MACRA Strategies for 2017: Advantages and Disadvantages of Four Options

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While the Medicare Access and CHIP Reauthorization Act (MACRA) Final Rule was released nearly three weeks ago, many providers and health information management professionals are still analyzing the 2,200-plus pages to diagnose just what it says and how it impacts healthcare. While the final rule contains many different provisions, this article looks at the advantages and disadvantages of four MACRA options providers can choose to implement in 2017.

On October 14, 2016, the Centers for Medicare and Medicaid Services (CMS) released a final rule with comment period titled "Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentives under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models." This final rule represents the consolidation of three existing programs: the Physician Quality Reporting System (PQRS), the Physician Value-based Payment Modifier (VM) and the Medicare Electronic Health Record (EHR) Incentive Program for Eligible Professionals (EPs) under MACRA.

In this rule, CMS provided several alternatives for avoiding negative payment adjustments and for potentially earning positive payment adjustments in 2017. CMS is referring to the 2017 year as a transition year, allowing eligible clinicians to "pick their pace" and engage in MACRA at a level at which they feel comfortable. CMS will not subject eligible clinicians to negative payment adjustment associated with the 2017 performance year unless they fail to engage in one of the four options described below. This article will review these options and provide pros and cons for each available choice.

Option One: Participate in an Advanced Alternative Payment Model (APM)

CMS is actively encouraging eligible clinicians to join Advanced Alternative Payment Models (APMs). Participation in an Advanced APM rewards eligible clinicians with a five percent incentive payment should they meet the criteria for an Advanced APM and become a Qualifying APM Participant (QP). In addition, QPs will avoid another provision of MIPS, as their Composite Performance Scores will not be made public on the CMS Physician Compare website

To qualify for Advanced APM status, CMS requires an APM to meet the following criteria:

1. The APM must require participants to use CEHRT
2. The APM must provide for payment for covered professional services based on quality measures comparable to those in the quality performance category under MIPS
3. The APM must either require that participating APM entities bear the risk for monetary losses of more than nominal amount under the APM, or be a Medical Home Model expanded under section 1115A(c) of the Act

Only a limited number of these programs are available to most clinicians at this time for 2017, including shared risk arrangements such as Track 2 and Track 3 Shared Savings Programs, Comprehensive Primary Care Plus (CPC+) Model, Next Generation ACO Model, and the Comprehensive End Stage Renal Disease Care Model (with two-sided risk arrangements). Others are under consideration and a final list of approved Advanced APMs will be released by January 1, 2017.

Another potential barrier is the minimum payment or patient volume thresholds that must be met for a practitioner to be considered a Qualified Participant in an Advanced APM. For example, in the 2017 performance year, 25 percent of Medicare Part B payments or 20 percent of patient volume must be attributed to the Advanced APM. These requirements increase over several years so that by the 2021 performance year 75 percent of Medicare Part B payments or 50 percent of the clinician's patient volume needs to be attributed to the Advanced APM.

The disadvantages of the Advanced APM option include a minimum number of opportunities for clinicians to join Advanced APMs, the payment and patient volume thresholds, and the need to potentially absorb penalties associated with bearing the risk for monetary losses of more than a nominal amount under the APM.

Advanced APM Pros:

- Five percent bonus payment based on prior Medicare payments
- Medicare will not calculate a Composite Performance Score for providers for QPs, so there will not be public reporting of a MIPS score on the Performance Score on the CMS Physician Compare website
- Potential increased earnings associated with high-performance in a shared-risk advanced APM
- Establishing a new model for patient care in a practice designed to improve the quality of care while reducing cost
- Eligible clinicians who engage with an Advanced APM but do not meet the minimum payment or volume thresholds have the "option" of participating in the MIPS program during that performance year. In other words, if the clinician feels they may be eligible for a positive payment adjustment under the MIPS program they have the option of participating, but is not mandatory.

Advanced APM Cons:

- Limited availability of Advanced APMs in 2017. CMS estimates that approximately 70,000 to 120,000 eligible clinicians will engage in Advanced APMs in 2017. Approximately 600,000 eligible clinicians will be required to submit MIPS data. (These are eligible clinicians that: (1) are not QPs participating in Advanced APMs, (2) exceeded the low volume threshold, and (3) have been enrolled as Medicare physicians for more than one year.)
- Minimum payment and volume thresholds are (a) 25 percent of Medicare Part B payments, or (b) 20 percent patient volume associated with an Advanced APM
- The potential for revenue lost through the shared-risk programs (i.e., Track 3 ACOs)
- The overhead of engaging in an Advanced APM that meets Medicare requirements

Option Two: Full Participation in MIPS in 2017

This option remains available in 2017 where eligible clinicians can choose to report for a full 90-day period or, ideally, the full year as to allow them to qualify for up to 4 percent positive payment adjustment and an additional exceptional performance bonus based on the 2017 performance year. However, it requires eligible clinicians or groups to meet the requirements for three of the four performance categories of MIPS: Quality, Advancing Care Information, and Improvement Activities.

