

Acronymic Despair: MACRA, MIPS, and Me

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PRACTICE POINTS

- MACRA (Medicare Access and CHIP Reauthorization Act of 2015) and MIPS (Merit-Based Incentive Payments System) need not ruin your life this year.
- A single measure can eliminate your downside risk for 2019.

The year is moving ahead, and we are in the first year with a new president and a new administration. There have been multiple attempts to defund, revoke, or otherwise eliminate the Patient Protection and Affordable Care Act. As a physician, you may be asking, “What should I be doing for MACRA (Medicare Access and CHIP Reauthorization Act of 2015) and MIPS (Merit-Based Incentive Payments System)?” Everyone wants help, and there are lots of resources.¹ The American Academy of Dermatology has excellent resources focused on how to survive in the new world of acronymic programs that seem to create more unfunded mandates and paperwork for every one of us.²

What is MACRA?

The sustainable growth rate formula that had determined Medicare Part B reimbursement rates was repealed with MACRA. The sustainable growth rate, a flawed concept since it came into play under the Balanced Budget Act of 1997,³ in essence kept track of health care spending and tracked the increasing deficit that was accruing to providers, which led to statutory cuts in the Medicare conversion factor that usually were followed by Band-Aid fixes from Congress and increased each subsequent year to pay back that debt. In addition, MACRA provides a positive annual update of 0.5% in the Medicare fee schedule until 2019. This aspect of MACRA is good for providers, as was the reauthorization of the Children’s Health Insurance

Program. It would be difficult to argue against the benefits of these aspects of the law.

Of course, there is no such thing as a free lunch. The less pleasant side of MACRA is the Quality Payment Program under which providers will be paid based on the quality and effectiveness of the care provided; physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists also will be under the new system in addition to physicians. We are to be paid based on value, not volume. Heady stuff. The devil, as always, is in the details, as the factors we will be measured against are diverse. Having an electronic medical record (EMR) can make capturing data for some of these measures a bit less onerous. If you do not have an EMR, the cost of transitioning to one, especially if you are a small solo practice or approaching the end of your career, may outweigh the benefits.

What is MIPS?

Your traditional fee-for-service payment is linked to your performance on an overall physician quality score by MIPS. Most of us will take this route. The old systems that determined pleasure or pain for providers, including the Physician Quality Reporting System, meaningful use, and the Value-Based Payment Modifier (Value Modifier) are now gone.

A small group of providers, most likely those in large multispecialty groups or academic settings, will instead participate in advanced Alternative Payment Models that will provide a lump sum bonus payment of 5% of their Medicare charges from 2019 to 2024. Not for the faint of heart, this method is more complex for anyone who is not employed by a large enterprise.

For those taking the more common MIPS pathway, beginning in 2019 you can see a penalty of up to 4% on your Medicare payments if you do nothing and a bonus of up to 4% if you do it all. This rate will increase to a

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5% penalty or a reward of up to 5% in 2020, 7% in 2021, and 9% in 2022. The penalty is a result of nonparticipation, while complete participation might get you to the maximum bonus. Of course, the bonus pool is limited, and if everyone does it all, the bonus would be much less, assuming the program is not changed or eliminated by the current administration. At the time of writing this column, Senate Majority Leader Mitch McConnell (R-KY) has failed multiple times to pass a Patient Protection and Affordable Care Act repeal bill following rebellions in his own party.⁴

So what do you, dear colleague, need to do right now, or at least before the end of the calendar year? You could do it all and try to grab the brass ring 4% bonus for 2019, putting time, effort, and expense into going after what could be an elusive reward. Or you could simply avoid the penalty and go back to work knowing you have locked in normal payments (whatever that will be!) for 2019. We are both doing the latter, and so might you, especially if you have not done anything yet this year.

MIPS Made Merry

To learn what you need to do or can do, pay a visit to the Quality Payment Program website (<https://qpp.cms.gov/>) where you can look yourself up with your national provider identifier number and find out what system you are under. Unless you are part of a large enterprise, you are likely under MIPS, but it never hurts to check.

It will then give you the options for reporting as an individual or a group. Either way, you can send in quality data through your routine Medicare claims process, which is our suggested route; no registry, no EMR, just an extra line on a claim form. You can review the complete list of quality measures that are available on the Quality Payment Program website (<https://qpp.cms.gov/mips/quality-measures>). There are 271 measures to read through and ponder, but by now you already have a headache, so take the following advice:

- Filter with the “Data Submission Method” by checking off “Claims,” which gives you 74 choices.
- Filter further with the “Specialty Measure Set” by checking off “Dermatology,” which gives you 4 choices.
- The top choice and probably the easiest one to get your staff to help with is “Documentation of Current Medications in the Medical Record,” which if you click on it further identifies it as “Quality ID: 130,” the official name of this measure.

You can see the MIPS program information in all its bureaucratic glory on the Quality Payment Program website (<https://qpp.cms.gov/resources/education>); click on “Quality Measure Specifications” to download a 250 MB zip file that contains information on all the measures in detail. The Measure #130 (Documentation of Current Medications in the Medical Record) file indicates that the clinician must use a G code (G8427) to report that current medications have been documented. The

measure reads: “Eligible clinician attests to documenting, updating or reviewing a patient’s current medications using all immediate resources available on the date of encounter. This list **must** include ALL known prescriptions, over-the counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND **must** contain the medications’ name, dosages, frequency and route of administration.”⁵

You likely already confirm current medications with patients in some form or other, so simply look at the list of medications and supplements with all their dosages, frequencies, and routes of administration and sign the sheet of paper your practice likely already uses as an extra way of confirming that you have reviewed it. You report code G8427 as you would any *Current Procedural Terminology* code and link it to any *International Classification of Diseases, Tenth Revision*, code in your claim along with any evaluation and management and/or procedure codes that you would otherwise report for that encounter.

Some clearinghouses will not accept \$0 charges, so we recommend you place a \$0.01 charge for G8427 and write it off later. Upon receiving your explanation of benefits, you should notice 2 remark codes relating to the G8427 line: CO-246 and N620. Both of these codes indicate that the Centers for Medicare & Medicaid Services acknowledge your quality submission. To avoid that 4% penalty in 2019, you only need to do it once, but doing it a few times until you get back an explanation of benefits acknowledging it may help you sleep better.

Conclusion

Although the future of the Patient Protection and Affordable Care Act is still unclear, one thing is for sure: MACRA and MIPS are here to stay. Avoid the 4% penalty in 2019 and take good care of your patients and, if eligible, make donations to the American Academy of Dermatology Association Political Action Committee (skinPAC). It is going to be a wild ride.

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