The alphabet soup of government regulations around healthcare grew exponentially in late 2016 when the final rule for the Medicare Access and CHIP Reauthorization Act (MACRA) was released. Physicians and their lobbying groups were relieved to see the end of the Sustainable Growth Rate (SGR) which determined how much physicians would be reimbursed by the Medicare program from year to year. While SGR used a set of economic formulas to determine how much physicians would be reimbursed by the Medicare program each year, MACRA governs physician payments based upon clinician performance and patient outcomes.¹

To earn high scores, achieve incentives, and avoid penalties, clinicians must participate in the Merit-based Incentive Payment System (MIPS) or an Advanced Alternative Payment Model (APM), although the Centers for Medicaid and Medicare Services (CMS) predicts a smaller fraction of physicians will opt for Advanced APMs. For the majority of physicians, MIPS will now be the reporting mechanism that determines Medicare Part B reimbursement.

With the impact of MIPS increasing over past quality reporting programs, oncologists must take action. Under the new MACRA regulations, not only is their revenue at risk, but so is their reputation.

THERE WILL BE FINANCIAL WINNERS AND LOSERS

MIPS is considered by CMS to be a budget-neutral program, with incentives being funded by penalties. That means for every clinician who does exceptionally well and receives the maximum incentive, there will be other clinicians who receive negative pay adjustments.

For an oncologist earning the industry average of $330,000² annually who chooses not to participate, that could mean a loss of up to $13,200 per physician under the -4 percent penalty for 2017, growing to $29,700 per physician for 2020, when the maximum penalty increases to -9 percent. Of
course this will vary based upon the percentage of revenue from Medicare Part B reimbursement.

Conversely, oncologists who optimize their performance reporting could receive even more substantial rewards. For MIPS, if the budget neutrality factor is capped at 3.0 and the clinician earns the 10 percent “exceptional performance bonus,” the incentive would yield up to a 37 percent bonus – or $122,100 for Performance Year 2020 (9 percent x 3.0 + 10 percent = 37 percent).

<table>
<thead>
<tr>
<th>Program</th>
<th>Performance Year</th>
<th>Medicare Part B Payment Adjustment Year</th>
<th>Maximum -% Medicare Part B Payment Adjustment</th>
<th>Maximum +% Medicare Part B Payment Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>PQRS/VBM</td>
<td>2016</td>
<td>2018</td>
<td>-4% penalty</td>
<td>+4%*X incentive</td>
</tr>
<tr>
<td>MIPS</td>
<td>2017</td>
<td>2019</td>
<td>-4%penalty</td>
<td>+4%*X incentive</td>
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<tr>
<td>MIPS</td>
<td>2018</td>
<td>2020</td>
<td>-5%penalty</td>
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<td>MIPS</td>
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<td>2021</td>
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<td>MIPS</td>
<td>2020</td>
<td>2022</td>
<td>-9%penalty</td>
<td>+9%*X incentive</td>
</tr>
</tbody>
</table>

**PHYSICIAN REPUTATIONS AT STAKE**

If the financial incentives and penalties are not enough to convince oncologists to participate in MIPS, then they must consider the potential reputational and long-term career impact.

Previously, a primary care physician would refer a patient to a specialist and the patient would follow that directive. In today’s world, “Dr. Google” is a trusted consumer resource. In fact, 54 percent of millennials (aged 18-24) say they search online for health information and rely on online physician ratings before seeing a doctor. The global average for all patients was 39 percent.1

Thwarting this quest for knowledge has been a fragmented review system based on limited patient interactions. MACRA will change that by publishing physician quality scores online. A physician who chooses not to participate will receive a quality score of 0, while those who optimize their participation will have stronger scores, leading to a definite marketing advantage in a competitive marketplace.

A low score could also have a negative impact on future employment options. CMS binds the MIPS score to the clinician for each performance year, so that if the clinician changes organizations before the associated payment year (two years after the performance year), the clinician brings along his or her MIPS score and the associated Part B payment adjustment to the new organization. Because each MIPS score becomes part of a clinician’s profile and public reputation for the succeeding two years after the score is earned, it will have a large impact on physician recruiting, credentialing, contracting, and compensation plans.
REQUIREMENTS OF MIPS

Although MIPS inherits much from the PQRS, VBM, and Meaningful Use programs, high performance or penalty avoidance under these programs does not guarantee the same under MIPS. There are four categories under MIPS, each with its own set of measures, requirements, scoring, and reporting.

- Quality (60 percent for 2017)
- Advancing Care Information (ACI, renamed from Meaningful Use) (25 percent for 2017)
- Clinical Practice Improvement Activities (CPIA) (15 percent for 2017)
- Resource Use (0 percent for 2017, but will be weighted in the future)

The final score earned by a clinician for a given performance year determines MIPS payment adjustments in the second calendar year after the performance year.

HERE’S HOW 2017 PARTICIPATION WILL AFFECT PAYMENTS FOR 2019:

- Non-participation – negative 4 percent payment adjustment
- Submit something – avoid a downward payment adjustment
- Submit 90 days – may earn a neutral or small positive payment adjustment
- Submit a full year – may earn a positive payment adjustment

Further complicating quality improvement initiatives for physicians is that data submission for 2017 is due March 31, 2018 and it will take approximately six months for CMS to provide feedback. That means that without a method to internally monitor performance, any performance issues from the 2017 performance year cannot be addressed until almost the end of 2018.

