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MACRA: Time to Double Down on an Alternative Payment Strategy?




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I. MACRA in a Nutshell

The Medicare Access and CHIP Reauthorization Act (MACRA), passed in April 2015, changes the way Medicare will reimburse physician services beginning in 2019. Prior to MACRA, CMS had been taking incremental steps toward value-based incentives under Medicare Part B; with MACRA, the incentives are beginning to have real teeth. These changes will impact physicians and have significant financial consequences for hospitals and health systems that employ or affiliate with physician groups. Just as important to consider: we can expect commercial payers to follow suit with their own similar programs.

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MACRA establishes a reimbursement methodology through which one of two tracks will be used to compensate physicians under Medicare fee for service (FFS). The first track, which essentially replaces the traditional physician reimbursement methodology, is called the Merit-Based Incentive Payment System (MIPS). Under it, physicians will be reimbursed according to a modified resource-based relative value scale (RBRVS) formula that incorporates incentives in four categories, as shown in the table below.[1]

Incentive	Relative Weighting	Brief Description
Quality	30%	Modeled after the existing PQRS incentive system
Meaningful Use	25%	Modeled after the existing meaningful use incentive system
Clinical Practice Improvement	15%	New and largely undefined but based on access, population management, care coordination, beneficiary engagement, patient safety and practice assessment, and participation in an alternative payment model (APM)
Resource Utilization	30%	Modeled after the existing Value-Based Payment Modifier incentive system

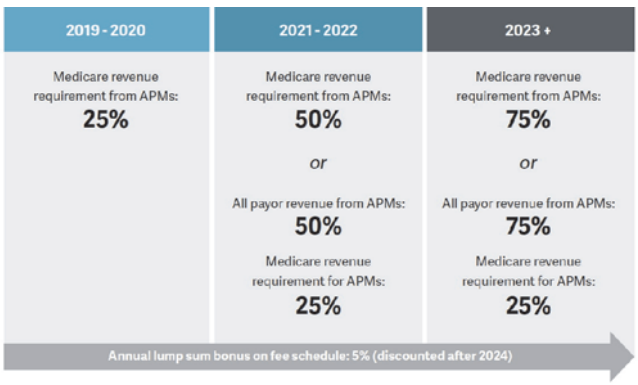
Under MIPS, physicians' FFS compensation is ''at risk'' based on his or her performance as measured by these metrics. The amount of FFS payment at risk will increase over time but stabilize at a maximum downside potential of 9 percent, with an upside potential that is likely to be approximately the same amount.[2] This re-

[1] In proposed rules published by CMS on April 27th there were changes to the relative weighting in each category. Final weightings will be published later this year.

[2] Technically, under the statute, the upside adjustment could be as much as three times the maximum downside adjustment. However, due to MACRA's budget neutrality requirement, it is unlikely that this would happen, because these large, positive adjustments would need to be offset by negative

flects roughly double the amount of at-risk funding under the existing programs in 2016.

The second track of MACRA is designed to encourage physicians to participate in alternative payment models (APMs) such as accountable care organizations (ACOs), bundled payments, and patient-centered medical homes (PCMHs), as well as additional models to be developed in the coming years. To qualify for the APM track, a minimum percentage of a physician's revenue must come through APMs (and thereby be subject to some level of upside and downside risk).[3] The minimum percentage of a physician's revenue that must come through APMs increases over time, presumably to encourage the continual development and participation in APMs. During the first five years of the program (through 2024), physicians qualifying for the APM track will also receive a 5 percent increase in their compensation as an incentive from Medicare to encourage participation. This is summarized in the graphic below:



It should be noted that MACRA was a product of years-long bipartisan work and support from healthcare stakeholders. In addition, the Obama-Biden Administration has made it a policy goal to shift physicians out of traditional FFS arrangements toward value-based APMs. The passage of MACRA accelerates an ongoing movement to value-based payment that has been occurring for over a decade. By establishing the financial incentives included in the APM track, Congress was seeking to encourage physicians to shift from the traditional FFS reimbursement models (as modified by MIPS) to APMs. Indeed, CMS' Office of the Actuary projects that over time, most physicians will opt to qualify for the APM track.

