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Subject: BREAKING NEWS: E-Reimbursement News: MACRA FINAL RULES Released 10-17-2016
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E-Reimbursement Newsletter

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Dear Jose Luis,

Welcome to the wonderful world of MIPS and MACRA. The good news is that this complicated rule, which will be implemented in less than three months, has been greatly simplified. Reporting and other obligations have been reduced. Further, if you are in the Oncology Care Model, MIPS has been simplified a bit for you.

See the article below for more details and information.

Be aware that this is the first in a series of regulations that will be introduced this month. At the end of the month, look for our newsletter highlighting the Medicare Fee Schedule and HOPPS rules and all the new CPT and HCPCS codes. Check your e-mail for our biggest issue coming in the next few weeks!

Da' Mistress

MACRA/MIPS Final Rule Delivered!

On October 14, 2016, **the Centers for Medicare & Medicaid Services (CMS) finally released the Final Rule outlining the implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The 2,398-page document memorializes the new Medicare Value-Based Payment program- the Quality Payment Program (QPP)**. As outlined by MACRA, the Program allows for two paths to fulfilling requirements for bonus or avoiding penalties by joining an Advanced Alternative Payment Model (APM), or reporting through the Merit-based Incentive Payment System (MIPS).

Rather than forcing everyone to read 2400 pages of regulatory drivel, CMS augmented the Final Rule with a big print, graphic-rich implementation guide to QPP--thank you, CMS! For greater simplicity, this Final Rule really only outlines the first year of the program. CMS has called 2017 the "Transition Year and Iterative Learning and Development Period" with 2018 being the "second transition year." More future year rules will be described next year, according to CMS.

Below is a summary of The Final Rule highlighting major changes from the proposed rule.

- Major Change #1: The low-volume threshold has been changed. If an individual provider does not bill at least $30,000 in Medicare Part B allowed charges or they see less than 100 Medicare patients per year, they are exempt from the QPP in 2017. This new provision reportedly excludes approximately 32.5% of all clinicians billing Medicare Part B services or more than 380,000 clinicians. Lucky them!
- Major Change #2: This 2017 initial performance year establishes your Medicare

payments in 2019, with an adjustment of 4%, up or down---these are much lower than the possible penalties for this reporting year, which total 11% if you flunk everything. Guess what! If you just want to avoid the penalty from reporting year 2017, you can actually postpone reporting until October 2, 2017. Then, you also can only report one measure, if you just want to avoid the penalty. Alternatively, a partial year (90 days) of reporting starting October 2 provides a neutral or small positive adjustment for the practice. A full year of reporting starting January 1 can get your practice the 'moderate' positive payment adjustment. Finally, there is another incentive to participate for the entire year starting January 1, 2017, qualifying participants who achieve a QPP composite score of 70 or higher to be eligible for the exceptional performance adjustment, to be taken from a pool of $500 million. So, pick your poison!! All MIPS reporting is required by March 31, 2018.

- Major Change #3: The cost/resource use component of the QPP has been postponed until 2018 and will not be part of MIPS in the 2017 reporting year, even though these data will be gathered by CMS. The 10% that cost represented as part of the QPP will be transferred to the Quality component representing 60% of the QPP in the 2017 reporting.
- Major Change #4: Responding to a myriad of commenters asking for more organizations that qualify for participation in the Advanced APMs, CMS highlights its new criteria related to APM qualification. But, ironically, the exclusive, approved list of 2017 reporting year's Advanced APMs was not released with this Final Rule. The 'list' is scheduled to be released before January 1. Assuming the criteria in the Final Rule is used, CMS estimates that 70,000 to 120,000 clinicians will be in APMs during the reporting year 2017. This reportedly represents approximately 5 to 8% of all clinicians billing under the Medicare Part B.
- Major Change #5: Clinical Practice Improvement Activities ("CPIA") has had a name

change. It is now "Improvement Activities". Moreover, only four activities need to be reported, and none if you're already recognized as a medical home by the appropriate certifying agencies or if you are part of the Oncology Care Model with or without risk.

- Major Change #6: The old Meaningful Use Criteria went from requiring from 11 measures to just five, But, you need to know that reporting on all of them is still necessary if you want to achieve a component score of 100%.

MIPS allows reporting by individual or as a group. Qualifying professionals are defined as physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse anesthetists. **There are only 3 reporting performance categories for 2017. Those three categories--Quality, Improvement Activities, and Advancing Care Information are, respectively, 60%, 15% and 25%**, to formulating your composite performance score. The QPP composite score determines your Medicare adjustment in 2019. Here's a summary of the requirements for these three categories 2017:

- **Quality (60%):** Report six measures out of 271 or one of 30 specialty measure sets, including an outcome measure, for a minimum of any continuous 90-day reporting period. If fewer than six apply, then you're only required to report on the measure(s) applicable to your situation. If you are using a web interface 15 quality measures apply. Remember we are at nine measures now, so this might be an improvement. But, take note: the Oncology Measures Group is gone--but there is a general oncology specialty series. In addition, OCM practices are exempt from this category, if they are reporting as required into the OCM portal.
- **Improvement Activities (15%)**: Report four activities out of 93, for a minimum of 90 days. Reporting possibilities include patient teaching, referral management, care planning, care coordination training, group visits, and telehealth. For small and rural practices, those in Healthcare

For small and rural practices, those in Healthcare Professional Shortage Areas (HPSAs) and those who are "non-patient-facing" clinicians, only one high or two medium-weighted activities need to be reported in 2017.

- **Advancing Care Information (25%)**: Report your practice's performance through the EMR or electronic information distribution, e.g. portals and such. For 2017, there are a minimum of five required measures include a security risk analysis, e-prescribing, electronic patient access and summary of care record. There are also nine (9) measures for extra credit for you EMR dweebs.

Participating in an Advanced APM offers a lump sum 5% incentive payment for Medicare services. As in the proposed rule, the options to join an Advanced APM are much more limited than you might think. It is estimated that there are less than 100 organizations which qualify right now, and, in those organizations, some providers won't reach CMS' requirement of receiving 25% of Part B payments or seeing 20% of its Medicare patients through the Advanced APM. As noted above, however, CMS announced that the "list may change" before January 1 as the official "list" is not yet final.

I totally encourage you to visit the new CMS interactive website on MACRA. It is visually pleasing and very easy to understand. Best of all, it is actually helpful.

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