

Maximizing Reimbursement Through MACRA's Merit-Based Incentive Payment System

A road map for how to take advantage of the financial opportunities available with MACRA.

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When the United States Department of Health & Human Services released the Final Rule for the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 on October 14, 2016,¹ it formalized one of the most dramatic changes to Medicare physician reimbursement since the implementation of the resource-based relative value system, and possibly, the launch of Medicare itself. MACRA essentially mandates that physicians assume financial risk with their Medicare Part B patient population.

The importance of this much-anticipated piece of legislation, which totals 2,398 pages, can be summarized as follows:

- It ended the sustainable growth rate formula that spelled the end to the annual game of physicians facing a large sustainable growth rate reimbursement cut, only to have Congress consistently postpone it with its last-minute “doc-fix” legislations. Without MACRA, it would have meant a 21% cut in Medicare payments to physicians.
- It created a new framework for rewarding health care providers for providing better care, not just more care. MACRA is beginning to shift Medicare physician reimbursement away from fee-for-service, which incentivized volume of services and has been the primary reimbursement formula with Medicare since 1965. Beginning in 2019, physicians will be at risk for a $\pm$ 4% payment adjustment with increasing risk to a $\pm$ 9% payment adjustment by 2022, with a higher reimbursement for the best performers. MACRA established a new program called the Quality Payment Program, which allows physicians to choose from two tracks: (1) participating in

an advanced alternative payment model (APM) or (2) participating in the Merit-based Incentive Payment System (MIPS). Physicians participating in an advanced APM are excluded from MIPS. MIPS is intended to simplify and replace the unpopular meaningful use, value-based payment modifier, and physician quality reporting system (PQRS). MIPS focuses on four areas in evaluating physician performance (and ultimately payment): quality, resource use (ie, cost), clinical practice improvement activities, and advancing care information.

The MACRA clock started ticking on January 1, 2017, and the data physicians submit this year will affect their reimbursement in 2019. Yet, a large survey in September 2016 suggested that only 20% of physicians were familiar with MACRA.² It's hard to understate how much complexity is involved in MACRA. Physicians have to review and pick from more than 200 quality measures. Plus, there are more than 90 clinical practice improvement activities to consider. This article is intended to be a road map for how to take full advantage of the financial opportunities that are available with MACRA.

MACRA is designed to be (generally) budget neutral, so there will be reimbursement winners and losers as well as opportunities for additional bonuses. Medicare will still pay for services as it always has, but every clinician will have the opportunity to be paid more for better care and for making investments that support patients.

WHO IS AFFECTED BY MACRA?

All physicians, as well as advanced practitioners who have at least 100 Medicare patients or who bill Medicare at least \$30,000 per year, begin participating in MACRA

effective January 1, 2017. However, if you are new to Medicare in 2017, you will not have to report this year. The \$30,000 billing threshold expanded the originally proposed billing threshold of \$10,000 and, as a result, excludes an estimated 384,000 physicians from MACRA, almost half of which are working in small practices.³ Only physician offices—not hospitals—are governed by MACRA rules, and this program only applies to payments that physicians receive from Medicare; Medicaid is not included.

WHAT PARTICIPATION OPTIONS ARE AVAILABLE?

As previously mentioned, there are two tracks under MACRA: MIPS and APMs. MIPS is designed for providers under Medicare's fee-for-service system, while the advanced APM is for organizations that have sufficient patients and/or payments in a qualified risk-based payment model. Given the small number of organizations that are qualified for participation in the advanced APM, it is estimated that the majority (about 90%) of physicians and advanced practice providers will be on the MIPS track.⁴

WHAT ARE THE OPTIONAL TRANSITIONS TO BEGIN PARTICIPATION IN MIPS IN 2017?

In response to strong pushback during the MACRA public comment period, the Centers for Medicare & Medicaid Services (CMS) opted to offer physicians four "pick your pace" participation options for 2017.⁵

Option 1: Voluntary Exclusion (No Participation)

MIPS-eligible clinicians may voluntarily elect to not participate in MIPS for 2017. However, selecting this option will result in a 4% negative payment adjustment in 2019 to the MIPS-eligible clinician's Medicare Part B reimbursement.

Option 2: Test Data Submission

This option allows a MIPS-eligible clinician to submit the minimum amount of 2017 data in order to avoid the 4% negative payment adjustment in 2019. The MIPS-eligible clinician can elect to report 2017 data on one measure from the quality performance category, one activity in the improvement activities performance category, or the required measures for the "base score" in the advancing care information performance category. Unlike Option 3, this submission does not require data to be reported for a minimum number of days during 2017. However, there is no potential to receive incentive payments with this option.