Point totals from each of these three categories will be summated to determine the Composite Performance Score under the MIPS (the "MIPS score") for each clinician or group. This score is then used to determine the payment adjustment associated with the 2017 performance year for the 2019 MIPS payment year. An eligible clinician's or group's final score and performance under each MIPS performance category as well as additional information will be published by CMS on its Physician Compare website (with the exception of new measures that have been in use for less than one year). The fourth MIPS Category referred to as "Cost" has been given zero weighting in 2017, but its contribution to the final score will gradually be increased in subsequent years up to 30 percent as required by MACRA by the third MIPS payment year of 2021.

Quality measure reporting has replaced the PQRS program. For 2017, a total of six measures need to be reported (for most specialties) for at least 90 days on 50 percent of patients that qualify for each measure for the calendar year. At least one of the measures must be an outcome measure. If no outcome measures are available, then a high-quality measure must be reported (appropriate use, patient safety, efficiency, patient experience, and care coordination measures). The quality performance category will account for 60 percent of the MIPS final in 2019. Many quality measures require more than 90 days of reporting to reach sufficient values, in particular high value measures that have associated bonus points, making it likely that reporting for periods longer than 90 days may lead to higher MIPS scores. Larger groups, generally groups of 100 or

more clinicians, using the CMS web interface must report 15 quality measures for a full year and are not eligible for any of the 2017 MIPS "pick your pace" options discussed in this article.

The second category of MIPS is Advancing Care Information (ACI), which has essentially replaced the Meaningful Use of Certified Electronic Health Record (EHR) Technology program for Eligible Professionals (EPs). Clinicians must use EHR technology certified to the 2014 or 2015 Edition during the 2017 performance year under MIPS. ACI is composed of two scores: a base score and a performance score. The base score has five objectives and measures that must be met to receive any score other than zero from the ACI category. These include a security risk analysis, patient access, transmittal of summary of care documents, electronic prescribing, and the ability to request and accept a summary of care record using certified EHR technology. Under the performance score component clinicians may choose from a number of measures to earn additional points in this category. The measures in the base and performance score of the ACI category must be reported for a minimum of 90 days and are then summated and to determine 25 percent of the MIPS final score for performance year 2017.

The third component of MIPS is referred to Improvement Activities performance category. To receive credit for improvement activities, clinicians must choose from a list of over 90 CMS-approved improvement activities in the final rule. These include such things as expanding practice access, creating care plans that meet specific needs, population management activities, expanding care coordination, implementing patient safety activities, and a range of other activities. Improvement activities that are designated as high-weighted are worth 20 points and those designated as medium-weighted are worth 10 points in the improvement activities performance category. A minimum of either two high-weighted or four medium-weighted improvement activities must be performed for at least 90 days for a total of 40 points to receive full credit under the improvement activities performance category. Smaller practices with fewer than 15 clinicians or those that are in a rural or health professional shortage area (HPSA) only need to achieve 20 points—two medium-weighted improvement activities or one high-weighted improvement activity. The impact of the improvement activities performance category on the overall final MIPS score is 15 percent for the 2019 payment year.

As noted above, the fourth performance category of MIPS is the cost associated to the eligible clinician or group. For 2017 this has a zero weighting in the determination of the eligible clinician's or group's MIPS final score for the 2019 payment year.

In summary, full participation in MIPS in 2017 requires engagement in three of the four MIPS categories. Some modifications have been made to these requirements to make them less onerous in 2017 than they will be in future years. Eligible clinicians have the potential of earning up to a four percent positive payment adjustment with the opportunity to obtain an additional positive payment adjustment for exceptional performance. However, another consideration may be that CMS has stated that they will publish MIPs scores on the Physician Compare Website only when they feel they have a complete set of data, as they only publicly report accurate, reliable data. Submitting MIPS data for a full year (as opposed to reporting minimal data) would meet this requirement, so at the end of the year an eligible clinician or group may wish to decide whether to choose this option if their measure data or other performance data is suboptimal. In that instance, they would have the option of reporting under Option 3 or 4, as described below.

Full MIPS Participation Pros:

- The potential to receive up to a four percent positive payment adjustment and in some cases a much larger exceptional performance payment adjustment.
- Even minimal participation in MIPS in 2017 will result in avoidance of any negative payment adjustments.

