The MACRA Final Rule: Key Takeaways for Health IT Vendors

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The Centers for Medicare and Medicaid Services (CMS) surprised everyone with its earlier than expected release on Friday, October 14, 2016 of the MACRA final rule. Given ongoing updates from CMS, the contents were not a surprise nor were most of the details of the 2,398 page rule. In addition to the text of a proposed rule published last April, CMS has regularly provided supplemental guidance on the new rule. Acting Administrator Andy Slavitt's steady blog posts and tweets about the rule have also been a good source of insights. Updating our previous article[1] on the proposed rule, this article updates key takeaways for healthcare technology vendors and offers some industry perspective for the benefit of health information technology providers.

In terms of timing, the MACRA final rule implements the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) on a more gradual basis. MACRA goes into effect January 1, 2017, but will slowly be phased in over several years.

MACRA seeks to replace the old fee-for-service model with value-based reimbursement of Medicare expenses. The new payment scheme applies to clinicians who see 100 or fewer Medicare patients or have $30,000 or less in Medicare Part B charges annually (excluding 32.5% of Medicare clinicians). Though the model rewards value of healthcare services rather than the quantity of services provided, MACRA is meant to be a revenue neutral program. Therefore, it also penalizes clinicians who do not report quality care; for every provider who receives a positive percentage payment adjustment, there is a corresponding provider whose payments are negatively adjusted.

Here are a few key takeaways:

Automation to Save Clinicians Time Will be Key for Health IT

By automating data collection and reporting with software, MACRA offers smart HCIT companies excellent opportunities themselves while improving patient care.

Consider the built-in payment adjustments. Due to the potentially significant investment to accurately collect and report the data requested by MACRA, however, many providers have said that they will simply choose to take the hit on a negative adjustment. For data collected in 2017, this adjustment will be up to 4% for payments made in 2019, and increase steadily to 9% in 2022. Thus, a vendor that can implement a turnkey solution for less than 9% of a provider's annual Medicare charges has his sales pitch written for him.

1 The previous article also highlighted new opportunities for big data and healthcare data analytics, which remains, especially with the 2015 Certified EHR Technology (CEHRT). Additionally, the earlier article discussed the Office of National Coordinator for Health IT, ONC's role in monitoring the EHR certification program. The final rule includes the additional ONC responsibility in ensuring the accountability and transparency of CEHRTs, and should help provide regulatory certainty to developing healthcare technologies. Much of the ONC's enhanced role is described in a companion regulation that was also released on October 14, 2016, ONC Health IT Certification Program: Enhanced Oversight and Accountability.

Providers Have Help (And Here is Some More)

Documenting and reporting on these measures and activities doesn't have to be as tough as it looks, nor does it require studying 2,400 pages of regulatory text. In addition to the massive final rule[2] (which primarily consists of a reprint of comments and CMS' responses), CMS also published a helpful 24-page summary,[3] and even more useful for both providers and HCIT vendors is the Quality Payment Program website at qpp.cms.gov.[4]

This website walks a user through the program with easy to understand graphics and a complete, sortable list of the reportable metrics under MIPS.
The site currently includes:

- 271 Quality measures. For most providers, in 2017, only 6 of these quality measures will need to be reported for a minimum of 90 days to get credit. In 2017, the Quality category comprises 60% of the MIPS performance adjustment.
- 93 Improvement Activities. Most providers must simply complete 4 Improvement Activities to get credit, which comprises 25% of the MIPS performance adjustment in 2017.
- 15 or 11 Advancing Care Information measures, depending on the type of EHR (previously referred to as Meaningful Use). At least 5 of these need to be reported (down from 11 in the proposed rule and down from 18 under Meaningful Use). Reporting more measures provides bonus credit. In 2017, the Advancing Care Information category comprises 15% of the MIPS performance adjustment.[5]

Healthcare providers who can capture this data seamlessly and report it through the right technology and vendor partnerships stand to gain a lot.

Specific to technology vendors, the Office of the National Coordinator for Health Information Technology (ONC) has also published a short Fact Sheet on MACRA.[6] The updated 2015 Certified Electronic Health Record Technology (CEHRT) standards, which will be required 2018 to participate in the MACRA payments schemes, are carefully detailed on the ONC's website[7] along with Certification Companion Guides[8] to provide development guidance, technical clarifications, and certification criteria for developers.

