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## Making Way for MACRA: Positioning Your Organization for Payment Reform



BY MARTY CORRY, BEN DURIE, DAVID WOFFORD,  
AND LAURA BARRERA

In April 2015, Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA), which represents the most sweeping set of changes to Medicare's physician payment methodology since the current system was put in place 25 years ago. MACRA has made headlines because it repeals the sustainable growth rate (SGR) formula, thereby averting the planned 21% across-the-board cut in Medicare's provider payments. Perhaps more importantly, it represents for Medicare a dramatic step away from traditional fee-for-service (FFS) reimbursement and toward value-based payments for physician services.

During the next five years, the Centers for Medicare and Medicaid Services (CMS) will implement a new reimbursement system under which providers will be rewarded for delivering high-quality, cost-effective care

and encouraged to shift toward alternative payment methodologies (APMs). With these changes to physician payment, hospitals and health systems must re-evaluate their existing financial relationships with physicians, whether they are employed or operating through Professional Services Agreements. This assessment will need to include not only a review of physician compensation itself, but also an evaluation of the organization's ability to implement and track the multitude of quality and resource-related metrics that CMS will use to establish physician reimbursement rates.

It is critical for providers to appreciate that the post-MACRA landscape will be essentially a zero-sum game that rewards certain providers at the expense of others. Although many of the changes outlined in MACRA will not take effect until 2019, providers who hope to be the most successful under the new payment methodology will need to start the process of planning for and implementing structural changes long before then.

*Marty Corry chairs the Government Relations & Public Policy department of Hooper, Lundy & Bookman, working in the firm's Washington office. He can be reached at [mccorry@health-law.com](mailto:mccorry@health-law.com). Ben Durie is an attorney in HLB's business department, working in the firm's San Francisco office. He can be reached at [bdurie@health-law.com](mailto:bdurie@health-law.com). Dave Wofford is a senior manager in the San Diego office of ECG Management Consultants. He can be reached at [dwofford@ecgmc.com](mailto:dwofford@ecgmc.com). Laura Barrera is a senior consultant, also in ECG's San Diego office. She can be reached at [lbarrera@ecgmc.com](mailto:lbarrera@ecgmc.com).*

### Background

Since the late 1980s, Medicare has reimbursed physician services using the Medicare Physician Fee Schedule (MPFS), which encompasses 10,000 procedure codes. Each code is assigned resource-based relative value units (RVUs), which are designed to reflect physician work, practice expense and malpractice expense. This system has tended to reward physicians for the volume of services provided.

With enactment of the Medicare Modernization Act (MMA) in 2003, Medicare began moving toward "value-based" payments, and the introduction of Affordable Care Act (ACA) in 2010 meant that Medicare acceler-

ated its use of value-based payments as a means of improving outcomes and managing overall costs.

## Key Elements of Legislation

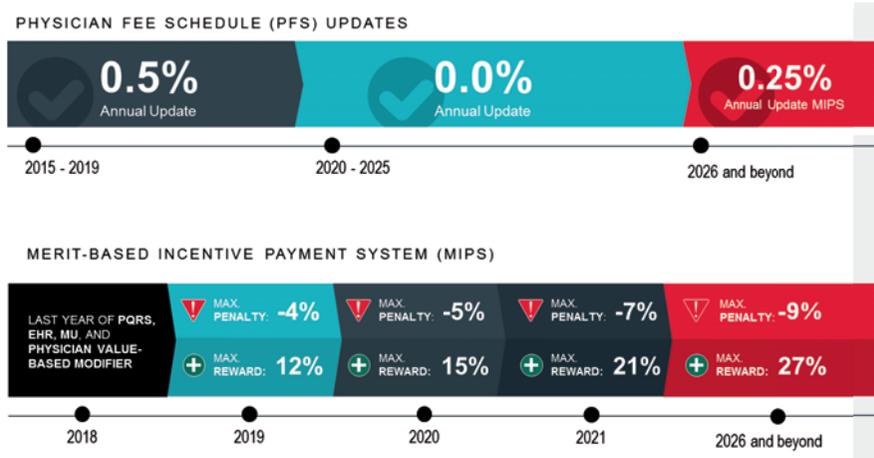
MACRA substantively reforms the way that Medicare reimburses for physician services. Beginning as soon as 2019, there will be a two-track system whereby providers can be reimbursed on a FFS basis, with enhanced incentives, or they can participate in alternative payment models. It is important to note that the substance of the legislation is provided in broad terms, and that the federal agencies, notably CMS, have been given tremendous discretion in fleshing out the details during the coming years.

