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Value-Based Payments Under MACRA - Outlook
(Part One of a Two-Part Series)

The *Centers for Medicare and Medicaid Services* (CMS) issued the final rule implementing the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA) on November 4, 2016.[1] This piece of legislation repealed the *Sustainable Growth Rate* (SGR) formula and replaced it with scheduled updates to the *Medicare Physician Fee Schedule* and the creation of the *Quality Payment Program* (QPP).[2] The intention of the QPP is to transition reimbursement for the provision of healthcare services from *volume-based to value-based* models in which providers are reimbursed *"based on quality, value, and results of the care they deliver and not piecemeal for individual services regardless of clinical need for or appropriateness of those services."*[3] With CMS projecting that up to 90-95% of Medicare Part B billings (i.e., billings for physician services) will meet the criteria for inclusion in the QPP, it is exceedingly important for physicians and other healthcare providers to prepare for MACRA implementation in 2017. This *Health Capital Topics* article is part one of a two-part series discussing the future implications of MACRA, and includes an overview of the QPP, the benefits and concerns regarding the QPP, and potential changes to MACRA under the current Trump Administration.

Under the QPP, eligible clinicians can choose between two payment tracks for Medicare reimbursement: (1) the *Merit-Based Payment System* (MIPS); or, (2) an *Alternative Payment Model* (APM).[4] Clinicians are eligible for the QPP if they bill Medicare Part B more than $30,000, and provide care for more than 100 Medicare patients, per year.[5] Whereas participation in MIPS incentivizes quality, efficient care through a *performance-based payment adjustment*, APM participants will earn incentive payments for participating in an *innovative payment model*.[6]

Starting in 2017, three performance categories will determine MIPS payment adjustments:[7]

(1) *Quality* (through six physician-selected clinical quality measures), which replaces the *Physician Quality Reporting System* (PQRS);
(2) *Improvement activities*, i.e., activities that physicians perform to improve their clinical practice (up to four for a minimum of 90 days); and,
(3) *Advancing care information* (i.e., whether *certified health record technology* (CEHRT) is used meaningfully to advance care information), which replaces the Medicare Electronic Health Record (EHR) Incentive Program.

In 2018, CMS will consider publicly reporting cost (i.e., *resource use*) data under MIPS.[8] This will be calculated by CMS from adjudicated claims, in contrast to the other three categories, which require physicians to report data to CMS.[9]

Quality currently determines 60% of Medicare reimbursement adjustments (but is decreasing to 30% starting in 2019); *Improvement Activities* determine 15% of reimbursement adjustments; *Advancing Care Information* determines 25% of reimbursement adjustments; and, *Cost* currently determines 0% of reimbursement adjustments (and is increasing to 30% starting in 2019).[10] Additionally, a 0.5% "inflationary adjustment" will be applied to reimbursement each year, irrespective of performance on quality metrics.[11]

Alternatively, the APM track, CMS partners with clinicians to provide incentives for higher quality and cost-efficient care.[12] The three main participation requirements for APMs include: (1) use of CEHRT technology; (2) reimbursement of base payments tied to quality measures comparable to those utilized in MIPS; and, (3) agreement by clinicians to take responsibility for financial losses or meeting the specifications of a *Medical Home* model.[13] Examples of APM models include: *Medicare Shared Savings Program Tracks* (MSSP), *Next Generation ACOs*, *Comprehensive Primary Care Plus* (CPC+), *End-Stage Renal Disease Model* (ESRD), and *One Care Models with 2-Sided Risk.*[14]

Because APMs are under development, most clinicians are expected to participate in MIPS during the early years of QPP implementation.[15] Starting in 2017, clinicians have three options regarding participation in MIPS: (1) opt out of participation; (2) limited participation; or, (3) full participation.[16] If a clinician chooses *not to participate*, they will experience an annual negative payment adjustment of four percent starting in 2019.[17] Those who *participate on a limited basis*, by either submission of fewer than all of the performance metrics,

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or participation in the program for more than 90 days (but less than a full year), will not incur a negative payment adjustment but are not guaranteed a positive payment adjustment.[18]

Clinicians who *fully participate* in the MIPS program are subject to payment adjustments based on their performance on the quality metrics in each of the three aforementioned performance categories.[19] Adjustment payments will start at up to four percent in 2019, and continue to grow to up to nine percent by 2022, and will be based on evidence-based and practice-specific quality data linked to physician performance.[20] Clinicians have from January 1, 2017 to October 2, 2017 to collect performance data for MIPS, and such data must be submitted by March 31, 2018 to receive adjusted reimbursements in 2019.[21] As stated above, clinicians will not be financially penalized so long as they submit data related to at least one *Quality, Advancing Care Information,* or *Improvement Activity* measure.[22]

There are both benefits and concerns regarding QPP implementation. Clinicians can expect a certainty of payments for the next ten years; however, clinicians have concerns regarding whether the automatic 0.5% payment increase for MIPS will keep up with the combined cost of inflation and QPP participation.[23] Small, rural practices also have concerns about meeting MIPS reporting requirements, although MACRA grants (i.e., funding from CMS to local organizations providing assistance to clinicians transitioning to MACRA), are expected to lessen the burden.[24]

There is still much debate surrounding MACRA and the QPP model. With the regulations for the second year of QPP implementation currently being drafted, there is an opportunity for organizations to suggest changes to the final rules through the comment and mark-up period.[25] During the first year of QPP implementation, physician groups such as the *American Medical Association* (AMA) successfully persuaded CMS to loosen MIPS participation specifications, with modifications such as, *"reducing reporting requirements for physicians to avoid penalties, creating a more realistic and flexible transition period, increasing the low-volume threshold that exempts more physicians, and eliminating the cost category in calculating the 2017 composite performance scores."*[26] For year two of QPP implementation, physician groups, including the *Association of American Physicians and Surgeons* (AAPS) and the *Medical Group Management Association* (MGMA), are arguing that the *U.S. Department of Health and Human Services* (HHS) is restricting freedom in medicine in countless ways, and are advocating for MACRA participation to be voluntary to *"allow patients and physicians to decline MACRA and adopt payment based on patient value rather than by bureaucratically dictated value."*[27] Other trade associations, such as the *American Hospital Association* (AHA), are urging CMS to expand the definition of APMs to include more physicians who partner on those models to qualify for incentives.[28] AHA is also advocating for CMS to create a hospital-based reporting option.[29]

It will be up to the Trump Administration to decide which suggestions from industry stakeholders will be implemented. MACRA received bipartisan support, passing 392-37 in the U.S. House of Representatives, including an affirmative vote by HHS Secretary Tom Price, M.D.[30] However, Secretary Price has stated his belief that, *"challenges remain with respect to provider burden,"* and has suggested more lenient QPP specifications for physicians.[31] Additionally, CMS Administrator Seema Verma, has stated support for value-based reimbursement initiatives such as those included in MACRA, articulating, *"There are concerns with fee-for-service, in terms of rewarding volume over quality. I do support efforts that hold providers accountable for outcomes and increasing the coordination of care."*[32] However, Ms. Verma has also expressed concerns over the increasing financial risk placed on physicians under certain value-based reimbursement models.[33] As a response to these concerns, *Voluntary Bundled-Payment models* and a *Track +1 ACO* will be added as APM models.[34]

The second article in this series will examine the impact of *value-based payment* models under MACRA on the threshold of *Commercial Reasonableness*.

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