

Physician Payment Reform Under the MACRA

The Issue

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) makes sweeping changes to how Medicare pays for physician services. The legislation repeals the Medicare physician sustainable growth rate (SGR) formula and instead provides predictable payment increases. The law also requires the Centers for Medicare & Medicaid Services (CMS) to implement, by 2019, a new two-track payment system – the Quality Payment Program (QPP) – for physicians and other eligible clinicians.

The two tracks of the QPP seek to tie an increased percentage of physicians' Medicare fee-for-service (FFS) payments to outcomes through the new Merit-based Incentive Payment System (MIPS) and to encourage the

adoption of “alternative payment models” (APMs). APMs move payment away from fee-for-service reimbursement, and instead pay providers based on the quality and cost of care for particular episodes (e.g., bundled payment), or defined patient populations (e.g., accountable care organizations (ACOs)).

On Apr. 27, 2016, CMS issued proposed regulations implementing the QPP, with a final rule due no later than Nov. 1, 2016. How CMS implements the changes contained in the MACRA will have a significant impact, not only on physicians, but also on the hospitals and health systems with whom they partner.

What the MACRA Does

The MACRA abolishes the SGR and from 2015 through 2025 provides physicians with a stable, sometimes flat, update to the Medicare physician fee schedule payment rates. Beginning in 2026, physicians and other health care professionals will receive different annual updates depending on whether they are paid under the new MIPS (0.25%) or primarily through advanced APMs (0.75%).

Merit-based Incentive Payment System (MIPS). The MIPS is based on the FFS model with a direct tie to quality performance. Beginning in 2019, the MIPS will be the default payment system for physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists and practice groups that include these professionals. The MACRA sunsets three current-law reporting and pay-for-performance programs – the physician quality reporting system (PQRS), Medicare Electronic Health Record (EHR) Incentive programs for eligible professionals, and the value-based payment modifier (VM) – and consolidates the measures and processes of these programs into the MIPS.

Physicians and other eligible clinicians will be assessed in the MIPS under four performance categories:

- **Quality:** CMS proposes that eligible clinicians would be expected to report on at least six measures drawn from a list of over 200 measures. Eligible clinicians would report using a single mechanism (e.g., registry, EHRs, Medicare claims).
- **Resource use:** CMS would calculate two overall cost measures currently used in the VM program, as well as several clinical condition and treatment episode cost measures.
- **Clinical practice improvement activities:** This category will reflect participation in activities such as expanded practice access; population management; care coordination; beneficiary engagement; patient safety and practice assessment; and participation in an APM. Clinicians would select from a list of available activities.
- **Advancing care information (ACI):** This category is a restructured approach to current-law meaningful use requirements.

Based on their performance in these four categories, physicians and eligible providers will receive a payment adjustment. The payment adjustment will be capped at +/- 4 percent in 2019, rising to +/- 9 percent in 2022 and subsequent years. In addition, for 2019 through 2024, the Secretary will designate a threshold for “exceptional performance” on the MIPS, and may spend up to \$500 million each year on bonus payments to top performing providers.

Participation in Advanced APMs. The MACRA creates incentives for physicians to participate in advanced APMs, thereby moving the Medicare program away from FFS and closer to a payment system tied to patient outcomes and population health. Beginning in 2019, the APM track allows physicians receiving a significant portion of their payments through advanced APMs to be exempt from most MIPS provisions, and through 2024, to receive a lump sum payment of 5 percent of their covered services from the previous year.

While CMS will specify in regulation which APMs qualify for the APM track, the MACRA requires that APMs meet certain criteria. Specifically, to qualify as an advanced

APM, a model must:

- require use of certified EHR technology;
- provide payment based on quality measures comparable to those used in the MIPS quality category; and
- bear financial risk for more than a nominal amount of monetary loss, or be a medical home that meets certain criteria. Specifically, advanced APM participants would be required to refund Medicare if their spending under the model exceeds a projected amount (known as downside risk).

APMs under Medicare include models tested by the Center for Medicare and Medicaid Innovation; a Medicare Shared Savings Program (MSSP) ACO; or certain other demonstrations required by federal law. Models that would qualify as advanced APMs are MSSP Tracks 2 and 3, the Next Generation ACO model, the Comprehensive End-stage Renal Disease Care model, and the Oncology Care program. The newly announced, but not yet implemented, Comprehensive Primary Care Plus initiative would qualify as a medical home.

Implications for Hospitals and Health Systems

The implementation of MACRA will have a significant impact not only on physicians, but also on the hospitals and health systems with whom they partner.

Hospitals that employ physicians will defray some cost from implementation of and ongoing compliance with the new physician performance reporting requirements, as well as be at risk for any payment adjustments. Moreover,

hospitals may participate in advanced APMs to help the physicians with whom they partner qualify for the advanced APM incentives. Finally, as a larger percentage of physician payment becomes at risk, there will likely be a continued shift in hospital-physician relationships, as hospitals and physicians seek greater collaboration on performance measurement and payment models.

AHA Position

The AHA is carefully monitoring the implementation of the QPP. CMS’s recent proposed regulation includes some policies we support, including a reduction in the number of required quality measures in the MIPS and movement towards greater flexibility in meeting meaningful use. However, the AHA believes significant changes must be made to policies that may impinge upon the ability of hospitals and physicians to successfully participate in the QPP. Specifically, we believe the QPP should include:

- An expanded definition of advanced APMs that recognizes the substantial investments that must be made to launch and operate APM arrangements;
- A quality and resource use measure reporting option in which hospital-based physicians can use CMS hospital

quality program measure performance in the MIPS;

- A socioeconomic adjustment in the calculation of performance as needed; and
- Alignment between the hospital meaningful use program and the ACI category of the MIPS, and simplified ACI requirements.

The AHA is actively working with hospitals, health systems and physician groups to prepare the field for MACRA implementation. Learn more at www.aha.org/MACRA, which includes a payment reform timeline, webinars, advisories and materials for physician and trustee education. We also welcome questions and feedback, please email MACRA@aha.org.