WEB FEATURE

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# analyzing where to invest for success under MACRA's new Quality Payment Program

The choice of payment model under MACRA should be informed by an in-depth assessment of the various potential financial impacts of each model that constitutes a viable option.

## AT A GLANCE

- The Quality Payment Program created by MACRA presents a complex array of incentives that providers will need to understand when selecting the payment option that will work best for them under the program.
- The primary choice involves whether to participate in either the Merit-based Incentive Payment System (MIPS) or to adopt an advanced alternative payment model (advanced APM).
- Providers should perform financial modeling that evaluates a range of potential scenarios under MIPS and various APMs to identify the option that offers the greatest likelihood of positive financial results.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is the most significant shift toward value-based payments in the U.S. health system to date. In its final rule implementing MACRA, released Oct. 14, 2016, the Centers for Medicare & Medicaid Services (CMS) has established a complex program known as the Quality Payment Program (QPP) with the aim of streamlining existing value-based payment programs and increasing provider accountability for quality outcomes and cost reduction.

By year three, after the two-year ramp up and phase in of the program, performance will be translated into significant upward or downward adjustments to the Medicare Physician Fee Schedule (MPFS), requiring major strategic decisions by physicians, health systems, and accountable care organizations (ACOs) as the majority of physicians are thrust into a Darwinian battle for success. QPP presents complex and, at times, conflicting incentives. Financial modeling can help untangle the conflicts and indicate a preferred path for physicians and health systems.

Through the new program, CMS aims to promote the effective management of quality and cost by offering eligible clinicians two options for future payments: participation in the Merit-based Incentive Payment System (MIPS) and adoption of an advanced alternative payment model (advanced APM).

Under MIPS, Part B payments will be adjusted based on how clinicians compare with their peers on measures of quality and cost performance and adoption of EHR technologies. Under the advanced APM option, physicians or physician practices must accept downside risk but are guaranteed a 5 percent increase in Part B payments from 2019 to 2024, and slightly higher inflation increases after 2026.

Despite the change in administration overseeing Medicare, it is likely that MACRA will remain largely intact because it passed with strong bipartisan support. However, the number and scope of advanced APMs offered by CMS may decrease, potentially lowering the number of clinicians that qualify for the advanced APM track.

To better understand these complex payment methodologies and their impact on physicians, health systems, and ACOs, organizations should use financial modeling to address the essential question of whether their best strategy is to invest to succeed in MIPS or accept downside risk in an advanced APM to obtain the 5 percent bonus. It is important to note that the purpose of this article is not to explore every opportunity for performing well; rather, it is to make reasonable assumptions and provide a financial framework for assessing different options. Here, we outline some key considerations in such modeling.

## MIPS Payment Model

CMS estimates that approximately 590,000 to 640,000 providers will be eligible for and participate in MIPS.[a] Within MIPS, providers will report activity for and be rated in four performance categories: quality, cost, improvement activities, and advancing care information. The intent is to streamline existing value-based programs, such as the Physician Quality Reporting System (PQRS), the Value-Based Payment Modifier (VBPM, or value modifier), and the Electronic Health Records (EHR) Incentive Program (i.e., "meaningful use"). Weighted scores for each of these categories will then be totaled to yield a final composite score of 0 to 100. This score will be compared with those of eligible clinicians across the country and serve as the basis for MIPS payment adjustments. Because CMS has significantly reduced real spending by capping yearly adjustments for inflation at between 0 percent and 0.5 percent annually, effectively reducing payment each year, it will be essential for providers to do everything they can to optimize payment.

To determine MIPS payment adjustments, CMS will establish a performance threshold for each performance year, beginning with measuring 2017 performance, which will impact 2019 payments. Providers with final scores equal to the performance threshold will have no MIPS adjustment to their Part B payments, while providers falling below the performance threshold will receive a negative adjustment and providers above the performance threshold will receive a positive adjustment. The size of the adjustment will be based on where the provider falls on a sliding scale. For example, the closer to a maximum score of 100 the provider is, the greater the positive adjustment. Conversely, the closer to a final score of zero, the larger the penalty.[b]

a. These numbers include Medicare physicians, dentists, chiropractors, nurse practitioners, physician assistants, clinical nurse specialists, and certified registered nurse anesthetists billing more than $30,000 a year and providing care for more than 100 Medicare patients a year. Excluded are providers who fall below low-volume threshold, who have been enrolled in Medicare for less than one year, and who are qualifying participants in advanced APMs.

b. Although adjustments are generally linear, providers with a final score greater than zero but not greater than one-quarter of the performance threshold will receive a MIPS adjustment equivalent to the maximum penalty.

