MACRA – A New Medicare Reimbursement Method for Physicians

Introduction

On April 16, 2015, a major adjustment to physician reimbursement occurred. The Medicare Access and CHIP Reauthorization Act (MACRA) repealed the Sustainable Growth Rate (SGR) mechanism to the Physician Fee Schedule (PFS), altering the way physicians are reimbursed under Medicare. By repealing SGR, Congress has made the fee-for-service structure less attractive in an attempt to move providers to a fee-for-value model.

Under the new model, Medicare payments will increase by 0.5% a year from July 2015 to December 2018. In January 2019, a new replacement Medicare formula will reimburse physicians under one of two methods (though 2017 is the first year for which many physicians will be bonused or penalized under these methods):

1. Merit-Based Incentive Payment System (MIPS): Combines the Physician Quality Reporting System (PQRS), the Value-Based Modifier (VBM), and meaningful use into one larger program that gives doctors a quality score. If their scores are above the average, Medicare reimbursement rates will go up, if at the average, there will be no adjustment, if below the average, Medicare payment will be cut.

2. Alternative Payment Models (APMs): Innovative payment arrangements that require a group of doctors to band together and take a lump sum of money to care for a certain group of patients. If they can provide the care for less — and hit certain quality metrics — they get to keep some of the leftover cash. The hope is that these models will force physicians to be vigilant against wasteful care, since they will have a financial incentive to spend less than their lump sum amount. Physicians who are eligible and who choose to participate in a qualifying APM will receive a 5% bonus each year from 2019 through 2024 on top of all their other Medicare payments. Beginning in 2026, they will qualify for a 0.75% increase in their payments each year. APMs include ACOs and must place material financial risk for monetary losses on providers, use quality measures comparable to MIPS, and use certified EHR technology.
Under both payment models, physicians will still be provided with a fee-for-service payment based on the Physician Fee Schedule. From 2020 to 2025, existing Medicare fee-for-service rates will remain at 2019 levels with no updates. By retaining a fee-for-service component it is hoped that physicians will remain productive as they will continue to be rewarded for volume of patients seen or volume of work done as measured by relative value units (RVUs). Realizing these payment systems may not appeal to some physicians, the law requires that CMS report on the number of doctors dropping out of Medicare.

Payment Scores Under MIPS

The MIPS program will assess physicians in four categories. Physicians will receive a score of 0 to 100, according to their performance in each of the four categories, including Quality, Improvement Activities, Advancing Care Information and Cost. The names of these categories and the amount each contributes to a physician’s score have altered somewhat since MACRA became law in 2015. The amount that each category contributes to the MIPS final score will change over time, but in 2017, Quality comprises 60% of the MIPS score, Improvement Activities 15%, Advancing Care Information 25% and Cost 0% (to ease the transition to MIPS). The methods to earn points in each category are as follows:

- **Quality (60%)**: the Quality category is scored by reporting on six quality measures for the full reporting period. For at least half of the episodes in the reporting period, physicians need to record their performance. (In future years, this reporting rate will increase.) This is a successor to the Physician Quality Reporting System (PQRS)
- **Improvement Activities (15%)**: Reporting Improvement Activities requires selecting activities from CMS’s list, which contains over 90 options
- **Advancing Care Information – ACI (25%)**: To participate in this category, physicians must complete four or five base requirements with a 2014 or 2015 Certified Electronic Health Record (EHR), respectively. Physicians may then score additional performance and bonus points. ACI's component measures will be familiar to those who have participated in the Meaningful Use or EHR incentive programs, but ACI's modular scoring and greater flexibility are different from those programs
- **Cost (0%)**: The Cost category measures resource use, and is the only category that does not require physicians to report anything. In 2017, CMS will calculate Cost scores from submitted claims. CMS will give physicians feedback through the Quality and Resource Use Reports (QRURs), which were previously used as individualized feedback for the Value Based Modifier


CMS intends to adjust the score weights and nature of these categories every year to adapt to providers' changing performance.
The Scoring System

The MIPS scoring system has four distinct thresholds. As 2017 is the transition year for clinicians to join the new program, CMS has tried to make the scoring system as friendly as possible to those just beginning to participate in MIPS. Not participating at all means a score of zero points, but even modest participation will translate to a score above the positive payment threshold of three points, thereby reaching the neutral payment adjustment.

- **0 Points:** Clinicians who do not participate in MIPS at all in 2017 will receive zero points and a negative 4% payment adjustment in 2019.
- **3 Points:** Even modest participation in MIPS, commonly called the “test pace” option, will earn three points and quality for a neutral payment adjustment (neither a positive nor negative change in payment).
- **4–69 Points:** This is the range where clinicians can begin to see modest payment adjustments. Positive payment adjustments will be assigned on a linear sliding scale, with higher scores bringing clinicians closer to the maximum 4% positive payment adjustment.
- **70–100 points:** This group is eligible for the exceptional performance bonus, which will use additional funds to boost positive payment adjustments for top performers.


