.

3. **Clinical Practice Improvement Activities** constitute 15 percent of a clinician's score in the first year. This metric rewards physicians for clinical practice improvement activities, including those focused on care coordination, beneficiary engagement, and patient safety. Clinicians may select activities that match their practice goals from a list of more than 90 options.

4. **Advancing Care Information** (also known as "**Meaningful Use**") constitutes 25 percent of a clinician's score in the first year. Clinicians report customizable measures that reflect how they use EHR technology in their day-to-day practices, particularly emphasizing interoperability and information exchange. Unlike the existing EHR program, this model does not require all-or-nothing EHR measurement or quarterly reporting.

As mentioned above, a physician's output score determines whether he or she receives a fee increase, a fee reduction, or no change at all. Using 2017 metrics as a performance baseline, MIPS establishes maximum fee increases and reductions of 4 percent in 2019, 5 percent in 2020, 7 percent in 2021, and 9 percent in 2022 and beyond. Importantly, clinicians should note that MIPS is revenue-neutral, which means that when one clinician receives more in fees, another clinician must receive less.

Advanced Alternative Payment Model ("Advanced APM")

The second pathway, Advanced APM, provides an opportunity for eligible clinicians to earn incentives for providing high-quality, efficient, and coordinated care. To qualify as an Advanced APM, a provider must: (1) use certified electronic health record technology; (2) pay clinicians based on measures of quality comparable to those used for MIPS; and (3) adopt a Medicaid Medical Home Model or bear more than a nominal amount of financial risk.

Advanced APMs provide more revenue variability than MIPS because they offer both greater potential financial risk and greater potential financial reward. For example, CMS requires that Advanced APMs link payment to performance for at least 25 percent of a clinician's Medicare revenue in 2019, and increases this to 75 percent in 2022. Additionally, CMS exempts Advanced APM providers from MIPS adjustments and instead gives them a lump sum incentive payment equal to 5 percent of the prior year's estimated aggregate expenditures under the fee schedule. Further, physicians that participate in Advanced APMs will receive an annual across the board fee increase of 0.75 percent in 2026, higher than the 0.25 percent annual increase scheduled for MIPS. Ultimately, because Advanced APMs function to assign more financial risk to clinicians, they incentivize clinicians to find ways to provide health care services more efficiently.

CMS provided a limited list of care models that qualify as Advanced APMs, which are discussed below.

A. Comprehensive End Stage Renal Disease Care Model (Large Dialysis Organization arrangement)

Comprehensive End Stage Renal Disease ("ESRD") Care Models are seamless care organizations in which dialysis clinics, nephrologists, and other providers join to coordinate care for beneficiaries suffering from end-stage renal disease. ESRD seamless care organizations may become Comprehensive ESRD Care Models if they possess at least 350 beneficiaries matched to their organization.

Comprehensive ESRD Care Models are noteworthy because organizations become clinically and financially responsible for all care given to their matched beneficiaries, not just for dialysis care or care that relates to ESRD. Further, if organizations successfully offer high value services that decrease the cost of care for Medicare patients, then the organizations will have the ability to share in such savings with CMS.

Special rules apply, however, for Comprehensive ESRD Care Models that include at least one dialysis facility owned by a Large Dialysis Organization ("LDO"). CMS defines LDOs as chains that have 200 or more dialysis facilities. CMS requires Care Models that include an LDO to share liability with CMS for both savings and losses associated with patients' cost of care. This means that Comprehensive ESRD Care Models with LDOs that increase the cost of care for patients are liable for such losses to the CMS.

B. Comprehensive Primary Care Plus

Comprehensive Primary Care Plus ("CPC+") constitutes an innovative payment structure that seeks to support the delivery of comprehensive primary care. CPC+ offers two "tracks," each with different care delivery requirements and payment structures.

For both Track 1 and Track 2, payers provide prospective monthly care management fees to practices based on beneficiary risk tiers. CMS hopes that the increased and non-visit-based compensation will financially support the staffing and training improvements needed to best serve Medicare patient populations. As seen below, Medicare care management fees average to $15 per-beneficiary per-month across four risk tiers in Track 1 and $28 per-beneficiary per-month across five risk tiers in Track 2.