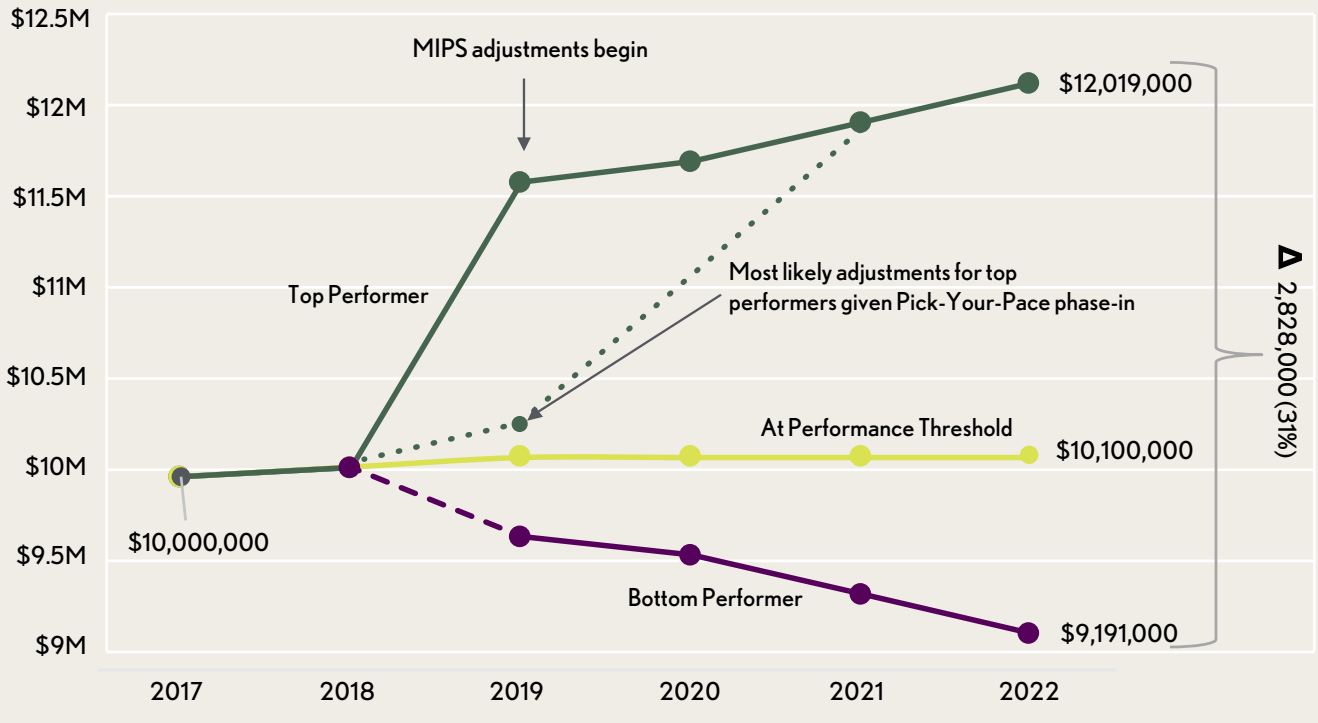
The range of payment adjustment percentages will begin at plus to minus 4 percent in 2019, increasing to plus to minus 9 percent by 2022. The system will be budget neutral, with negative adjustments paying for the positive adjustments and average payments corresponding to the level of the baseline fee schedule. Further, positive adjustments have the potential to increase or decrease by a sliding factor of up to three times to ensure budget neutrality. In other words, if total penalties are higher than positive adjustments, the positive adjustments can be increased to spend those funds.

Reporting for MIPS begins in 2017, the transition year. To ease the transition into MIPS payment adjustments that will apply in 2019, CMS has outlined several reporting options, although the options represent a range of consequences in terms of payment adjustments:

> Opt out of reporting and incur a negative 4 percent payment adjustment.
> "Test" report with some data and avoid penalties, with no adjustment in payments.
> Report for at least 90 continuous days out of the year and receive neutral or small adjustments.
> Submit a full year and obtain eligibility for a moderate positive adjustment.

For the transition year, the performance threshold has been set to a final score of 3, meaning that scores of 4 to 100 will receive positive adjustments. As such, CMS estimates that nearly 95 percent of eligible clinicians will receive a neutral or positive adjustment in 2019; however, given mandates that MIPS be budget neutral, positive adjustments for the majority of providers are expected to be modest.

**EXHIBIT 1: POTENTIAL REVENUE DIFFERENTIAL FOR A 60-PHYSICIAN PRACTICE WITH $10 MILLION IN 2017 MEDICARE REVENUE**




Note: Figures and calculations are simplified to best demonstrate MACRA concepts. This analysis assumes a maximum adjustment of +/- 9 percent by 2022 and a 10 percent additional adjustment for exceptional performance for top performers. Source information obtained from the Centers for Medicare & Medicaid Services, 2016.

In year two (2018 measurement for 2020 payment), the performance threshold will increase from 3 to closer to the median (to be determined), and by year 3 (2019 measurement for 2021 payment), it will rise to equal the mean or median score, causing about half of all eligible clinicians to receive a penalty.

To recognize exceptional performance and increase providers' incentive to succeed in MIPS, CMS also has set aside an additional $500 million for each year from 2019 through 2024 to be distributed to providers that meet an additional performance threshold for exceptional performance, which will be set to a final score of 70 in year one. Thus, providers with a final score in the range of 70 to 100 could earn an incremental bonus, or aggregate incentive payment, of up to 10 percent.[c]

## Should We Invest for MIPS Success?

Taken together, the annual MIPS adjustment and additional adjustment for exceptional performance will allow for a 31 percent difference in potential Medicare payment between top performers and bottom performers, as shown in the Exhibit 1 on page 3.[d] Given this large difference in revenue, MIPS success would appear to be a critical component of future financial performance for most physicians, especially considering that the MPFS inflation adjustments will be very low for the next 10 years.

However, it may require significant investment to succeed in MIPS. Here, we first model the impact of MIPS investment and payment adjustments for large physician practices. A discussion of these impacts for small physician practices follows on page 7.

*MIPS options for large practices.* To demonstrate financial modeling of the impact of MIPS-related revenue adjustments on a large physician practice, we will look at a 60-physician multispecialty group, similar to those owned by health systems, with $10,000,000 in 2017 Medicare revenue.

c. Subject to a sliding scale adjustment factor between 0 and 1 to ensure overall payout does not exceed $500 million.

d. Assumes sliding scale factors of 1.0.

