Healthcare Systems and Services Practice

The Quality Payment Program under MACRA: Strategic implications for providers and payers

Deepali Narula; Laura Medford-Davis, MD; Seema Parmar; and Edward Levine, MD

The Quality Payment Program under MACRA: Strategic implications for providers and payers

Performance measurement for the Quality Payment Program (QPP) has begun. Although 2017 is a transition year, providers and payors need to start planning for the future, given the QPP's implications for them.

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The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 ended the Sustainable Growth Rate (SGR) methodology that had previously been used to limit growth in Medicare reimbursement. The SGR methodology mandated significant reductions in Medicare physician payments. To avert these cuts, Congress was required to pass "doc fixes" every year from 2002 to 2015. MACRA replaced the SGR methodology with flat updates to the fee schedule and introduced a redesigned reimbursement framework known as the QPP, which began in 2017. The QPP is consolidating previous quality and cost programs under a single program designed to expose clinicians to risk based on the value of their care.

On October 14, 2016, the Centers for Medicare and Medicaid Services (CMS) published the Final Rule for measurement of the 2017 QPP performance period, and on November 2, 2017, it published the Final Rule for the 2018 QPP performance year. Below, we provide a brief summary of the program's key elements, including changes for 2018, and discuss their implications for stakeholders.

Overview

The QPP will eventually affect nearly all clinicians, but in 2017 and 2018 its major provisions pertain only to certain clinicians: MDs, DOs, chiropractors, podiatrists, dentists, optometrists, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists.[1] However, these clinicians are exempt from the QPP if they are in their first year of Medicare participation or meet the Medicare low-volume threshold (no more than either 100 Medicare Part B patients or $30,000 in allowed Medicare Part B charges annually). CMS estimates that as a result of these exemptions, about 470,000 clinicians in these categories were excluded from the QPP in 2017. CMS has increased the 2018 low-volume threshold to no more than either 200 Medicare Part B patients or $90,000 in allowed Medicare Part B charges annually. This change exempts another 150,000 clinicians from the program in 2018.

QPP performance is measured for each calendar year, with payment adjustments disbursed two years later (i.e., 2017 performance will determine 2019 adjustments). Between 2017 and 2019, the increase to the base Medicare physician fee schedule is 0.5% annually. Between 2020 and 2025, the base Medicare physician fee schedule will be held constant (0% increase); adjustments to reimbursement during that time will come exclusively from payments made through the QPP. Starting in 2026, participants in the Merit-based Incentive Payment System (MIPS) will receive a 0.25% annual increase in the base rate; participants in Advanced Alternative Payment Models (Advanced APMs) will receive a 0.75% annual increase in the base rate,

[1]Providers can choose to have reporting done, and financial bonuses/penalties assessed, at the individual clinician level or at the group level (entity based on taxpayer identification number). Starting in 2018, CMS will offer QPP-eligible solo clinicians or groups with 10 or fewer QPP-eligible clinicians the option of participating in the QPP via "virtual groups" to boost performance and create efficiencies in reporting.

in addition to performance-based payment adjustments through either MIPS or their APM.

Clinicians can choose to participate in one of two tracks under the QPP:

Merit-based Incentive Payment System track. MIPS is a pay-for-value program that combines three existing initiatives—the Physician Quality Reporting System, value-based payment modifiers, and meaningful use incentives—into a single program with four components of performance: quality, cost (sometimes referred to as resource use), improvement activities (originally introduced as clinical practice improvement), and advancing care information (certified electronic health record, or EHR, use).

Advanced Alternative Payment Model track. Advanced APMs are payment models that meet CMS criteria related to use of certified EHR technology, linkage of payments to quality, and assumption of downside risk. Clinicians who meet participation thresholds based on the percentage of Medicare payments or patients attributed to these models are eligible for the APM track instead of MIPS. For 2017 and 2018, a clinician's eligibility to participate in the Advanced APM track is based solely on participation in Medicare Advanced APMs. Beginning in the 2019 performance year, CMS is introducing an all-payer option under which clinicians can achieve these participation thresholds using a combination of Medicare Advanced APMs and "Other Payer Advanced APMs"—value-based payment arrangements with non-Medicare payers, including Medicare Advantage, Medicaid, the all-payer models established by the Center for Medicare and Medicaid Innovation (CMMI), and commercial payers.

MIPS

Clinicians receive a score in each of four performance categories (quality, cost, improvement activities, and advancing care information); the scores are then aggregated into a composite score. In 2017, CMS is not factoring cost into the MIPS score. However, it is evaluating cost performance and giving clinicians reports to help them understand how the cost category will be evaluated in the future. As shown in Exhibit 1, the scores in each area are weighted, and the weighting will change over time.

The specific metrics included in each of the four areas and the weighting assigned to them vary for different groups of clinicians. For example, specialists have their own specific quality metrics. Hospital-based physicians are excluded from the advancing-care-information category. Physicians who do not interact directly with patients are excluded from the advancing-care-information category and are required to report on only two, rather than four, clinical improvement measures (they are still evaluated on quality and will not be automatically excluded from cost, although the majority are expected to meet separate exclusion criteria for the cost category).

CMS will establish a performance threshold for the composite score for each year. Clinicians who score above the threshold earn bonuses; those who score below it face penalties. Bonus and penalty amounts align with the scores (e.g., the higher the score, the greater the bonus).

For the 2017 performance period, the performance threshold was set at 3 points, which can be met to avoid a penalty by reporting one

quality measure, one improvement activity, or the basic metrics within the advancing-care-information category. For the 2018 performance period, the performance threshold is 15 points, which can be met by reporting all improvement activities, or by reporting the minimum for the advancing-care-information category plus one improvement activity.

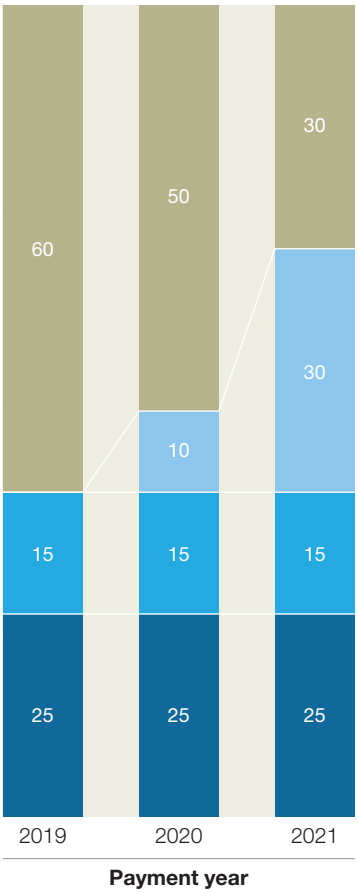
EXHIBIT 1 MIPS measures four performance categories based on 2017 Final Rule

Quality Cost Improvement activities Advancing care information

Categories

Quality	• Replaces PQRS • Provider must choose 6 measures from 271 possible measures,[1] including 1 outcome measure • Specialists choose from specific specialty sets • Bonus points for high-priority and additional outcome measures and for electronic reporting
Cost	• Replaces value-based payment modifiers; automatically evaluated using claims data • Measures include total (annual) per-capita costs for all attributed beneficiaries, Medicare spending per beneficiary during any inpatient admission, and 10 episode-based cost measures
Improvement activities	• Provider must choose 2–4 activities from 92 activities[2] in 8 categories (health equity, beneficiary engagement, behavioral health, care coordination, expanded practice access, emergency preparedness, practice safety, population management); can choose either A) 2 high-priority activities, B) 1 high-priority and 2 medium-priority activities, or C) 4 medium-priority activities
Advancing care information	• Similar to meaningful use requirements; specific QPP requirements for 2017 vary based on EHR-certified edition used (2014 or 2015) • 5 required measures include security risk analysis, e-prescribing, provide patient access, send summary of care, and request/accept summary of care[3] • Bonus points for performance and submission of additional measures

Change to score weighting over time



CMS, Centers for Medicare and Medicaid Services; EHR, electronic health record; MIPS, Merit-based Incentive Payment System; PQRS, Physician Quality Reporting System; QPP, Quality Payment Program.

[1]The 271 measures and 92 activities were specified in the final rule.

[2]The number of measures that need to be reported depends on the clinician's special status (e.g., non-patient facing, rural, MIPS, APM) and the weight of the measures selected (high or medium).

[3]For certain editions, clinicians may only need to report on 4 measures (security risk analysis, e-prescribing, provide patient access, health information exchange), and on potential allowances for provider type, e.g., small and rural practices and non-patient-facing providers only report 2 medium-priority or 1 high-priority activity.

Source: CMS Quality Payment Program Final Rule

CMS has also added a number of "bonus" point opportunities to help clinicians boost their 2018 scores. For example, clinicians can receive bonus points if they are part of a small practice or see patients with more complex medical conditions (assessed by using Hierarchical Conditions Category scores). Also, the quality score can be increased up to 10 percentage points based on year-over-year improvement. Beginning in 2019, the threshold will be adjusted annually based on either the mean or median of the composite scores for a previous performance period.

CMS described 2017 as a "transition year," during which it offered clinicians the option to "pick your pace." Reporting is required for a minimum of only 90 days rather than the full year. For 2018, clinicians are required to submit quality data for the full year, but would only have to submit improvement activities and advancing care information data for 90 days.

Clinicians participating in MIPS must submit all 2017 data by March 31, 2018. Required data is a mix of self-reported attestations and information that CMS will extract from claims (e.g., cost). Clinicians are required to use a certified EHR system for the advancing-care-information category and can receive bonus points in the quality category by using electronic clinical quality measure (eCQM) reporting. They may submit data with support from approved third-party intermediaries, such as health IT vendors, that are able to meet CMS's data submission requirements.

The bonuses and penalties issued in payment years 2019 and 2020 based on performance in years 2017 and 2018 will be a maximum of 4% and 5%, respectively, of the payment year's Medicare Part B payments. They will then gradually increase to 9% in 2022 and later. In each year between 2019 and 2024, exceptional performers can receive additional bonus payments of up to 10% (Exhibit 2).

Advanced APMs

Under the QPP, only some alternative payment models qualify as Advanced APMs. These models must meet certain criteria:

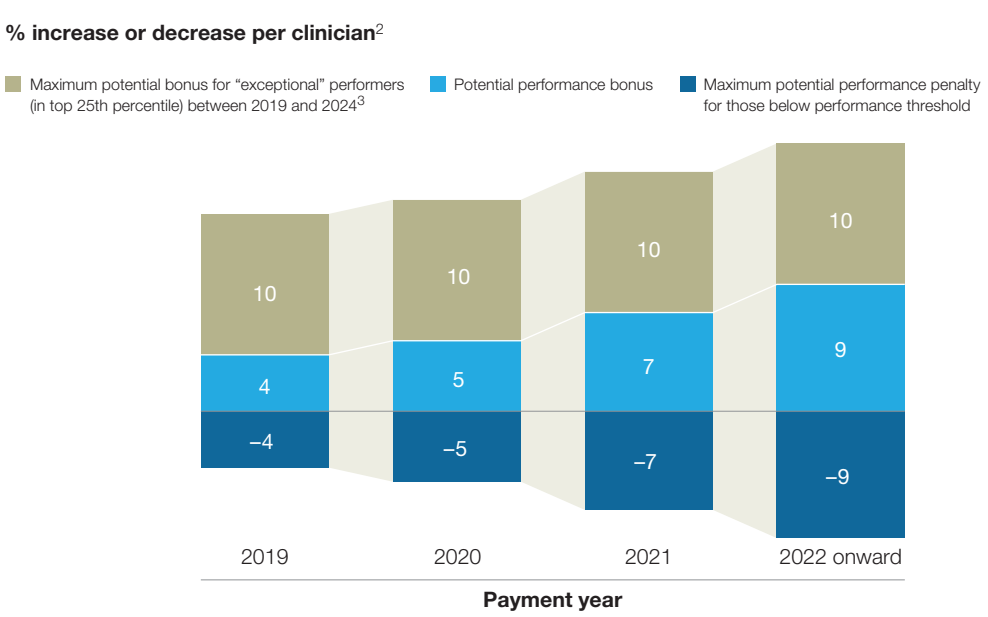
- A defined percentage of their practitioners must use certified EHR technology
- The models must base payments on quality metrics comparable to those used in the MIPS quality category
- The models must either bear more than nominal financial risk based on a percentage of revenues and/or expenditures at risk (including downside risk) or qualify as a medical-home model expanded under the authority of the CMMI