### »Track 1: Enhanced FFS Model — Merit-Based Incentive Payments

This track most closely resembles the existing Medicare Physician Payment System and is the more fully defined of the two. In lieu of the SGR, MPFS rates will increase by 0.5% each year from July 2015 to 2019 and then will remain static (0%) through 2025. Starting in 2026, payment rates will again be increased by 0.25% annually.

In effect, annual increases will be flat over the next 10 years. However, while the base rate will change relatively little, beginning in 2019 a merit-based incentive payment system (MIPS) will introduce opportunities as well as risks based on value criteria. MIPS is designed to replace three existing performance programs: Physician Quality Reporting System (PQRS), EHR “meaningful use” (MU), and the physician value-based modifier (VBM). This will be phased in over a 4-year schedule and will essentially be budget-neutral; that is, there will be winners and losers under this program. The penalty/reward structure will be phased in over time, such that by 2026, the maximum payment penalty will be 9% and maximum reward will be 27%. However, because this is intended to be budget-neutral, the maximum upside will likely never be realized. Instead, it is expected that a significant number of providers will be paid less. An additional \$500 million will be provided each year from 2019 to 2024 for providers demonstrating exceptional performance (i.e., the top quarter).

The rollout of payment updates and risk/reward is shown in the illustration below.



Performance will be assessed using the following MIPS’s four categories, which have been assigned relative weighting:

**Clinical Quality (30%).** Clinical quality performance will be assessed against the following subcategories: clinical care, safety, care coordination, patient and caregiver experience, and population health and prevention. In addition to replacing CMS’s current quality performance programs (i.e., PQRS, VBM, and MU), CMS will be soliciting comments on the new clinical quality measures as well as providing funding to develop further measures.

**Resource Utilization (30%).** This category will scale up over the first few years. Congress has directed the secretary of health and human services to base this category on the cost parameters under the current physician value-based

payment modifier (Section 1848(p)) that also takes into account socioeconomic, demographic, and other risk factors.

**Meaningful Use (15%).** MU incentives will be based on the same requirements that are currently in place, with the difference being in how they will translate to the differential Medicare payments. Providers who report MIPS quality measures through certified EHR systems will be deemed, de facto, to meet the MU clinical quality component.

**Clinical Practice Improvement (25%).** 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.

This is going to be challenging for some specialties with little or no real patient contact, such as radiology and pathology.

Providers' performance in each of these categories will be compiled into a composite score on a scale of 0 to 100. This score will in turn be used to differentiate between the best and worst performers. The precise scoring mechanism, as well as the means of translating the score into differential payments, is yet to be defined. However, it is expected that because this is budget neutral, a significant number of providers in the system will be paid less.

» **Track 2: Alternative Payment Models**

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

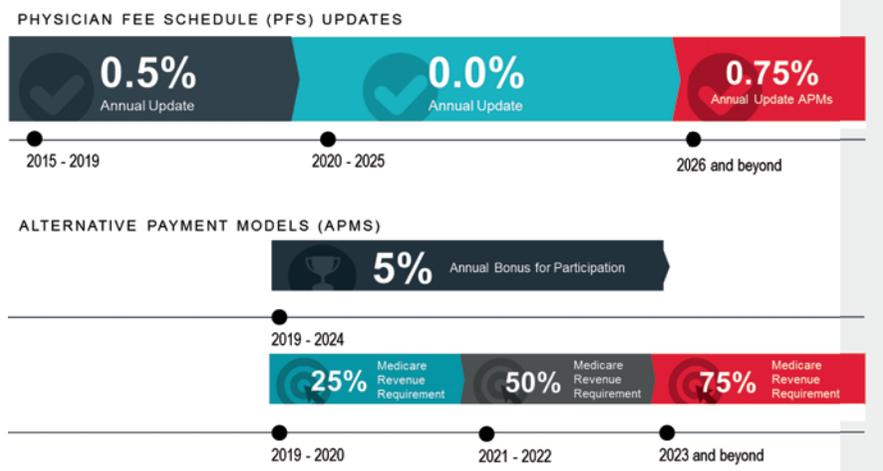
Under this track, providers will participate in alternative payment models (APMs) such as accountable care organizations (ACOs), patient-