**EXHIBIT 2: STATUS QUO***

| | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|---|---|
| **Medicare Revenue** | | | | | | |
| Baseline Medicare Physician Fee Schedule (MPFS) Revenue† | $10,000,000 | $10,050,000 | $10,100,000 | $10,100,000 | $10,100,000 | $10,100,000 |
| Pre-MACRA Value-Based Program Adjustment‡ | $- | $- | N/A | N/A | N/A | N/A |
| Estimated MIPS Adjustment§ | N/A | N/A | $51,000 | $253,000 | $354,000 | $455,000 |
| **Total Medicare Revenue** | $10,000,000 | $10,050,000 | $10,151,000 | $10,353,000 | $10,454,000 | $10,555,000 |
| **Percentage Change from MPFS** | 0.0% | 0.0% | 0.5% | 2.5% | 3.5% | 4.5% |
| **MIPS-Related Costs‖** | $108,000 | $108,000 | $109,000 | $110,000 | $110,000 | $111,000 |
| **Net Impact of MIPS** | $(108,000) | $(108,000) | $(58,000) | $143,000 | $244,000 | $344,000 |

* All figures rounded.
† Includes a 0.5 percent annual increase from 2017 through 2019.
‡ Assumes the practice meets the Physician Quality Reporting System reporting requirements, has a certified EHR, and has no value-modifier adjustment (neutral).
§ Assumes the practice improves performance to receive one-half of maximum positive adjustment in 2019-22.
‖ Includes capital investment (amoritzed) for performance monitoring platform, disease registry, and data warehouse; annual operating expenses for EHR dissemination, data monitoring and reports, and IT maintenance; and total compensation, plus benefits, for 1.0 administrative/IT support FTEs. All cost estimated adjusted 1 percent annually for inflation

**EXHIBIT 3: INVESTMENT FOR MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) PERFORMANCE IMPROVEMENT***

| | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|---|---|
| **Medicare Revenue** | | | | | | |
| Baseline Medicare Physician Fee Schedule (MPFS) Revenue† | $10,000,000 | $10,050,000 | $10,100,000 | $10,100,000 | $10,100,000 | $10,100,000 |
| Pre-MACRA Value-Based Program Adjustment‡ | $- | $- | N/A | N/A | N/A | N/A |
| Estimated MIPS Adjustment§ | N/A | N/A | $91,000 | $455,000 | $636,000 | $818,000 |
| Estimated Additional Adjustment for Exceptional Performance‖ | N/A | N/A | $274,000 | $274,000 | $274,000 | $274,000 |
| **Total Medicare Revenue** | **$10,000,000** | **$10,050,000** | **$10,465,000** | **$10,829,000** | **$11,010,000** | **$11,192,000** |
| **Percentage Change from MPFS** | 0% | 0% | 4% | 7% | 9% | 11% |
| **MIPS-Related Costs¶** | $452,000 | $455,000 | $467,000 | $478,000 | $484,000 | $490,000 |
| **Impact of MIPS** | $(452,000) | $(455,000) | $(102,000) | $251,000 | $426,000 | $602,000 |
| **Difference from Exhibit Status Quo Scenario** | $(344,000) | $(347,000) | $(44,000) | $108,000 | $182,000 | $258,000 |

* All figures rounded.
† Includes a 0.5 percent annual increase from 2017 through 2019.
‡ Assumes the practice meets the Physician Quality Reporting System reporting requirements, has a certified EHR, and has no value-modifier adjustment (neutral).
§ Assumes the practice improves performance to receive 90 percent of maximum positive adjustment in 2019-22.
‖ Assumes the practice receives an exceptional-performance bonus of more than $4,000 per physician FTE from 2019 through 2022.
¶ Includes capital investment (amoritzed) for performance monitoring platform, disease registry, and data warehouse; annual operating expenses for EHR dissemination, data monitoring and reports, and IT maintenance; and total compensation, plus benefits, for 1.0 clinical support FTEs and 1.0 administrative/IT support FTEs. All cost estimated adjusted 1 percent annually for inflation.

Although this article does not assess scoring for each MIPS category, we have assumed that if a large practice already reports PQRS, meets meaningful-use requirements, and receives a favorable VBPM adjustment, then the practice has a fairly robust IT and care management foundation to achieve a positive MIPS adjustment.

In the scenario modeled in Exhibit 2, we specifically assume the practice has these capabilities and will receive a neutral VBPM adjustment through 2018 and no PQRS or meaningful-use penalties. For 2019 to 2022, we assume the practice can perform at one-half of the maximum positive adjustment with minimal investment other than small enhancements to its performance-monitoring platform and data warehouse set-up, plus an IT staff member (1.0 FTEs) to report MIPS metrics to CMS for all physicians, given its solid MIPS foundation.

In this scenario, a 2022 MIPS adjustment of $455,000 offsets MIPS-related costs of $111,000, allowing for a $344,000 increase in income. (See Exhibit 2 on page 4.)

If this practice were to commit additional resources to intensive performance improvement to succeed in MIPS, significant revenue gains could be realized, as shown in Exhibit 3 above.

For example, if the practice were to hire one additional clinical staff member to help improve performance enough to receive MIPS adjustments at 90 percent of the maximum and surpass the additional performance threshold to receive an additional adjustment for exceptional performance, net income could increase by approximately $258,000 annually by 2022 ($818,000 in MIPS adjustment plus $274,000 exceptional performance bonus equals $1,092,000 in

