MACRA Strategies for 2018 and 2019 (Update)

By Michael Marron-Stearns, MD, CPC, CFPC

Editor's Note: This article was originally published in February 2018 and was updated on October 24, 2018 to present the latest information on MACRA.

The Centers for Medicare and Medicaid Services (CMS) Quality Payment Program (QPP) was created in response to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). It has two tracks: the Merit-based Incentive Payment System (MIPS) and the Advanced Alternative Payment Models. These programs started on January 1, 2017 and the first year of the QPP was referred to as the "Transition Year."

The QPP 2018 Final Rule was released on November 2, 2017 and provided details on polices for "Quality Payment Program Year 2." Congress subsequently made specific modifications to the MACRA legislation via the Bipartisan Budget Act of 2018 that became public law on February 9, 2018. This article has been updated from its original February 2018 version to reflect aspects the Quality Payment Program impacted by this Bipartisan Balanced Budget Act of 2018.

In the 2018 QPP Final Rule, CMS elected to continue with many of the policies established for the 2017 performance year with some notable differences. The 2018 MACRA Rule also provided information on selected policies for the 2019 performance year. The Bipartisan Budget Act of 2018 included providing CMS with significant flexibility in the first five years of the QPP, most significantly impacting how performance thresholds and MIPS performance category weightings are determined.

The majority of eligible clinicians will find themselves in the MIPS for the first few years of the QPP. For these practices, 2018 represents a low-risk opportunity to develop or refine approaches to achieving high levels of performance. Attaining high performance in the MIPS will become increasing challenging in 2019 and future years. MIPS performance scores will determine positive and negative payment adjustments to Part B payments and will be made available to the public.

This article will discuss key components of the QPP with an emphasis on changes to the policy for the 2018 performance year, and proposed changes for 2019. For additional information please refer to the 2018 QPP Final Rule.[1]

MIPS: Strategic Considerations

There are several strategic considerations related to modification to MIPS for the 2018 performance year that will be addressed in this overview document. These include changes to exclusion criteria thresholds, the MIPS performance threshold, MIPS performance category weightings, quality performance category reporting period and data completeness criteria, qualifying CEHRT versions, complex patient bonuses, small practice bonuses, virtual groups, hardship exemptions for extreme circumstances, and other elements of the QPP.

Threshold Criteria for Exclusion

The threshold criteria for exclusion from the MIPS has been increased. In the 2018 performance year CMS will exclude otherwise eligible clinicians and groups (based on cumulative numbers, not on averages) from the MIPS if they are less than or equal to $90,000 in Part B allowed charges or have fewer than 201 Part B beneficiaries. A primary reason why Medicare raised these thresholds was to reduce the burden on rural clinicians.

Qualifying Alternative Payment Model (APM) Participants (i.e., Qualifying Participants or "QPs"), Partial QPs, and clinicians new to Medicare are also excluded from MIPS, as they were for the 2017 performance year. Partial QPs have the option of participating in MIPS. Partial QPs are defined as they were in 2017 as eligible clinicians in Advanced APMs who have at least 20 percent, but less than 25 percent, of their payments for Part B covered professional services through an Advanced APM Entity, or furnish Part B covered professional services to at least 10 percent, but less than 20 percent, of their Medicare

beneficiaries through an Advanced APM Entity. If they elect to participate they will receive a score using the APM Scoring Standard (i.e., the standard used for MIPS APM scoring determinations).[2]

MIPS Performance Threshold

The MIPS performance threshold is the MIPS score that results in neutral payment adjustments. Scores above the payment threshold receive positive payment adjustments and scores below the payment threshold receive negative payment adjustments in the corresponding payment year, which is two years after the performance year. The MIPS performance threshold is chosen by CMS through the rule-making process during the first five years of the QPP. It was established at three points in the 2017 performance year and has been raised to 15 points in 2018. It will likely be raised to 30 points in 2019 and gradually increase in 2020 and 2021. Starting in the 2022 performance year, the performance threshold will be determined by the mean or median scores of all MIPS-eligible practices. Data released by CMS suggesting the 2019 performance threshold could be in excess of 75 points.

Achieving a MIPS Score of 15 points in 2018 can be done through a variety of mechanisms. For example, achieving the maximal score in the Improvement Activities performance category alone would yield 15 points. Any combination of activities in the four performance categories (Quality, Promoting Interoperability (formerly Advancing Care Information), Improvement Activities, and Cost) that yield a total 15 or more points would allow practices to avoid negative payment adjustments in the 2020 payment year.

Practices that score between zero and 3.75 points in 2018 will receive the maximum negative payment adjustment of five percent for all Medicare Part B allowable charges in 2020. Practices that achieve scores of over 3.75 points up to just under 15 points will receive proportionally negative payment adjustments ranging from between just under an estimated negative -4 percent to a fraction of a percent. CMS estimates that between 2.9 percent to 4.7 percent of clinicians will receive negative payment adjustments in 2020 based on performance in 2018.

