MACRA's Medicare Part B Payments under MIPS

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As many providers are now aware, the Medicare Access and CHIP Reauthorization Act (MACRA) dictates the amount of Medicare Part B payments providers will receive, with the measuring period beginning in 2017 and the first payment adjustments occurring in 2019. Revolutionizing the way CMS compensates physicians and other providers under Medicare Part B, MACRA consolidates multiple quality reporting programs into the Merit-based Incentive Payment System (MIPS) and also provides incentives for participation in Alternative Payment Models (APMs).[1]

First, providers will receive payment in accordance with the Medicare fee schedule. The APM component of MACRA specifically increases physician payments by 0.5% each year from 2016 to 2019. There are no planned increases in payments from 2020 to 2025; from 2026 on, the CMS fee schedule will increase annually 0.25% - 0.75% for APMs and 0.75% for AAPMs. After CMS receives the below-stated quality cost and other data from the providers, under MIPS CMS will then determine whether to award extra money or require providers to pay back a portion of the received Medicare Part B Payments, as detailed below.

MIPS will measure participant performance through a composite score that takes into account four factors:

1. Quality;
2. Resource use (i.e., cost);
3. Clinical practice improvement activities (CPIA); and
4. Advancing care information (ACI).

MIPS then consolidates these four previously voluntary performance measuring programs into one composite score.

CMS will determine the provider's resource use score by comparing the provider's cost efficiency for similar care episodes across practices, this score will be risk-adjusted. CMS has stated that this factor will not be taken into account when determining the payment amount for 2017; however, cost will be taken into account for subsequent years. CPIAs will track activities such as care coordination, shared decision-making, safety checklists, and expanding practice access and ACI metrics will mirror those measures now in place under the meaningful use program.[2]

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[1] For the sake of brevity, the details of the alternative payment models are beyond the scope of this article.
[2] *"MACRA NPRM Overview,"* Centers for Medicare and Medicaid Services (last accessed May 17, 2016) < https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-Events.html>.

Each of the above categories of performance within MIPS also will be weighted, with Year One performance weights distributed as follows:

- Cost - 10%
- Quality - 50%[3]
- ACI - 25%, and,
- CPIA - 15%

These weightings are expected to change as the program evolves and takes into account alterations in the delivery system, such as an increase in providers who adopt electronic health records and comply with ACI criteria. Expectations are that the MIPS quality component will decrease to 30% after year one while the cost component increases to 30%.

Once implemented in 2019, the MIPS composite performance score (CPS) that factors in the scores from all four (subject to the cost accounting category not being considered in 2017) categories described above. A MIPS-eligible clinician's payment adjustment percentage is based on the relationship between their CPS and the MIPS performance threshold. A CPS below the threshold will yield a negative payment adjustment, and a CPS above the threshold will yield a neutral or positive adjustment.[4]

For instance, a CPS less than or equal to 25% of the threshold will yield the maximum negative adjustment of 4% in the first year. An additional bonus (not to exceed 10%) will be applied to payments to eligible clinicians with exceptional performance where the CPS is equal to or greater than an *additional performance threshold* defined as the 25th percentile of possible values above the performance threshold.[5]

Once CMS calculates the initial payment adjustments for the MIPS-eligible providers, CMS can positively adjust the payments up to a factor of three in order to achieve budget neutrality of the MIPS payments. For example, a provider who would originally receive a payment adjustment of 4% could be eligible to receive a maximum positive adjustment of 12% if CMS was required to triple the payment adjustment in order to achieve budget neutrality.

CMS intends to set the payment threshold so that 50% of eligible clinicians will receive a favorable adjustment and 50% will receive a negative adjustment. This alteration will result in budget neutrality for CMS as it relates to MIPS payments. As mentioned, exceptional performers will receive additional positive adjustment payments from a bonus pool of $500 million each

[3] Because the cost factor will not be taken into account for the first year, quality will account for 60% of a provider's composite score for the first year only. *What's the Merit-based Incentive Payment System (MIPS)?,* Centers for Medicare and Medicaid Services, (last accessed October 30, 2016), https://qpp.cms.gov/learn/qpp.
[4] *Supra,* note 2.
[5] *Id.*

year from 2019 through 2024, and these payments are not subject to the budget neutrality provision of MACRA.[6]

The burden for physicians reporting their quality data to CMS *in only 2017* can be fairly minimal to quite extensive, depending on the provider's preference. First, the provider can choose to not participate in the MIPS program. In that event, the provider will receive a negative 4% payment adjustment in their Medicare Part B payments in 2019. Second, the provider can submit a minimum amount of 2017 data (as it pertains to one measure or activity). If the provider chooses to submit the bare minimum, the provider will neither receive a payment increase nor decrease. Third, the provider can submit 90 days of 2017 data, wherein that provider will earn a small positive or neutral payment adjustment. Finally, if the provider fully participates in the MIPS program and submits a full year of data, the provider will be eligible to earn a positive payment adjustment.[7]

Providers must submit their 2017 data by March 31, 2018. CMS has stated that they will provide feedback regarding the provider's 2017 data in 2018. Finally, as noted earlier, the actual payment will be received in 2019.[8]

The Medicare Access and CHIP Reauthorization Act is a landmark piece of legislation and represents a dramatic change in the way CMS will pay healthcare professionals. While complex, all providers should avail themselves of as much information about MACRA as possible. Preparatory efforts should start immediately in provider organizations affected by MACRA.

Please share your thoughts about the MACRA's Medicare part B payments under MIPS and any questions you may have about how this affects your organization by contacting Ellis "Mac" Knight, MD, Senior Vice President/CMO at mknight@cokergroup.com or by calling 678-832-2021.

[6] *Id.*
[7] *Quality Payment Program,* Centers for Medicare and Medicaid Services, (last accessed October 30, 2016), https://qpp.cms.gov/
[8] *Id.*