Full MIPS Participation Cons:

- The potential to have a less than optimal MIPs final score published on the CMS Physician Compare website.
- The additional resources needed to capture and analyze the necessary data, establish workflows, and educate staff about the need to attain very high measure reporting levels.
- By choosing to enroll in MIPS the eligible clinician or group loses the potential five percent bonus associated with being a qualified participant in an Advanced APM.

Option Three: Partial MIPS Participation

CMS has stated that for performance year 2017 eligible clinicians or groups who engage in MIPS for less than the full year but for a full 90-day period may avoid a negative MIPS payment adjustment and be eligible to receive a positive payment adjustment. In other words, eligible clinicians can elect to report more than one quality measure, more than one improvement activity, or more than the required measures in the advancing care information performance category any time after January 1, 2017 through October 3, 2017 and still qualify for a positive payment adjustment under MIPS, if they engage in each category of MIPS for 90 consecutive days, either simultaneously or at different times. The positive payment adjustment would likely be less than the full 4 percent, but a "moderate" positive adjustment is possible. This option also avoids a negative payment adjustment. The MIPS score has the potential to reach a higher value if multiple measures and activities are reported as compared to the minimum reporting requirement for this option. CMS has not determined their data completeness threshold for reporting Composite Performance Scores on the Physician Compare website. The amount of data submitted under this option could impact whether the MIPS score reaches this threshold. Further information on this topic will be made available next year.

Partial MIPS Participation Pros:

- Practices will have more time to prepare for MIPS
- There is the potential to achieve a small positive payment adjustment
- The clinician avoids potential negative payment adjustments under MIPS
- This level of participation will help practices prepare for 2018, when reporting under MIPS may require a full year of data

Partial MIPS Participation Cons:

- Practices will not be able to achieve the higher payment adjustment levels or the exceptional payment adjustment
- By choosing to enroll in MIPS, an eligible clinician or group loses the potential five percent bonus associated with being a qualified participant in an Advanced APM

Option Four: Minimal MIPS Participation

CMS will allow eligible clinicians to avoid negative payment adjustments if they engage in one of the following:

- Submit data on one quality measure
- Report one activity in the improvement activities performance category
- Report the required measures of the advancing care information performance category.

In summary, choosing one of these three options is relatively straightforward for practices that have been engaging in PQRS and meaningful use in prior years. It is likely that a high percentage of eligible clinicians will choose this option given the timelines for the Quality Payment Program. Of note, 2016 had far more onerous reporting requirements and potential penalties associated with PQRS, meaningful use, and utilization than MIPS in 2017.

Minimal MIPS Participation Pros:

- Avoid negative payment adjustments associated with non-participation or poor performance in 2017
- Relatively little effort needs to be expended in order to meet this minimum requirement
- CMS will not have a complete data set, therefore the Composite Performance Score will not be published

Minimal MIPS Participation Cons:

- Choosing this option will most likely eliminate any potential positive payment adjustment associated with the 2017 performance year.

- By chosing to enroll in MIPS, the eligible clinician or group loses the potential five percent bonus associated with being a qualified participant in an Advanced APM
- The minimum level of effort required may not position the practice well for required reporting under MIPS in 2018

Ready or Not, it is Time to Choose an Option

In conclusion, CMS has responded to concerns from stakeholders related to the readiness of clinicians to perform well under the Quality Payment Programs in 2017. The Advanced APM option, when available and when payment and volume thresholds can be met, may be the most attractive option in 2017 and in later years—at least until 2024, the last year of the five percent Advanced APM payment bonus.

Organizations that have achieved high PQRS measure performance scores and high measure scores in the meaningful use program may be well-positioned to perform well under MIPS. Others that feel they can achieve high scores in 2017 may wish to engage in the full MIPS initiative starting on January 1, 2017. Later in the year they will have the option of deciding whether to report participation in the full, partial, or minimal MIPS depending on their performance. This at least positions these organizations to potentially receive a positive payment adjustment.

Other eligible clinicians may elect to engage in a partial year as they do not have the organizational readiness to achieve high performance under MIPS. They will also have the potential of receiving a small positive payment adjustment and they have no risk of a negative payment adjustment. Finally, a significant number of clinicians may choose the minimal MIPS participation route as it has markedly low reporting requirements and is a good fit for clinicians that have not participated in the past, or those that do not have the resources to perform at high levels under MIPS.

Regardless of what options clinicians or groups may choose, as long as they submit even one quality measure or one improvement activity they will avoid a negative payment adjustment based on 2017 performance. If these minimum requirements are not met, then Eligible MIPS Clinicians' payments in 2019 will be subjected to the full 4 percent negative payment adjustment. CMS has provided a number of reporting options that should be achievable by the vast majority of informed clinicians.

CMS is collecting comments on the final rule 60 days after its release, and said changes could be made based on that feedback.

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