Issue Brief: The Impact of ACOs on MIPS Payments for All Eligible Clinicians

By Lynn Barr, MPH and LeeAnn Hastings, JD, MPH

Unlike the Physician Quality Reporting System, Meaningful Use, and the Value-Based Modifier, the Centers for Medicare & Medicaid Services’ (CMS) new Merit-Based Incentive Payment System (MIPS) places the performance of each clinician on a curve, and adjusts their Part B payments based on their precise location in the distribution compared to others.

In 2019, the first payment year, MIPS will take approximately $199 million from eligible clinicians below the performance threshold and redistribute those funds to providers above the performance threshold. Eventually, the redistributed dollars will be equivalent to nine percent of Medicare physician payments. In addition, for the first five years $500 million in supplemental funding will be awarded each year. During this time, MIPS adjustments could add ten percent in addition to the maximum positive payment adjustment, which is three times the amount of penalty. For example, taking into account CMS scaling factor and the exceptional performance bonus, a top-performing practice could theoretically earn up to a 25 percent payment adjustment in the 2018 performance year. To predict payments and potential bonuses under MIPS, clinicians must know both their performance score and estimate the score of the rest of the providers in the pool.

Forty percent of eligible clinicians are expected to be participants in Track 1 Medicare Shared Savings Program Accountable Care Organizations (MIPS-ACOs). MIPS-ACOs have special scoring standards that will cause most other MIPS-eligible clinicians to receive lower adjustments in comparison.

WHO IS IN THE MIPS POOL?
The MIPS pool is comprised of eligible clinicians who are not excluded from the program because of low volume or participation in a Qualifying Advanced Payment Model. All other clinicians are in the MIPS pool, including clinicians that participate in risk-free Track 1 ACOs.

1 A Qualifying Advanced Payment Model either takes more than a nominal amount of risk or is a CMMI Medical Home model such as Comprehensive Primary Care Plus.
CMS estimates that 50 percent of clinicians will participate in Advanced Payment Models in 2018, of which at least 80 percent will be in Track 1 ACOs. Therefore, an estimated 40 percent of clinicians in the MIPS pool are expected to be participating in Track 1 ACOs.

SCORING DIFFERENCES BETWEEN MIPS AND MIPS-ACO PARTICIPANTS
Although both MIPS and MIPS-ACO clinicians are subject to a MIPS payment adjustment and competing for the same set of redistributed dollars, scoring is markedly different for the two groups. While all practices should be able to achieve high scores with effort and good measure selection, MIPS-ACOs have several inherent advantages.

QUALITY
For standard MIPS clinicians, the quality score will be based upon six measures to be selected by the clinician or group, depending upon how the practice wants to be scored. All clinicians, including specialists, are required to report on quality.

In contrast, ACOs are scored collectively, with the ACO quality submission applying to all providers billing under the ACO’s tax ID numbers (TINs). All ACO providers are covered by this submission, including specialists and hospital clinicians. Additionally, MIPS-ACO reporting allows providers to submit the first 248 consecutive patients for each of 15 primary care measures through the CMS Group Reporting Option (GPRO). Clinicians are provided a list of selected Medicare patients and given six weeks to retrieve missing data and “polish” their scores. Track 1 ACOs average 92 percent quality scores, resulting in 40 percent of clinicians in the MIPS pool having a quality score that is nearly perfect.

MIPS providers can also submit quality measures via the GPRO option, however GPRO is only applicable for primary care groups, multi-specialty groups, or hospitals with primary care providers. For all other MIPS participants submitting quality data outside of GPRO, MIPS reporting requires uploading at least 50 percent of patient data for six selected measures. With that volume of patients, it will be very difficult and expensive to review every chart for missing data elements.

GPRO reporters will typically have higher quality scores than MIPS-Electronic Health Record (EHR) reporters. Those that report through Qualified Clinical Data Registries (QCDR) or other indirect means are likely to suffer data loss, and many MIPS-QCDR reporters are expected to have the lowest scores unless they manually override the data.