PHYSICIANS UNPREPARED FOR MACRA

Of the 926,119 active physicians in the United States, slightly more than half (484,384) are categorized as specialists. While primary care physicians have become accustomed to the reporting requirements of Meaningful Use and the Physician Quality Reporting System (PQRS), many specialty practices used the PQRS group practice reporting option for administrative simplicity, as it only required the reporting of 20 patients. Other specialty practices ignored PQRS and accepted the small negative payment adjustment.

When Healthcare Informatics surveyed more than 2,000 physicians, just one in five practices (20 percent) with 15 or fewer physicians, and approximately one in four practices (28 percent) with 16 to 50 physicians reported that they are “ready to go” to meet the core requirements of MACRA.

The 2017 Medscape Physician Compensation Report also found that physicians are ill-prepared for MACRA. Respondents were most likely to say either that they will participate (43 percent) or that they are still undecided (35 percent). The number of oncologists stating that they intend to participate was slightly higher at 48 percent.
MORE PAPERWORK, MORE BURNOUT

Oncologists report that too many bureaucratic tasks, too many hours at work, and increasing computerization are the top three causes of burnout.\(^6\) Paperwork can consume a significant amount of time that could be spent with patients. In 2014, 35 percent of employed and 26 percent of self-employed physicians reported spending at least 10 hours per week on paperwork. For 2017, more than half (57 percent) of all physicians spent this amount of time, with 19 percent spending 20+ hours per week.\(^2\)

Burnout rates for all respondents to the Medscape study have been trending up since 2013, when the overall rate was 40 percent. In 2017, the survey shows 51 percent, which is more than a 25 percent increase over just four years.\(^2\) The results of another recent, major survey support this unfortunate trend, finding that burnout had worsened between 2011 and 2014, with more than half of physicians reporting it.\(^7\) Oncologists placed slightly lower than all physicians, with 47 percent reporting burnout.\(^4\)

The burden of paperwork is especially onerous for specialists; like virtually all EHRs, specialty EHRs lack the data elements and/or capabilities to support quality reporting. Not only can data extraction be difficult and time-consuming with these systems, it is usually descriptive rather than prescriptive, offering few insights into trends, causes and solutions.

BENCHMARKS COMPLICATED FOR SPECIALISTS

With MIPS, each specialty is benchmarked against peers and it is no longer a pass/fail measurement; every tenth of a point translates into proportional financial and reputational impacts.

The MIPS quality performance category incorporates specialty measure sets, which are groups of measures designed to assist specialists in the selection of their measures. Unfortunately, many specialties’ measures lack peer benchmarks which, per the 2017 MIPS rules, means that each such measure will only earn three out of 10 quality points, regardless of how well a clinician is actually performing on the measure. This significantly depresses the potential quality score, and thereby MIPS score, achievable by that clinician.

The lack of benchmarks also applies to many of the measures available through the Qualified Clinical Data Registry reporting method, increasingly favored by specialty clinicians through their specialty societies. However, it can be a significant effort to optimize and integrate a multi-specialty organization’s generic EHR to support a specialty-specific QCDR.

New reporting requirements and changes in quality measures may require significant workflow changes for specialists, complicating their already limited choices around quality measures.
While cost performance is excluded for 2017, the following year it will account for 10 percent of the MIPS score. This category is largely centered on episode-based cost measures which gauge the average Part A (in-patient) and Part B costs to Medicare for each episode of care and compares that average to a national peer benchmark. MIPS cost measures tend to be centered on procedures initiated and delivered by specialists, while most MIPS quality measures are primary-care focused.

As these measures are relatively new, specialists will need to analyze the impacts on their workflows, how they account for costs and, based on CMS performance feedback reports, where improvements can be made.

DIY VS. BRINGING IN EXPERTS IN AN AGE OF CONTINUAL CHANGE

Is it possible for specialty physicians to take a “do-it-yourself” approach and be successful? That depends largely on the technological sophistication of the practice, appetite for risk, and ability to remain updated on evolving regulations – and CMS has already indicated there will be at least annual changes to the reporting structure and quality measures. According to a Health Affairs study prior to MIPS, U.S. physician practices in four common specialties spend, on average, 785 hours per physician complying with value-based programs and the programs have become more complex.

Acknowledging the complexity of integrating MIPS reporting into small practices, CMS has set aside $20 million annually for five years to fund training and education for Medicare clinicians in individual or small group practices of 15 clinicians or fewer and those working in underserved areas.

Physicians in larger practices face a number of choices, ranging from whether they should report as an individual or as part of a group, to restructuring into a multi-specialty practice or joining an ACO. Each path has choices which will have long-lasting financial and reputational consequences.

According to a Health Affairs study prior to MIPS, U.S. physician practices in four common specialties spend, on average, 785 hours per physician complying with value-based programs and the programs have become more complex.

Working with a proven expert in quality reporting can shed light on what each alternative entails. For example, SA Ignite offers the ability to:

- Decide which measures will optimize your quality score
- Determine which measure improvements will move the needle most
- See what your quality scores will look like under different scenarios
- Estimate the program’s overall financial impact on your organization
- Predict and monitor your performance as compared to benchmarks
- Assess which reporting method will produce optimal scores for your organization

You can also expect a company that is fully committed to your success to continue to review, interpret, and integrate the complex and ever-changing rules as they are released and assist your organization in navigating those changes.
About SA Ignite. SA Ignite’s compliance management and predictive analytics platform simplifies the complexities of evolving value-based initiatives. Some of the nation’s largest healthcare organizations optimize their quality scores to reduce reputational and financial risk with the help of timely, actionable insights from SA Ignite.

For more information visit saignite.com.