The maximum negative payment adjustments increase to -7 percent in the 2021 payment year (i.e., the 2019 performance year) and nine percent in the 2022 and subsequent payment years. As defined in the MACRA legislation, all clinicians that score in the bottom quartile below the performance threshold receive the full negative payment adjustment. The 2019 performance threshold is projected to be in the vicinity of 30 points. Based on this assumption, all clinicians with a MIPS score of 7.5 or lower in 2019 performance year would receive the full negative payment adjustment of seven percent in the 2021 payment year. Those that score between 7.5 and 29 points would receive negative payment adjustments on a sliding scale from approximately -6.9 percent to -0.1 percent as shown in Figure 2.

The MIPS positive payment adjustments are funded by the negative payment adjustments, allowing the program to remain budget-neutral. The maximum positive payment adjustment (excluding the Additional Positive Payment Adjustment for high performers described below) in 2020 (based on 2018 performance) is five percent, but this will only occur if there are sufficient funds from negative payment adjustments to provide adequate funding for the positive payment adjustments at this level. Medicare estimates that approximately $118 million dollars will be redistributed from low performers to high performers in the 2020 payment year.

Given the relatively low performance threshold of 15 points set by CMS in 2018, it is highly unlikely that there will be adequate funds to fully compensate the high-performing practices at the maximum of five percent. The actual payment adjustment amounts based on 2018 performance will not be determined until mid-2019 and the information shared in this article is based upon CMS estimates provided in the 2018 QPP Final Rule. CMS estimates that a MIPS Score of 100 points may only result in positive payment adjustments, again excluding the additional positive payment adjustment described below, of one to two percent.

However, Congress authorized an independent fund of $500 million to allow for additional positive payment adjustments for exceptional performance. These funds are only available in the first six years of the MIPS program. CMS was given the authority by MACRA and the Bipartisan Budget Act of 2018 to determine the performance thresholds for the additional positive payment adjustment in the 2017, 2018, 2019, 2021, and 2022 performance years. In 2018 the performance threshold for the additional positive payment adjustment remained at 70 points, but is proposed to go to 80 points in 2019. Practices that receive a MIPS score of 70 points in 2018 will have an additional adjustment of +0.5 percent added to their “standard”

payment adjustment earned by the practice. From here it will increase proportional to the practice's MIPS score on a sliding scale, reaching a maximum of 10 percent for MIPS scores of 100 points, assuming there are adequate funds.

CMS estimates that approximately 74 percent of clinicians will achieve MIPS scores of 70 or higher, making them eligible for the additional positive payment adjustment. This will dilute the $500 million pool of funds considerably. For example, practices that achieve a MIPS score of 85 points in 2018 may only receive an additional positive payment adjustment of up to one percentage point. This would be added to their "standard" positive payment adjustment, which will also be markedly diluted in the 2020 payment year. Scores of 100 MIPS points could potentially result in practices seeing up to an additional two percent or higher payment adjustment during the 2020 payment year. As stated previously, these numbers are based on estimates and the actual adjustments may be significantly higher or lower depending on the number of clinicians that score below 15 points and the number that achieve the 70-point additional payment adjustment threshold. Please see Figures 1-3 below for a graphical representation of hypothetical payment adjustments based on MIPS scores in the 2018, 2019, and 2020 performance years.

Figure 1: Estimated MIPS Payment Adjustments in 2020 Based on 2018 Performance Scores

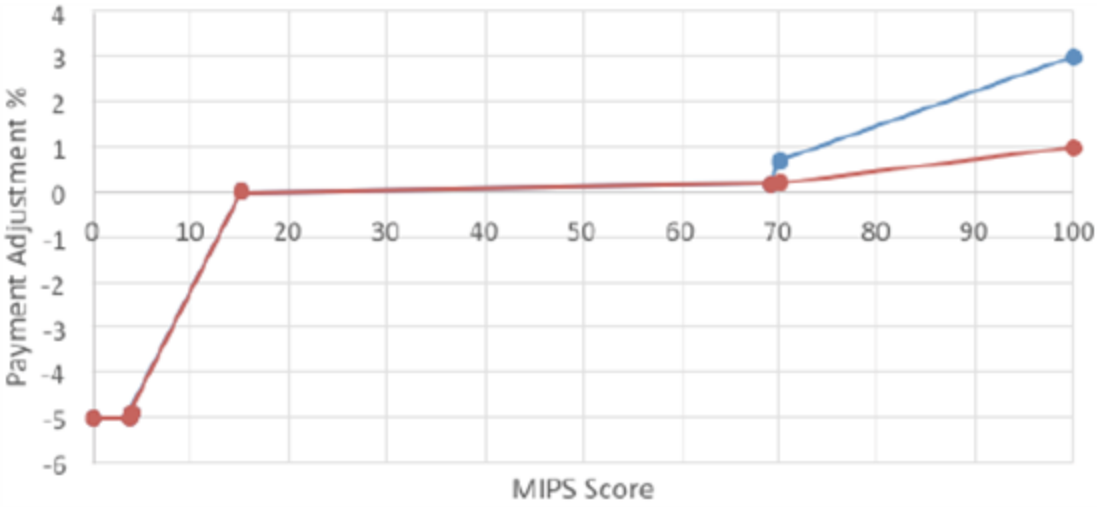


Figure 2: Estimated MIPS Payment Adjustments in 2021 Based on 2019 Performance Scores