RESOURCE UTILIZATION
In general, more MIPS-ACO participants will achieve the exceptional performance bonus because they will not be scored on resource utilization (cost). Under the APM scoring standard, Track 1 ACO participants are exempt from this category. These MIPS-ACO clinicians will have their resource utilization points re-weighted to the quality, advancing care information, and improvement activities categories, giving them a strong advantage by excusing them from the category that is the hardest for clinicians to control. MIPS clinicians who wish to estimate their points in this category can do so by looking at their Quality and Resource Utilization Reports in 2017. MIPS-ACO clinicians need not be concerned. While resource utilization is not considered for the 2017 performance year and will equal only 10% in 2018, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires that category account for 30% of the overall score beginning in the 2019 performance year.
CLINICAL PRACTICE IMPROVEMENT ACTIVITIES

Although most providers should be able to do well in this category, scoring will become more difficult over time. For the first several years of the program, MIPS-ACO participants will automatically get 100 percent in this category, further widening the gap between MIPS and MIPS-ACO participants.

ADVANCING CARE INFORMATION

The new “meaningful use” category will be where MIPS-ACO participants compete for the exceptional performance bonus, given that MIPS-ACO participants will have virtually identical scores for the other three categories (and occupy the majority of the right side of the bell curve). Implementing workflows where patients log into the portal during office visits and diligently send and request summary of care documents on all referrals outside the organization can help practices achieve a perfect score.

MIPS-ACO participants will receive a single score for the entire ACO. Performance reported by each ACO TIN will be weighted by the number of clinicians to calculate an overall ACO score. In this way, a high-performing hospital TIN with provider-based clinics and 200 clinicians that earns one hundred points can easily bolster it’s smaller ACO partners and preserve the reputations and incomes of the local community-based physicians.

IMPACT OF MIPS ACOs ON ELIGIBLE CLINICIANS

Track 1 participation virtually guarantees strong MIPS performance to ACO participants due to their special scoring, which in turn reduces the potential dollars for non-ACO clinicians. The following table illustrates the differences in the MIPS score for a high performing practice depending on which scoring standard is used. For this illustration, we assume the practice achieves top scores in quality, advancing care information, and improvement activities. Assuming an average cost score, the effect of being exempt from the cost category yields up to a 15-point advantage for the MIPS-ACO participant in 2019. An organization with high cost patients can forfeit as much as 30 points, while a very efficient organization with the lowest costs are the only MIPS participants who can compete with Track 1 ACOs.

If 40 percent of providers are getting special scoring, it is possible that when the performance threshold is set, many MIPS participants may not exceed the minimum performance threshold and may have to pay the MIPS penalty by the 2019 performance year. Every point earned in MIPS will adjust Part B payments upward or downward incrementally two years later.

COMPARISON OF MIPS SCORES BETWEEN MIPS AND MIPS-ACO PARTICIPANTS
(HIGH PERFORMING ENTITIES WITH AVERAGE COST)

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CONCLUSION
High performing MIPS participants with average costs will score 15 percent lower than equivalent MIPS participants that are in a risk-free Track 1 ACO and may find it difficult to earn the exceptional performance bonus. High performing MIPS participants with high costs will score 30 percent lower than equivalent MIPS participants that are in a risk-free Track 1 ACO and may face MIPS penalties. Hospitals can avoid hundreds of thousands of dollars in downward MIPS adjustments, and potentially earn the exceptional performance bonus by enrolling in an ACO to take advantage of special scoring for their clinicians. Small practices should consider joining an ACO to avoid penalties for generally lower scores due to lack of infrastructure, and providers in rural areas may want to join ACOs to avoid MIPS penalties due to their higher cost structure.

In the ACO model, only PCPs report quality. All other clinicians are only responsible for reporting under Advancing Care Information (ACI). Hospitals can support their community physicians, particularly specialists, by enrolling them in their ACO, protecting their incomes and reducing their administrative burden. This will also protect the reputations of community providers and create closer integration within the community health system, improve patient care and provide new sources of income from managing population health.

ABOUT THE AUTHORS:
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