Option 3: Partial Data Submission

MIPS-eligible clinicians can submit the minimum amount of 2017 data to CMS to avoid a negative payment adjustment in 2019 and could possibly receive a positive

MIPS payment adjustment. Under this option, a MIPS-eligible clinician needs to submit data for at least a consecutive 90-day period for more than one quality measure, more than one improvement activity, or more than the required measures for the "base score" in the advancing care information performance category. This option is different than Option 2 because it requires submitted data on more than one measure and also requires the clinician to submit data covering at least a consecutive 90-day period during 2017. The increased reporting requirements provide an additional benefit because MIPS-eligible clinicians could potentially receive a positive payment adjustment in addition to avoiding a negative payment adjustment. However, the positive payment adjustment will likely be less than the full 4% adjustment available in Option 4.

Option 4: Full Data Submission

To maximize the prospects of obtaining a higher positive adjustment in 2019, a MIPS-eligible clinician may elect to fully participate in MIPS for 2017. For full participation, a MIPS-eligible clinician needs to submit data on each of the required MIPS performance categories for all of 2017. Under this option, whether a MIPS-eligible clinician receives a positive, negative, or neutral payment adjustment in 2019 will depend on the clinician's performance from scores received in three of the four MIPS performance categories: (1) quality; (2) resource use; (3) clinical practice improvement activities; and (4) advancing care information.

For full MIPS participation in this option, a MIPS-eligible clinician must submit data for a consecutive 90-day period on the four performance categories, which are assigned different scoring weights for purposes of computing a MIPS score for the eligible clinician.

- **Quality.** For 2017, the quality performance category will comprise 60% of the MIPS score. A MIPS-eligible clinician must report at least six quality measures, which must include at least one outcome measure.
- **Resource use.** During 2017, cost will be weighted to zero.
- **Clinical practice improvement activities.** The Final Rule reduces the number of activities required to achieve full credit in this category, which comprises 15% of a clinician's final score. A MIPS-eligible clinician can engage in either two high-weighted or four medium-weighted activities. Practices that are small, rural, or located in geographic areas with a shortage of health professionals and nonpatient-facing MIPS-eligible clinicians will only be required to report on one high-weighted or two medium-weighted activities.
- **Advancing care information.** This category will comprise 25% of a clinician's MIPS score. There are five required measures that must be reported for this category.

HOW TO MAXIMIZE MACRA'S REIMBURSEMENT OPTIONS

For the chance to maximize the MIPS 4% reimbursement potential in 2019, you will want to choose option 4 and be a full participant in 2017. However, not only do you want to capture the full 4% increase in 2019, but also prepare to obtain larger increases in subsequent years (Figure 1).⁶

Beginning in 2019, physicians participating in MIPS will be eligible for positive or negative Medicare payment adjustments that start at 4% and gradually increase to 9% in 2022. Distribution of payment adjustments will be made on a sliding scale and will be budget neutral. Payment adjustments will be based on the following:

- Physicians who score at the threshold will receive no payment adjustment.
- Physicians whose composite score is above the threshold will receive a positive payment adjustment on each Medicare Part B claim for the following year.
- Physicians whose composite score is below the threshold will receive a negative payment adjustment on each Medicare Part B claim for the following year.
- Physicians whose composite score is in the lowest quartile will automatically be adjusted to the maximum negative adjustment on each Medicare Part B claim for the following year.

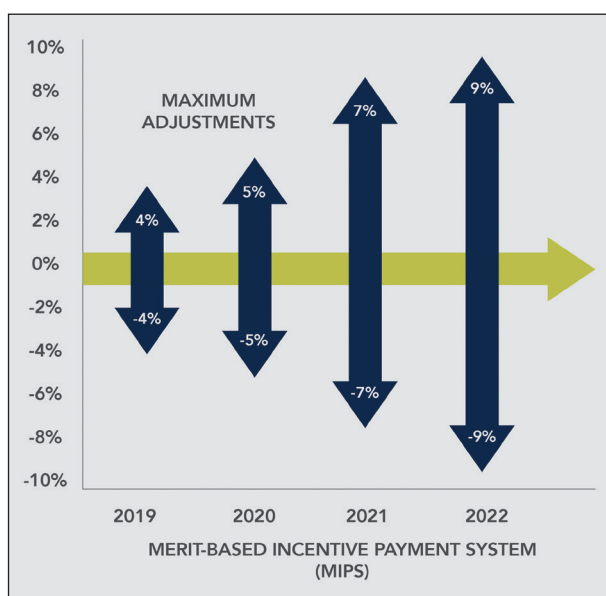


Figure 1. Payment adjustments based on MIPS composite performance score starting in 2019 and beyond. Reproduced with permission from Centers for Medicare & Medicaid Services. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MIPS-Scoring-Methodology-slide-deck.pdf>.

ADDITIONAL BONUS POTENTIAL FOR HIGH PERFORMERS

It's important to understand that because physicians in the lowest quartile will receive the maximum negative adjustment to maintain budget neutrality, physicians with higher composite scores may be eligible for a positive payment adjustment up to three times the baseline positive payment adjustment for a given year. This means that in 2019, physicians can earn up to 12% on all 2019 Medicare physician fee schedule payments.⁷

In addition, physicians can be eligible for an additional exceptional performance bonus of up to 10% of Part B charges if their composite score is > 70 (out of 100). The bonus amount will be determined based on all composite performance scores and distribution of a \$500 million annual fund. Exceptional performers must meet an additional performance threshold that will be set by CMS. This additional positive payment adjustment does not fall under the budget-neutrality requirements.