**EXHIBIT 4: SUMMARY OF THE POTENTIAL IMPACT OF MIPS IN 2021**

| | | | | *See Exhibit 2* | *See Exhibit 3* | |
|---|---|---|---|---|---|---|
| 2021 MIPS Payment Adjustment | -7% | -3.5% | 0% | 4% | 6% | 7% |
| Percentage of Maximum Positive Adjustment | -100% | -50% | 0% | 50% | 90% | 100% |
| **Medicare Revenue** | | | | | | |
| Baseline Medicare Revenue | $10,100,000 | $10,100,000 | $10,100,000 | $10,100,000 | $10,100,000 | $10,100,000 |
| Estimated MIPS Adjustment | $(707,000) | $(354,000) | $- | $354,000 | $636,000 | $707,000 |
| Exceptional Performance Bonus | $- | $- | | $- | $274,000 | $325,000 |
| Total Medicare Revenue | $9,393,000 | $9,746,000 | $10,100,000 | $10,454,000 | $11,010,000 | $11,132,000 |
| **Status Quo Scenario** | | | | | | |
| Estimated MIPS Costs* | $110,000 | $110,000 | $110,000 | $110,000 | $110,000 | $110,000 |
| Net Impact of MIPS | $(817,000) | $(464,000) | $(110,000) | $244,000 | $800,000 | $922,000 |
| **Invest for Performance Improvement Scenario** | | | | | | |
| Estimated MIPS Costs† | $484,000 | $484,000 | $484,000 | $484,000 | $484,000 | $484,000 |
| Net Impact of MIPS | $(1,191,000) | $(838,000) | $(484,000) | $(130,000) | $426,000 | $548,000 |

* Assumes practices invest only in building capabilities to report for MIPS within existing EHR and accounts for staff FTEs required to report on MIPS measures to CMS.
† Assumes practices invest significantly in EHR upgrades and MIPS reporting capabilities and hire additional information technology, data analyst, and clinical support staff to support performance improvement efforts.

adjusted revenue. Subtracting $490,000 in MIPS-related costs totals $602,000 in incremental income compared with $344,000 in the status quo scenario).

The example above is simply intended to illustrate the modeling a practice should undertake when developing a MACRA strategy. It is unclear how much effort will be required to achieve specific levels of composite score improvement. In addition, the payment adjustment is applied on a curve compared with clinicians nationwide, who also may be improving. However, in Exhibit 4 above, we have provided a summary of the potential impact of MIPS in 2021 based on two levels of investment and a range of payment of adjustments. Here, practices can consider the value of composite score and payment adjustment improvement against MIPS investment.

To further demonstrate the potential revenue gains from MIPS investment and performance improvement for practices by size, Exhibit 5 on page 7 presents potential revenue increases over time from a practice that is able to increase its final score by one-quartile. Assuming a baseline score of a 0 percent adjustment at the performance threshold, or baseline MPFS, the practice ends up receiving half of the maximum positive MIPS adjustment as a result of this level of improvement.

*MIPS implications for large practices.* Large practices have a better outlook than small practices, for a number of reasons.

First, the exceptional performance payments provide a tangible benefit to being a top performer (e.g., top quartile or decile). It therefore is worth extra, incremental investment to pursue performance improvement initiatives that will help the practice achieve a high final score.

Second, many large practices already have made large IT and other infrastructure investments, which position them well to succeed in MIPS. As such, the incremental investment is much smaller than that required for smaller practices.

Third, because large practices are better positioned to succeed in MIPS, there is a high likelihood that smaller practices may seek strategic affiliations with larger practices (in most cases involving acquisitions) to bolster their chances of success.

Hospital-owned large practices may be in a position to assist small practices with education, quality improvement, preferred EHR vendor discounts, clinical practice improvement, and utilization reduction strategies. A Track 1 ACO can be a good vehicle for providing this assistance because ACO participants receive some preferred scoring in MIPS.

## Small Practices and MIPS

Small practices and those in rural or underserved areas will struggle to succeed under the Merit-based Incentive Payment System (MIPS), as defined in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). They will do so despite the efforts of the Centers for Medicare & Medicaid Service (CMS) to soften the impact of MIPS for such practices. In financial modeling of the effect of MIPS, it is reasonable to assume the cost of significant value-based payment infrastructure requirements (e.g., EHR, additional staff time) outweighs the potential payment adjustments from MIPS success.

Initially, negative MIPS adjustments will not be as great as pre-MACRA value-based program penalties on small practices that are not currently reporting on PQRS and lack a certified electronic health record technology (CEHRT). In the longer-term, however, MIPS adjustments, which increase to up to negative 9 percent, will exceed the value-based payment penalties, with the result that most small practices will likely be penalized under MIPS.

This effect will not be universal. Some small practices with a solid value-based payment program foundation in place (e.g., practices that report on PQRS, attest to CEHRT, and receive neutral or positive value-based payment modifier [VBPM] adjustments) are well positioned to compete for favorable MIPS adjustments. However, the majority of small practices are likely to be harmed by MIPS in the long term.

As a result, many independent physicians may seek employment or strategic affiliations with health systems or ACOs to help succeed in MIPS. Small practices may be able to boost their final score and related payment adjustments by partnering with a larger organization and accessing preferred scoring in ACOs.

**EXHIBIT 5: INCREMENTAL REVENUE GAINS FOR MIPS IMPROVEMENT BY PRACTICE SIZE***

| | Medicare Revenue (Baseline Medicare Physician Fee Schedule) | Revenue Gained From a One-Quartile Final Score Improvement† | | | |
|---|---|---|---|---|---|
| Est. No. Physicians‡ | 2016 | 2019 | 2020 | 2021 | 2022 |
| 3 | $500,000 | $10,000 | $13,000 | $18,000 | $23,000 |
| 6 | $1,000,000 | $20,000 | $25,000 | $36,000 | $46,000 |
| 30 | $5,000,000 | $102,000 | $127,000 | $178,000 | $228,000 |
| 60 | $10,000,000 | $203,000 | $254,000 | $355,000 | $457,000 |
| 310 | $50,000,000 | $1,015,000 | $1,269,000 | $1,776,000 | $2,284,000 |

* This analysis excludes any revenue from exceptional performance bonus, and it assumes a sliding scale factor of 1.0.
† Assumes adjustment from baseline MPFS to 50 percent of maximum positive adjustment.
‡ Medicare revenue per FTE equals $160,000.