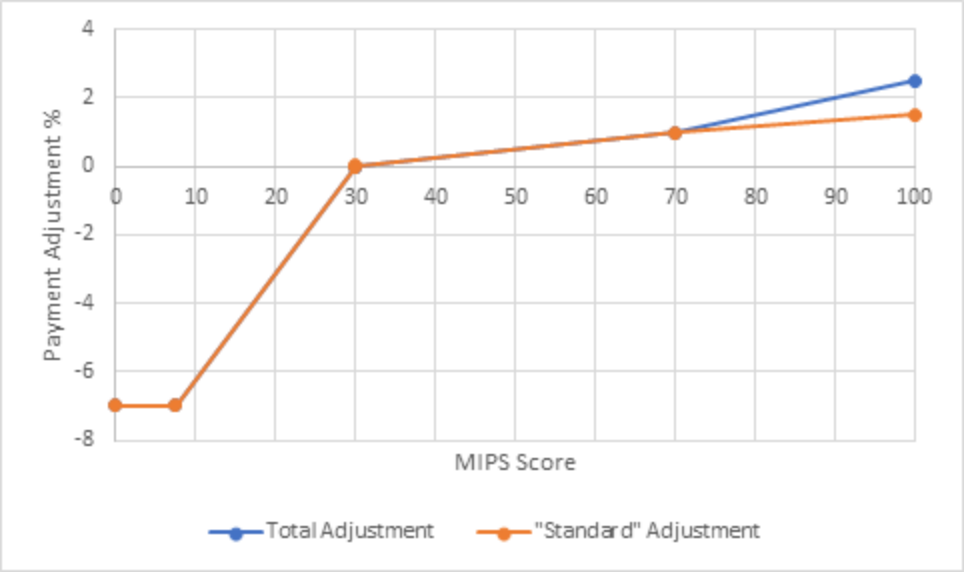
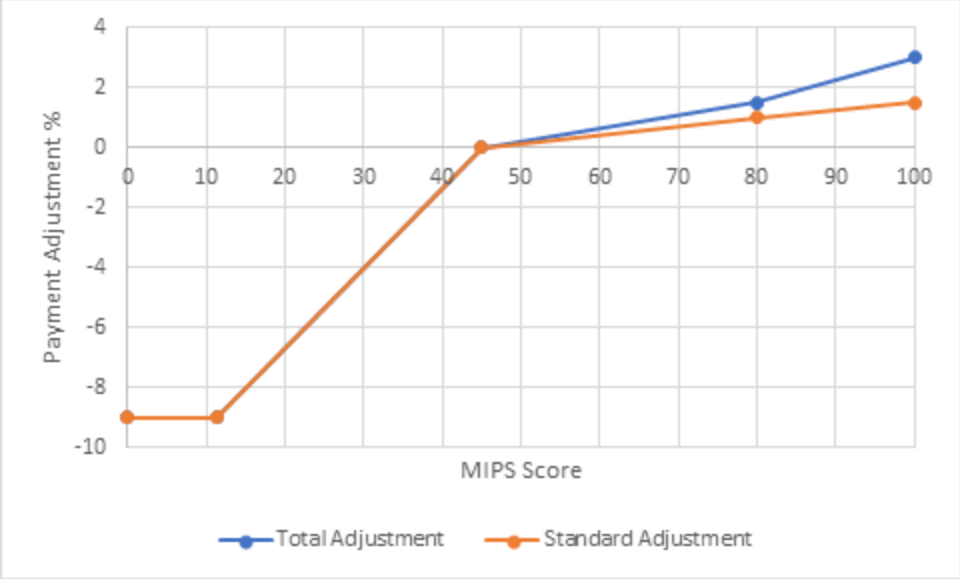


Figure 3: Estimated MIPS Payment Adjustments in 2022 Based on 2020 Performance Scores (Performance Threshold 45 Points)



In future years, starting in 2024 (based on 2022 performance) there will be a significantly greater amount of funds available for positive payment adjustments as nearly 50 percent of all MIPS participants will receive negative payment adjustments. High MIPS scores in 2022 are projected to provide significantly higher positive payment adjustments than in the first five years of the MIPS.

