

In The Spotlight: Shifting to Value with MACRA

In April 2015, the Medicare Access and CHIP Reauthorization Act (MACRA) was signed into law to further ignite the shift from volume-focused to value-focused care. This bi-partisan legislation reformed the Medicare payment system by repealing the problematic Sustainable Growth Rate (SGR) formula used for updating payments to Medicare clinicians, and replacing it with annual payment updates based on quality. With MACRA, the government created a law that not only aligns with the provisions of the Affordable Care Act that push for transparency and quality improvement, but one that transforms the way that physicians receive payment to make them more accountable for the care they provide. MACRA makes three essential changes to the physician payment system:

- Replaces the Sustainable Growth Rate
- Sets specific and predictable Medicare payment schedules
- Consolidates complicated physician incentive programs into the comprehensive Quality Payment Program

This *In the Spotlight* will review the components and current implementation of MACRA and related regulations in an effort to improve the state of our health care system.

MACRA: An Overview

The MACRA changes how physicians within the traditional Medicare system will receive payment. Specifically, it replaces the Sustainable Growth Rate (SGR) formula used to set Medicare payments for providers, and further incentivizes physicians to provide better care quality under a new comprehensive quality reporting system. The SGR was enacted in 1997 to control Medicare physician payment rates by adjusting service payment amounts in response to growth in the gross domestic product (GDP).¹ Unfortunately, this formula became problematic as physician reimbursement rate cuts grew progressively larger, requiring Congress to issue “doc-fixes” or overrides to the requirements established by the measure. In addition to the rising payment cuts, cost for physician services also increased, which led to physicians taking on more work in order to maintain their income levels. If the repeal of SGR had not taken place, clinicians would have received a 21.2% cut in provider payments in 2015.² However, under MACRA, existing quality programs are consolidated into a single payment system that focuses on better value and improved care. This enables providers’ cost management and quality of patient care to become stronger determinants of Medicare payments. As such, MACRA encourages providers to participate in a system that rewards for improved health outcomes and cost-efficiency.

Predictable Medicare Payment Schedules. As opposed to the SGR’s formulaic approach to setting payment rates, MACRA sets automatic rate increases for clinicians from 2015 through 2019. Between 2020 and 2025 rate changes will be made based on clinicians’ performance alone. For 2026 and beyond, clinicians can receive a payment increase of 0.25% or 0.75% annually, based on eligibility.

Consolidated Incentive Programs. Medicare currently measures value and providers’ care quality using a medley of programs, which include the Physician Quality Reporting System, the Value Modifier Program, and the Medicare Electronic Health Record (EHR) Incentive Program. Providers can also participate in one

¹Health Affairs Blog. [May The Era of Medicare’s Doc Fix \(1997 – 2015\) Rest In Peace. Now What?](#) April 2015.

²Kaiser Family Foundation. [How Much \(More\) Will Seniors Pay for a Doc Fix?](#) March 2015.

or more of many Alternative Payment Models with the federal government today, including Next Generation Accountable Care Organizations and Medicare Shared Savings Programs. Alternative Payment Models are physician-focused approaches to reimbursement that help practices redesign their care delivery to help improve service quality and patient outcomes. MACRA streamlines these various incentive programs into a framework that allows providers to participate in only one of two value-based payment systems, collectively called the Quality Payment Program. Beginning in 2019, this program will measure physician performance based on a provider's participation in either the Merit-Based Incentive Payment System (MIPS) or an Advanced Payment Model (APM).

Below is a description of these two reimbursement systems as outlined in MACRA and subsequent proposed federal regulations. Final regulations are expected by November 1, 2016.