The small physician practices that will be most challenged to succeed in MIPS will be those lacking significant investment to report on MIPS measures, including a CEHRT and clinical and administrative personnel to support MIPS-related improvement activities and report performance on selected measures to CMS. These smaller practices will need to evaluate whether to invest alone, forgo investment, or seek a strategic partnership in the form of an ACO or employment by a larger practice or health system.

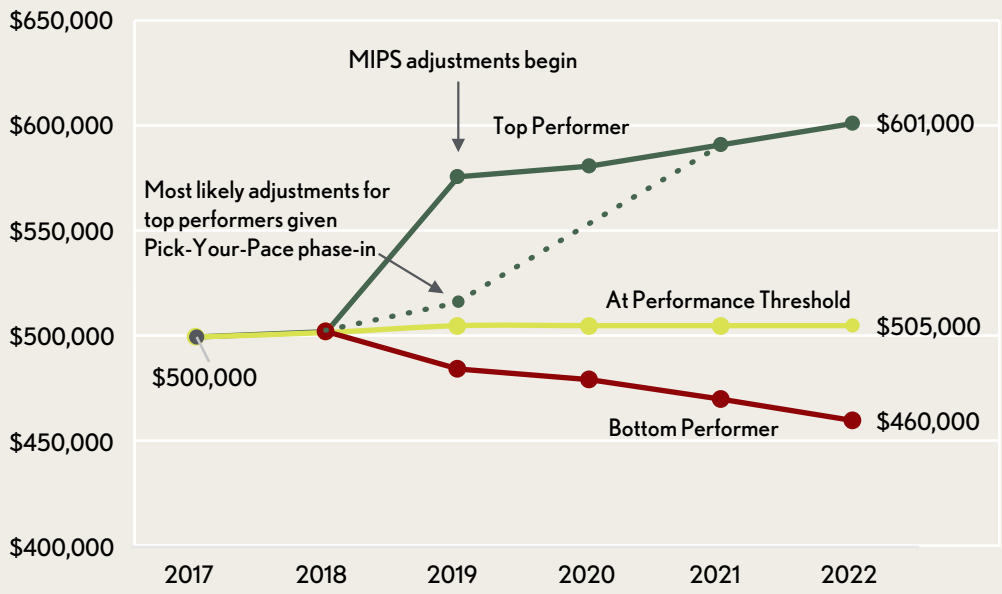
As with larger physician practices, the annual MIPS adjustment and additional adjustment for exceptional performance will allow for a 31 percent difference in potential Medicare payment between top-performers and bottom-performers, as shown in Exhibit 6 below.

*MIPS options for small practices.* Exhibits 7 and 8 on pages 9 and 10 compare financial impacts of two scenarios for a small, independent practice with three physicians and approximately $500,000 in Medicare revenue in 2017. The options are to invest in MIPS (maintain status quo) and to invest in MIPS without a partner.

Because smaller practices are less likely to report on the Physician Quality Reporting System (PQRS) and attest to use of an EHR, our analysis assumes that this practice would be penalized approximately 7 percent annually for PQRS, meaningful use and the VBPM scores. (See Exhibit 7 on page 9.)

Assuming the practice does not submit any data during measurement periods, an automatic negative 4 percent payment adjustment is applied in 2019. Interestingly, as noted previously, this adjustment is less than the aggregate penalties for pre-QPP value-based payment programs. However, by 2022, a maximum MIPS penalty of negative 9 percent exceeds that of pre-QPP programs.

**EXHIBIT 6: POTENTIAL REVENUE DIFFERENTIAL FOR A 3-PHYSICIAN PRACTICE WITH $500,000 IN 2017 MEDICARE REVENUE**




Note: Figures and calculations are simplified to best demonstrate MACRA concepts. This analysis assumes a maximum adjustment of +/- 9 percent by 2022 and a 10 percent additional adjustment for exceptional performance for top performers. Source information obtained from the Centers for Medicare & Medicaid Services, 2016.

As outlined in Exhibit 8 on page 10, if a practice is able to invest in an EHR in 2017 and attest to 2018 meaningful use, it can increase its Medicare revenue by 3 percent in 2018. Further, investment in and dissemination of an EHR, coupled with hiring of additional clinical (0.5 FTEs) and administrative/information technology staff (0.5 FTEs) to support clinical practice improvement activities and report quality data are likely to help this hypothetical practice receive a modest positive adjustment each year. In this model, we estimate positive adjustments to be approximately one-third of the maximum and assume a sliding scale factor of 1.0.

These modest positive adjustments represent revenue increases of approximately $27,000 in 2019 and $61,000 in 2022 relative to the status quo scenario presented in Exhibit 7 below. However, these revenue gains are insufficient to offset MIPS-related costs ranging from $122,000 to $129,000.

*MIPS Implications for small practices.* For small practices participating in MIPS that neither report to the PQRS nor have a CEHRT in place, these two scenarios have two important strategic implications. The first is, as noted previously, that MIPS adjustments will not initially be as drastic as pre-MACRA value-based programs. The second implication, however, is more significant: MIPS investment for these practices simply does not generate a positive ROI (i.e., risk is greater than the reward).

This implication for ROI means that these practices should consider employment or strategic affiliations with hospitals, health systems, or ACOs or clinically integrate networks to achieve economies of scale when investing in MIPS. Partnering with a larger organization with existing infrastructure to report, measure, and monitor MIPS metrics, and implement performance improvement can help small practices boost their final score and related payment adjustments.

