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The Time to Plan is NOW

MACRA Means Big Changes in How Medicare Will Reimburse Physicians – The Continued Shift from Quantity to Value

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The old adage *be careful what you wish for* may be applicable to physicians' long-standing discontent with many aspects of Medicare payment rules. In a Notice of Proposed Rulemaking published in the May 9, 2016 Federal Register (which may be found **here**), the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS), finally unveiled the details of its plan to implement the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and overhaul physician reimbursement under Medicare. But the jury is still out as to whether the proposed plan is actually the solution the healthcare industry has been waiting for.

The Basics

At its most basic, MACRA introduces a number of seismic changes that continue Medicare's march from paying for volume under the traditional fee-for-service model to paying for value-based, risk-bearing, coordinated care models. MACRA is also noteworthy because it brought an end to the annual Congressional game of brinksmanship over the delay of huge Medicare Physician Fee Schedule payment cuts of up to 27%, as required by the Sustainable Growth Rate formula. MACRA also ended the despised Physician Quality Reporting System. The MACRA proposal is quite complex and, as discussed in more detail below, will most likely prompt many solo and small physician groups to consider joining larger groups or become employees of hospital systems.

The proposed rules apply to Medicare payment for physicians and many other non-physician practitioners, such as physician assistants, nurse practitioners, clinical nurse specialists, and Certified Registered Nurse Anesthetists (CRNAs). These providers will be reimbursed according to one of two new payment methodologies: the Merit-Based Incentive Payment System (MIPS) or the Advanced Alternative Payment Models (APM). These new payment methodologies will blend the metrics involved in three previous payment programs: the Physician Quality Reporting System, the Value Modifier Program, and the Medicare Electronic Health Record Incentive Program (also known as Meaningful Use).

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Although the new payment systems will not begin until January 1, 2019, they will be based upon physicians' experience in *2017* – this means that beginning in just six months, a physician's performance will have major financial implications several years from now. Physicians and hospitals are well-advised to understand the new systems and begin the planning necessary to succeed in 2019.

Merit-Based Incentive Payment System (MIPS)

The vast majority of physicians will fall within the MIPS payment track, at least during the early years of MACRA's implementation. Under the MIPS methodology, physicians will still participate in Medicare under the Physician Fee Schedule but will receive merit-based bonuses or penalties based on various quality measures. The bonuses or penalties are significant: the bonus or penalty will be equal to 4% in 2019 and increase to up to 9% in 2022.

Quality measures fall into four separate categories:

- **Cost** (which initially accounts for 10% of the physician's overall score)
- **Quality** (which initially accounts for 50% of the physician's overall score)
- **Clinical practice improvement** (which initially accounts for 15% of the physician's overall score)
- **Advancing care information** (which initially accounts for 25% of the physician's overall score)

There are various measurement criteria under each one of these categories. A physician's final score is a composite one, which relieves physicians of the rigidity of the previous "all or nothing" approach in which physicians either achieved or did not achieve success under the various measurements, regardless of how close they came to meeting all of the criteria. A physician's final score will determine whether the physician receives an upward adjustment in payment or a financial penalty. As noted, the use of these quality measurements will begin in 2017 and will inform the 2019 adjustment period.

Advanced Alternative Payment Model (APM)

The second payment methodology, the Advanced APM, places more financial risk on physicians. To qualify under this model the participants must meet three criteria:

- **Marginal risk levels**: financial risk for at least 30% of the amount by which actual expenditures exceed expected expenditures
- **Minimal loss rate**: the amount of spending over the benchmark before shared losses are triggered may not be more than 4%
- **Total potential risk**: the total amount for which an organization is at risk must be at least 4% of expected expenditures

One attractive element of the Advanced APM is the 5% annual inflation increase through 2024, far higher than that to be paid under MIPS.

The Advanced APM model will impact far fewer physicians than MIPS. In fact, many if not most current APMs and their physician members, such as 95% of those in the current Medicare Shared Savings Program/ACO program, will not qualify under the Advanced APM payment system. Initially, it will be available only to participants in qualifying APMs such as Comprehensive Primary Care Plus, Next Generation Accountable Care Organizations, and

Medicare Shared Savings Programs Tracks 2 and 3. Participants in this model are exempt from the MIPS quality reporting requirements.

Payments under Medicare Advantage plans are not counted as being under an Advanced APM, at least for the first few years under MACRA. CMS will consider adding them in the future.

What does this all mean?

The MIPS, which, as proposed, will initially apply to most physicians, presents both benefits and challenges to physicians and groups, but especially to solo and small practitioners. On the positive side, the quality measurements for physicians under MIPS are designed with flexibility in mind; physicians need only report on six out of nine quality measures, each tailored by specialty. