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## paving the way for Medicare reform

Changes under the Medicare Access and CHIP Reauthorization Act (MACRA) won't be implemented until 2019, but preparation should start now.

In the spring of 2015, Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA), which repealed the sustainable growth rate (SGR) formula and averted the planned 21 percent across-the-board cut in Medicare's physician payment. The legislation was greeted with much fanfare and celebration, but now people are waking up to the realization that MACRA also introduces significant changes in the way Medicare pays for physician services. The details of those changes have not yet been determined, but they are sure to create a new set of challenges.

### AT A GLANCE

Major changes set forth in the Medicare Access and CHIP Reauthorization Act are coming in 2019, but the time to prepare is now. The legislation includes three major changes:

- > Pay-for-performance metrics
- > A two-track payment system
- > Consistent rate increases

Beginning in 2019, the Centers for Medicare & Medicaid Services (CMS) will implement a new payment system under which providers will be rewarded for delivering high-quality, cost-effective care and encouraged to shift toward alternative payment methodologies. Although the changes outlined in MACRA will not take effect for several years, providers that hope to succeed under the new payment methodology need to begin making changes now. The post-MACRA landscape will essentially be a zero-sum game that financially rewards certain providers at the expense of others. Standing still means accepting lower Medicare Part B payment.

MACRA is noteworthy not simply because of its financial implications for providers but also because it represents a shift in approach to how health-care legislation is crafted and implemented. The legislation was enacted with broad bipartisan support, passing the Senate 92-8. Stakeholder input was actively sought throughout the development of the legislative language.

The law directs CMS to solicit from the industry—on a prospective basis—suggested quality metrics, which is a departure from the usual practice in which the agency publishes a proposal and then solicits comments. Also, the effects of MACRA will be studied by various government agencies and reported back to Congress, ostensibly in recognition that adjustments will continue to be made along the way.

**MACRA Highlights**

MACRA substantively reforms the way that Medicare pays for physician services. At the highest level, the current system will see three major changes.

**Integration of pay-for-performance metrics.** Medicare’s current physician payment methodology incorporates three separate pay-for-performance metrics: the physician quality reporting system (PQRS), electronic health record (EHR) meaningful use, and the value-based modifier (VBM). These programs will continue through 2019 but will then be rolled into a two-track payment system comprising the merit-based incentive payment system (MIPS) and alternative payment models (APMs), under which physicians will begin to receive payment as early as 2019.

MIPS, which constitutes the first track, is essentially a modified version of the existing Medicare physician fee schedule with enhanced pay-for-performance incentives. APMs make up the second track and constitute a variety of other payment models, including accountable care organizations (ACOs) and other models yet to be named, that require certain conditions to be met.

**More consistent rate increases.** In lieu of the SGR formula, MACRA outlines the fee schedule rate increases through the next decade. Under both MIPS and APMs, the fee schedule will increase at the rate of 0.5 percent annually through 2019. From 2020 through 2025, fees will remain static. Beginning in 2026, fee schedule increases will begin at the rate of 0.25 percent annually under MIPS and 0.75 percent annually under APMs.

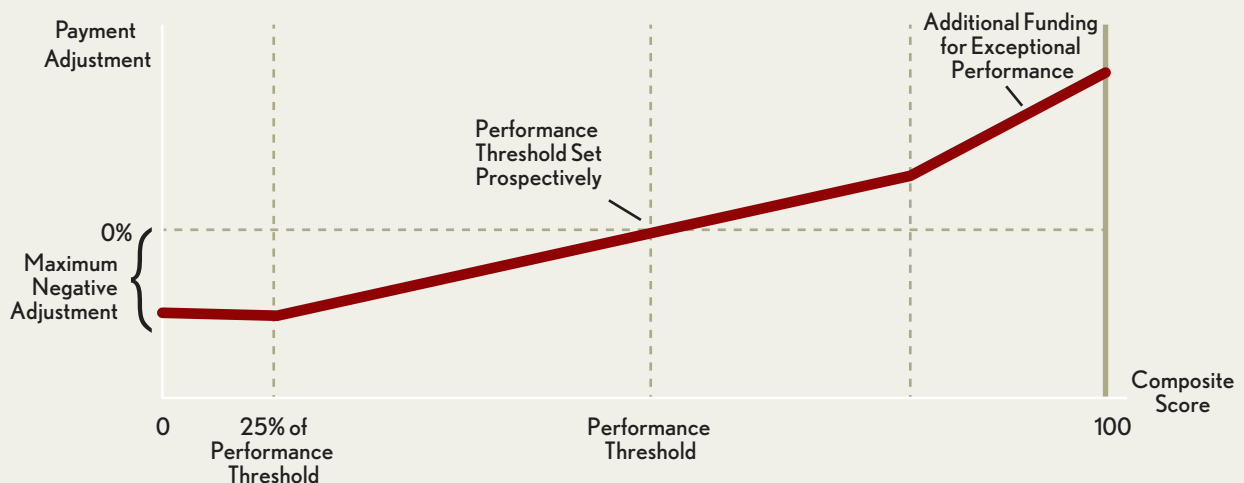
**Decoding the Two-Track Payment System**

As noted previously, MIPS incorporates performance incentives from the existing Medicare physician fee schedule and is the more fully defined of the two tracks. In replacing the existing PQRS, meaningful use, and VBM incentives, MIPS will introduce an incentive comprising four weighted components.

**Clinical quality (30 percent).** Clinical quality performance will likely resemble the current PQRS system. New measures are anticipated, however, as CMS will be soliciting comments on the new clinical quality measures, as well as providing funding to develop further measures.