Merit-Based Incentive Payment System (MIPS)

The first path of MACRA's Quality Payment Program is MIPS – a comprehensive incentive program used to measure clinician performance in traditional Medicare. The federal government has proposed to start measuring the performance of participating clinicians in 2017. Due to the increased risk-bearing required to pursue the other APM path, the majority of clinicians will begin participating in the Quality Payment Program under MIPS.³ In the first two years of the program, Medicare Part B clinicians (physicians, physician assistants, nurse practitioners, and nurse specialists) will be eligible to participate as an individual or small group. MIPS enables providers to report their performance on measures that align with their specialty and pays them for successfully providing efficient care in the following four categories:

- **Quality:** Clinicians can choose six clinical performance measures to be evaluated on based on their specialty and practice (accounts for 50% of total performance score in 2019, the first year that physicians will receive their performance scores).
- **Resource Use:** Also known as cost, Resource Use measures Medicare spending per beneficiary based on quantities of Medicare claims, which will remove reporting requirements for clinicians and may help reduce administrative costs (10% of total score in 2019).
- **Clinical Practice Improvement Activities:** Clinicians may choose from a list of over 90 activities aimed at improving clinical practice and care quality, including better care coordination and patient safety (15% of total score in 2019).
- **Advancing Care Information:** Clinicians select measures that show how they use certified Electronic Health Record technology. This category prioritizes interoperability and data exchange, and includes measures such as electronic prescribing, patient electronic access, coordination of care through patient engagement, and health information exchange (25% of total score in 2019).

The federal government combines these four categories into a composite score of up to 100, which provides the basis for the calculation of bonuses and penalties for participating clinicians. In the first year of the program, clinicians will be eligible for a MIPS payment adjustment ranging from + 4% to - 4%, with greater positive adjustments awarded to high performers and negative adjustments to those clinicians who do not perform as well. The higher the performance score, the greater the incentive bonus a clinician will receive. Scores will be calculated throughout 2018, which clinicians will receive in 2019 following the close of the performance period when payment adjustments go into effect.

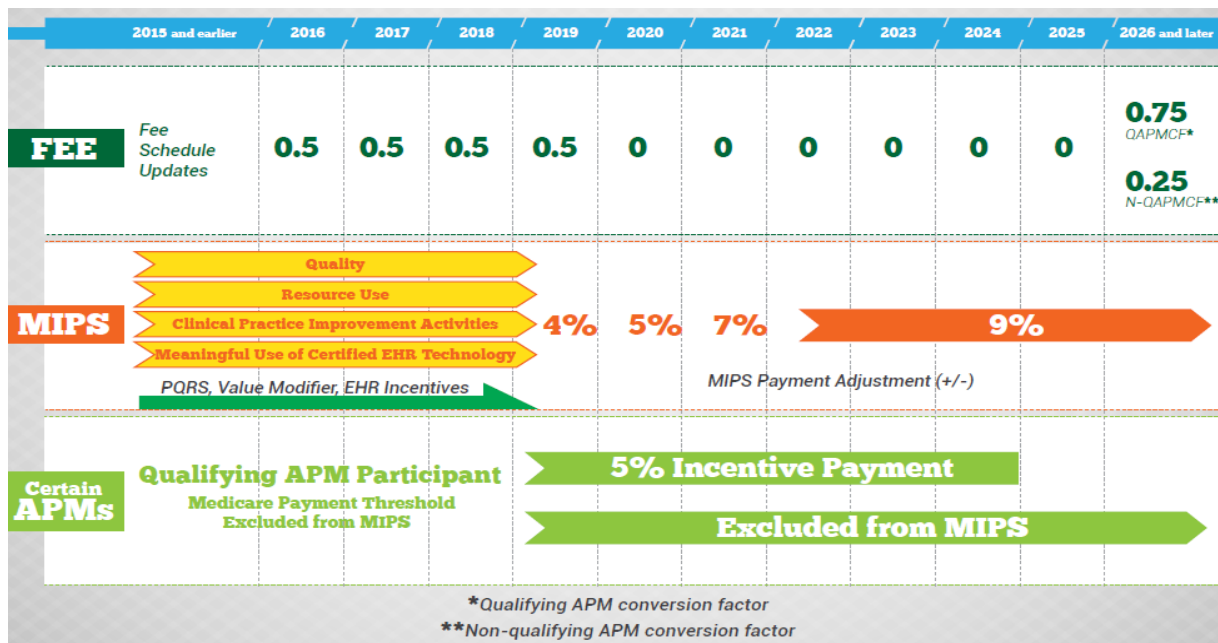
³ U.S. Department of Health and Human Services. [Administration takes first step to implement legislation modernizing how Medicare pays physicians for quality](#). April 2016

