

ISSUE BRIEF

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PERSPECTIVES FOR THE HEALTHCARE INDUSTRY

Medicare Access and CHIP Reauthorization Act (MACRA) Quality Payment Program

WHAT IS MACRA?

The Medicare Access and CHIP Reauthorization Act (MACRA) was enacted in April, 2015 and creates a Quality Payment Program to accomplish three key goals for Medicare physician payments:

1. Repeal the Sustainable Growth Rate (SGR), which tried but failed to bend the rising physician cost trend;
2. Establish a new framework to reward physicians for better care, not more care; and
3. Combine the Centers for Medicare & Medicare Services (CMS)'s physician quality reporting programs into one new system, the Merit-based Incentive Payment System (MIPS).¹

MACRA will help the Department of Health and Human Services (HHS) accomplish its goal to tie 85% of Medicare payments to quality or value and 30% to alternative payment models by the end of 2016. HHS aims to increase those goals to 90% and 50% by the end of 2018.²

HOW IS MACRA DIFFERENT FROM THE SGR?

MACRA establishes a series of scheduled physician payment increases, whereas the SGR tied payments to prior year spending and GDP. The SGR mandated physician payment cuts anytime yearly spending growth exceeded growth in GDP. However, physician spending rose consistently while the SGR was in effect so Congress passed yearly "doc fixes" to delay payment cuts.³

1. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html>

2. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-LAN-PPT.pdf>

3. "Health Policy Brief: Medicare Payments to Physicians," Health Affairs, Updated January 10, 2013.

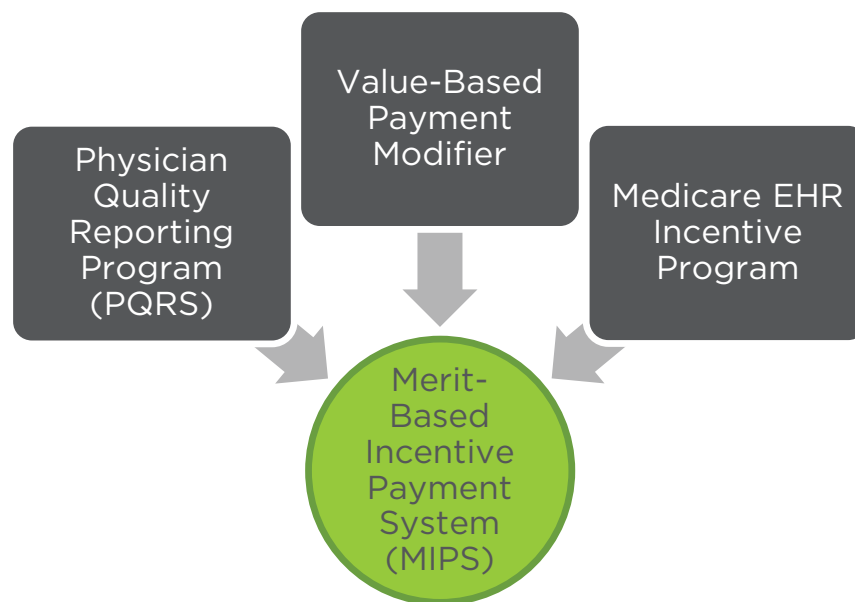
4. https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/HIMSS16_10IMIPSLIsteningSession.pdf

With MACRA, Congress is trying for a permanent “doc fix.” To ensure a smooth transition for physicians, MACRA guarantees 0.5% payment increases for five years (2015-2019) as Medicare transitions to reimbursement focused on increasing quality and lowering costs. In 2020, physicians will no longer receive automatic rate increases; they will instead receive a payment increase or decrease based on their MIPS “composite performance score” (performance score), which takes effect in 2019.⁴

WHAT IS MIPS?

MIPS combines the three existing Medicare physician quality reporting measures and replaces them with a new composite performance score.