Small practices can consider the advanced APM track, therefore avoiding MIPS altogether, by joining a risk-bearing ACO or by participating in a medical home initiative, like Comprehensive Primary Care Initiative Plus (which will reopen for applications). Although less likely alternatives, some small practices may just take the revenue hit and try to increase productivity, shift payer mix toward more self-pay patients, and/or consider not taking Medicare.

**EXHIBIT 7: STATUS QUO, WITH NO INVESTMENT IN MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)***

| | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|---|---|
| **Medicare Revenue** | | | | | | |
| Baseline Medicare Physician Fee Schedule (MPFS) Revenue† | $500,000 | $503,000 | $505,000 | $505,000 | $505,000 | $505,000 |
| Pre-MACRA Value-Based Program Adjustment‡ | $(35,000) | $(35,000) | N/A | N/A | N/A | N/A |
| Estimated MIPS Adjustment§ | N/A | N/A | $(20,000) | $(25,000) | $(36,000) | $(46,000) |
| **Total Medicare Revenue** | $465,000 | $468,000 | $485,000 | $480,000 | $469,000 | $459,000 |
| **Percentage Change from MPFS** | –7% | –7% | –4% | –5% | –7% | –9% |

* All figures rounded.
† Includes a 0.5 percent annual increase from 2017 through 2019.
‡ Assumes the practice is penalized for not meeting all meaningful use and the Physician Quality Reporting System requirements in 2017 and 2018, and therefore incurs –2 percent and –3 percent value-modifier adjustments in 2017 and 2018, respectively.
§ Assumes that the practice is subject to the maximum negative adjustment in 2019-22, that physician productivity has not changed, and that the practice has made no investment to fully or partially report MIPS in 2017-22.

**EXHIBIT 8: INVESTMENT IN MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)***

| | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|---|---|
| **Medicare Revenue** | | | | | | |
| Baseline Medicare Physician Fee Schedule (MPFS) Revenue† | $500,000 | $503,000 | $505,000 | $505,000 | $505,000 | $505,000 |
| Pre-MACRA Value-Based Program Adjustment‡ | $(35,000) | $(20,000) | N/A | N/A | N/A | N/A |
| Estimated MIPS Adjustment§ | N/A | N/A | $- | $8,000 | $12,000 | $15,000 |
| Total Medicare Revenue | $465,000 | $483,000 | $505,000 | $513,000 | $517,000 | $520,000 |
| Percentage Change from MPFS | –7% | –4% | 0.0% | 1.6% | 2.4% | 3.0% |
| MIPS-Related Costs‖ | $122,000 | $123,000 | $125,000 | $127,000 | $128,000 | $129,000 |
| **Impact of MIPS** | | | | | | |
| MIPS Adjustment | N/A | N/A | $- | $8,000 | $12,000 | $15,000 |
| Avoided Penalty | N/A | N/A | $(20,000) | $(25,000) | $(36,000) | $(46,000) |
| **Adjustment Less Penalty** | N/A | N/A | $20,000 | $33,000 | $48,000 | $61,000 |
| **MIPS-Related Costs** | $122,000 | $123,000 | $125,000 | $127,000 | $128,000 | $129,000 |
| **Net Impact of MIPS** | $(122,000) | $(123,000) | $(105,000) | $(94,000) | $(80,000) | $(68,000) |

* All figures rounded.
† Includes a 0.5 percent annual increase from 2017 through 2019.
‡ Assumes the practice is penalized for not meeting all meaningful use and the Physician Quality Reporting System requirements in 2017 and 2018, and therefore incurs –2 percent and –3 percent value-modifier adjustments in both years.
§ Assumes the practice improves performance to receive one-third of maximum positive adjustment in 2019-22.
‖ Includes capital investment (amortized over 6 years) for EHR, performance monitoring platform, disease registry, and data warehouse; annual operating expenses for EHR dissemination, data monitoring and report and IT maintenance; and total compensation, plus benefits, 0.5 clinical support FTEs and 0.5 administrative/IT support FTEs. All cost estimates adjusted 1 percent annually for inflation.

### Should We Be an Advanced APM?

It also is imperative to consider the option of avoiding MIPS by participating in an advanced APM, thereby receiving an automatic 5 percent bonus. Some practices may pursue the advanced APM track to obtain the guaranteed annual 5 percent lump sum bonus and avoid MIPS.[e] Advanced APMs also include downside risk, however, so physicians should carefully weigh the risks and benefits.

Only certain types of CMS APMs qualify as advanced APMs. Some APMs will qualify in 2017, and others are expected to be added in 2018. New APMs will continue to be defined throughout the program. The current status of APMs is provided in Exhibit 9 on page 11.

Even when physicians participate in an advanced APM, they must provide a certain minimum amount of care through the advanced APM to qualify for the 5 percent bonus. This minimum threshold rises over time as depicted in Exhibit 10 on page 12. Providers who meet the partially qualifying provider threshold do not receive the 5 percent advanced APM bonus, but they have an option of opting in or out of MIPS.

*Considerations for Track 1 ACOs.* Among the various advanced APM model options, most physicians will likely choose to participate in an ACO under the Medicare Shared Savings Program (MSSP), although Track 1 ACOs are excluded. Many Track 1 ACOs will likely choose to

e. The 5 percent bonus is paid at the beginning of the year and is available for up to six years (2019-24). Beginning in 2026, the fee schedule for providers in advanced APMs will be inflated at a higher annual rate (0.75 percent instead of 0.25 percent).

participate under Track 1+, which is expected to include less downside risk. However, the Track 1+ program has not been defined by CMS as of the publication date, so we have modeled Track 2.