Additional money from the $500 million additional positive payment adjustment funds should also be available to high performers in the 2024 payment year, however, this is the last year of this fund. CMS is required, starting in the 2022 performance year, to establish the performance threshold for the additional positive payment adjustment at 25 percent of the difference between the MIPS payment threshold and 100 points. For example, if the MIPS payment threshold is 80 points in 2022, the additional positive payment adjustment would have a threshold of 85 points.

Available funds for high-performing practices may increase to a small degree in payment years 2022-2024 as the maximum negative payment adjustment will reach nine percent, which would potentially create a larger pool of funds for positive payment adjustments. Positive payment adjustments for high performance may reach nine percent or higher in the 2024 performance year when nearly 50 percent of MIPS participants will receive negative payment adjustments.

If there are adequate funds from negative adjustments, the positive adjustment can be multiplied by a factor of up to three to maintain budget neutrality. Although this is not likely to occur, a practice with a MIPS score of 100 points in 2022 could receive payment adjustments as high as 37 percent in 2024, based on the maximum “standard” positive payment adjustment of nine percent multiplied by a factor of three, and the 10 percent additional positive payment adjustment.

MIPS Performance Category Weightings

Two of the MIPS performance category weightings for the 2018 performance year have been modified as compared to 2017.

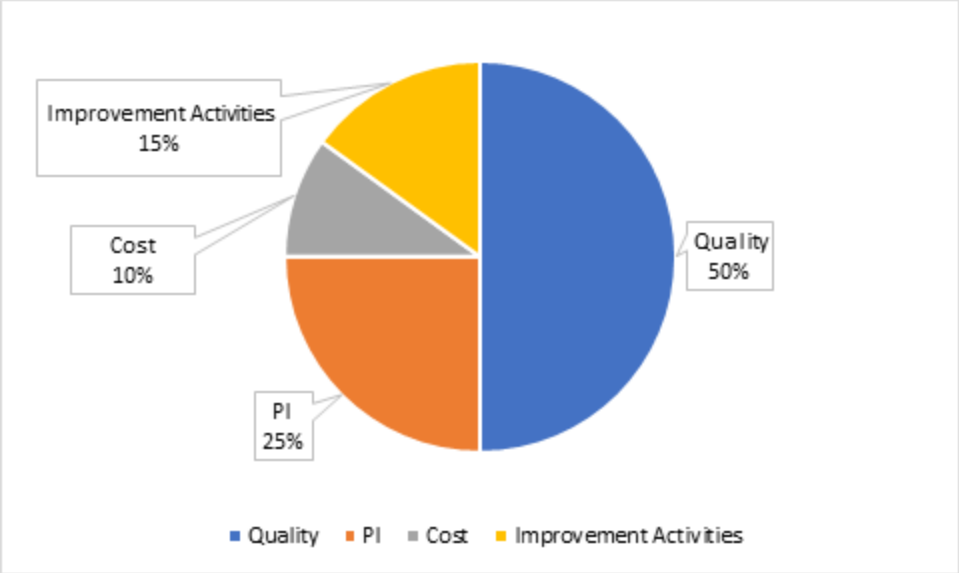
The Cost performance category will be weighted at 10 percent of the final MIPS score. It was weighted at zero percent in the 2017 performance period, and as proposed will increase to 15 percent in 2019. The Bipartisan Budget Act of 2018 allowed CMS to set the weighting of the Cost category from 10 percent to 30 percent in the first five years of the QPP. By statute Cost will be weighted at 30 percent in the 2022 performance period.

For the 2018 performance period, CMS will base Cost performance on the Medicare Spending Per Beneficiary (MSPB) and Total Per Capita Cost (TPCC) measures. Each measure will only be used if a case minimum of attributed patients (35 patients for the MSPB and 20 patients for the TPCC) can be established for the practice. If this requirement is met for both measures, the average performance for the two measures is used to determine the Cost category performance score. If only one of the two measures meets this requirement, then it is used alone. If the case minimum requirements cannot be met for either measure, the Cost category is given a weighting of zero percent. Under these circumstances the Cost category’s 10 percent weighting is shifted to the Quality performance category, which would then have a weighting of 60 percent.

Both of these measures factor in Risk Adjustment Factor scores when determining Cost category performance. Optimal coding and supporting documentation will play an increasingly important role in MIPS performance given that the Cost category's weighting will likely increase each year until it reaches 30 percent in the 2022 performance year. CMS intends to implement multiple new "episode-based" cost measures in 2019 that will be used to determine Cost performance when case minimums are met for individual providers or, more likely, groups. Cost performance is determined by claims data and practices have no reporting requirement for this category.