Figure 1: Physician Quality Reporting Measures Consolidated Into MIPS



The Physician Quality Reporting System, Medicare Electronic Health Record Incentive Program, and Value-Based Payment Modifier are deconstructed and accounted for in four performance categories. The 2019 payment increases/decreases depend on physicians' performance scores in those categories, weighted as follows:

Table 1: Composite performance score category weights, by year⁵

CATEGORY	DESCRIPTION	2019	2020	2021 AND LATER
Quality	Clinicians choose to report at least 6 measures, including one cross-cutting measure and an outcome measure	50%	45%	30%
Resource Use	Uses episode-specific measures to account for differences among specialties. Based on Medicare claims – no reporting required.	10%	15%	30%
Advancing Care Information	A revised version of the EHR Meaningful Use program. Clinicians choose to report customizable measures that reflect day-to-day use of technology. Does not require all-or-nothing EHR measurement or quality reporting.	25%	25%	25%
Clinical Practice Improvement Activities	Rewards improvements focused on care coordination, beneficiary engagement, and patient safety, among others. Clinicians select their activities from a list of 90+ options.	15%	15%	15%

Physicians' MIPS scores, including aggregate and individual scores for each performance category, will be publicly available on the CMS Physician Compare web site.

Between 2016 and 2018, CMS will establish the measures in each of the four categories. A public call for proposed measures ends June 2016, and the first final rule with proposed measures will be published in November, 2016. In 2017 and 2018, there will be new calls for measures and new final rules. CMS will provide confidential feedback reports to MIPS participants starting in July, 2017.²

5. 4/27/2016 Notice of Proposed Rulemaking: <https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-10032.pdf>

HOW WILL COMPOSITE PERFORMANCE SCORES BE CALCULATED?

Each year, the HHS Secretary determines a performance threshold that is the mean or median performance score across all Medicare physicians during a prior period. The Secretary will select either the mean or the median as the metric, and will revisit this every three years. Physicians whose MIPS scores exceed the performance threshold receive bonuses, and those who fall below owe a penalty.⁴

Each physician is assigned a positive or negative adjustment factor that is determined using a linear sliding scale relative to the performance threshold. Physicians above the performance threshold are assigned a factor between 0% and that year's maximum (e.g., 4% in 2019) based on where their MIPS score falls. Below the threshold, the sliding scale stops at 25%; physicians at or below 25% of the threshold receive the maximum penalty. The adjustment factor's maximum/minimum values increase each year until 2022.⁴

Table 2: Adjustment Factor Max/Min Values by Year

YEAR	MAX/MIN PERCENT (+/-)
2019	4%
2020	5%
2021	7%
2022 and later	9%

Table 3: Adjustment Factor Calculation

MIPS SCORE	ADJUSTMENT FACTOR
100	Max %
PT to 100	Linear: 0% to Max %
Performance Threshold (PT)	0%
25% PT to PT	Linear: Min% to 0%
0 to 25% PT	Min %

CMS adds two other components to the adjustment factors of physicians who exceed the performance threshold: an adjustment for budget neutrality and an adjustment for exceptional performance. To ensure budget neutrality, all positive adjustment factors are increased or decreased by a scaling factor (not to exceed 3) so that the positive and negative adjustments cancel each other out. Additionally, physicians who exceed a second performance threshold may receive a supplemental positive adjustment. \$500 million is available each year from 2019 – 2024 to reward exceptional performance.⁴

WHO PARTICIPATES IN MIPS?

Most eligible clinicians who are not participating in advanced alternative payment models (APMs) will participate in MIPS. Eligible clinicians include physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and groups that include such clinicians. The HHS Secretary may expand this definition in 2021. The three key groups of clinicians excluded from MIPS are:

1. Clinicians in their first year of Medicare participation;
2. Participants whose share of Medicare reimbursements through advanced alternative payment models (APMs) exceeds a designated threshold; and
3. Clinicians below the low volume threshold (less than \$10,000 of Medicare charges and ≤ 100 Medicare beneficiaries).²

HOW DO APMs FACTOR IN?

