MACRA Physician Payment Reform: Board Considerations for Strategy, Financial Risk, and Physician Alignment

BY GUY M. MASTERS, PREMIER, INC.

The Medicare Access and CHIP Reauthorization Act (MACRA) was passed by Congress and signed by President Obama on April 15, 2015, receiving broad bipartisan support. MACRA replaces the outdated Medicare Part B sustainable growth rate (SGR), the fee-for-service (FFS) adjustment method used since 1997 to reimburse physicians for Medicare services. MACRA creates two new payment formula options for physicians and other clinicians: the Merit-Based Incentive Payment System (MIPS) and eligible advanced Alternative Payment Models (APMs).

MACRA will have economic and strategic impacts for physicians, clinicians, hospitals, and health systems and will accelerate the transition to population health-oriented, value-based payment structures. It is essential to assess the potential effects of MIPS and APM options to determine which is best suited for employed, aligned, and independent clinicians associated with your organization. (Note that payments for physician services provided to Medicare Advantage [HMO] patients are not affected by MACRA.)

Key Elements of MIPS

The proposed MACRA rule consolidates three historic FFS payment adjusters into a single program under MIPS. A portion of an eligible clinician's payments are put at risk, beginning at 4 percent in 2019, increasing up to 9 percent by 2022. Individual physicians will be measured and given a score based on performance across four population health-oriented domains:

- Quality: Physician Quality Reporting System (PQRS) measures, Prevention Quality Indicators (acute and chronic), readmissions
- Resource use: value-based payment modifier measures, total per capita cost, episode
- Advancing care information: Meaningful Use/electronic health record (EHR) incentive program measures
- Clinical practice improvement activities including:
  - » Expanded access (same-day appointments)
  - » Population management (participation in a qualified clinical data registry)
  - » Care coordination (remote monitoring or telehealth use)
  - » Beneficiary engagement (shared decision making)
  - » Patient safety and practice assessment (surgical checklists)
  - » APM participation

The weighting of the domains in the payment equation will evolve over time, with an increasing emphasis on resource use.

CMS has augmented the measurement methodology for eligible provider participation in a non-qualifying APM, with a goal to incent participation in these population health models.

Key Elements of APMs

MACRA creates a second reimbursement option to reward providers engaged in qualifying APMs. Final regulations will define which risk-sharing arrangements qualify as APMs. They will likely include Medicare Shared Savings Program (MSSP) Tracks 2 and 3 ACOs, Next Generation ACOs, Oncology Care Model (OCM) at-risk models, and Comprehensive Primary Care Plus (CPC+) for certain practices. As proposed, MSSP Track 1 ACOs will not qualify as advanced APMs. Providers in qualifying APMs will receive an automatic 5 percent upward adjustment on their qualifying Part B payments each year from 2019 through 2025.

To qualify for the payment adjustment, providers must meet thresholds for payments or beneficiaries through the APM. These include:

- **2019–2020:** 25 percent of Medicare payments (Medicare Option)
- **2021–2022:** 50 percent of Medicare payments (Medicare Option) or 50 percent of total payments regardless of payer, and at least 25 percent of Medicare payments (All-Payer Combination Option)
- **2023 and beyond:** 75 percent of Medicare payments (Medicare Option) or 75 percent of total payments, and at least 25 percent of Medicare payments (All-Payer Combination Option)

To achieve the APM bonus, providers need to take risk and must derive a substantial portion of their revenues from an APM program, and may need to push multiple payers in the same direction. Like the MIPS component, this seems designed to move the market and providers toward population health.

Some organizations may be tempted to pursue the eligible APM track due to the guaranteed 5 percent annual bonus. However, it is critical to assess both the MIPS and APM options prior to accepting risk for Medicare Parts A and B. If your organization does not have much experience managing downside risk, moving to this type of model prematurely could be detrimental to financial performance and relationships with providers.

Strategic Implications and Action Items

Many independent physicians and small medical groups will not have the resources to meet MACRA performance measuring and data reporting requirements. This can create integration opportunities to facilitate access to capabilities and the systems necessary to be successful as part of a critical mass of aligned providers.

Consider the following issues regarding the MIPS and APM options:

- How do MACRA options align with our assumptions about the longer-term outlook for payment from Medicare and other payers?
- How does each option align with the context and vision for our population health strategy?
- Identify and evaluate APMs that currently exist in the market. Could a competitor qualify to become an APM first and use it

Key Board Takeaways

Under MACRA, physician performance measurement is tentatively scheduled to begin on January 1, 2017. The data collected in 2017 will determine how much a physician will be reimbursed for Medicare services starting in 2019. MACRA offers strategic opportunities to further align with physicians by:

- Providing access to information technology and connectivity
- Expanding clinical integration capabilities and resources
- Training and educating physicians to lead clinical integration and care redesign efforts
- Providing operating structures and data reporting mechanisms to track, organize, and use data to improve patient care and optimize financial reimbursement

to shift market share or increase physician alignment?
- Are the core capabilities essential for financial success in place or being developed?
- Is our organization ready to proceed with two-sided risk?
- Can we implement operational offsets if revenues decrease due to declining use rates?

As a board, be prepared to address these questions:
- Is the board comfortable with assuming the financial risk of an APM?
- What are potential impacts on bond ratings or our ability to raise capital?
- Is our leadership ready and capable to manage added risk?
- Is offering an advanced APM likely to draw physicians to our hospital/system?
- Can we partner with others to reduce the impact?
- What additional IT/EMR funding might be needed to add physicians and/or to meet Meaningful Use standards?

The following work streams should be considered to prepare for MACRA:
- Develop a roadmap to understand and assess merits and risks of MIPS and APMs for employed and independent physicians, and the organization.
- Assess the MIPS/APM options based on your unique market position, resources, experience with, and appetite for financial risk, IT capabilities, care coordination, and care management capabilities.
- Determine how the disruption caused by MACRA can be used to align with independent physicians by providing appropriate resources for them to meet MACRA requirements.

Final Word

MACRA establishes financial incentives to accelerate the physician transition to population health and value-based reimbursement models. These options increase both financial risks and potential rewards to physicians. MACRA ensures that status quo is not an option. There will be winners, and there will be losers. There are opportunities to increase alignment with physicians, improve quality, and create efficiencies. Do not become so distracted by the details that you lose sight of potential strategic, financial, and patient care benefits associated with this change.

The Governance Institute thanks Guy M. Masters, Principal, Premier, Inc., and Governance Institute Advisor, and Seth Edwards, Director, Population Health Management Collaborative, Premier, Inc., for contributing this article. *They can be reached at Guy_Masters@PremierInc.com and Seth_Edwards@PremierInc.com.*