MACRA 101

Participate or Penalty? You Decide.

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TEXAS MEDICAL ASSOCIATION
Physicians Caring for Texans

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Medicare Access and CHIP Reauthorization Act of 2015

- Permanently repealed SGR and eliminated the 21% cut that had been scheduled for 2015
- Participation in alternative payment models including ACOs, medical homes, and bundled payments programs still voluntary, but some types of "advanced" APMs receive incentives of 5% and, after 2026, enhanced fee schedule updates
- In fee-for-service, a new Merit-Based Incentive Payment System (MIPS) replaces PQRS, eRx, meaningful use, and the value-based payment modifier (VBM). Those penalties will not end until 2019
- Bonuses and penalties in MIPS limited to ±4% in 2019 then gradually increasing to a maximum of ±9% after 2021

ET55

Incentives and Penalties in FFS

PQRS + MU + VBM	MACRA — MIPS
Maximum Penalties (few bonuses)	Maximum Penalties and Bonuses
2015 -4.5%	2015-2018 PQRS etc.
2016 -6%	2019 ±4%
2017* -9%	2020 ±5%
2018 -10% or more	2021 ±7%
~~2019 on -11% or more~~	2022 on ±9%
	Plus additional bonus possible

*-7 for groups of less than 10 EPs

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Slide 4

ET44 In the chart head, I changed "VBPM" to "VBM" to match the previous slide (also is the abbreviation we typically use)
Ellen Terry, 8/19/2016

ET55 Changed the dash to an em (long) dash (TMA style thing)
Ellen Terry, 8/19/2016

MACRA — Alternate Practice Models

- Only advanced APMs will get 5% bonus, be exempt from MIPS scoring
  - "More than nominal" downside risk or a medical home model
  - Requires certified EHR technology
  - Payment to professionals based partially on quality and cost
  - Includes: Track 2 & 3 ACOs, Next Generation ACOs, Comprehensive ESRD Care, Comprehensive Primary Care Plus
- CMS projects that large majority of physicians will be in MIPS in 2019, including those currently in APMs
  - Physicians in APMs will have slightly different MIPS scoring

Alternate Practice Models

- Issues to consider in taking risk:
  - Financial reserves
  - Size of covered group
  - Population risk
  - Risk adjustment — adequate?
    - CMS currently does not adjust for most socioeconomic variables that are known to influence outcomes and/or patient adherence to medical advice
  - Utilization controls – are you willing to, and can you control choices of patients and other providers
- Are MIPS incentives better?
  - Are compliance costs approximately equal?
  - Compare shared savings plus 5% with potential MIPS incentives (and triple bonuses?) Consider risk of loss

Merit-Based Incentive Payment System

- FFS with ±4%, increasing to ±9% maximum, but bonuses for outstanding performance can be up to 3 times that amount
- Penalty/incentive based on composite performance score (CPS):
  - Cost 10% to 30%
  - "Quality" 50% to 30%
  - ~~MU~~ Advancing Care Information (ACI) 25%
  - Clinical practice improvement activities (CPIA) 15%

Compliance

- Cost-benefit question (unless purely for patient care quality improvement)
- Cost to comply includes all labor and other cost required to:
  - Learn the requirements
  - Change operating procedures and protocols
  - Train all staff
  - Perform or provide the service
  - Document what you performed or provided
  - Report what you documented
  - Verify reported data
  - Defend reported data in audit

MACRA MIPS Rules

- MIPS
  - Payment adjustments will be budget neutral — no winners unless there are losers
  - Adjustments still based on two-year-old performance data
  - Exemption for low volume — proposed: under $10,000 and fewer than 100 patients
  - Some simplified reporting options for individual physicians (claims-based or attestation), but CMS is incentivizing use of QCDRs and/or CEHRT for all reporting with extra points

Quality (Formerly PQRS)

- 50% of total composite score — decreasing to 30% in 2 years
- Report 6 measures including 1 cross-cutting, 1 outcome or high priority
- Plus population measures automatically calculated from claims data (by attribution)
- Under PQRS, penalties/incentives were awarded for reporting. Now score is based on what you reported
- Each measure scored 1-10 based on historical benchmark (2 years prior)
- Proposed: All-payer reporting for most reporting methods (not claims)

Quality Measure Issues

- No credit for reporting
- Are we measuring the things that matter?
  - Many physicians say no
  - Specialty measures in some cases inadequate
- Are we measuring physician performance or something else?
  - Patient compliance?
  - IT vendor performance?
- Attribution problems
- No risk adjustment for many population variables that affect outcomes
- Statistical volatility in small numbers

Resource Use (Cost)

- 10% of total composite score — increasing to 30% in 2 years
- Calculated by CMS (no separate reporting)
- For 2017:
  - Per-capita cost for all attributed beneficiaries
  - Medicare spending per beneficiary (MSPB)
- After 2017 — Some new (untested) episode measures
- CMS uses attribution rules to assign all patient cost to physicians
- All based on performance 2 years prior

Attribution

- Medicare says its attribution rules are based on "primary care services"
- Definition of "primary care services" includes all outpatient E&M codes plus TCM and CCM
- Two steps
  - TIN of primary care physician (FP, IM, geriatrician, GP) or nonphysician who provided the most primary care services (or the most recent, if tied). If none,
  - TIN of any eligible professional (including specialists) who provided the most "primary care services".

