MACRA: Key issues for providers

This article was updated on December 15, 2016.

Christopher Kunkel, FSA, MAAA, PhD
Colleen Norris, FSA, MAAA
Lynn F. Dong, FSA, MAAA

Milliman

At over 2000 pages, the final regulation for Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) is complex and full of details.

There are many high-level summaries that describe the basics of what is in this rule. But looking past the surface, what do affected providers really need to know about how MACRA will impact the market and how they can respond?

We have compiled a list of five important considerations regarding MACRA and how these may affect providers. For each item, we provide key details from the final regulation as well as potential implications for providers. Centers for Medicare & Medicaid Services (CMS) has set up a Quality Payment Program website[1] with summarized information for providers and links to the full regulations.

1. Under MACRA, the Part B fee schedule increases only slightly through 2019 and not at all from 2020 through 2025. After 2025, there will be minimal annual increases to the Part B fee schedule.

MACRA is the long-term replacement for the previous Medicare sustainable growth rate. A key provision of MACRA is its overall impact to Part B reimbursement. The table below highlights the aggregate changes to the Part B fee schedule.

FIGURE 1

YEARS	OVERALL FEE SCHEDULE CHANGES
2015 through 2019	0.5% annually
2020 through 2025	No overall increases (relative to 2019)
2026 and future years	0.75% annual increase for Qualifying Participants 0.25% annual increase for other providers

1 https://qpp.cms.gov/

Amid all the complexities and intricacies regarding the relative scoring and payment adjustments (discussed below), a key aspect of MACRA is that, on an overall basis, Part B fees will be flat or minimally increasing for the foreseeable future.

As providers' fixed and variable operating expenses continue to increase, the flat to minimal fee schedule increases will likely put a significant strain on providers' practices. In particular, for clinicians providing a significant volume of Part B services, multi-year and long-range financial planning will be key in order to understand and prepare for the likely impact to an organization's payments. MACRA highlights that there are significant challenges ahead as providers continue to care for Medicare beneficiaries.

2. The Merit-Based Incentive Payment System (MIPS) consolidates and streamlines three existing programs, resulting in both negative and positive adjustments to providers' current reimbursement.

MIPS consolidates and streamlines three existing programs: the Physician Quality Reporting System, Physician Value-Based Payment Modifier, and Medicare Electronic Health Record (EHR) Incentive Program.

In the near term, we expect that most Part B providers will be subject to the MIPS adjustment.[2] Because the MIPS adjustments to Part B payments are designed to be generally cost neutral,[3] some providers will see an increase in reimbursement while others will see a decrease.

Time is of the essence because providers will soon need to make several critical decisions. The performance/measurement period for reimbursement adjustments under MACRA starts on January 1, 2017.

2 Examples of exempt clinicians are clinicians new to Medicare, clinicians with less than or equal to $30,000 in Medicare billings, and clinicians providing care for 100 or fewer Medicare beneficiaries.

3 Cost neutrality can be abandoned in cases where a significant number of physicians fall below their benchmarks, resulting in an overall payment reduction.

The year 2019 will be the first year in which providers' fees will reflect the MIPS adjustment. However, the first performance period (on which the 2019 payment adjustments will be based) starts on **January 1, 2017**. The timeline below provides key dates for the first several years of the MIPS adjustments.

FIGURE 2: MIPS TIMELINE

	PERFORMANCE PERIOD*	ANALYSIS PERIOD	MIPS ADJUSTMENT APPLIES TO PAYMENT YEAR
Period 1	2017	2018	2019
Period 2	2018	2019	2020
Period 3	2019	2020	2021
Period 4	2020	2021	2022

*For Advanced APM participants, Qualifying APM Participant (QP) status will be determined **based on performance in 2017**. (The actual bonus will be based on 2018 Part B reimbursement).

It could be easy to look at the MACRA timelines and conclude that the impact is still a few years away. However, the reality is that, due to the impending timelines, providers' MACRA response strategies need to start today. In particular, there are key decisions that will need to be made regarding the tracking and reporting of specific quality metrics as well as participating in clinical practice improvement activities (referred to as "improvement activities" or "IA"). Since some of these will require heavy resources, advance planning is critical.