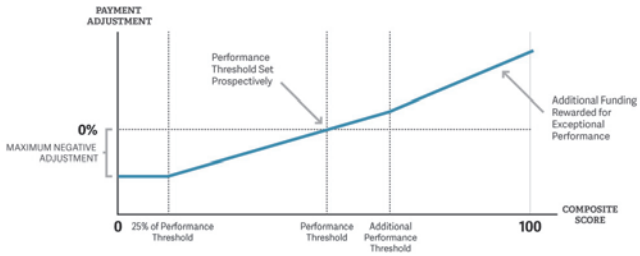
Just as importantly, whether Congress intended it or not, MIPS compensation poses some potential challenges; physicians should consider them carefully before selecting (or remaining in) this track. These challenges are likely to have the effect of steering physicians away from the MIPS track and toward APMs (although APMs have had their own challenges and growth pains).

payment adjustments for an even larger number of physicians.

[3] The U.S. Department of Health and Human Services (HHS) has the authority to determine the threshold criteria; it also included in the recent Request for Information (RFI) a call for comment on alternatively using a patient count threshold for the purpose of APM eligibility.

II. Potential Challenges to Physicians Under the MIPS Payment Track

As our earlier white paper describes (24 HLR 1163, 9/3/15), the MIPS track's four incentive categories will be rolled into a single, composite score ranging from zero to 100. This composite score will be based on each individual eligible physician using an undetermined identifier. Depending on physicians' scores relative to a predetermined performance threshold, his or her payments under the Medicare Physician Fee Schedule will be adjusted upward or downward by a percentage amount as shown in the graphic below.



While fairly straightforward in concept, the administration of the MIPS payment program is likely to create several significant challenges to participating physicians, as described below.

A. Use of Aged Data in Incentive Calculations

Given the complexities of MIPS, CMS will need time to determine eligible physicians' composite scores and payment adjustments. While MACRA does not yet provide entirely clear timing, recent experience with the programs that MIPS replaces suggests a potential 2-year delay between a physician's actual performance and receipt of payment for MIPS program participation. This is likely to present a number of challenges and concerns to physicians, including:

» **Changes in Medical Group Composition.** Incentives are measured at the individual physician level but administered at the Taxpayer Identification Number (TIN) level, which means physician organizations could be impacted (positively or negatively) by the performance of physicians who are no longer practicing there. This could be alleviated by means of an national provider identifier/TIN combination identifier, which has been recommended by the AMA[4] and other stakeholders. However, it remains to be seen if CMS will adopt such a measure.

» **Abbreviated Preparation Time.** Assuming a two-year lag period, along with MIPS taking effect in 2019, financial incentives paid to physicians in that year could be based on their performance from 2017. Measures are not expected to be finalized until November 2016, following several rounds of public input and CMS review. CMS has not yet determined when the performance year will

[4] According to a letter dated November 17, 2015, from James Madara, M.D., Executive Vice President and CEO of AMA to Andy Slavitt, Acting Administrator of CMS.

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begin, but in other programs it has historically provided an abbreviated performance schedule in order to give vendors and physicians enough time for the transition.

» **Weak Linkage Between Performance and Penalty/Reward.**
A lengthy lag time between physician behavior and the realization of a penalty/reward may undermine the incentive's influence on performance. Timely feedback is a key factor in changing practice patterns, as is the establishment of a clear linkage between the behavior and the resulting reward/penalty. However, as we discuss below, that linkage may be anything but clear.

B. Complexity of Incentives and Quality of Feedback

We expect that another challenge to participating physicians will be the complexity in calculating the incentive categories and the quality of feedback provided to physicians. We anticipate that the calculation of the MIPS incentives categories are going to be driven by an enormously complex data set. For example, the current Physician Quality Reporting System (PQRS) (on which the MIPS quality incentive component—accounting for 30 percent of the composite score—is based) includes over 280 potential measures from which physicians must choose. Of these, physicians are currently required to select nine measures from three different domains. We anticipate that the other three incentive categories are also likely to have many different measures for different specialties as well.