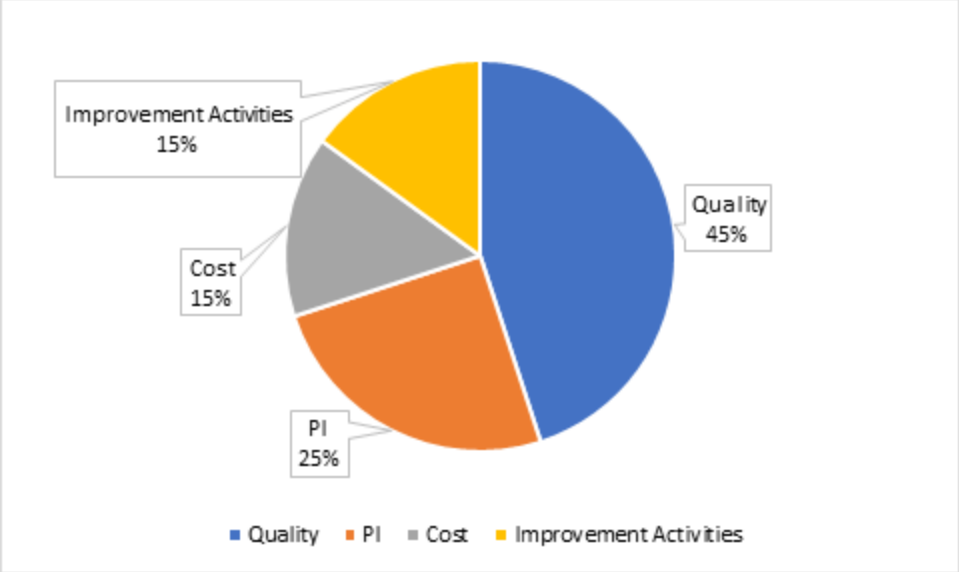
The weighting of the Quality performance score has been reduced from 60 percent to 50 percent in the 2018 performance year as per the 2018 MACRA Final Rule. (It will be weighted, as proposed, at 45 percent in 2019.) The Promoting Interoperability (PI) performance category weighting remains at 25 percent and the Improvement Activities performance category weighting remains at 15 percent (see Figure 4 below).

Figure 4: 2018 MIPS Performance Category Weightings



The category weightings for 2019, as proposed, are shown in Figure 5. Over the following two years the PI and Improvement Activity weightings will likely remain stable. Cost will gradually increase from 15 percent to as high as 30 percent. CMS has the option of reducing the PI category weighting to as low as 15 percent if CMS determines that an adequate percentage (75 percent) of MIPS clinicians are "meaningful users" of Certified EHR Technology. Any additional weighting points will be distributed to other performance categories.

Figure 5: 2019 MIPS Performance Category Weightings (Proposed)



Quality Performance Category Reporting Period and Criteria

The Quality category performance period was increased from 90 days in 2017 to a full year in 2018. Performance on Quality Category measures needs to date back to January 1, 2018. However, with the exception of claims-based reporting, practices can implement their quality strategy after January 1, 2018 as data can be collected retrospectively. This would apply to practices reporting quality measure performance through qualified registries, qualified clinical data registries, EHRs, and the CMS Web Interface. The claims reporting mechanism requires that the Quality Data Codes used for reporting quality measure data be included on the initial claims submission.

Medicare will use claims data for the entire performance year to determine Cost category performance. The ACI and Improvement Activities performance periods remain at a minimum of 90 continuous days in 2018. The 2018 Final Rule also states that the ACI performance period will remain at a minimum of 90 continuous days in the 2019 performance year.

The data completeness criteria for the Quality performance category has increased. The threshold has gone from 50 percent in 2017 to 60 percent in the 2018 and 2019 performance years. Medicare intends to increase this threshold in future years of the program, but as proposed it will remain at 60 percent in 2019.

In summary, practices that submit data through certified clinical registries, QCDRs, or EHR reporting mechanisms will need to submit data on 60 percent of all patients that meet the denominator requirements (taking into consideration any potential exclusions or exceptions) for the measures submitted for the entire year, regardless of payer. In addition, each submitted quality measure needs to meet the case minimum requirement of 20 patients/encounters to be reported by the group or individual clinician. Individual clinicians that report Quality measure data via claims need to report data on 60 percent of Medicare beneficiaries only for the year. The claims data reporting option is only available to individual clinicians, not clinicians reporting as groups.

Qualifying CEHRT Versions and Bonuses in 2018

The use of both the 2014 and 2015 Edition Certified EHR Technologies (CEHRT) will meet the requirement for reporting PI performance data in 2018. However, all practices will need to use 2015 CEHRT in 2019, according to the 2018 QPP Final Rule. Practices that use 2015 Edition CEHRT for a continuous 90-day or longer period in 2018 will receive a 10 percent bonus in the PI category. This bonus, as proposed, will not extend into the 2019 performance year.