"PICK YOUR PACE" FOR FIRST PERFORMANCE PERIOD (CY 2017)

For the first performance period, CMS has introduced a "pick your pace" option to allow greater flexibility for MIPS-eligible clinicians. The four options are:

- **Option 1 / Nonparticipation:** If a MIPS-eligible clinician chooses not to submit data for any of the required categories, the clinician will receive the maximum negative adjustment (-4%).
- **Option 2 / Test submission:** A MIPS-eligible clinician may report a minimum amount of data[4] and thus avoid a negative payment adjustment. The clinician need only achieve 3 points (out of 100) to avoid a negative adjustment.
- **Option 3 / Partial-year submission:** By submitting data[5] for a full 90-day period, a MIS-eligible clinician will avoid a negative adjustment and possibly receive a positive MIPS adjustment.
- **Option 4 / Full submission:** By fully complying with the MIPS submission requirements, a clinician will maximize the opportunity to qualify for a positive MIPS adjustment.

4 One quality measure and one IA activity for 90-day minimum or report more than required measures of the ACI category.

5 More than one quality measure, more than one IA, or more than required ACI submission.

THE LOWEST-PERFORMING PROVIDERS WILL SEE SIGNIFICANT DECREASES IN THEIR REIMBURSEMENT.

Based on the data submissions for the performance period, CMS will construct an aggregate "final score" ranging from 0 to 100, which is used to set the MIPS adjustment for the payment period. Due to the "Pick Your Pace" option in the final rule, only providers who choose not to submit any data in 2017 will receive the full 4% negative adjustment for the first performance year. In future years of the program, providers with the lowest final scores (scores less than 1/4 of the threshold score) will receive the maximum negative adjustment through MIPS. This means that providers who choose not to report the MIPS-required information will effectively penalize themselves and may receive the most significant decreases in reimbursement. The maximum negative MIPS adjustment (-4% in 2019 to -9% in 2022 and beyond) is always fixed, and will apply to the lowest performing providers.

THERE IS AN OPPORTUNITY FOR HIGH-PERFORMING PROVIDERS.

The MIPS adjustment is often portrayed as a symmetric adjustment to provider reimbursement, but in actuality, this may not be the case. The maximum MIPS adjustment is highly variable and will be scaled so that the total MIPS adjustment is cost neutral (subject to a maximum positive MIPS adjustment). For example, in CY 2019, the lowest-performing providers will receive a 4% reduction to their fees while high-performing providers may see increases up to 12%.

The actual distribution of final scores will have a significant impact on the adjustment for high-performing providers. CMS sets a "performance threshold" score that serves as the dividing line between positive and negative MIPS adjustments. If the final score distribution is skewed below the threshold, then providers with a high final score potentially receive a large MIPS adjustment. Conversely, if most providers exceed expectations and have final scores above the threshold, the adjustment will be lower than expected.

In addition to the variable maximum adjustment, high-performing providers also have the opportunity to share in a $500 million bonus for top performers. This bonus for "exceptional performers" provides the opportunity for an additional increase of up to 10% for payment years 2019 through 2024.

In the first year of the program, due to the "Pick Your Pace" option in the final rule, it is likely that the opportunity for a significant positive adjustment will be limited, due to the options that mitigate providers' potential for negative scores.

The table below shows the minimum and maximum MIPS adjustments by calendar year, excluding the adjustments for exceptional performance.

FIGURE 3: MAXIMUM MIPS ADJUSTMENTS BY YEAR – EXCLUDING ADJUSTMENTS FOR EXCEPTIONAL PERFORMANCE

	MINIMUM ADJUSTMENT	MAXIMUM ADJUSTMENT*
2019	-4%	4% (0% - 12%)
2020	-5%	5% (0% - 15%)
2021	-7%	7% (0% - 21%)
2022 onward	-9%	9% (0% - 27%)

*The maximum adjustment may be scaled by a factor of up to 3 to achieve budget neutrality. Additionally, the "exceptional performers" adjustment may further increase the final adjustment.

Providers will need to be prepared for numerous revenue scenarios because they may face either a positive or negative payment adjustment for future years. Multi-year modeling under favorable or unfavorable situations is key to preparing for a range of outcomes. To the extent possible, providers should also endeavor to understand likely outcomes under MIPS.

3. MACRA encourages providers to participate in Alternative Payment Models.

MACRA provides incentives for providers to participate in Advanced Alternative Payment Models (Advanced APMs). These incentives include the following:

- **Qualifying Participant (QP) Status:** Providers who meet the claim volume or patient volume thresholds, through their care for attributed beneficiaries in Advanced APMs, receive the QP status. QPs receive a 5% payment bonus for payment years 2019 through 2024.
- **Partial QP Status:** Providers who meet a lower claim volume or patient volume threshold are considered Partial QPs. Partial QPs can elect whether to accept the MIPS payment adjustment.
- **Other Providers:** Some providers who participate in Advanced APMs may not meet the claim volume or patient volume threshold for the QP or Partial QP status. These providers receive credit toward the Clinical Practice Improvement Activities category and different scoring weights for the final score.