While solo practice or single-specialty groups may focus on a select number of relevant measures, a large multispecialty group would likely be evaluated according to a long list of measures due to the differing practice characteristics of its various specialties. This means that within a given TIN, there could be physicians in a range of specialties being assessed according to disparate measures and generating many different performance levels. The number of potential combinations of metrics and national provider identifiers is going to be administratively complex, to say the least. Each individual physician will in theory have his or her own composite score, but penalties and rewards will be administered at the TIN level (assuming his or her practice decides to participate as a group), and it will be difficult for physicians to predict their likely results.

Further, MACRA leaves the methodology for administering penalties and rewards to the secretary of HHS to determine. While this methodology has not yet been published, we expect most practices will have difficulty forecasting their performance under these incentives.

Further, it remains to be seen how transparent CMS will be in showing its own calculations. Yet, for the MIPS track to be effective as an incentive, it will be critical for physicians to understand the basis for how their performance was determined, particularly if incentive compensation results are to be passed down to the individual physician level. Absent this, entities will be left to structure compensation with their physicians using their own calculations based on the data that they submit to CMS, and hope that their internally determined MIPS incentives mirror what CMS eventually calculates. This not only introduces a layer of uncertainty but also involves the commitment of additional resources to replicate CMS' calculations. For example, it might be possible to know an individual physician's likely composite score but to have little or no idea where the ''cut point'' will be for payment increases or decreases.

C. Operational Challenges

In addition to the purely administrative challenges of understanding and measuring performance under MIPS, the practical implications of effecting change will be significant. To understand how MACRA incentives can change the dynamic between hospitals and physicians, it is instructive to consider an example of an incentive that may take place.

Just as hospitals are ''on the hook'' for readmissions under Medicare Part A, it is likely that CMS will make physicians financially accountable for readmissions through Part B as well; the resource use incentive under MIPS provides the means for creating that tie. MACRA creates a large and growing set of episode groups which are coupled with patient/physician relationship and patient condition codes, and these, in turn, will be added to claims as they are submitted. In this manner, a physician may be identified as a specific patient's primary caregiver; if that patient is admitted and subsequently readmitted for certain clinical conditions, the physician's reimbursement may be adversely impacted.

For a physician to maximize performance under this metric, there needs to be effective communication and coordination across care settings as well as sufficient patient engagement. This assumes clinical data flow across both varied care settings and clinical protocols that loop in physicians (ideally, best-performing) from these disparate settings. Physicians need to be able to identify that a given patient is being treated as part of this network of care.

Note that the activities described above are usually not performed by the physician but by nurses, case managers and other members of the care team. Therefore, if health systems wish to pass these incentives down to individual physicians, they will need to be very careful in how they go about doing this. Economic alignment is a worthy goal to be pursued, but physicians should be afforded a reasonable degree of influence over the measures to which they are being held accountable.

D. Considerations for Independent Physicians

MACRA's value-based incentives also may be particularly challenging for small, independent physician practices because it exposes them to greater financial risk for activities that they may not personally perform and that require care-coordination resources and infrastructure that they do not possess. Although MACRA does include provisions to assist small practices, some potential considerations include the following:

» While some independent physicians may seek to minimize their Medicare business or opt out altogether in favor of concierge practices or other models, most will not be able to entertain such approaches.

» The resource utilization incentive will cause referring physicians to pay more attention to the performance profiles of the physicians to whom they send patients.

» Physicians may have difficulty building the capacity to manage cost and demonstrate quality, yet they could stand to lose if they do nothing.

» The complexity and uncertainty posed by MACRA may make physicians more interested in affiliation as a means of mitigating risk.

The net effect of these considerations is that independent physicians who have been considering integration with a health system may find value-based incentives to be the determining factor, particularly if they are in smaller practices. A development we anticipate is the rise of a cottage industry of vendors offering data-tracking and care-coordination solutions to small practices. Further, those who wish to remain independent will likely have greater interest in affiliating more closely with health systems. Therefore, MACRA's ultimate target audience may turn out to be not physicians themselves but the health systems that employ them.

III. Making a Choice

Choosing to stay in the MIPS track or shifting to an APM is not going to be an easy decision. Indeed, such a decision would be premature until more of the necessary details have been released. That said, based on what we know today, it is entirely possible that shifting to an APM may prove more beneficial to physicians than staying in the MIPS track, for the following reasons:

» Data collection and reporting for MIPS will be a significant administrative burden and expense (less detail is available, but APMs will also be required to provide some sort of quality metric data not unlike that of MIPS).

