STRATEGY FOR MAXIMIZING MEDICARE REIMBURSEMENT

By

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This author is writing a series of articles that attempt to assist physicians in maximizing their opportunities to benefit from the practice and business of medicine. These articles focus on business and financial strategies being used by physicians across the country to increase current reimbursement rates, increase compensation rates, and maximize the value of their practices when eventually sold to third parties or they otherwise retire from the practice of medicine. This article will focus on the strategy for maximizing Medicare reimbursement under the new MACRA rules.

Physicians need to begin planning now for the impact of the Medicare Access and CHIP Reauthorization Act (“MACRA”) which mandates various changes to the Medicare clinician payment system. In addition to eliminating SGR, the two (2) primary components of this law are that it locks in provider payment rates at a near zero growth rate and stipulates the development of two (2) new payment tracks.

The first payment track is the Merit-Based Incentive Payment System (“MIPS”) and the second track is the Advanced Alternative Payment Model (“APM”). Beginning January 1, 2019 MACRA will be implemented and may significantly impact physicians based upon which of the two (2) tracks utilized by the physicians. Unfortunately, CMS is intending to use performance data from 2017 to determine payment adjustments and assign tracks for 2019. Thus, use of 2017 information creates the need for immediate planning.

The MIPS track is the consolidation of three (3) prior pay for performance programs. These programs include Meaning Use, the Value Based Payment Modifier and the Physician Quality Reporting System. The new MIPS program will be revenue neutral to Medicare so providers need to understand how to maximize reimbursement under this program.

Under MIPS, CMS will score clinicians based upon Quality, Resource Use, Advancing Care Information (“ACI”) and Clinical Practice Improvement Activities (“CPIA”). Starting in 2019, physicians will receive payment adjustments starting with potential penalties of a 4% reduction in reimbursement and bonuses up to 12% of prior payment. The penalties expand to a 9% decrease in payment and bonus increases up to 27% of payment in later program years.

Conversely, those physicians who qualify for APM can earn financial awards based upon a risk based payment model. The APM reimbursement rates will allow providers to receive a 5% annual payment bump from 2019 through 2024 and will allow them to be exempt from the
MIPS reporting requirements.

Many physicians will try to participate under the APM track to achieve opportunities for higher Medicare reimbursement. Those who do not qualify for the APM track will automatically fall into the MIPS track. Each year, physicians have a new opportunity to qualify for the APM track.

To qualify for Advanced APM track, clinicians must satisfy a number of criteria and be part of a program listed below. At a minimum, physicians must demonstrate the use of certified EHR technology, bear a certain amount of risk that is greater than nominal financial risk or qualify as a patient centered medical home. The risk threshold must be no greater than 4% with a maximum possible loss of 4% and loss sharing of at least 30%. The loss sharing of 30% can be mitigated by stop loss insurance to reach the 4% aggregate risk limitation. Also, clinician payments within the group must be tied to certain quality measures comparable to those under the MIPS program.

Under the proposed rule, CMS states that qualifying programs for the Advanced APMS will include:

1. Medicare Shared Savings Program Tracks Two and Three
2. Next Generation Accountable Care Organization (“ACO”) Model
3. The Oncology Care Model Two-Sided Risk Arrangement
4. Comprehensive End Stage Renal Disease (“ESRD”) Care Model
5. Comprehensive Primary Care Plus (“CPC+”)
6. Certain commercial contractors with sufficient risks, including Medicare Advantage programs (starting in 2021)

Secondly, the APM entity must also meet requirements regarding a minimum percentage of payments OR a minimum number of patients tied to an Advanced APM. CMS will choose to use whichever threshold is more favorable for the group practice in determining eligibility for the APM track.

CMS suggests that approximately 92% of all physicians will fall into the MIPS track and 8% into the APM track. Thus, it is critical for most physicians to understand how they will be issued a performance score under the MIPS payment track. Those physicians who fall into the MIPS payment track will be scored based upon their performance across four (4) key categories:

1. Quality
2. Clinical Practice Improvement Activities (CPIA)
3. Advancing Care Information
4. Cost/Resource Use

Beginning in 2019, the scores assigned to each category will be allocated as follows: Quality--50%; Clinical Practice Improvement Activities--15%; Advancing Care Information--25%; and Cost/Resource Use--10%.

From 2021 and after, the assigned weights for each category will be: Quality--30%; Clinical Practice Improvement Activities--15%; Advancing Care Information--25% and Cost/Resource use--30%. However, some clinicians such as non-patient direct treatment clinicians (radiologists, pathologists) may have different weights for each MIPS category.

CMS will then translate the performance score into a bonus arrangement. Clinicians and their groups will be assigned a weighted performance score of 0 to 100. That score will be compared to the performance threshold selected by CMS from the composite performance scores for all MIPS participants. Clinicians and groups that fall above the CMS performance threshold will receive bonuses and clinicians that fall below the performance threshold will face the penalties described above.

From a planning perspective, physicians who participate in a patient centered medical home will receive full credit for the CPIA category of MIPS. This category only includes medical homes that are accredited by the Accreditation Association for Ambulatory Health Care, the National Committee for Quality Assurance PCMH Recognition, the Joint Commission Designation or the Utilization Review Accreditation Commission (“URAC”).

MSSP Track One does not qualify clinicians or groups for the APM track but it does qualify them for favorable scoring under the MIPS track. In order to do so, the physician who is MIPS eligible must report MIPS for the aggregate ACO entity. All MIPS eligible clinicians in the ACO should receive the same score that is calculated at the ACO level.

As you can see, the calculation of MIPS and APM track programs are very complicated and require some advanced planning in order to access one of the two programs. Although a physician can do very little and fall within the MIPS program, the opportunity for penalties is great without appropriate planning. Those physicians who desire to enter into more advantaged planning to enable to achieve APM status should contact their legal advisors on how to develop these structures.

This article is only intended to impress upon physicians that a need for action is imminent. Again, CMS will begin tracking activity in 2017 for purposes of making payment in 2019. Therefore, it is critical that you take action now to most properly position your practice to take advantage of these new Medicare opportunities.

If you have any questions regarding any of the above or would like information on how to take the next step to achieve your MIPS or APM track objectives, please feel free to contact this author.