In 2017, the transition year, CMS has tried to make scoring points as achievable as possible by weighting the categories toward familiar activities (such as quality reporting). CMS has also tried to provide accommodations for non-patient facing and hospital-based providers and providers in rural or small settings. Finally, for 2017 only, providers only need to participate for 90 days to be eligible to score in the 4-100 point range.

The sliding scale for payment adjustments will depend on several factors, ranging from the available money retained in negative payment adjustments to the scores of participating clinicians. CMS will take scores in the 4-100 range and apply an adjustment factor that takes these factors into account. For those scoring in the exceptional performance range of 70-100 points, additional funds are available for a minimum 0.5% performance bonus, possibly scaling as high as a 10% bonus.

Physician MIPS scores will be publicly available through “Physician Compare”. Adoption of telehealth and remote patient monitoring by physicians participating in MIPS are specifically named as potential score-boosters. Since from 2020 to 2025 Medicare fee-for-service rates will remain at 2019 levels with no updates, it is these scores that will determine the total amount physicians participating in MIPS earn from Medicare payments.

For those physicians participating in MIPS, 2017 will be the first year for which they will be bonused or penalized. In 2019 (based on 2017 performance), MIPS scores will impact physician Medicare payments plus or minus 4%. Payments will be plus or minus 7% in 2020 based on 2018 performance, and plus or minus
9% in 2021 based on 2019 performance.

It should be kept in mind that bonuses higher than 4%, 7% and 9% are possible, because in an attempt at budget neutrality, bonuses will be paid out of the penalties. Using a sliding scale specified in MACRA, bonuses offered will max out at 3 times the penalties. This means that if many doctors are penalized, and few receive bonuses, the amount of the bonus could increase. In 2021, for example, high performing physicians could receive three times the 9% bonus for a total of a 27% bonus.

An additional incentive payment for “superstars” will be available, capped at an aggregate amount of $500 million for each of the years 2018-2023.

Hypothetically, in 2021 a MIPS participating physician could receive a $100 fee-for-service payment for treating a particular Medicare patient. With a high MIPS score, that payment could increase to $109 or higher the following year when the payment bonus kicks in. With an average MIPS score it would remain $100 the following year. With a poor MIPS score it could decrease to $91 the following year. Given current profit margins for many physician practices, low MIPS scores would be difficult if not impossible to maintain.

What is an Alternative Payment Model?

If a physician or healthcare organization chooses to opt-out of MIPS and pursue an APM, they have another choice to make – which type of APM? Participation in ACOs, a Patient Centered Medical Home (PCMH), or a bundled payment model will qualify as an APM under MACRA.

*Accountable Care Organizations*

One way physicians can participate in an ACO is through the Medicare Shared Savings Program (MSSP). Like other ACO models, the MSSP rewards ACOs that lower growth in health care costs while meeting performance standards on the quality of care. To become part of the program, eligible providers can create or participate in an ACO.

Participants must meet quality performance measures from four domains: patient/caregiver experience, preventive health, care coordination/patient safety, and at-risk populations. Much like MIPS, providers must meet a threshold (at least the 30th percentile) in order to be eligible for the shared savings. Paying for performance will be phased in over subsequent years.

This type of payment model encourages *population health management* in which large healthcare organizations such as ACOs attempt to control costs and improve quality through patient interventions that address unhealthy behaviors, by addressing the societal determinants of ill-health, and through rigorous management of care (for more information on population health management see the Merritt Hawkins’ white paper *Population Health Management and Physician Staffing*).
Patient Centered Medical Home

Another option for an APM is the PCMH model. Research from the Patient-Centered Primary Care Collaborative (PCPCC) indicates that PCMHs reduce visits to the emergency room by 57% and readmissions by 29%. In addition, a 57% reduction in cost provides evidence that PCMHs may prove to be extremely effective.

Yet, experts say that the PCMH model requires significant up-front investment, and costs for continued support can be very expensive as well. The time, effort, and spending it takes to produce a substantial return may signify that the model is not as universally applicable as may be desired.

Bundled Payments

Beginning in 2012, the ACA-founded Medicare and Medicaid Innovation Center established the Bundled Payments for Care Improvement (BCPI) to assess the ability of a variety of payment models to improve patient care and lower costs to Medicare. The BCPI began evaluating the four models in 2013. These models include:

- **Model 1:** Inpatient stay in the acute care hospital
- **Model 2:** Retrospective bundled payment where actual expenditures are reconciled against a target price for an inpatient stay in an acute care hospital plus the post-acute care and all related services up to 90 days after hospital discharge
- **Model 3:** Retrospective bundled payment where actual expenditures are reconciled against a target price for an acute care hospital stay but begins at initiation of post-acute care services with a skilled nursing facility, inpatient rehabilitation facility, long-term care hospital or home health agency
- **Model 4:** Single, prospectively determined bundled payment to the hospital that encompasses all services furnished by the hospital, physicians, and other practitioners during the episode of care, which lasts the entire inpatient stay. This is considered the preferable model for enhancing care and reducing costs toward which healthcare organizations are encouraged to move.