In 2015, 31 percent of MSSP ACOs shared in savings. If Track 1 ACOs were to shift to Track 2and experience the same results as they did as Track 1 ACOs in 2015, about one-third would not experience any shared savings or shared losses, about one-third would generate shareable savings, and about one-third would generate shareable losses.[f]

The key question, with one-third of ACOs potentially experiencing shared losses, is whether establishing an advanced APM through a Track 2 ACO will be an effective strategy. In addition to weighing the basic advantages and disadvantages, Track 1 ACOs should consider their historical performance to assess the likelihood that they will experience shareable losses.

In short, there are three key advantages:
> Qualifying providers receive a 5 percent lump sum bonus.
> The bonus is not counted as a medical expenditure when calculating ACO savings (whereas positive MIPS adjustments are counted).
> Physicians are likely to be attracted to an advanced APM to avoid MIPS.

The key disadvantage is the risk of losses that would need to be paid back to CMS.

## Comparing MIPS With the Advanced APM Option

To better understand the benefits and risks associated with pursuit of an advanced APM, we have modeled how revenues might compare for a large, hospital-owned multispecialty physician practice with $10,000,000 in Medicare revenue, similar that outlined above. We also assume the practice is a member of a Track 1 ACO, and the

f. Track 2 ACOs can share in up to up to 60 percent of savings and are at risk to share up to 40 percent of losses. Although Track 2 ACOs have options for risk/reward minimums at which they either share in gains or losses, to simplify this analysis, we have assumed that the Track 2 ACO selects a 2 percent minimum savings rate and –2 percent minimum loss rate.

**EXHIBIT 9: ANTICIPATED ADVANCED ALTERNATIVE PAYMENT MODELS (APMS), 2017-18**

| | | 2017 | Anticipated 2018 |
|---|---|---|---|
| ACOs | Track 1 Medicare Shard Savings Programs (MSSP) | Not a CMS Advanced APM | Not a CMS Advanced APM |
| | Track 1+ MSSP | Not a CMS Advanced APM | CMS Advanced APM |
| | Track 2 MSSP | CMS Advanced APM | CMS Advanced APM |
| | Track 3 MSSP | CMS Advanced APM | CMS Advanced APM |
| | Next Generation | CMS Advanced APM | CMS Advanced APM |
| Comprehensive End-Stage Renal Disease (two-sided and large dialysis organization)* | | CMS Advanced APM | CMS Advanced APM |
| Comprehensive Primary Care Plus | | CMS Advanced APM | CMS Advanced APM |
| Oncology Care Model (two-sided risk arrangement) | | CMS Advanced APM | CMS Advanced APM |
| Bundled Payments for Care Improvement | | Not a CMS Advanced APM | Not a CMS Advanced APM |
| Comprehensive Care for Joint Replacement Model (CEHRT Track) (proposed) | | CMS Advanced APM | CMS Advanced APM |
| Episode Payment Model CEHRT Track (proposed) | | | CMS Advanced APM |
| New Voluntary Bundled Payment Model (proposed) | | | CMS Advanced APM |
| Vermont All-Payer ACO Model | | | CMS Advanced APM |

Final list of 2017 Advanced APMs to be published before Jan 1, 2017. Final list of 2018 Advanced APMs to be published before Jan 1, 2018.

focus of our analysis is to determine whether it should convert to a Track 2 ACO to become an advanced APM. Five potential scenarios are outlined below and modeled in Exhibit 11 on page 13:

> Scenario 1: If the Track 1 ACO generates no shared savings, the practice still benefits from ACO participation by receiving some preferred scoring in MIPS.

> Scenario 2: If the Track 1 ACO generates savings and successfully receives MIPS payments, there could be potentially significant combined rewards.

> Scenario 3: If the potential Track 2 ACO were to experience shared losses, its losses would likely to outweigh the 5 percent bonus.

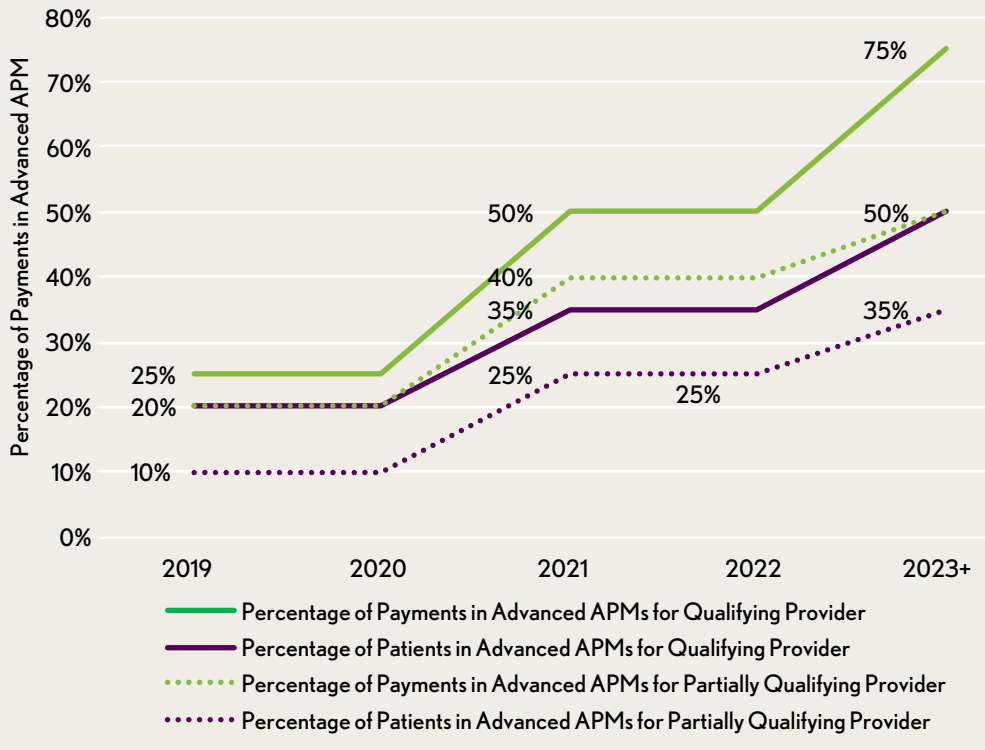
> Scenario 4: If the Track 2 ACO were to experience neither shared savings nor shared losses, the physicians would still benefit from the 5 percent bonus.