CMS will award up to five bonus points for practices that care for complex patients. The determination of complexity will be based on Risk Adjustment Factor scores (that are determined based on demographics and Hierarchal Condition Classification (HCC) coding) and the percentage of dual-eligible (Medicaid and Medicare) patients cared for by the practice.

Small Practices

A small practice bonus will be available for the 2018 performance year. Small practices, defined as groups of 15 or fewer eligible clinicians, will automatically have a small practice bonus of five MIPS points added to the total MIPS score.

Small practices will be awarded a minimum of three points for quality measures that do not meet data completeness requirements. Larger practices of 16 or more eligible clinicians will receive scores of one point for Quality measures that do not meet data completeness requirements.

Small practices may be awarded hardship exemptions for the PI category. Small practices that face significant technology challenges, such as a lack of access to internet connectivity, may apply for a hardship exemption for the PI performance category.

Virtual Groups

Virtual groups have been approved for the 2018 and later performance years. Practices made up of between one and 10 eligible clinicians, based on Taxpayer Identification Numbers (TINs), may join to form virtual groups. The group must form independently, and all clinicians must explicitly state they are members of the group via a formal written agreement. Each virtual group will aggregate data in the Quality, PI, and Improvement activities categories and submit this data to CMS through an approved reporting mechanism, for example, a qualified registry.

For the 2018 performance year the registration deadline for virtual groups was December 31, 2017. Practices that wish to form virtual groups in future years must register by December 1st of the year preceding the corresponding performance year. Practices are required to commit to being part of a virtual group for the full performance year. All members of a virtual group receive the same MIPS score and payment adjustment. The only exceptions are clinicians participating in CMS-recognized APMs, including MIPS APMS and Qualifying Participants in Advanced APMs. MIPS APM participants will receive a MIPS score based on the APM scoring standard. Qualifying Advanced APM Participants are exempt from the MIPS.

There is no limit placed on the number of eligible clinicians that can be in a single virtual group, if the maximum number of eligible clinicians in each TIN does not exceed 10. An additional consideration when forming a virtual group is that virtual groups made up of more than 15 total providers will not qualify for the five point small practice bonus.

Hardship Exemptions for Uncontrollable Circumstances

MIPS-eligible clinicians that were impacted by extreme and uncontrollable circumstances such as hurricanes and other natural disasters or public health emergencies may be awarded a hardship exemption that will weight all four performance categories to zero percent in 2017 and 2018. Clinicians in affected areas will not need to submit data to avoid a negative payment adjustment, but must submit a hardship exemption request. The specific locations impacted in 2017—including counties and parishes in the US mainland, and territories and municipalities in Puerto Rico—are listed in the 2018 QPP Final Rule.

21st Century Cures Act

Certain provisions within the 21st Century Cures Act are being implemented in 2018. These include the reweighting of the PI category to zero percent for eligible clinicians based in ambulatory surgical centers and hospitals. Hospital-based clinicians who will have their PI performance category weighted to zero percent include those that see 75 percent or more of their patients in an inpatient, on-campus outpatient, off-campus outpatient, or emergency department setting.

Multiple Reporting Mechanisms will be Allowed in 2019

Practices will be allowed to use multiple reporting mechanisms when submitting measures from one performance category in 2019. For the 2017 and 2018 MIPS performance periods, practices must choose one reporting mechanism per performance category. This can create challenges when submitting data for the Quality category in particular. Quality measures have limitations on their reporting mechanisms. Being allowed to report through one mechanism limits the Quality measure choices for practices. In addition, Quality measure benchmarks vary by performing mechanism. Quality measure benchmarks are used to determine the final score for Quality measures when benchmarks are available, and the ability to choose measures that have more favorable benchmarks based on reporting mechanism could potentially improve MIPS quality performance scores.

MIPS APM Participation Considerations

MIPS APMs are entities that include clinicians that are participating in an APM that is not recognized by CMS as an Advanced APM and clinicians that do not have adequate Advanced APM patient volumes or revenues tied to achieve the status of Qualifying Participant.

Since this includes essentially all participants in Track 1 Medicare Accountable Care Organizations, it represents a significant number of clinicians. Clinicians participating in MIPS APMs will receive a MIPS score based on the following weightings, regardless of what type of APM they are participating with: Quality: 50 percent, PI: 30 percent, Improvement Activities: 20 percent, and Cost: 0 percent. The quality score is determined by APM performance on the APM's quality measures. The PI score is derived from aggregated data across all MIPS APM participants. CMS will determine if the APM's Improvement Activities are consistent with MIPS requirements and award between 50 percent and 100 percent of the points in this category. If an APM entity is not given full credit it has the option of participating in an additional Improvement Activities to reach the 100 percent performance threshold for this category.