THE DIFFERENCE BETWEEN TOP AND BOTTOM PERFORMERS CAN BE HUGE

If half of all MIPS-eligible clinicians earn an incentive for their 2017 performance and the other half are assessed a penalty, then the budget-neutrality factor would be approximately 1 for 2019 if both sets of clinicians bill about the same amount of Part B payments. This would result in a maximum base incentive of 5% (5% X 1) for achieving a final score of 100. However, the exceptional performance bonus would add an additional 10% for progressively higher performers who exceed an exceptional performance threshold number of MIPS points. Hence, the sum of the maximum base incentive and exceptional performance bonus equals a maximum total upside potential of 15% (5% + 10%) for 2018. This means that the top-to-bottom MIPS potential impact on Part B payments for the 2019 cumulative year may be between a 15% incentive to a -5% penalty.

However, theoretically, the budget-neutrality factor could reach a capped value of 3 if many more clinicians are penalized as compared with receiving incentives in a given year. So the base adjustment could reach as high as 15% (5% X 3), resulting in an even higher maximum incentive of 25% (15% base + 10% exceptional performance bonus). Similarly, the maximum possible incentive for 2020 could reach 37% (9% X 3 + 10%).

Achieving additional reimbursement through performance bonuses will also come with considerable uncertainty for physicians because bonuses will depend on where their performance falls relative to the performance for all others in the pool each year. To earn the highest-available bonuses, a physician will need to score well above CMS's "performance threshold," which will

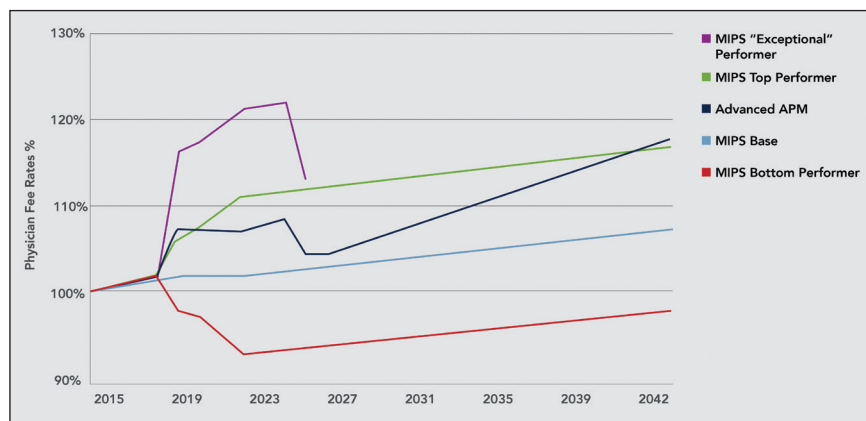


Figure 2. Graph representing potential earnings for MIPS participants as compared with APM participants over time. Reproduced with permission from Patel K, Adler L, Darling M, et al. How the money flows under MACRA. http://healthpolicy.usc.edu/How_the_Money_Flows_Under_MACRA.aspx. Accessed November 26, 2016.

change every year. Regardless, the chance to increase Medicare reimbursements by over 30% should be very compelling in an era where it is increasingly difficult to maintain profit margins. Although many feel that the APM offers the highest reimbursement potential, Figure 2 illustrates that MIPS may offer greater opportunity in the long term.⁸

SUMMARY

It is not too late to put yourself on track to capture additional reimbursement in 2019. Here are four must-do actions if you want to get there.

- 1. Choose option No. 4 in pick your pace and report for all of 2017.** Although flexible measures during 2017 allow for additional preparation time for some, the urgency remains high to understand MIPS requirements, set a strategy for reporting, and improve performance across all categories.
- 2. Start reporting.** If you haven't reported data on quality measures through PQRS or as part of meaningful use, get started now. Negative payment adjustments

NEED MACRA HELP?

A new website, <http://qpp.cms.gov>, is intended to help providers understand how to adhere to MACRA and find the best ways for them to participate. CMS is also rolling out a full service center with email and phone response capabilities for those with additional questions. In addition, CMS is providing \$100 million in technical assistance to clinicians participating in MIPS who are in small practices, rural areas, and in areas with a shortage of health professionals.

for not reporting will otherwise affect your payments in 2019.

3. Check your progress. Access your quality and resource use report, which will help you understand your performance in terms of cost and quality so you can prioritize potential areas for improvement.

4. Implement a certified electronic health record (EHR). A certified EHR can help providers fulfill reporting requirements with much less effort. EHRs can provide summaries of quality measure progress and can generate the documentation required for attestation. In fact, the govern-

ment says it's moving to align the measurement of certified EHR technology with the improvement activities. Be sure to select a provider that has a high attestation rate for meaningful use. ■

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