Risk Tier	Attribution Criteria	Track 1	Track 2
Tier 1	1st quartile HCC	$6	$9
Tier 2	2nd quartile HCC	$8	$11
Tier 3	3rd quartile HCC	$16	$19
Tier 4	4th quartile HCC for Track 1; 75-89 percent HCC for Track 2	$30	$33
Complex (Track 2 only)	Top 10 percent HCC OR Dementia	N/A	$100
Average PBPM		$15	$28

CPC+ provides performance-based incentive payments to practices, which depend on their patient experiences, clinical quality, and utilization measures. At the beginning of a performance year, CPC+ pays $2.50 per-beneficiary per-month for Track 1 and $4.00 per-beneficiary per-month for Track 2. Clinicians should note, however, that CMS will recoup such payments if practices fail to meet performance thresholds.

C. Medicare Shared Savings Program (Tracks 2 and 3)

The Medicare Shared Savings Program seeks to reward accountable care organizations ("ACOs") that lower the growth of their health care costs and meet certain quality performance standards for patient care.

CMS allows an ACO to participate in the Shared Savings Program if it meets several requirements. First, the ACO must have at least 5,000 assigned Medicare Fee-For-Service beneficiaries. Second, the ACO must establish a governing body that represents ACO participants and Medicare beneficiaries. Third, ACOs must engage in routine self-evaluation to ensure they continuously improve the care delivered to Medicare patients.

Two of the three financial Shared Savings Program options require ACOs to share in both Medicare savings and losses and, therefore, qualify as Advanced APMs. ACOs share a maximum of 60 percent of risk under Track 2 and a maximum of 70 percent of risk under Track 3. CMS, however, limits the total amount an ACO may save, capping Track 2's savings at 15 percent of the ACO's updated benchmark and Track 3 at 20 percent of the benchmark.

D. Next Generation ACO Model

Next Generation ACO Models constitute the highest risk Advanced APM and are noteworthy for several reasons.

First, Next Generation ACO Models employ a prospectively set benchmark for how much an ACO should spend, which CMS determines by considering historical information, regional trends, and risk scores for the ACO's population.

Second, Next Generation ACO Models test the ability of ACOs to assume almost all financial risk by providing two risk arrangements that determine the portion of the savings or losses that accrue to the Next Generation ACO. In arrangement A, ACOs have an 80 percent sharing rate for years 1-3 and 85 percent for years 4-5. In arrangement B, ACOs have a 100 percent sharing rate. Both arrangements cap total savings or losses at 15 percent of the benchmark.

Third, Next Generation ACO Models also test the effectiveness of alternative payment mechanisms in facilitating investments in infrastructure and care coordination to improve health outcomes. The Model provides four payment mechanism options:

1. Nominal FFS Payment

Next Generation participants and preferred providers have the option of receiving payment from CMS for services through the normal fee-for-service channels at standard payment levels.

2. Nominal FFS Payment + Monthly Infrastructure Payment

Next Generation participants and preferred providers have the option of receiving the normal fee-for-service payment plus an additional per-beneficiary per-month payment to invest in infrastructure to support ACO activities. CMS will make the infrastructure payment at a rate of no more than $6 per-beneficiary per-month, which CMS then recoups in full during the reconciliation process.

3. Population-Based Payments ("PBPs")

Next Generation participants and preferred providers have the option of receiving "population based payments." PBPs constitute an estimate of the aggregate amount by which fee-for-service payments will be reduced for Medicare Part A and B services rendered by PBP-participating Next Generation participants and preferred providers who agree to receive reduced fee-for-service payments when providing care to aligned beneficiaries during the upcoming performance year.

4. All-Inclusive Population-Based Payments ("AIPBP")

Next Generation participants and preferred providers will have the option to receive All-Inclusive Population-Based Payments in 2017. AIPBPs will be determined by estimating the total annual expenditures for care furnished to beneficiaries by Next Generation participants and preferred providers who have agreed to participate in AIPBP. CMS will pay that projected amount to the ACO in a PBPM payment. An organization participating in an AIBP will be responsible for paying claims for its Next Generation participants and preferred providers with which the ACO has written agreements regarding participation in AIPBP.

Conclusion

Industry experts believe that MACRA's dual pathway structure significantly improves previous law. U.S. Department Health and Human Services Secretary Sylvia M. Burwell, for example, described MACRA as "a milestone in our efforts to advance a health care system that rewards better care, smarter spending, and healthier people." Financial projections reflect this optimism, as government estimates project that in 2019 (the first year in which payment consequences will exist for MIPS performance), CMS will distribute $500 million in "exceptional performance payments" to eligible clinicians and around $200 million in APM incentive payments.

Although MIPS and Advanced APMs each establish innovative systems that change how clinicians receive payment, both expose clinicians to significant risk. There is speculation that the effective dates of these systems will be delayed as there has been substantial commentary about the lack of awareness and understanding on behalf of physicians and the lack of clarity around the quality factors.

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