HSG | WHAT YOUR DOCTORS NEED TO KNOW TO PREPARE FOR MACRA AND MIPS

Numerous interactions with clients led us to the conclusion that there are basically three groupings of physicians when it comes to MACRA and MIPS. The first, and perhaps the largest, group is not familiar with MIPS and MACRA at all – or the impact that the new Medicare physician reimbursement program may have on them.

The second group is at least aware that changes are coming but think there is plenty of time to fret since the new payment model is several years away (2019). In truth, time is of the essence. The performance period for the 2019 payment year is scheduled to start January 1, 2017 – less than 6 months away. Even if the start date gets delayed until next July, individuals and groups must prepare now – with a sense of urgency.

The third grouping of physicians realize that all of this is coming at them very quickly and wonder how to prepare for it so they don't get overrun.

Regardless of your starting point, understanding the basics of the model – which CMS (Centers for Medicare and Medicaid Services) has named the Quality Payment Program – should be important to all doctors.

WHAT IS MACRA?

MACRA is the Medicare Access and CHIP Reauthorization Act of 2015 – legislation that replaced the Sustainable Growth Rate (SGR) as Medicare's basis for determining physician reimbursement. MACRA is often referred to as the "SGR Fix" and had strong bi-partisan support when it passed by wide margins in both houses of Congress. Thus, it is expected to survive well into the future, regardless of the upcoming federal election results.

MACRA legislated annual 0.5% increases in the Medicare physician services reimbursement rates for 2015 through 2019. The reimbursement rates will then remain unchanged until a scheduled increase in 2026.

MACRA also legislated two paths through which physicians can receive annual incentive bonuses (or penalties) starting in 2019. Of the two paths, most physicians will follow the one known as MIPS, the Merit-based Incentive Payment System. The other path, which is more attractive but much more restricted, is known as the Advanced APM (Alternative Payment Model) path. Since the MIPS path is expected to include more than 90% of physicians (and NPs, PAs, CNSs, and CRNAs), we will focus our discussion on this route. The actual amount of the bonuses or penalties physicians will receive under MIPS will rely on how well they perform on defined measures two years prior to the payment year – i.e., 2017 for the 2019 payment year, 2018 for the 2020 payment year, etc.

CMS is tasked with developing the regulations that actually implement the MACRA legislation. They published the proposed final rule on April 27, 2016 with the required public comment period ending on June 27th. By the time the comment period closed, CMS had received literally thousands of formally submitted comments. CMS must review each of the formal comments and determine whether to modify the proposed regulations. The ultimate Final Rule (regulations) is anticipated for an early November release.

WHAT IS MIPS?

MIPS essentially consolidates and replaces the current CMS quality programs – PQRS (Physician Quality Reporting System), the Physician Value-based Payment Modifier (VM), and Meaningful Use (Medicare Electronic Health Record Incentive Program). Comments that these programs are being eliminated is factual – they will cease to exist – but not real – they will just morph into the new consolidated MIPS program.

Under MIPS, an individual's annual total score related to measure performance will determine whether the individual receives an incentive bonus or a penalty. The total score, or CPS (Composite Performance Score), is the weighted summation of scores from four separate performance categories –

- Quality – which replaces PQRS and the quality/outcomes components of VM and accounts for 50% of the 2017 performance year total
- Advancing Care Information – which replaces Meaningful Use and accounts for 25% of the 2017 performance year total
- Resource Use – which replaces the cost component of VM and accounts for 10% of the 2017 performance year total
- Clinical Practice Improvement Activities (CPIA) – which is a totally new category and accounts for 15% of the 2017 performance year total

In any given payment year, about half of physicians will receive a bonus and half will receive a penalty as the amount of bonuses and penalties balance out to zero – the basic program is a zero sum game.

WHAT IS SORT OF NEW?