In 2017, Advanced APM participants include clinicians in Medicare Shared Savings Program (MSSP) Tracks 2 and 3 accountable care organizations (ACOs), Next Generation ACOs, and any of the following models: Comprehensive Primary Care Plus, Comprehensive End-Stage Renal Disease Care (two-sided risk), or Oncology Care (two-sided risk). The list of Advanced APMs will be enlarged in 2018 to include the Vermont All-Payer ACO Model, the Comprehensive Care for Joint Replacement Payment Model (CEHRT track), and the Medicare ACO Track 1+ Model (which requires ACOs to accept downside risk, albeit at a lower level than is specified in MSSP Tracks 2 and 3).

Clinicians participating in CMS APMs that do not meet the criteria for an Advanced APM[2] are still part of the MIPS track. However, they have a separate APM scoring standard

[2]Medicare Shared Savings Program (MSSP) Track 1 accountable care organizations, which are eligible for shared savings but do not accept financial risk, are an example of such APMs.

EXHIBIT 2 **Range of adjustments to Medicare Part B clinician payments under MIPS**[1]



CMS, Centers for Medicare and Medicaid Services; MIPS, Merit-based Incentive Payment System.
[1]To ensure budget neutrality, CMS will scale positive payment adjustments (down or up to three times more than their current level) in the event the total amount of negative payment adjustments does not equal the total amount of positive payment adjustments.
[2]Percentage increases and decreases are specified in the MACRA legislation (statutory).
[3]The exceptional bonus is also subject to a positive or negative scaling factor to make total exceptional payments equal to $500M/year.
Source: CMS Quality Payment Program Final Rule

within MIPS to reduce the burden of having to report to multiple programs and to reward the quality, cost, practice, and EHR improvements achieved through the APMs.

Clinicians who are in Advanced APMs can become "Qualifying APM Participants (QPs)" if they can meet certain payment and patient-volume thresholds. Specifically, 20% of a clinician's patients or 25% of his or her Medicare Part B payments must be attributed to an Advanced APM. QPs on the APM track receive a lump-sum bonus payment of 5% of Medicare Part B payments in the year prior to the payment year, in addition to any payments earned directly through the APM.

Clinicians can also become "Partial QPs" if they meet a threshold of 10% of patients or 20% of payments. These clinicians are not eligible for the 5% bonus but can choose to opt out of MIPS to avoid penalty payments.

QPP financing and costs

CMS estimates that in the first year of the program, about 700,000 individual clinicians who receive approximately 88% of Medicare Part B payments will receive adjustments through the QPP. Clinicians in smaller group practices are more likely to receive negative adjustments than those in larger practices (Exhibit 3). For this reason, CMS changed the eligibility thresh-