Advanced Alternative Payment Model

Eligible clinicians who are prepared to meet certain thresholds can go a step further than MIPS by aligning their practices with Advanced APMs, which are reimbursement models based on the value of care they provide. This path of the Quality Payment Program creates extra incentives for clinicians that meet the Advanced APM program requirements by qualifying them for enhanced payments. Beginning in 2019 and running through 2024, participating clinicians who meet Advanced APM standards will qualify for a 5% annual Medicare Part B incentive payment. In 2026 and onward, clinicians in an Advanced APM will be eligible to receive a payment increase of 0.75% each year. Clinicians must meet stringent requirements to demonstrate full accountability for providing high-quality, coordinated care in an Advanced APM. As a result, Medicare clinicians who choose to participate in an Advanced APM are exempt from MIPS reporting requirements.

Payment models that qualify as Advanced APMs include Center for Medicare and Medicaid Services Innovation (CMMI) pilots, Shared Savings Program tracks, and certain ACOs. As stated in the proposed federal rule, to qualify for payment under the Advanced APM program, the federal government requires clinicians to practice with an entity that participates in a qualifying Advanced APM and to have a specified minimum percentage of the Medicare Part B services that they provide paid for through that Advanced APM. In order to qualify as an Advanced APM, the payment model must (1) require use of certified EHR technology, (2) provide for payment based on quality measures comparable to those used under MIPS, and (3) either require the participating entity to bear sufficient financial risk for monetary losses or qualify as a Medical Home Model under Section 115A(c) of the Social Security Act.

MACRA Implementation Timeline



Source: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Timeline.PDF>

Impacts of MACRA on Private Payers and the Market

Private payers will likely be impacted by the payment programs created by MACRA. Here are a few expected impacts:

Creates Models for Private Industry: First, the Medicare payment updates and streamlined incentive paths under the Quality Payment Program may establish a payment model that private payers can follow to incentivize high quality of care and effective cost management in their provider contracts.

Participation in Other Payer Advanced APMs: Beginning in 2021, clinicians can qualify for payment incentives from traditional Medicare for participating in Other Payer Advanced APMs. In order to qualify, clinicians must meet certain criteria as an Advanced APM in arrangements with other private or public payers. As a result, private payers may need to be more stringent about aligning their payments with MACRA requirements to ensure that participating clinicians can meet the incentive threshold.⁴

Opportunities for Interoperability: The requirements set by MIPS for clinicians to adopt certified EHR technology could create opportunity for cross-collaboration and data-sharing between providers and payers.

Greater Market Consolidation: The complicated requirements and high administrative costs to participate in Medicare through the Quality Payment Program may be difficult for small practices to maintain, leading to consolidation with larger practices or health systems. Consolidation may increase costs for private payers and their members, as larger practices have more leverage in payment negotiations and limit provider network options for consumers.

BCBSNC Views

BCBSNC recognizes the need for the transition to value-focused provider payments and is supportive of efforts by the federal government to incentivize provider quality performance and cost management. BCBSNC already has several provider engagements in place to reward quality performance and cost management. Additionally, BCBSNC is committed to helping facilitate change within the health industry by strengthening the prevalence of value-based payment models. For successful implementation across the industry, BCBSNC believes that both collaboration and transparency between private payers, providers, and consumers is necessary to improve accountability for the rising costs of care.

MACRA Implementation Update: As recent as September 8th, the federal government released a [blog post](#) to indicate that the upcoming MACRA final rule would offer new options for how providers participate and submit data reporting in 2017. The new options allow providers flexibility to supply partial data for 2017 without being subject to penalties in 2019. More details are expected in the final rule, due for release by November 1, 2016.

⁴ Deloitte. MACRA: [Disrupting the health care system at every level](#). May 2016.

For More Information:**Health Affairs: Health Policy Brief: Medicare's New Physician Payment System:**

http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_156.pdf

Centers for Medicare and Medicaid Services. Medicare Access and CHIP Reauthorization Act of 2015: Quality Payment Program:

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/NPRM-QPP-Fact-Sheet.pdf>

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