PQRS. Many of the current PQRS measures will continue unchanged under MIPS while some will be significantly modified and others will be eliminated entirely. PQRS was really a pay for reporting program (or a penalty for not reporting since 2015) and actual performance only entered the equation through the Value-based Modifier program. The MIPS Quality Performance Category will compare individual performance on selected measures against national benchmark performance and assign a score relative to the benchmark. Clinicians can select six (6) measures to report (instead of 9 in PQRS), one of which must be a cross cutting measure (same as PQRS) and one of which must be an outcome measure (new requirement). The reporting process can remain unchanged from PQRS. However, if a hospital reported generic measures for you, you might want to reconsider both the selected measures and the reporting mechanism. A new MIPS twist – the category now includes all payers, not just Medicare beneficiaries, so the reported population for each measure will grow.

Meaningful Use. Sorry, it's not dead yet – just becoming known as the Advancing Care Information Performance Category. The program continues to march toward Stage 3 measures and 2015 IT certification requirements by 2018. The all-or-none Meaningful Use scoring methodology persists to some degree when determining the base score (have to do certain things) but is eliminated when gauging actual performance – which will be scored against national benchmarks. The MIPS category also offers a bonus point for reporting data to central data repositories other than the required immunization registry (such as disease surveillance or public health registries). MIPS offers a degree of greater flexibility and eliminates the one-size-fits-all concept.

Resource Use. The good news is that clinicians do not have to report any data for this category. The bad news is that it is based entirely on claims data, much like its VM predecessor. The other bad news is that the weight of this category increases from 10% in the 2017 performance year to 15% for 2018 and 30% for 2019. These increases are balanced by corresponding decreases in the Quality score weight (50% to 45% to 30% respectively).

Degree of Bonuses. While physicians were eligible to receive bonuses under VM and Meaningful Use, the maximum bonus amount will start at 4% in 2019 then increase to 5% in 2020, 7% in 2021, and 9% thereafter. In addition, top performers (top quartile of those receiving bonuses) are eligible for an additional bonus that can reach a total of 10% in 2019 and represents the potential for receiving a greater bonus than ever before.

Degree of Penalties. While physicians are eligible to receive penalties for not reporting PQRS and Meaningful Use measures, clinicians reporting under MIPS may receive penalties if performance does not compare well to national benchmarks – even when compliant with all reporting requirements. Clinicians in solo and small group practices are projected to be overrepresented in the penalty category.

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WHAT IS COMPLETELY NEW?

CPIA. The CPIA (Clinical Practice Improvement Activities) category was newly created by MACRA for the MIPS path and fosters principles inherent in medical home constructs. CMS expects every clinician/ practice to be able to report activities in this category (unlike some of the other categories). Many individuals/ practices do not have a history of doing these types of things. The good news is that recognized PCMHs (Patient Centered Medical Homes) and PCSPs (Patient Centered Specialty Practices) receive full credit for this category by maintaining recognition; APMs like MSSP ACOs receive partial credit (50%) for this category; and small and rural practices have a reduced requirement.

Included Provider Types. NPs, PAs, CNSs, CRNAs were not included in the Meaningful Use program but are eligible for inclusion in the Advancing Care Information category. Participation in this category is optional for these providers in the first performance year but represents an opportunity if they are part of a practice that is doing well with the associated measures.

WHAT SHOULD YOU DO?

Much of the information presented about MACRA and MIPS (including this article) make the program sound relatively straight forward, but the actual nuances are quite complex. There is much to be done.

- A first step is pursuing education about and becoming familiar with the actual program requirements.
- A second step is conducting a participation readiness assessment to cross walk current reporting processes and measures with those included in MIPS. This process will determine strengths and weaknesses and what needs to change.
- A third step is exploring opportunities to score better through performance improvement efforts, preferred reporting mechanisms, alternate care delivery model exploration, and clinical practice transformation.

WHERE CAN WE GET HELP?

Although the AMA, AAFP, CMS, and other organizations offer suggestions and checklists, HSG can offer direct assistance with individual or group education, practice readiness assessments, performance improvement program development, and clinical practice transformation including PCMH and PCSP pursuit.

Call us. We'll partner with you as you strive to be the best you can be in this increasingly complex healthcare environment. Call Dr. Terry McWilliams, Chief Clinical Consultant, at (502) 419-1954 to discuss this further.