*Source: CMS*

Models 2, 3, and 4 include two phases. The first phase is the “preparation” period. In the second phase participants assume financial liability.

As of July 1, 2015, the BCPI initiative had 2115 voluntary participants in Phase 2. Skilled nursing facilities make up just over half of the providers with 1,071 participants. Acute care hospitals (423), physician group practices (441), home health agencies (101), inpatient rehabilitation facilities (9), and long-term care hospitals (1) make up the remainder of participating providers.

A key difference between the global/bundled payment/ACO models of today and the capitated model
prevalent during the HMO/managed care boom of the 1990s is that today's models typically include a quality component that helps ensure that appropriate treatment is provided. To be paid under these models, providers generally have to follow stipulated quality measures, such as following up with patients post-surgery, to ensure full payment. These quality measures are derived from the comparatively much more robust data available on treatment effectiveness available today through EHR. At least in theory, providers cannot be paid more simply by doing less.

**Orthopedic Bundled Payments**

Under the ACA, Medicare can “scale up” payment models that have been found to reduce costs without limiting quality through BPCI model evaluations. In July, 2009, CMS announced it will require hospitals in 75 geographic areas, including Los Angeles and New York, to participate in a test of bundled payments for hip and knee replacement (*Modern Healthcare, July 9, 2015*). Some 800 hospitals will be affected.

The announcement is a signal that the federal government does not believe that voluntary efforts to participate in bundled payments will be enough to move the needle and is a further signal of its intention to move away from fee-for-service payments.

**According to Modern Healthcare:**

“The program will begin January 1, 2016 and run for five years. Episodes included in the bundle will begin with admission to the hospital and end 90 days after discharge. The hospital will bear financial risk for the procedure, the inpatient stay and all care related to the patient’s recovery.”

“The hospitals will continue to get paid for their services under Medicare’s fee-for-service system. At the end of the year, depending on the hospital’s quality and cost performance, the hospital will receive an additional payment or be required to repay Medicare for a portion of the episode costs. Hospitals will not be at risk for the first year but must absorb losses starting in year two.”

**More of the Same Coming**

In addition to hip and knee replacements, CMS is likely to scale up bundled payments for other services, the most likely being services to treat chronic obstructive pulmonary disease (COPD) and percutaneous coronary interventions.

In addition, in 2016, CMS will launch its Oncology Care Model, a reimbursement plan that will incentivize oncologists to reduce hospital and pharmacy costs through better care coordination.
The MIPS/APM Vetting Process

Much of the negotiating over what qualifies as an alternative payment model will be done by a panel of experts. The panel, called the Physician-Focused Payment Model Advisory Committee, met for the first time on February 1, 2016. Over the next three years there will be a vetting process in which various parties can weigh in on MIPS and APMs, and patient and provider groups such as medical specialty societies are invited to participate. More details about the specifics of quality scoring and other MIPS and APM features will no doubt emerge from the advisory panel over the next several years.

CMS Releases Final Rule On MACRA

In October, 2016, CMS released its final rule outlining requirements of MACRA. Reacting to comments received by physician and other healthcare groups, significant modifications were made to the law, at least as it will be carried out in 2017. In terms of nomenclature, the final rule established that the new Medicare payment system implemented by MACRA will be called the Quality Payment Program (QPP), an acronym likely to soon be in widespread use.

The new rule calls for a transition period by which physicians can avoid the penalties imposed by what is now called QPP referenced above. Initially, QPP mandated that physicians would have to successfully report in all four MIPS payment categories to avoid a negative payment adjustment. In the final rule, the only physicians who will experience a negative 4% penalty in 2019 (based on 2017 reporting) are those who choose to report no data.

Participating in just one of the four MIPS payment categories under the so-called “Pick Your Pace” system will allow physicians to avoid penalties. If physicians choose to report for only one patient on just one quality measure, one improvement activity, or the four required Advancing Care Information (ACI – the new term for “meaningful use”) measures, they can avoid a negative payment.

The final rule also establishes a 90-day reporting period, a significant change over the proposed rule’s full calendar year requirement for most reporting. If physicians report at least 90 continuous days in 2017, they will be eligible for a positive payment adjustment in 2019. This revision allows physicians to start reporting later in the year, rather than on January 1 of 2017.

