Big Decisions

MACRA pushes the value agenda and forces physicians to choose how they get paid.

BY RYAN GRAVER, CATHIE BIGA, AND KELSEY REICHERT

The road to health care transformation is anything but smooth—it continues to wind, split, and dip in new and unexpected ways. It won't be enough to simply buckle up for the very bumpy ride; physicians and organizations that want to thrive in the value-based world need to prepare for the trip now—research the best route to take, weigh the options, plan for detours, anticipate the unknown, and keep a GPS handy. One of the latest examples of the ever-changing health care landscape is MACRA, the Medicare Access and CHIP Reauthorization Act of 2015, which was signed into law on April 16th as the fix for the sustainable growth rate (SGR). It is, however, much bigger than that. The real impact of MACRA will be its role as the road map for the implementation of a value agenda. Although many details about MACRA are yet to be determined, it will (in absolute terms) force a migration away from fee-for-service reimbursement and push health care toward its goal of achieving the triple aim of high-quality, low-cost care with an exceptional patient experience. MACRA advances the movement away from payment for volume and replaces it with a system that ties payment to mandates for quality, outcomes, and efficient care; it achieves this with the introduction of the merit-based incentive payment system (MIPS) and the alternative payment models (APMs) (Figure 1).

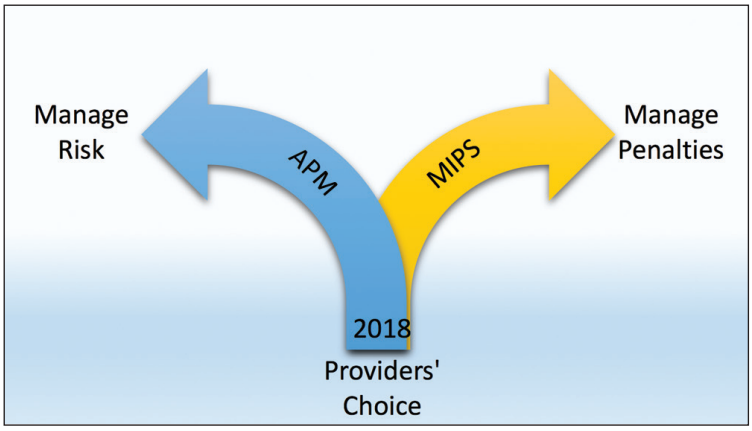

Figure 1. The reimbursement decision for providers.

THE VALUE AGENDA

MACRA is largely focused on furthering the value agenda under the Affordable Care Act. The initiatives that were created by the current value-based modifier program (also known as physician value-based purchasing program), along with the *physician quality reporting system* (PQRS) and Meaningful Use, will sunset on December 31, 2018. After that, physicians will be faced with deciding between following the guidelines for participating in MIPS or choosing to be in an APM. Both options pose financial risk to reimbursement if preset quality measures and savings goals are not met. Regardless of which program a physician chooses, MACRA is pushing physicians to focus on delivering value, not just providing services for patients.

MIPS

Although many unknowns continue to persist, MACRA does outline that MIPS will be one of two pathways that physicians may choose in terms of how they will be paid. It is believed that MIPS will embrace many of the current quality elements, while developing a new methodology to assess performance in order to create a performance score to use for calculating payment incentives and penalties. Beginning in 2019, physicians will choose from an annual list of quality measures to report (somewhat similar to the current PQRS). After 2 years, other eligible providers, such as advanced practice providers (APPs), social workers, and occupational therapists can be added. Physicians need to be aware that individual program penalties will continue through 2018, and data collected in the coming years will be used for the MIPS incentive payments starting in 2017 (2 years after the year of performance).

The MIPS program will be divided into four main categories: quality, resource use, meaningful use, and clinical practice improvement (Figure 2). Each category is scored and then combined to create a total score from 0 to 100, weighted on differing levels. Quality will account for 30% of the score, resource use will be 30%, clinical practice improvement will be 15%, and mean-

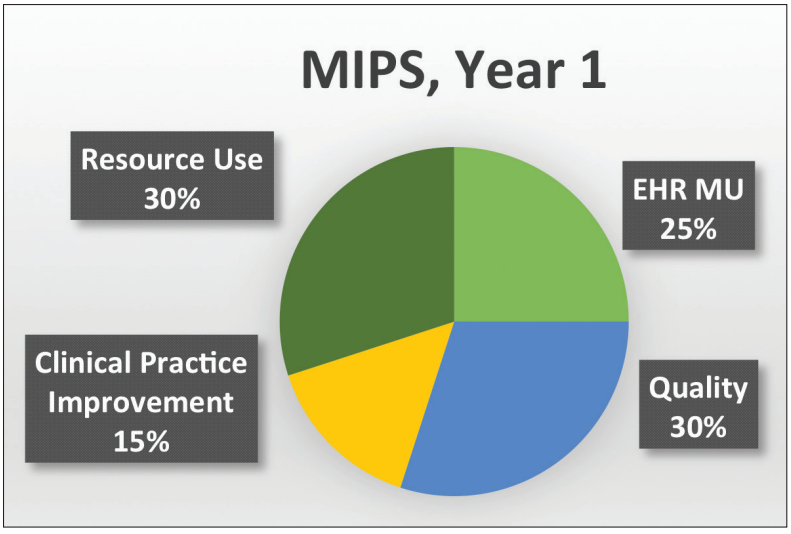

Figure 2. Performance score breakdown.

ingful use will be 25%. It is noted in this original Bill that these may be adjusted. Each eligible provider will receive a composite performance score based on these categories, which will determine the reimbursement for that specific year. It is interesting to note that although there will be a "group" measure, unlike the value modifier program, MIPS will be based on individual National Provider Identifier numbers.