QPs receive a lump-sum 5% bonus on their prior year's Part B reimbursement from 2019 through 2024, and benefit from a slightly higher fee schedule increase in later years. Because of this, we anticipate that many providers will desire to achieve QP status.[6] However, it is likely that few providers will actually achieve this status in the early years of MIPS. There are parallels to the Medicare Advantage world where only a small percentage of organizations attain the coveted 5-star status.

Broadly, a provider needs to accomplish two things in order to achieve QP status.

- A provider needs to be aligned with an Advanced APM. Advanced APMs are defined by substantial use of EHR, adherence to Quality standards and acceptance of more than nominal financial risk. The current definition of an Advanced APM includes only a few types of entities, including two of the three Medicare Shared Savings Program (MSSP) tracks (Tracks 2 & 3) and Next Generation ACOs (NextGens).[7] As a result, the entities that would currently qualify as Advanced APMs represent only a small fraction of the market.
- The Advanced APM Entity must provide a significant amount of care to **attributed beneficiaries**. The Advanced APM would need to satisfy either a claim volume threshold or a patient count threshold as shown in the table below.

FIGURE 4: QP AND PARTIAL QP THRESHOLDS FOR 2019 (BASED ON 2017 PERFORMANCE YEAR) CLAIMS VOLUMES AND/OR PATIENT COUNTS FROM ADVANCED APM MUST SATISFY THESE REQUIREMENTS

	CLAIM THRESHOLD	PATIENT THRESHOLD
QP Status	25%	20%
Partial QP Status	20%	10%

The parameters for how an Advanced APM Entity meets the various thresholds are complicated, but are all based on two key populations: **Attributed Beneficiaries** and **Attribution-eligible Beneficiaries**. We note that the calculations for determining the numerator and denominator for the claim and patient thresholds are complex, and an organization participating in an Advanced APM will need to work through the details of the calculations.

6 In the proposed rule, CMS estimates that roughly 70,000 to 120,000 Part B providers will meet the QP threshold.

7 For 2019, the list of qualifying entities includes MSSP Tracks 2 and 3; Next Generation ACOs, Oncology Care Model (two-sided risk arrangement), Comprehensive ESRD Care (all arrangements), and Comprehensive Primary Care Plus (CPC +).

For future years, non-Medicare risk-sharing arrangements will be included in the claim and patient thresholds, offering another option for providers to attain QP status.

Two years after the roll-out of MACRA provisions, CMS will introduce the "All Payer" option for achieving QP status. In this arrangement, providers can use risk-based payments from both Medicare Part B and other payers to meet the threshold. Because many providers are already developing or actively involved in commercial and Medicaid risk-sharing arrangements, the inclusion of these programs in the Advanced APM thresholds may help qualify more organizations for this status in the future. An important consideration is that, as CMS provides another option through the "All Payer" claim and patient thresholds, the thresholds themselves will be increasing over time. Therefore, although there will be more options by which providers can attain the QP status, the thresholds themselves will increase.

4. Providers will need to make numerous decisions regarding the submission of quality metrics, participation in improvement activities, and Advancing Care Information.

The four components of the MIPS final score are Quality, Cost, Clinical Practice Improvement Activities (IAs), and Advancing Care Information. There are complexities and subtleties with each of the components. There is no submission for the Cost category as CMS will calculate this score using Medicare claims data, so there is no additional reporting requirement. The Cost category has a weight of 0% for the first performance period (2017), but will be calculated so providers can see their results. For the other three categories, providers will need to compile and submit data for the other three categories, which may be a very resource-intensive process.

QUALITY METRICS

The quality score has a high weight of 60% in the final score for 2019,[8] and is based not on a provider or provider group's absolute performance, but their performance relative to the rest of the market. Therefore, careful strategy is involved to select quality measures in which a provider does not just perform well, but performs well compared to their peers who submit on the same quality measure. Additionally, there are mechanisms for receiving "extra credit" points.

There are hundreds of quality measures, some of which are general and some of which are specialty-specific, which can be found in Tables A through E of the final rule. Quality measures are characterized into the National Quality Strategy Domains, measure type, and whether the measurement is considered "high-priority."

A provider or provider organization must report on at least six measures. Additionally, depending on eligibility, each provider or provider organization will be scored on an additional measure, the all-cause readmission measure that CMS will evaluate based on claims data.