» The use of two-year-old data will create a host of operational challenges and may result in significant dissatisfaction within the physician community.

» The calculation of MIPS incentives may prove to be complex that CMS will have difficulty translating it for physicians. This will turn the system into a ''black box'' exercise, which will hinder its effectiveness as a motivational tool.

» There is a good possibility that political pressure would force CMS to design the composite score in such a way that the vast majority of physicians' scores will be close to the performance threshold, thereby minimizing the payment redistribution and diluting its incentive effect.

» Therefore, physicians who participate in MIPS may have to invest resources in data collection and submission (because failure to do so results in the maximum negative penalty) for a program that, for many, offers very little upside opportunity during the initial few years of implementation.

Because of these potential challenges, we believe that physician organizations should carefully consider and fully explore APMs as an option in order to avoid remaining on the MIPS track. As previously mentioned, APMs will come with their own uncertainties, including some of the very same challenges as MIPS, such as data collection and reporting. Indeed, we know only a few of the models that will qualify and very little more than that. To complicate matters further, the presumably most prevalent model—the ACO—has experienced its share of difficulties with adoption and will likely need to undergo significant revision before it will be embraced by physicians on a large scale.

However, there are several compelling reasons that may ultimately make APMs the payment model of choice, including:

» **More favorable financial incentives.**
Unlike the MIPS model, which offers fixed levels of reward or penalty (i.e., ± 4 percent in 2019), APMs afford more flexibility for physicians to opt into variable incentive models that can more directly tie to cost and quality performance incentive levels.

» **Direct link between performance and payment.**
Physicians have the opportunity to define financial arrangements with the contracted APM entity, which means they can negotiate payments to hold themselves accountable for aspects of spending and quality for which they have direct influence.

» **Bonus payments that support care coordination.**
With greater upside and downside risks, APMs necessitate coordination and the integration of care among physicians, which require both initial investment and ongoing resources to establish systems of care. While the upside risk is not guaranteed, APMs at least offer participants the opportunity to receive higher payments to offset the investment costs.

» **Timeliness of performance data.**
Based on what is known about the existing APMs such as ACOs and bundled payments, there will likely be a maximum 12-month gap from the performance reporting period to receipt of payment. By more closely linking reporting to payment periods, it is easier to align physician behaviors with performance objectives. While a lag period still exists, it does allow physicians to take steps to improve behavior based on better information about where performance gains may occur.

» **A path to additional APMs.**
Physicians qualifying for APMs will have greater flexibility to participate in future programs put forth by Center for Medicare and Medicaid Innovation demonstrations. With the creation of the Physician Focused Payment Models (PFPMs), physicians have an opportunity to develop and submit for approval of new models. The added transparency of these models through the review by CMS' Technical Advisory Committee should allow APM participants to accelerate innovation through shared knowledge.

» **Commonality with similar structures under commercial payers.**
Beginning in 2021, the APM participation threshold will allow qualifying physicians to count non-

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Medicare arrangements toward the minimum threshold for receiving the 5 percent compensation incentive. Therefore, physicians with experience in APMs will likely be better positioned to perform across a broader patient base by capitalizing on experience and infrastructure.

As APMs evolve, and existing models are revised and new models are created, physicians should be evaluating their strategies to meet the APM participation thresholds and determine if the MACRA track offers the ability to better link payment arrangements to the strategic and operational goals of their practice.

In light of many unresolved issues regarding the timeline and measure development, it is imperative that physicians and health systems stay informed and participate by providing input as comment periods materialize. Stakeholder input will likely be taken into consideration when future decisions are made regarding MACRA, and a number of opportunities will continue to be available to help define and find solutions for MACRA's challenges and uncertainties.

This article is based on the second installment of a collaborative series on MACRA developed by HLB and ECG. It was prepared prior to the April 27th release of the Medicare Access and CHIP Reauthorization Act (MACRA) proposed rule. The themes and considerations of this article remain the same but specifics and terminology may differ from the proposal which will be finalized later this year.