What are these categories based on? The quality portion of the score may be based on measures currently used in the value programs. Resource use will rely on data similar to the value-based modifier, but with some significant changes (such as including Part D drug information). This category does allow for attribution and risk-adjustment methodology. It is intended that meaningful use measures will continue to be utilized to create the scoring for the category. Finally, clinical practice improvement will be based on access, population management, care coordination, beneficiary engagement, patient safety, and practice assessment. This critical component of MACRA is intended to get the Medicare beneficiary actively involved in their care.

How will your score affect your payment adjustments? Physicians will be placed into three categories based on where their score lands against the decided threshold. If physicians are below the threshold, they will receive negative payment adjustments starting at 4% in 2019, and slowly increase as shown in Table 1. Neutral adjustments will be made for those who reach the threshold. For physicians above the threshold, there will be the opportunity to gain positive adjustments for a maximum of up to three times the annual cap for negative adjustments. It should be noted that benchmarks are set on the previous year's data for a performance period. This will necessitate better data turnaround times than are currently experienced.

APM

On January 26, 2015, Health & Human Services announced measurable goals and a timeline for shifting Medicare from the traditional fee-for-service system to one that pays on the basis of quality of care and outcomes, or a "value-based" payment system. The Centers for Medicare & Medicaid Services (CMS) pandor called for a specific, year-by-year increase in the percentage of Medicare payments that are value based. According to the schedule, by the end of 2016 at least 30% of traditional, or fee-for-service, Medicare payments will be tied to quality or value through alternative payment models, such as accountable care organizations (ACOs) or bundled payment arrangements. By the end of 2018, that value will be 50%. The goals also include tying 85% of all traditional Medicare payments to quality or value

TABLE 1. THRESHOLDS FOR NEGATIVE AND POSITIVE ADJUSTMENTS

Performance Year	Payment Year	Maximum Negative Adjustment	Maximum Positive Adjustment
2017	2019	-4%	12%
2018	2020	-5%	15%
2019	2021	-7%	21%
2020	2022	-9%	27%

by 2016 (and 90% by the end of 2018) through programs such as the hospital value-based purchase and hospital readmissions reduction programs.[1]

MACRA has further provided clarity to the means by which CMS will achieve these stated goals. MACRA included four models that would be available for those choosing the APM pathway. The first model must come from CMS Innovation, but cannot be one that has received an innovation award. Second, is the Medicare shared savings program—similar to the current methodology. The final two are "yet to be determined" and will be based on demonstration projects approved under Section 1866C SSA, or a demonstration model that is required by federal law. There are certain core requirements for the APM pathway, which include the mandate to use certified electronic health records (EHRs) and a process that pays for services based on quality measures, while bearing some financial risk. It is believed that 60% of physicians will be in an ACO by 2019, and all physicians will be part of an ACO by 2038. With this in mind, MACRA seems to be pushing physicians to adopt an APM model.

Participation in an APM must follow one of two routes. The first option is to track the amount of revenue received from Medicare APM payments. To qualify, 25% of a provider's revenue must come from a Medicare APM in 2019 and 2020. In 2021 and 2022, 50% of revenue needs to come from a Medicare APM. The second track states that 50% or more of revenue must come from an APM with Medicare, or APM payments from other payors by 2021 and 2022. Physicians electing to participate in APMs will be exempt from MIPS and most meaningful use requirements. In addition, from 2019 to 2024, providers qualifying for the APM track will receive a 5% annual lump sum bonus on their Medicare Physician Fee Schedule payments from the preceding year. This percentage will increase annually. The APM option under the value agenda for MACRA may come with more financial risk, but it has potential to offer the greatest financial reward.

MAKING AN INFORMED DECISION (OR PUTTING YOUR MONEY WHERE YOUR MOUTH IS)

What is known for sure is that MACRA creates a value agenda to steer physicians toward advancing quality improvement initiatives and cost-cutting efforts. The time to wait and see what happens is over. CMS is the country's single largest payor, and it is leading our rapid advance to transformation. There are still many questions to be answered and details to be worked out. This is good news—it means that physician understanding of and involvement with MACRA as it develops can influence appropriate structure and implementation. Now is the time to get involved; MACRA states the Secretary of Health and Human Services and key stakeholders must develop and publish a plan for MIPS and APM development by May 2016.

> Physicians will be faced with deciding between following the guidelines for participating in MIPS or choosing to be in an APM; both options pose financial risk to reimbursement.

The big question for physicians: how do you want to be paid? What are the pros and cons of penalty-based payment versus population risk-based payment? How will physicians be measured and benchmarked? Are your practices and service lines ready for what comes with each track? What will the impact be—for health care systems and the communities they serve? What is the best way to achieve high-quality health care at lower costs? As providers, are you leading the transformation of your care delivery to be successful in this new normal of health care?

Success in the evolving value-based world requires understanding of the nuances of programs like MACRA that are pushing the industry forward. Being involved with the process, networking with peers, talking with experts, and having a voice in how MACRA develops will help each physician make smarter and more sustainable choices. ■

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1. Better care. Smarter spending. Healthier people: paying providers for value, not volume. Centers for Medicare & Medicaid Services Web site. https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html. Accessed August 10, 2015.