Advancing Care Information (MU)

- Base score 50%
  - Meet each of 11 measures at least once
- Performance score — up to 80%
  - Not all needed to get maximum score, so offers some flexibility
- Many measures still based on patient performance

Clinical Practice Improvement (CPIA)

- Compliance options to choose from including:
  - Expanded access (same day-appts., after-hours care)
  - Population management (monitoring, registries)
  - Beneficiary engagement (care plans, self-management training, shared decisionmaking)
  - Patient safety and practice assessment (checklists, MOC)
  - Alternate payment model
- In some cases, reporting will be a simple attestation
- Might be the only component that is in physician control

Scoring

- Composite performance score example: ET58

MIPS Category	Performance %	Category Points	Score
Cost	50%	10	5
Quality	50%	50	25
ACI	0%	25	0
CPIA	100%	15	15
CPS Total		100	45

- CMS will set a benchmark value. Below it, physicians will get penalties. Above it, incentives

Slide 16

ET58 Lowercased "performance score example"
Ellen Terry, 8/19/2016

MIPS Cost/Benefit Example

Return on Investment — Full Compliance							
Example Assumptions:							
Interest rate = 0% ET52							
Medicare Revenue per Physician	**$250,00**						
Year	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**
Penalty/Incentive Amount				**4%**	**5%**	**7%**	**9%**
Activity							
EHR Implementation Costs — First 90 days	**$32,409**						
EHR Maintenance Costs		**$17,100**	**$17,100**	**$17,100**	**$17,100**	**$17,100**	**$17,100**
Quality Reporting — Physician and staff labor		**$10,598**	**$10,598**	**$10,598**	**$10,598**	**$10,598**	**$10,598**
ACI (MU) Reporting — Labor cost unknown		**?**	**?**	**?**	**?**	**?**	**?**
CPIA Cost — Unknown but probably small		**?**	**?**	**?**	**?**	**?**	**?**
Total Annual Cost	**$32,409**	**$27,698**	**$27,698**	**$27,698**	**$27,698**	**$27,698**	**$27,698**
Return if penalties are avoided and incentives are earned	**$0**	**$0**	**$0**	**$20,000**	**$25,000**	**$35,000**	**$45,000**
Annual Profit/Loss	**-$32,409**	**-$27,698**	**-$27,698**	**-$7,698**	**-$2,698**	**$7,302**	**$17,302**
Accumulated Profit/Loss	**-$32,409**	**-$60,107**	**-$87,806**	**-$95,504**	**-$98,202**	**-$90,900**	**-$73,599**
Result: Even though we are unable to estimate some costs, compliance costs far exceed any return from incentives and avoided penalties. Physicians would accumulate large net losses through 2022.							

ET53

MIPS Cost/Benefit Example

Return on Investment — Considering Reporting Cost Only						
Example Assumptions:						
Interest rate = 0%						
Medicare Revenue per Physician	$250,000					
Year	2017	2018	2019	2020	2021	2022
Penalty/Incentive Amount			4%	5%	7%	9%
Quality Reporting — Physician and staff labor	$10,598	$10,598	$10,598	$10,598	$10,598	$10,598
ACI (MU) Reporting — Labor cost unknown	?	?	?	?	?	?
CPIA Cost — Unknown but probably small	?	?	?	?	?	?
Accumulated Cost	$10,598	$21,197	$31,795	$42,393	$52,991	$63,590
Return if all penalties are avoided			$10,000	$12,500	$17,500	$22,500
Annual Profit/Loss	-$10,598	-$10,598	-$598	$1,902	$6,902	$11,902
Accumulated Profit/Loss	-$10,598	-$21,197	-$21,795	-$19,893	-$12,991	-$1,090

Slide 17

ET52 Made the capital/lowercase consistent in the chart
Ellen Terry, 8/19/2016

Slide 18

ET53 Made the capital/lowercase consistent in the chart
Ellen Terry, 8/19/2016

Participation Options

Medicare Options

- Participating ET54
  - Accept Medicare allowable as payment in full — collect only coinsurance and deductible
  - Mandatory claim filing — payment directly to physician
  - Can change to nonpar status only during open enrollment at end of each year
- Nonparticipating
  - Mandatory claim filing, but can choose:
    - Accept assignment — 95% of Medicare allowable
    - Collect from patient — limiting charge — 109.25% of Medicare allowable. Patient gets partial payment from Medicare
  - PQRS, meaningful use, and VBM penalties apply!
  - All physicians are considered nonpar when they enroll as a new provider in Medicare or reenroll due to a tax ID number change unless they send in a par agreement

Slide 20

ET54 Deleted "s" in "Accept"
Deleted hyphen in "reenroll"
Ellen Terry, 8/19/2016

Medicare Options (cont.)

ET59

- Opt out
  - File special notice with Medicare — accept no Medicare payment except in emergencies
  - Can cancel opt-out at two-year anniversaries with 30-day notice
  - Written agreement with every Medicare patient
  - Collect your standard charge directly from Medicare patient. Medicare pays nothing

Questions?

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Slide 21

ET59 Lowercased "out"
Ellen Terry, 8/19/2016