**Resource utilization (30 percent).** This category will be based on the current physician value-based

**MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) SLIDING SCALE**



payment modifier and will scale up during the first few years.

**Meaningful use (25 percent).** Meaningful use incentives will be based on the same requirements that are currently in place, differing only in how they translate to the differential Medicare payments. Providers that report MIPS quality measures through certified EHRs will be deemed, *de facto*, to meet the meaningful use clinical quality component.

**Clinical practice improvement (15 percent).** This component seeks to engage providers in clinical practice improvement activities, which will be established by CMS in collaboration with professionals. Activities must be applicable to all specialties and attainable for small practices and professionals in rural and underserved areas. Meeting this requirement will be challenging for some specialties with little or no real patient contact, such as radiology and pathology.

Providers' performance in these categories will be compiled into a composite score ranging from 0 to 100, which will, in turn, drive an upward or downward percentage adjustment to their payment rates as follows.

Based on historical performance, CMS will establish a performance threshold and a sliding scale such that providers whose composite scores are at the threshold will receive no payment adjustments, with those below or above it differentially penalized or rewarded. The sliding scale will be established with the intent of achieving budget neutrality (that is, total penalties should equal total rewards).

Each year, there will be maximum penalties that could be incurred by providers that do not meet performance thresholds, with the percentages increasing each year for the first four years, as follows: 2019: -4 percent; 2020: -5 percent; 2021: -7 percent; and 2022: -9 percent.

Providers that do not report necessary MIPS performance data, or whose composite score is

less than 25 percent of the threshold, will incur the maximum penalty.

Depending on how the industry performs, any surplus funds will be distributed to providers that perform above an additional performance threshold. An additional \$500 million in annual funding is earmarked for the best performers, as shown in the exhibit on page 2.

As an alternative to participation in the underlying physician payment fee schedule, providers may qualify to participate in the second track, which represents a more dramatic departure from the historical payment model. It is important to note that this track is not as clearly defined under MACRA, although CMS has been charged with defining the details over time, with input from stakeholders.

Under this track, providers will participate in APMs such as ACOs, patient-centered medical homes, and other models that have been vetted by the Center for Medicare and Medicaid Innovation. APMs will also have quality incentives similar to MIPS, with criteria based on a notice-and-comment process. Stakeholders can review criteria posted by CMS or the U.S. Department of Health and Human Services (HHS) and propose new models that meet those criteria.

To create incentives for physicians to enter into APMs, MACRA offers an additional 5 percent in annual bonuses for services in 2019-24 and a higher cumulative payment update (0.75 percent). However, to qualify for this track (and the bonus), providers must have a minimum percentage of their patient volumes enrolled in APMs, and this percentage will increase over time. The two features are indicative of CMS's desire to see large numbers of patients transitioned into APMs.

### Resource Use Management

As part of the process for developing the resource-based metrics for the two incentive payment tracks, MACRA directs the HHS secretary to collaborate with physicians and other

stakeholders on improving resource use management for physician services. This MACRA provision, although seemingly innocuous, deserves close attention because it may signal HHS's and CMS's intent for further changes down the road. The bill calls for the development of episode groups, aligned with other factors that are to account for half of Medicare Part A and Part B expenditures. The HHS secretary is also directed to develop a set of "patient relationship" codes, to be aligned with patient condition groups.

In this manner, HHS and CMS will be looking at specific physicians' resource utilization (including Medicare Part A and Part B) for certain episodes of care, associated with certain patient conditions. For example, just as hospitals are now on the hook for readmission rates under Part A, the same type of risk/reward can now be extended to physicians. This development deserves careful attention during the next few years. Ultimately, we can expect to see greater reliance on these episode groupings as a way to monitor and incentivize efficiency.

### Unanswered Questions

Among the many features of MACRA that have not yet been defined, one prime example is how CMS will define the incentives and scoring mechanisms under MIPS and the models that will be accepted under APMs. Some less obvious questions include the following:

- > How aggressive will CMS be in redistributing payments under MIPS?
- > How will data collection take place for the incentives that have not yet been defined?
- > What timing and procedures will CMS establish around the administration of penalties or rewards under MIPS?
- > What accommodations will be made for smaller practices?
- > How will the clinical practice improvements incentive work for specialties that have limited patient interaction?
- > Will subsequent legislation create incentives for patients to enroll in APMs?

### Implications

Clearly, the incentive systems described in MACRA are a significant step toward value-based payment. The introduction of MIPS certainly ups the ante on the amount of financial risk being transferred to providers. In other words, providers no longer have the option of standing on the sidelines waiting to see what will happen. Significant payment change is happening. But it is clear that what CMS really wants is to have more providers take the APM route. Moreover, the resource utilization feature built around care episodes and the physician-patient relationship is likely to be a signal of things to come. We can expect CMS to push for the continued integration of incentives under Medicare Parts A and B and, as it gains experience with this system, to look for ways to use the system to exert more leverage on provider organizations.

All of these effects will place an even greater premium on clinical integration among physicians, hospitals, and other providers, underscoring the need for hospitals and health systems to consider stepping up their integration efforts with physicians and other care providers. A good way to start is by educating physicians about the types of changes MACRA is ushering in.

Invariably, hospitals and physician groups should increase their focus on building the technology, management, and clinical oversight resources to perform under value-based incentives. Although these incentives have not been fully defined, hospitals and health systems should begin preparations now by developing the decision-making process, measurement capabilities, and management competencies that will enable them to adapt quickly as the measures come into focus. ■

### About the author



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