More on MACRA

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The Medicare Access and CHIP Reauthorization Act (MACRA) passed in April 2015 changing the way Medicare will reimburse physician services beginning in 2019. MACRA accelerates an ongoing movement to value-based payment that has been occurring for over a decade. MACRA establishes a reimbursement methodology through which one of two tracks will be used to compensate physicians under Medicare fee for service (FFS). The first track, which essentially replaces the traditional physician reimbursement methodology, is called the Merit-Based Incentive Payment System (MIPS). The second track of MACRA is designed to encourage physicians to participate in APMs such as accountable care organizations (ACOs), bundled payments, and patient-centered medical homes (PCMHs), as well as additional models to be developed in the coming years. During the first 5 years of the program (through 2024), physicians qualifying for the APM track will also receive a 5% increase in their compensation as an incentive from Medicare to encourage participation. 2017 performance year is the first year and practices should be well on their way of implementing the changes necessary to meet the reporting requirements.

The following table shows the weightings depending on track and patient facing type for 2017.

Category Weightings 2017

	MIPS Patient Facing	MIPS Non-Patient Facing	MIPS Hospital Based	MIPS APM Scoring Standard
Quality	**60%**	**85%**	**85%**	**APM Score**
Cost/Resource Use	**0%**	**0%**	**0%**	**0%**
Clinical Practice Improvement Activities (CPIA)	**15%**	**15%**	**15%**	**15%**
Advancing Care Information (ACI)	**25% - Must use 2014 or 2015 certified EHR technology or a combination of the two to report**	**0%**	**0%**	**APM Average Score Each ACO member practice/provider is responsible for reporting ACI**

Non-Patient-Facing Rules

With the initial passage of MACRA a concern among radiology practices is how MIPS performance metrics effect the unique needs of non-patient-facing clinicians, like radiologists. The Centers for Medicare and Medicaid Services (CMS) created a new definition for non-patient-facing clinicians, addressing several issues with the definition used under the current quality reporting programs.

Eligible clinicians considered "Non-patient-facing": An individual or group that bills 25 or fewer patient-facing encounters during a performance period (one calendar year). CMS established the 25-patient encounter threshold based on an analysis of specific Healthcare Common Procedure Coding System (HCPCS) codes. CMS estimates that 25% of MIPS eligible clinicians will qualify as non-patient-facing.

Patient-facing encounter: An instance in which the MIPS eligible clinician or group billed for services such as general office visits, outpatient visits, and surgical codes under the Physician Fee Schedule (PFS). The proposed list of face-to-face encounter codes is available on the Quality Payment Program website at https://qpp.cms.gov/

At this point in the year your practice should have:

- Determined who is an Eligible Clinician
- Determined which providers in the group are patient facing or non-patient facing
- Determined if practice is patient facing or non -patient facing
- Identified Six Quality Measures
- Determined if additional bonus measures are going to be submitted
- Picked what Improvement Activities your providers or the group will attest to completing
- Identified which track and what categories you are responsible for participating in year 1

On June 20, 2017 CMS released its 2018 proposed rule to implement MACRA's Quality Payment Program (QPP). The agency is accepting comments on the proposal through August 21, and we expect a final rule to be released in the fall. After review of the document you will see that payment and delivery system reform is moving forward and that CMS is offering more flexibility to providers to reduce the regulatory burden especially for smaller practices (those with 15 or fewer providers). The agency is proposing that the exemption for providers be broadened to allow practices making less than $90,000 or providing care for less than 200 Medicare patients would not have to participate.

The proposal is also offering bonus points to small practices as well as practices that treat a larger complex patient population. Small practices would have to submit data on at least one performance category to earn five additional points to their final score. If the practice provides care to a patient population deemed to be complex as measured by the Hierarchical Conditions Category (HCC) risk scores they may be awarded one to three bonus points. The rule would allow hospital-based clinicians to submit their facility's inpatient value-based purchasing score to be used to calculate an individual score for the cost and quality categories of MIPS. The cost category is supposed to be implemented by the 2019 performance year and be weighted at 30%, providers will need to begin preparing for this category. The proposal also offers solo practitioners to form a virtual group with other small groups to help them succeed under MIPS. In 2018 providers will be expected to submit a full year of data in the quality category. To avoid a payment penalty a clinician will have to earn 15 points for the 2018 performance year.

All said and done MACRA is here to stay and we will need to be ready when other payors establish similar programs. It is important to stay current on the topic and how it will impact your practice. Stay tuned here at AZMGMA for more updates on MACRA. If you have other topics you will like covered send an email to lmead@crownehc.com

The proposed rule can be found here