The advanced APMs that exclude eligible clinicians from MIPS include the Next Generation Accountable Care Organizations (ACOs), Medicare Shared Savings Program Tracks 2 & 3, Comprehensive Primary Care Plus Program, and patient-centered medical homes, among others. Stakeholders may propose additional models for consideration as APMs as long as they meet CMS criteria, which require that the proposed APM:

1. Base payments on quality measures comparable to those in MIPS;
2. Require use of CMS-certified EHR technology; and
3. Either (a) bear more than nominal financial risk for losses or (b) be a medical home model expanded under Centers for Medicare and Medicaid Innovation authority.²

Only some APM participants are considered “Qualifying APM Participants” (QPs), which excludes them from MIPS. The share of the APM participant’s payments through their APM must exceed a threshold each year in order to be a QP, per the following table:⁶

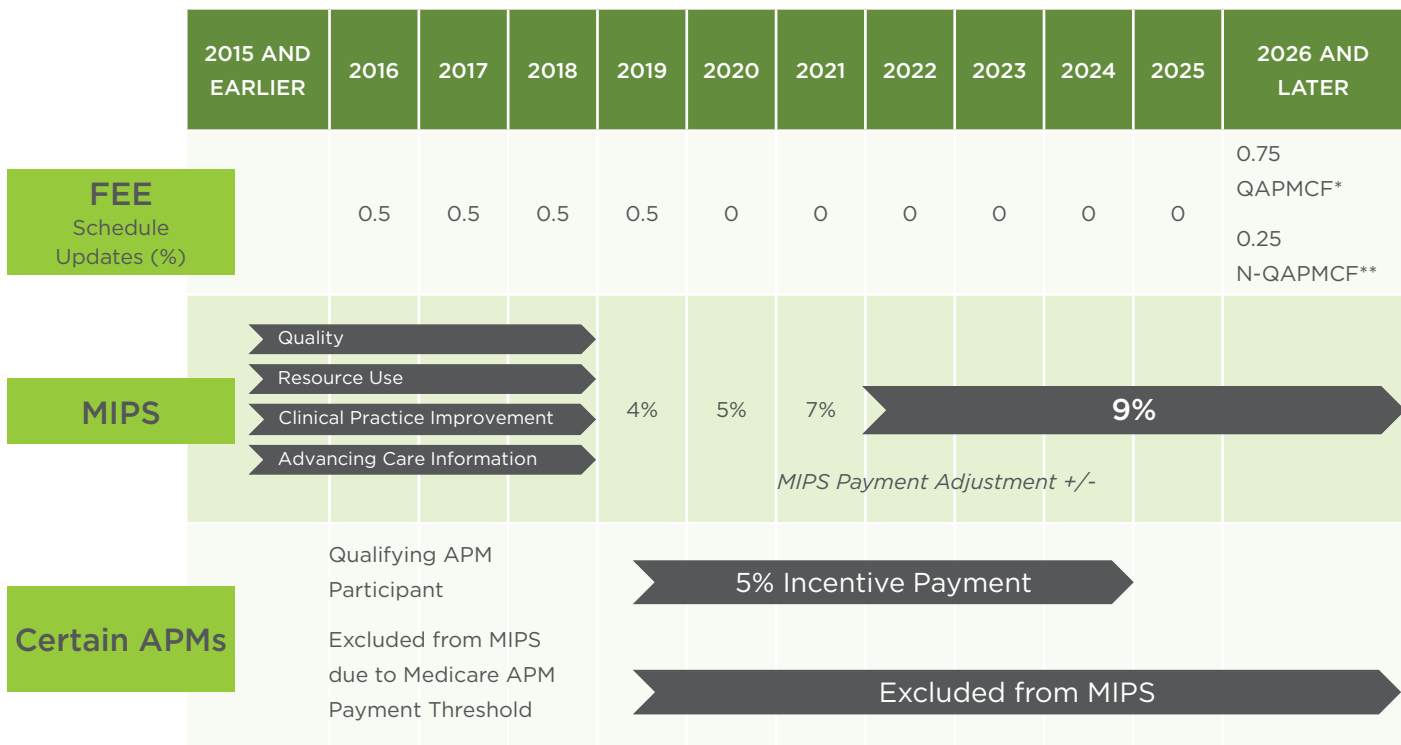
Table 4: Qualifying APM Participant (QP) Thresholds⁷

METRIC	2019-2020	2021-2022	2022 AND LATER
% of Patients	25%	50%	75%
% of Payments	25%	50%	75%
Source	from a Medicare eligible APM	from any payer eligible APM, with at least 25% from a Medicare APM	

WHAT IS THE FULL MACRA TIMELINE?