Clinicians that optionally participate in MIPS APM entities should evaluate the performance of the MIPS APM in preparation for 2019. MIPS APMs have the advantage of reduced reporting requirements for the practice and high-performing MIPS APMs may yield significant positive payment adjustments for the practice. However, participation in low-performing MIPS APMs may lead to MIPS scores that could have been surpassed by the practice's direct performance in the MIPS. Clinicians on an APM participation list on the snapshot dates of March 31, June 30, August 31, or December 31 are obligated to receive the MIPS score assigned to the MIPS APM and the associated payment adjustments for that performance period. The December 31 snapshot date was added in the 2018 MACRA Final Rule, but is only applicable to MIPS APMs that require all members of a TIN to participate in the APM, such as Track 1 ACOs.

Other Miscellaneous Strategic Considerations

CMS has determined that several measures have historically high performance rates and are no longer optimal for quality improvement efforts. Six Quality measures have been identified as "topped out" for 2018 and will receive a maximum of seven points per measure instead of a maximum score of 10 points for other measures. CMS will be removing overly high-performing measures through a structured process, but practices should make sure the measures they are reporting are not on the "topped out" list for a given performance year.

CMS will begin rewarding practices for improvements in scoring in the Quality and Cost performance categories. A practice may earn up to 10 percentage points in the Quality performance category for scoring improvements. For Cost, up to one percentage point may be awarded.

The number of approved Improvement Activities have increased from 93 in the 2017 performance year to 112 activities in the 2018 performance year. This includes new highly-weighted and medium-weighted Improvement Activities, as well as new activities that require use of CEHRT technology that also 10 percent PI category bonus.

Advanced Alternative Payment Models: Strategic Considerations

Participation in an Advanced APM is in general an attractive option but there are limited opportunities for most clinicians. CMS anticipates a continuous shift towards enrollment in advanced APMs. CMS anticipates that between 185,000 and 250,000 clinicians will become QPs in 2018, as compared to 622,000 that will be eligible for the MIPS.

In the early years of the QPP there were limited options available to clinicians to join Advanced APMs, but opportunities are increasing as new Advanced APMs (e.g., Track 1+ ACOs) are approved by CMS and existing Advanced APMs (CPC+ and Next Generation ACOs) increase their clinician enrollment.

Becoming a Qualifying Participant (QP) in an Advanced APM enables the clinician to be eligible for a five percent lump sum bonus payment based on historical Part B Medicare payments at the beginning of the corresponding payment year. This will continue for the first six years of the QPP; following this, QPs will receive a 0.75 percent Part B Medicare positive payment adjustment.

QPs are excluded from MIPS payment adjustments and public reporting of MIPS performance scores. To become a QP, clinicians need to meet minimum patient volumes or revenues tied to the Advanced APM. In 2018 the thresholds are 25 percent of payments or 20 percent of patients must be attributed to the Advanced APM. For the 2019 and 2020 performance

years this increases to 50 percent of payments or 35 percent patient volume. In 2021 and later, this increases to 75 percent of payments and 50 percent of patients through the Advanced APM. Clinicians also need to be listed as participants in the Advanced APM on one of three snapshot dates: March 31, June 30, or August 31.

Potential downsides include shared financial risk based on Advanced APM performance, which in general will increase over time, narrowing margins to demonstrate improvement, and the increasing patient volume and payment thresholds needed to achieve QP status noted above. Advanced APMs could potentially become more selective towards their membership, with high-performing clinicians and practices becoming increasingly valued.

The New ACO Track 1+ Model and Expanded Enrollment in Existing Advanced APMs

The Medicare Shared Savings Program ACO Track 1+ Model is available for participation in 2018. CMS anticipates that a significant number of Track 1 Medicare ACOs will convert to the Track 1+ model, which qualifies as an Advanced APM. This will create new opportunities for MIPS-eligible clinicians to become QPs in Advanced APMs.

Expanded enrollment is anticipated for other existing Advanced APM models. There will be additional enrollment opportunities in 2018 and future years for clinicians to join the Next Generation ACO model and the Comprehensive Primary Care Plus (CPC+) Model.

All-Payer Advanced APMs

All-Payer Combination Advanced APMs will be available starting in the 2019 performance year. All-Payer Combination Option participation requires that clinicians participate in both a CMS-approved Advanced APM and an Other Payer Advanced APM. These range from Medicaid, Medicare Advantage, and CMS multi-payer models to commercial/private payer Advanced APMs. Eligible clinicians would still need to meet the relevant QPP or Partial QPP thresholds under the All-Payer Combination Option on one of the three snapshot dates: March 31, June 30, or August 31.

MACRA Strategies for 2018 and Future Performance Years

Three high-level approaches that practices may wish to consider are reviewed below.