Other changes in the final rule include an increase in the low-volume exemption threshold. The initial rule set the threshold at which physicians could be exempt from QPP at $10,000 or less in Medicare payments per per physician, per year, or 100 or fewer Medicare patients per physician, per year. The baseline was changed in the final rule to $30,000 or less in Medicare payments per physician, per year, while the baseline of 100 or fewer Medicare patients per year remains in effect. Physicians new to Medicare in 2017 also will be exempt.
In May, 2017, CMS sent letters out to hundreds of thousands of physicians letting them know they not have to comply with MIPS in 2017 because of these exemptions after missing the notice deadline in December of 2016. However, it is estimated that over 400,000 physicians will need to comply.

Under the ACI category (again, the new term for “meaningful use”), the number of required reporting measures was cut from 11 in the initial, proposed rule to four in 2017 and five thereafter in the final rule.

As is referenced above, one of the four payment categories of MIPS is resource use. The final rule sets resource use at zero percent of a physician’s score in the first year, down from 30% in the proposed rule, though CMS will provide feedback on how physicians performed on those measures. In addition, the final rule reduces the percent of patients on whom physicians will have to report measures for 2017 to 50%, down from 90% in the proposed rule.

Other measures affecting QPP may be pending and it is unclear yet how the program will be affected by the results of the 2016 presidential election.

What About Hospitals (Including CAHs), Federally Qualified Health Centers, and Rural Health Centers?

According to the American Hospital Association (AHA) hospitals directly employed 249,000 physicians in 2014, the last year for which data is available, and had individual or group contractual arrangements with at least 289,000 more. Given the trend toward hospital employment of physicians, those numbers are likely to be significantly larger today. This means hospitals will directly bear the cost of complying with MIPS on behalf of the physicians they employ who are not exempt, including hospital-based physicians such as anesthesiologists and emergency medicine physicians. Hospitals also will realize any bonuses or losses resulting from MIPS performance adjustments. This applies to critical access hospitals (CAHs) where MIPS will apply to physicians and other clinicians who have assigned their billing rights to the CAH.

CAHs and smaller rural hospitals in general will need to look closely at the cost of trying to achieve bonuses under MIPS. “For example, a CAH with $40,000 in Part B (physician) Medicare billing under MIPS might have to spend $50,000 on information technology and data analytics to have the potential to earn a 4% bonus.” (Trustee magazine, January 9, 2017).

The number of physicians hospitals employ is likely to further increase as the cost and complexity of complying with MIPS will cause more physicians to seek hospital employment or to join larger organizations of various kinds. In the long-term, physicians are likely to seek participation in APMs, which also typically require employment by an ACO, hospital system or large medical group, leading to more declines in the number of private practice physicians.

By contrast, physicians employed by Federally Qualified Health Centers (FQHCs) and Rural Health Centers
(RHCs) are exempt from MIPS provided they participate in the FQHC/RHC payment system. This is likely to make FQHCs and RHCs more attractive to physicians and enhance their chances of recruiting successfully.

**MACRA and Locum Tenens**

Physicians who are fully employed by hospitals and other organizations have less to worry about when it comes to MACRA as they do not bill Medicare directly and can leave this to employers. The same principle also holds true for physicians working on a locum tenens basis through companies such as Staff Care. Because reimbursement is complicated and somewhat subjective under MACRA, it can be anticipated that more physicians will opt out of private practice, where the compliance burden is highest, and choose to work as employees or on as locum tenens.

Staff Care estimates that approximately 48,000 physicians now work as locums during the year, either moonlighting from permanent jobs, working occasional locum assignments or working locums year round. This represents about six percent of the total physician workforce, a number that could grow significantly given the rising regulatory and compliance burden facing physicians. This is a trend to watch for those responsible for staffing hospitals, medical groups, community health centers and other healthcare facilities.

Additional information about MACRA/MIPS/APMs may be found in the form of a Q&A provided by the American Academy of Family Practice (AAFP) at:

About Staff Care

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Staff Care executives authored the book on locum tenens staffing. Entitled, *Have Stethoscope, Will Travel: Staff Care’s Guide to Locum Tenens*, the book outlines locum tenens staffing principles, uses and procedures for both healthcare facilities and physicians. Staff Care is proud to sponsor the Country Doctor of the Year Award, a national honor that recognizes the spirit, skill and dedication of America’s rural medical practitioners.

This white paper is one is a series that Staff Care has produced. Others in the series include:

- The Growing Use and Recruitment of Hospitalists
- Ten Keys to Enhancing Physician/Hospital Relations: A Guide for Hospital Leaders
- The Growing Use of Locum Tenens Dentists
- Rural Physician Recruiting Challenges and Solutions
- Cost of a Physician Vacancy
- Nurse Practitioners and Physician Assistants: Supply, Distribution, and Scope of Practice Considerations
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