> Scenario 5: If the Track 2 ACO were to experience shared savings, it would benefit from both the higher shared savings and the 5 percent bonus.

This financial analysis raises one of the complex twists in the QPP. Although participation in a successful Track 1 ACO may help bolster MIPS performance, MIPS payment adjustments are counted as ACO medical expenditures. As a result, in our case example, the large physician group with a Track 1 ACO would have more difficulty meeting its minimum savings rate (MSR) thresholds, and sharing in savings.

Because physician and other clinician fees account for about 22 percent of medical

**EXHIBIT 10: ADVANCED ALTERNATIVE PAYMENT MODEL (APM) THRESHOLD REQUIREMENTS**




Note: Figures and calculations are simplified to best demonstrate MACRA concepts. This analysis assumes a maximum adjustment of +/- 9 percent by 2022 and a 10 percent additional adjustment for exceptional performance for top performers. Source information obtained from the Centers for Medicare & Medicaid Services, 2016.

**EXHIBIT 11: COMPARISON OF MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) AND ALTERNATIVE PAYMENT MODELS (APMS), 2020***

| | Scenario 1 Track 1 No Savings | Scenario 2 Track 1 Shared Savings† | Scenario 3 Track 2 Loss† | Scenario 4 Track 2 No Savings/Loss | Scenario 5 Track 2 Shared Savings† |
|---|---|---|---|---|---|
| **Medicare Revenue** | | | | | |
| Baseline Medicare Physician Fee Schedule Revenue‡ | $10,100,000 | $10,100,000 | $10,100,000 | $10,100,000 | $10,100,000 |
| Estimated MIPS Adjustment§ | $455,000 | $455,000 | N/A | N/A | N/A |
| Estimated Additional Adjustment for Exceptional Performance‖ | $274,000 | $274,000 | N/A | N/A | N/A |
| Estimated APM Bonus ¶ | N/A | N/A | $505,000 | $505,000 | $505,000 |
| Revenue from ACO Shared Savings (Loss) | $- | $2,844,000 | $(2,212,000) | $- | $(2,325,000) |
| **Total Medicare Revenue** | $10,829,000 | $13,673,000 | $8,393,000 | $10,605,000 | $8,280,000 |
| **Estimated Additional Costs for Track 2**** | N/A | N/A | $500,000 | $500,000 | $500,000 |
| **Revenue Less Incremental Costs** | **$10,829,000** | **$13,673,000** | **$7,893,000** | **$10,105,000** | **$7,780,000** |

* All figures rounded.
† Assumes ACO performance improvement of 0.5 percent each year.
‡ Includes a 0.5 percent annual increase from 2017 through 2019.
§ Assumes practice receives 90 percent of maximum positive adjustment.
‖ Assumes practice receives exceptional performance bonus of more than $4,000 per physician FTE.
¶ Assumes a 5 percent lump sum bonus.
** Includes enhanced risk management capabilities and network management tools.

expenditures, a 9 percent increase in Part B fees under MIPS would raise overall ACO medical spend by 2 percent. Many ACOs missed their MSR by less than 2 percent, so it could make the difference between receiving shared savings or not. Even if an ACO still exceeds its MSR, its earned shared savings would be lower. Essentially, choosing to stay in Track 1 (and MIPS) could mean sacrificing shared savings wins.[g]

On the other hand, advanced APM bonuses are not counted against ACO budgets. Thus, the 5 percent bonuses to physicians would not increase ACO medical expenditures, and the ACO would be more likely to yield shared savings. As a result, although Track 2 ACOs include downside risk, they have a better chance of beating their MSR.

Track 2 ACOs have the potential to share in much higher savings than their Track 1 counterparts. Ultimately, this advantage makes Track 2 models a more attractive option for practices that have a realistic chance of sharing in savings. However, participation in MIPS as a Track 1 ACO is the more attractive option than participation in an advanced APM as a Track 2 ACO that generates a loss, given the potential under MIPS for fee-schedule adjustments far greater than 5 percent for top-performing practices.

## Key Considerations for Health Plans and Physicians

For health systems that are sponsoring ACOs, the decision of whether to stay in Track 1 or accept downside risk is complex. Such health systems must consider what is best for their employed physicians and their independent physician alignment strategy. They also must decide

g. Of course, poor MIPS performance could lower expenditures on physician payments, and help ACO budgets, but physicians performing poorly on MIPS are unlikely to help an ACO succeed.

whether to bear all of the downside risk or share it with physicians.

Moreover, all ACOs will need to evaluate the Track 1+ ACO model when it is released, because it may provide a better balance of risk and reward as an advanced APM.

In the QPP, CMS has created a complex tangle of incentives that overlap and sometimes conflict. Whether in MIPS or in advanced APMs, managing quality and costs will be critically important. Some independent physicians may seek the shelter of an advanced APM to avoid the potential penalties associated with MIPS. Health systems will need to decide whether to provide this shelter for the benefit of attracting more physicians.

Selecting the best path requires an analysis of historic performance, thoughtful financial modeling, realistic assessment of risk, engagement of physicians in decisions, and careful consideration of the organization's value-based care strategy. ■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