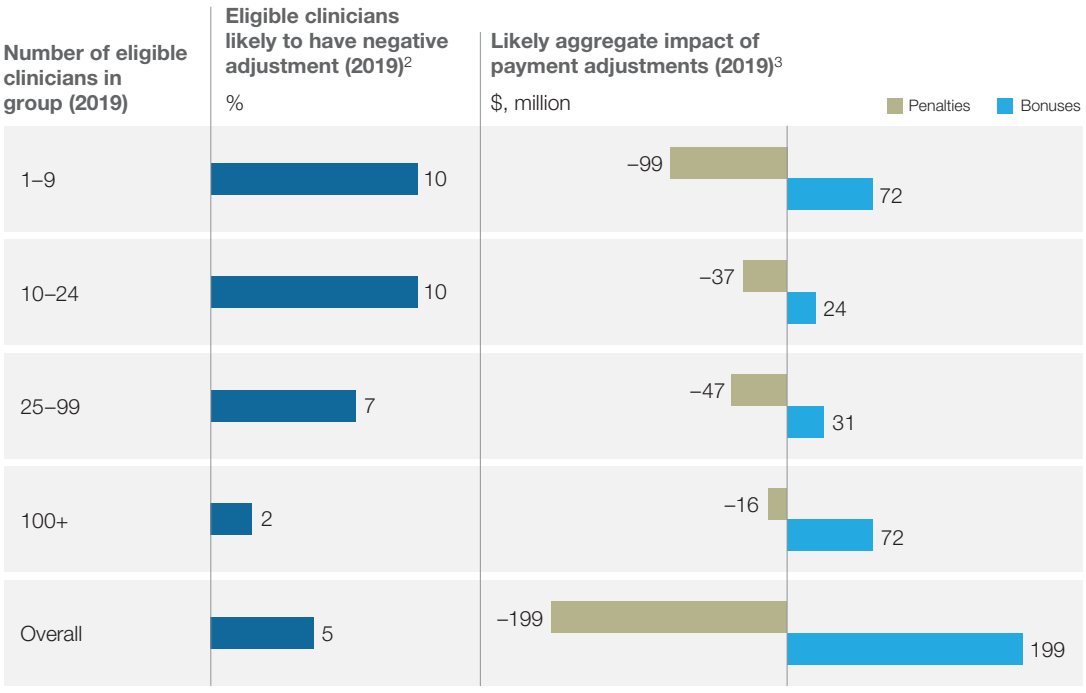
olds and added bonus points and virtual-group options to assist small practices in 2018.[3] The 70,000 to 120,000 clinicians who CMS estimates participated in Advanced APMs in 2017 are expected to earn, on average, between $4,000 and $5,000 in APM incentive payments (in addition to earnings or penalties from the APM itself). CMS estimates that in 2018 the number of clinicians in Advanced APMs will increase to between 185,000 to 250,000 because of the introduction of new models and the expansion of previously included models.

Early implications for providers

Financial implications. In the near term, actual bonus and penalty amounts may be relatively small (e.g., 2% to 4%) and will affect only a moderate subset of most providers' book of business, given that Medicare fee-for-service patients are often only 15% to 20% of a typical clinician's volume. Nevertheless, the combined impact of the penalties on margin and the reduction in the fee schedule annual growth

EXHIBIT 3 **CMS's estimated range of Medicare Part B clinician payment adjustments under MIPS by group size from 2017 Final Rule**

Estimated range, excluding additional bonus payments for exceptional performers[1]



CMS, Centers for Medicare and Medicaid Services; MIPS, Merit-based Incentive Payment System.
[1]CMS used 2015 data to estimate 2017 performance and then used those estimates to gauge the potential payment bonuses and penalties in 2019, with the assumption that a minimum of 90% of clinicians within each practice size category participate in data submission.
[2]CMS has noted that use of historical data as a basis for calculation and the use of a standard set of participation assumptions may overestimate the negative impact on small practices.
[3]Payments estimated using 2015 dollars.

Source: CMS Quality Payment Program Final Rule

[3]Based on the historical performance of smaller practices in quality programs (e.g., value modifiers) and the difficulties such practices often face in affording the investments needed for performance improvements and reporting requirements.

rate make the opportunity cost of not performing well under the QPP more substantial.

Physician alignment. Small practices exempt from the QPP will still be affected by the removal of fee schedule rate increases. Thus, they may look to align with health systems or larger physician groups that could potentially enable them to receive MIPS or Advanced APM bonuses. Midsize practices at risk of being penalized through MIPS may also seek alignment with larger systems able to offer them the capabilities needed to optimize MIPS or Advanced APM performance. Management services providers (or possibly some payers) might be able to lighten the burden on these practices by providing additional data gathering and reporting services.