Assistance for Smaller Providers and HCIT Vendors

There is understandably concern[9] that smaller EHR vendors may not be able to meet the 2015 CEHRT requirements because 75% of healthcare providers still use the 2014 version, and by 2018, they will need to migrate to the 2015 version. But this challenge may also be an opportunity.

In addition to rolling out the requirements slowly and easing providers into MACRA payment models over the next few years, CMS also announced that $100,000 in technical assistance will be available to clinicians in small practices and rural areas. These smaller providers, who are often the most strapped for resources, will now have what they need to fund the technology and develop the vendor relationships necessary to comply with MACRA. With the right innovations, healthcare technology vendors can compete for these funds.

Putting Doctors Back in Front of Patients

Physicians' biggest complaint with MACRA has been lack of choice: the forced reporting, forced EHR use, and forced changes to their practice. Physicians complain that they now spend most of their time checking boxes on computer

2 http://www.hhs.gov/about/news/2016/10/14/hhs-issues-final-rule-enhance-reliability-transparency-accountability-and-safety-certified-health.html
3 https://qpp.cms.gov/docs/QPP_Executive_Summary_of_Final_Rule.pdf
4 https://qpp.cms.gov/docs/QPP_Executive_Summary_of_Final_Rule.pdf
5 In later years, Cost will be a fourth performance adjustment category. Cost data is pulled automatically.
6 https://www.healthit.gov/sites/default/files/macra_health_it_fact_sheet_final.pdf
7 https://www.healthit.gov/policy-researchers-implementers/2015-edition-final-rule
8 https://www.healthit.gov/policy-researchers-implementers/2015-edition-test-method
9 http://www.modernhealthcare.com/article/20161018/NEWS/161019917

screens rather than engaging with patients. "Meaningful Use is not meaningful to me," they say.

Recognizing this concern, MACRA builds in more flexibility. Its goal is for the software to reside underneath the practice management and EHR system and collect the data silently. Contrary to some of the early physician impressions, current technology and continued innovation is on track to truly save doctors time, putting them back in front of patients. MACRA provides the financial incentives to accelerate that process. So while a dedicated IT employee, or technology vendor, may be necessary to maintain the software and run reports, it is still a better choice for the practice because it frees the doctor's time for patients.

Relatedly, the new reportable EHR measures for Advancing Care Information exemplify this focus on quality care and patient engagement. For instance, clinicians will now be rewarded for using secure messaging with patients and for providing easy patient access and interaction with their health data.

Telemedicine Lacking

Despite some of these recognized benefits, there are other areas where, according to some industry commentators,[10] MACRA still falls short. Notable examples relate to telehealth and remote monitoring, which many advocated to be specific quality measures or reportable metrics under MIPS. The primary discussion of telehealth in the MACRA final rule, however, is related to when it counts as a patient-facing encounter, i.e., in determining if MACRA applies to the clinician. CMS also noted that it included a Care Coordination metric ("Ensuring that there is bilateral exchange of necessary patient information to guide patient care that could include participating in a Health Information Exchange"), which may include telehealth, as well as an incentive for remote monitoring of warfarin (Coumadin) therapy.

Otherwise, MACRA remains surprisingly silent on telemedicine. To fill this gap, advocates are pushing Congress to expand Medicare's payment policy on telehealth with the CONNECT for Health Act.[11] This act would waive several limitations on telehealth and remote monitoring, and would specifically allow for such technology to be reimbursable under Medicare in several circumstances.

There Will be More Changes Ahead

Finally, the changes are by no means complete. Even with this final rule, CMS left the window open for a 60-day additional comment period before publishing the rule in the *Federal Register*. In several places and in response to many comments, the final rule also mentions "future rulemaking" (the phrase appears 187 times in the final rule). Obviously, this will be an evolution, and it is very clear that CMS will be looking to input during a transitional 2017 and that the agency is open to changes and additional feedback.

Ultimately, this is good news for HCIT vendors. With the right approach, information technology systems are going to be critical in supporting a physician's ability to be paid under either the new MIPS[12] model (Merit-based Incentive Program) or an Advanced APM[13] (Alternative Payment Model). For vendors who are at the nexus where technology and healthcare are changing together, MACRA presents an enormous opportunity.

10 http://www.politico.com/tipsheets/morning-ehealth/2016/10/telemedicine-largely-left-out-of-macra-216942
11 https://www.congress.gov/bill/114th-congress/senate-bill/2484/text
12 https://qpp.cms.gov/learn/qpp
13 https://qpp.cms.gov/learn/apms

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