The following table illustrates the timeline for rolling out the MACRA components described above. CMS recently published the Proposed Rule and solicits public comment until June 26, 2016. The first performance year begins January 1, 2017 and will be used for the 2019 payment adjustment.⁵

Figure 2: MACRA Timeline⁸



*Qualifying APM Conversion Factor

**Non-Qualifying APM Conversion Factor

6. <https://innovation.cms.gov/Files/x/macra-faq.pdf>

7. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/NPRM-QPP-Fact-Sheet.pdf>

8. Adapted from CMS’s “MACRA Timeline”: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Timeline.PDF>

WHAT DOES THIS MEAN FOR ME?

Commitment to Value-Based Payments and Health IT

As Navigant wrote in our April 7th post “Perspectives on Physician Pressure Points in 2016,” physicians need to develop the infrastructure and capabilities to succeed under an increasingly rapid shift towards value-based models where physician payments will require effective documentation and scoring on outcomes of care. Success in MIPS and APM will require use of a certified EHR for any physician practice. With MACRA, CMS is making a firm commitment to value-based payment and health IT; Medicare is paving the way for other payers to follow. Medicare is a market leader on payment reform — take the DRG system, for example — and will continue to exert its influence on the ~17%⁹ of the population and ~20%¹⁰ of National Health Expenditures (not including out of pocket expenses) it controls.

CMS places a clear emphasis on APM participation, and has built in incentives to help providers make the leap to risk-based contracting. Positive incentives exist for physicians who participate in APMs, not those who choose to stay in the fee-for-service world. CMS is encouraging providers to shift towards value-based reimbursement through (a) exemption from MIPS, (b) 5% bonus payments from 2019-2024, and (c) higher fee schedule updates beginning in 2026. If they generate savings, physicians may receive a separate bonus from their APM as well. Even for physicians who don't reach the QP threshold, APM participation can be a benefit; APM participation is considered a Clinical Practice Improvement Activity under MIPS and will contribute towards the MIPS performance score.

On the path to value, CMS recognizes the crucial role that IT infrastructure plays. A certified EHR is the first step, but interoperability, information exchange, and user-friendly technology are key to success in an APM. Since there is no one-size-fits-all approach to IT, MACRA sunsets the “all or nothing” approach of the Meaningful Use program and allows more room for physician groups to tailor their IT to their practice's needs. The 26%¹¹ of physicians who haven't adopted a certified EHR are missing out on easy points — physicians receive 50 of the 100 points in the Advancing Care Information performance category by simply reporting the numerator/denominator or yes/no for each objective and measure¹².

Flexibility Generates Complexity

With the move to more choices in reporting, notably in the Advancing Care Information and Quality performance categories, physicians now have more flexibility, but with flexibility comes complexity. Groups must select the reporting measures that best fit their practice and ensure that the necessary clinical and IT infrastructure is in place to support that reporting. MACRA has set an aggressive timeline, and physicians need to keep up. Performance and reporting starting January 1, 2017 will affect the rate at which a physician gets paid in the future. Plan now to ensure your group's continued success as MACRA is implemented.

9. <http://kff.org/medicare/state-indicator/medicare-beneficiaries-as-of-total-pop/>

10. <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html>

11. <http://www.healthcareitnews.com/news/more-80-percent-docs-use-ehrs>

12. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-MACRA-NPRM-Slides.pdf>

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HOW SHOULD I PREPARE?

You can take these straightforward steps to prepare for MACRA:

- Consider your group's readiness for APM participation, including factors such as timing, financial impact, physician alignment, risk tolerance, capability readiness, operational cost, and beneficiary attribution.
- Participate in the Physician Quality Reporting System (PQRS) if you are not already doing so.
- If you are participating in PQRS, use your Quality and Resource Use Report (QRUR) to help understand your cost and quality performance.
- Consider the cost-benefit opportunity for adding chronic care management services if you do not already have them. Medicare began paying for these services in January, 2015 and they can aid in lowering total cost of care.
- Confirm that your EHR is certified and that EHR documentation is a regular part of your work flow. This will be important for documenting quality measures.
- Read and understand the CMS [materials](#) on the MACRA Quality Payment Program. Submit comments if you have them.