Physician hiring. MIPS scores earned by clinicians during the performance periods will determine their payment adjustments two years later, regardless of whether they are still working in the same practice. Practices may start screening clinician scores and anticipated payment adjustments prior to making final hiring decisions.

Care patterns. Over the long term, care patterns may change as clinicians become more aggregated, use of EHR becomes more prevalent, and care protocols become more standardized for quality and cost purposes.

Post-acute care. Clinicians participating in Advanced APMs who are responsible for a patient's total cost of care will likely show greater interest in aligning with high-performing post-acute systems to better coordinate care. However, there may be increased pressure on post-acute utilization if APMs become more widely used and physician incentives are geared toward ensuring appropriate utilization of those services.

The sidebar on the next page includes a set of key questions health systems should ask themselves.

Early implications for payers

Although MACRA primarily affects providers, it has important implications for payers as well. At present, however, it is unclear whether MACRA presents payers with a significant opportunity—or disruption. Under the new administration, the adjustments that could most affect the QPP are any changes it might opt to make to the current focus on Advanced APMs introduced by CMMI (e.g., by cancelling episode-payment models) or to the criteria for the "Other Payer Advanced APMs." Private payers that chose to "piggyback" on these CMMI models to encourage providers to invest in the infrastructure for value-based arrangements may need to reconsider their direction. Payers may also consider introducing models that meet the criteria for Other Payer Advanced APMs that enable provider partners to be exempt from MIPS and therefore increase their incentive for value-based arrangements.

Medicare Advantage (MA). Shifts in the base Medicare physician fee schedule could slow growth in MA physician reimbursement. Potential provider consolidation (as smaller, underperforming providers look to align with larger, more capable systems) could affect network structure and pricing. Providers at risk of penalties under MIPS may look to shift patients into MA plans, where they can negotiate contract terms and are better able to meet reporting requirements and, in some cases, performance expectations. Overlaps between QPP and Stars metrics could create positive

Key questions providers should ask themselves

- Given your clinicians' existing participation and scale in APMs, are they likely to be excluded from MIPS or be able to opt out of it?
- How are your clinicians likely to perform under MIPS based on their existing quality scores and national benchmarks?
- Will you earn more through group or individual reporting? What infrastructure is required to support your reporting choice?
- Given the range of evaluation metric choices under MIPS, which combination(s) of metrics will optimize your total score, considering the points assigned to each metric, your clinicians' performance in each metric, and the specific concessions offered to participants in certain APMs?
- What investments, if any, will you need to make to optimize MIPS performance and avoid any potential negative financial impact from penalties and the reduction in the annual base rate increase?
- Which physician practices in your market are likely to be squeezed out or consolidated, given the resources and capabilities required to succeed in the QPP?
- How should you approach opportunities to partner with or acquire high-value physician practices or post-acute providers?
- How can you utilize capabilities you build in response to the QPP to enter into other value-based agreements?
- What factors most influence where and how you choose to participate prospectively in value-based agreements? What terms of contracts/partnerships with payers are necessary for you to succeed in these models?
- How will other providers respond to private payers that mimic CMS in their commercial and MA contracts?

momentum, encouraging both payers and providers to work on quality and cost management efforts systematically. Payers may consider how to structure their MA value-based reimbursement plans to meet CMS criteria for Advanced APMs under the QPP.

Value-based models across all segments. Clinicians who do not have the necessary payments or patient volume in Medicare Advanced APMs to meet the participation thresholds for the QPP's Advanced APM track may show a greater appetite for participating in value-based models with non-Medicare payers, given that in 2019 participation in non-Medicare models could count toward those thresholds and help them qualify for the Advanced APM track. Contrary to historical norms, some providers may move ahead of their payer partners in value-based reimburse-

ment—it is possible that providers participating in Advanced APMs could try to leverage their investments in QPP capabilities to enter into value-based arrangements and secure patient volume across payers.

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Now that performance measurement for the QPP has started, providers and payers can begin to determine how MACRA is likely to affect them.

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