Option One: Participate in an Advanced APM (if available). As noted previously, eligible clinicians that achieve QP status are excluded from MIPS payment adjustments. QPs receive a five percent lump sum payment during the corresponding payment year for the first six years of the QPP and may be eligible for shared savings. Advanced APMs may be the most attractive option for many clinicians and practices, although the shared risk component needs to be taken into consideration. In addition, as noted previously, APMs are under increasing pressure to perform and may become increasingly selective towards membership. An individual clinician's or group's ability to demonstrate high performance in the MIPS could be seen as an indicator of potential high performance in an Advanced APM.

Option Two: Participate fully in the MIPS in 2018 and 2019 and attempt to attain the highest possible MIPS score. Average performance scores are not expected to be at their highest level during the 2018 and 2019 performance years since a high percentage of clinicians are new to the program. This creates an opportunity for engaged practices to obtain optimal MIPS performance scores. As noted in Figure 1 on page 24, MIPS scores of 100 points in 2018 may generate positive payment adjustments of approximately 3 percent in 2020.

The greatest challenge to attaining high MIPS scores is performance in the quality category. CMS anticipates that a high percentage of practices will achieve the maximum scores for the PI and Improvement Activities categories. A significantly lower percentage will achieve maximum scores in the quality and cost performance categories

Quality also has the highest weighting of any category in 2018 and this will likely continue for several more years. A high percentage of quality measures have elevated benchmarks that make achieving optimal scores more challenging. In order to achieve a high Quality category performance score, practices will need to establish workflows that facilitate optimal scoring for each targeted quality measure. This will require a detailed assessment of available measures including reporting mechanisms, benchmarks, population requirements, potential denominator exclusions and exceptions, and data capture methodologies. The data completeness requirement is 60 percent for this category, allowing for some flexibility if programs were not in place on January 1, 2018. The data can be collected retrospectively, but high performance is generally dependent

upon prospective efforts to educate clinicians and staff on best practices for addressing measure requirements and capturing/documenting needed data elements, an important consideration for 2019. It also requires the individuals managing MIPS performance to be responsive to negative trends; allowing them to perform root cause analysis and interventions when low performance is identified.

The PI and Improvement Activities categories require a minimum period of 90 days of continuous engagement in 2018 and as proposed in 2019. The Cost category performance period is a full calendar year, but there is no reporting requirement. However, as noted previously, cost performance is dependent upon risk-adjusted scores which are determined by demographics and clinical conditions. This places additional emphasis on ICD-10-CM/HCC coding completeness and specificity. The complex patient bonus is also partially determined by HCC coding. Together these factors should drive high-performing practices to increase or maintain their levels of disease coding accuracy.

Full participation in the MIPS in 2018 is recommended when Advanced APM options are not available or not felt to be a good fit for the practice. Concentrated efforts to optimize performance in MIPS represents the best option to prepare for performance in 2019 and future years. As noted above, CMS anticipates that 74 percent of clinicians will have MIPS scores of 70 points or higher in 2018. Low scores may create challenges with patient recruitment and retention, clinician recruitment and retention, marketing by competitors, and, potentially, with fee schedule negotiations with payers. The year 2018 represents an opportunity to prepare for 2019 and future years, when the risks and rewards of MIPS participation will be amplified.

Option Three: Target a minimum MIPS score of 15 or more points during the 2018 performance year. Depending on levels of preparedness and resources, some practices may elect to choose this option. It would require substantially less effort, and a score of 15 points or above would still allow the practice to avoid negative payment adjustments in the 2020 payment year. However, this option would not give practices the experience needed to perform well in 2019 and future years.

Review of Changes

In summary, QPP performance year 2018 requirements are in many ways similar to 2017. Significant changes include an increase in the reporting period for quality measures from 90 to 365 days, an increase in the weighting of the Cost category from zero percent to 10 percent, the addition of the Track 1+ACO as an Advanced APM, and virtual groups. The 2019 performance year requirements, as proposed, will represent a gradual increase in requirements as compared to 2018. Changes to the MIPS in the Bipartisan Budget Act of 2018 have extended the transitional period from two years to five years, allowing CMS to adjust performance thresholds and Cost category weightings as practices become more familiar with these programs.

Notes

1. Centers for Medicare and Medicaid Services. “Medicare Program; CY 2018 Updates to the Quality Payment Program.” Federal Register 82, no. 220 (November 16, 2017): 53,568-54,229. www.federalregister.gov/documents/2017/11/16/2017-24067/medicare-program-cy-2018-updates-to-the-quality-payment-program-and-quality-payment-program-extreme.
2. Bradshaw, Susan R., Donald G. Krause, and Michael Marron-Stearns. “MIPS APMs and How They May Impact Your MACRA Strategy.” *Journal of AHIMA* 88, no. 9 (September 2017): 22-25.

Michael Marron-Stearns (Michael@apollohit.com) is CEO and founder of Apollo HIT, LLC.

Article citation:
Marron-Stearns, Michael. "MACRA Strategies for 2018 and 2019 (Update) " *Journal of AHIMA* 89, no.2 (February 2018): 22-27.