A provider's choice of submitted quality metrics can significantly impact the relative score for this category, as all measures are scored on a relative basis and "graded on a curve." Popular measures may be "topped out," meaning that many providers may achieve similarly high scores. CMS is continuing to refine its definition of "topped out" measures and the impact they will have on a provider's MIPS final score.

In a separate article,[9] we provide examples of the complex scoring methodology for the quality category in the final rule.

IMPROVEMENT ACTIVITIES (IA) SCORE

In contrast to the quality measure scoring, the CPIA category of the final score is the simplest to describe. The MIPS provider must carry out activities to achieve CPIA points, or may have points automatically by way of their MIPS APM structure. There are a total of 92 CPIA categories listed in Table H in the proposed rule, and a provider must select from a combination of high-weighted and medium-weighted measures. Any CPIA must be performed for at least 90 days during the performance period.

Because the resource requirements to meet the CPIA requirement may differ significantly by activity, providers will need to consider carefully their choice of activities.

ADVANCING CARE INFORMATION SCORE

The Advancing Care Information category sunsets the meaningful use of EHR payment adjustment at the end of CY2018. This category introduces new measures for evaluating the meaningful use of EHR and folds these into the overall MIPS adjustment for reimbursement.

5. Participation in an Alternative Payment Model (APM) requires a careful review of potential financial risks and opportunities.

The inclusion of non-Medicare APMs in determining QP status in future years may encourage organizations to consider or continue their participation in commercial, Medicare, and other risk-sharing contracts. While participating in these contracts may have advantages in terms of helping an organization meet the requirements for QP status, it is also critical to understand the potential risks inherent in each APM.

8 The quality category has a weight of 60% for MIPS-eligible clinicians, 50% for clinicians participating in the MSSP or Next Generation ACO programs, and 0% for clinicians participating in "other" MIPS APMs.

9 http://us.milliman.com/insight/2016/MIPS-adjustment-overview/

As an example, the two-sided Medicare Advanced APMs have significant downside risk that encompasses both Part A and B services, so an organization's downside risk is potentially greater than the maximum negative MIPS adjustment (which is applied only to the Part B services). Similarly, an organization may be assuming considerable financial risk under two-sided commercial risk-sharing agreements.

A potential outcome is that an organization participating in an Advanced APM could owe CMS a large payment due to actual costs exceeding the target for a two-sided risk model. At the same time, the organization could meet the threshold for QP status, so it would receive the 5% bonus for Part B services. In some cases, the relative magnitude of the Part A/B payment to CMS and the Part B bonus payment may be roughly offsetting; however, in other cases, it is possible that the payment to CMS could significantly exceed the 5% QP bonus.

For a specific organization, an understanding of the specific financial terms of each risk contract, potential outcomes under the risk-sharing contracts and MIPS, the organization's appetite for risk, and other considerations should factor into the decision regarding whether entering an Advanced APM is the best choice. There is no "one-size-fits-all" answer because each organization's risk tolerance, strategic objectives, and financial considerations will differ.

Milliman has extensive experience helping organizations identify and quantify areas of potential financial risk in APMs. From our experience, we note that even risk contracts that appear relatively straightforward often contain a complex interaction of parameters—such as differing attribution models, quality gating/quality metrics, minimum savings/loss thresholds, outlier provisions, and cost targets. We strongly recommend that organizations considering risk-sharing contracts work with a qualified actuary in order to ensure that the organization fully understands the potential risk it is assuming.

Conclusion

As evidenced by the list of key impacts, the MACRA regulation is complex and full of nuances and subtleties. Keeping abreast of the details and impact of the regulation will be key in planning ahead and trying to "beat the curve" with respect to the relative performance metrics. Multi-year financial modeling of a range of possible outcomes can also help organizations to plan for the various scenarios regarding payment adjustments. The entry into any APM should be done with care and consideration after quantifying potential risks and the combined impact of the APM participation and MIPS. Milliman consultants are available and excited to assist providers with the changing needs, requirements, and opportunities that MACRA presents.

FOR MORE ON MILLIMAN'S PERSPECTIVE ON MACRA:
Visit milliman.com/macra
Visit our blog at healthcaretownhall.com
Follow us at twitter.com/millimanhealth

Milliman

Milliman is among the world's largest providers of actuarial and related products and services. The firm has consulting practices in life insurance and financial services, property & casualty insurance, healthcare, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

milliman.com

CONTACT

Christopher Kunkel
chris.kunkel@milliman.com

Colleen Norris
colleen.norris@milliman.com

Lynn F. Dong
lynn.dong@milliman.com