centered medical homes (PCMHs), and other models that have been vetted by the Center for Medicare and Medicaid Innovation (CMMI). Alternatively, stakeholders can propose other models that meet criteria that will be posted by CMS/HHS for comment. In order to incentivize physicians to enter into APMs, MACRA offers an additional 5% in annual bonuses for services in 2019 to 2024 and a higher cumulative payment update (0.75%) beginning in 2026. Like Track 1, APMs will also have quality reporting requirements, in which additional increases or decreases may apply. Providers will have the ability to phase into the APM track over several years.

The criteria for APMs will be based on a notice and comment process, affording an opportunity to provide input on the alignment of incentives for evidence-based outcomes payment methods.

By the introduction of this track, Congress is giving providers a clear choice: stick with the current system, with modifications, and accept essentially flat reimbursement, or move into alternate models with a greater opportunity for both potential and risk.

The illustration below shows the timing of implementation for APMs.



» **Resource Use Management**

As part of the process for developing the resource-based metrics for the two incentive payment tracks, MACRA also includes a separate section directing the secretary to collaborate with physicians and other stakeholders to improve resource use management for physician services. This provision (found in subsection (f) of Section 101) is a bit of a “sleeper,” but physicians ought to pay close attention for what it portends for the future, as it is likely indicative of the next round of payment changes after 2020, if not sooner. The law establishes an ambitious schedule for the development of episode groups,

aligned with other factors that are to account for one-half of Medicare Part A and Part B expenditures.

Beginning in October, CMS will post the first of a series of lists around episode groups, building on the current list. At the same time, the secretary will develop a set of “patient relationship” codes, with opportunity for stakeholder comment, to be aligned with patient condition groups. After further opportunities for public comment, CMS will by 2018 post a revised set of episode groups, patient condition groups, and physician-patient relationship codes aligned with payment codes. This development will re-

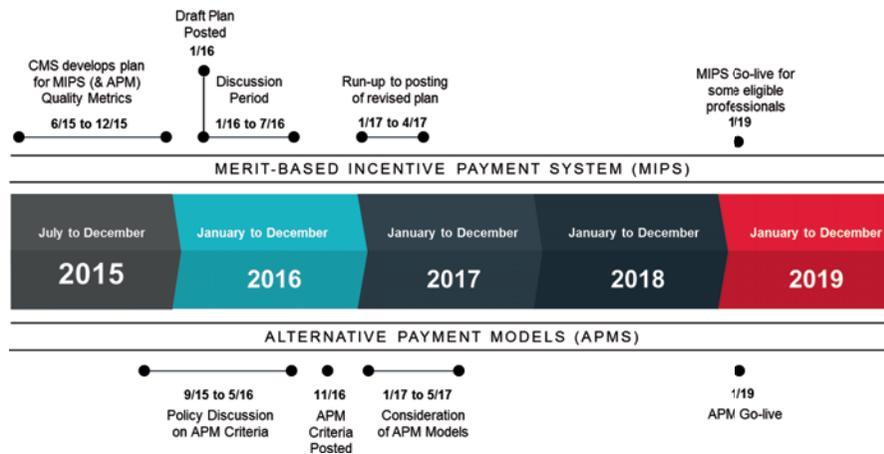
quire careful attention and stakeholder input over the next few years. Ultimately, we can expect to see Congress and CMS turn to these new episode/patient groupings to drive payment.

## Finalizing the Details

While the exact timing of the regulatory and administrative rollout process has not been provided, it can be reasonably inferred from past experience. We expect that these new programs will, as much as possible, “ride” the annual MPFS payment rule, rather than being implemented through separate rule-making. As a

practical matter, the development of each year’s MPFS is a full year process, so the earlier stakeholders engage CMS for the next year’s rule, the better. Given the complexity and likelihood for controversy, some provisions, such as the MIPS measures, will take more time. This means that although implementation in 2019 seems far off, the timeline for implementation is actually highly compressed by government standards, particularly for an agency with very stretched resources and an already full set of responsibilities.

The illustration below provides a graphical representation of the process and timing for developing the details of MACRA.



## Implications and Considerations for Providers

Overall, MACRA represents a significant shift away from FFS as we currently know it, in favor of a greater emphasis on value. This places even greater importance on providers’ efforts at building the capability to understand and manage the cost of care and to demonstrate value to patients and payors. Additionally, MACRA will have implications in ways that are not as obvious, several of which are listed below.

**Changes to CMS’s payment methodologies for non-physician services should be expected as well.** CMS’s decision to measure and pay differently for physician resource utilization will affect costs in every setting where physicians provide services. A real change should be expected in physician behavior regarding ordered services, which will in turn transform how those services are paid for.

**Understanding the relationship between Medicare Parts A and B will become more complicated.** Providers will need to be able to become more sophisticated in understanding how performance under Part B—particularly the resource utilization incentive—will impact reimbursement under Part A. Therefore, providers must evaluate their Medicare strategy and participation in various programs (e.g., MIPS, APMS, Medicare Advantage), as it may not be effective simply to be a passive participant in Medicare FFS.

**Physician practice consolidation and acquisitions will continue.** Many smaller physician practices are un-

likely to have the internal resources necessary to take full advantage of, and manage their performance against, MIPS or participate in an APM. This will likely accelerate consolidation into larger freestanding physician practices or integrated delivery systems. Additionally, given the impact that MIPS’s resource utilization feature will have on hospital reimbursement, health systems may be even more motivated to employ physicians in order to shape their incentives appropriately.

**Physician compensation and service agreements will need to evolve.** Physician compensation arrangements, as well as professional services agreements, will need to include physician incentives that reflect those being implemented by CMS. There will need to be a strategy to address the disparate performances of different physicians; certain physicians will have the potential for much lower or higher reimbursement rates. The question of who (i.e., the physician or the health system) bears the risk and reaps the reward will be a hot topic, especially considering the cost associated with ramping up technology capabilities for tracking the quality metrics built into MIPS.

While these changes will not happen overnight, they will begin to take place within just a few years. Therefore, assessing the implications of MACRA on any long-term physician contracts that are or may come into negotiation or renegotiation should take into account these future payment changes and incentives.

**Commercial contracts will need to be amended.** Many commercial payor contracts contain language that defines reimbursement in terms of a percentage of

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Medicare. While that has worked well in the traditional FFS world, it will not translate with the introduction of MIPS, and many commercial contracts do not have sufficient flexibility in them to accommodate this new feature. Therefore, commercial payor contracts should be reviewed in order to determine their compatibility with MACRA and language should be adjusted as necessary.

**Providers can have a voice in shaping the final product.** MACRA involves an extraordinary degree of delegation to CMS in fleshing out the details of the plan, and it mandates that stakeholder input be considered in developing these finer points. Therefore, providers should take advantage of the opportunity to make their voices heard during the stakeholder comment and review process. For instance, in July, CMS published its first proposed rule implementing certain MACRA provisions in the 2016 Physician Fee Schedule including setting statutory payment rates and timelines. In the proposed rule, CMS requested stakeholder input on clinical practice improvement activities and low volume threshold for the MIPS program, certain criteria for

APMs and other items. In the proposal, CMS also indicated it would be requesting additional stakeholder feedback concerning APMs later this year. This is the first of many opportunities to provide feedback as the MIPS structure and measures are developed and the criteria for APMs is determined.

### **More to Come**

The rollout and details of MACRA are going to be defined over the next few years, and the secretary has been granted exceptional authority in that definition. While this is a long-term project with many details yet to be determined, the need for organizations to think about the future implications is immediate. Positioning and planning for the payment changes will need to begin long before the initial effects are felt.

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*This article is based on the first installment of a collaborative series on MACRA to be developed by HLB and ECG.*