A Checklist for MACRA

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LAST YEAR, THE Medicare Access and CHIP Reauthorization Act (MACRA) eliminated Medicare's SGR formula and required Medicare, beginning in 2019, to provide value-based reimbursement to physicians. MACRA represents a big step away from traditional Medicare fee-for-service. (In the meantime, the Medicare physician fee schedule will increase .5 percent annually). As you weigh your options for adapting to the MACRA changes, the following are some thoughts to bear in mind.

Verify that MACRA applies to your practice. Certain payments and physicians are exempt: IPPS, OPPS, and ASC Payment System payments; physicians who fall under Medicare's low volume threshold ($10,000 or less in Medicare charges and 100 or fewer Medicare patients); and physicians in their first year billing Medicare.

Determine which track of MACRA applies to you: the Advanced Practice Model (APM) or Merit Based Incentive System (MIPS).

If your practice participates in an APM, determine whether it is a qualified advanced APM, as such APMs are exempt from MIPS. An advanced APM has more than "nominal" financial risk to the participating physicians. Examples include Tracks 2 and 3 accountable care organizations (ACOs) (i.e., those with shared risk), next generation ACOs, the Oncology Care Model Two-Sided Risk Arrangements, Comprehensive End Stage Renal Disease Care Models, and certain bundled payment initiatives. Track 1 ACOs and the Comprehensive Joint Replacement program are not considered advanced APMs. Practices on the APM track will receive upfront, lump sum annual payments of 5 percent of their previous year's Medicare Part B payments in 2019 through 2024, with a higher fee schedule update to follow (as compared to the MIPS track).

If your practice is not in an advanced APM — the majority of practices are not — then it will fall into the MIPS track. The MIPS model bases payment adjustments to the Medicare fee schedule on existing PQRS, value-based modifier, and meaningful use incentive arrangements. The adjustment amount will depend on each physician's overall composite score, scaled against a benchmark score established by CMS, and will range from -4 percent to 37 percent.

Review the MIPS metric categories and assess the practice's ability to satisfy and report on the appropriate measures beginning in 2017. Implement corrective action as necessary.

+ Quality is 50 percent of the practice's total score in the first year of MACRA. CMS will track population-based performance measures using claims information. Practices must report six measures including one outcome measure and one cross-cutting measure.
+ Advancing Care Information (formerly Meaningful Use) is 25 percent of the score. Practices must report on eleven measures indicating day-to-day use of healthcare information technology, including interoperability and information exchange.
+ Clinical Practice Improvement Activities is 15 percent of the score. This category measures practice access, beneficiary engagement, population health management, and emergency preparedness. Practices will have some flexibility in choosing options; there will be over 90 options from nine categories.
+ Resource Use (formerly, value-based modifier) is 10 percent of the score. There will be 40 additional measures based on episodes of care. This measure will look at claims data; there is no practice reporting obligation.

Medicare has not yet finalized the MACRA rules and is unlikely to do so until later this year (with 2017 remaining as year one). The final rules may deviate significantly from the current proposed rules; practitioners very well may see additional guidance on these issues.

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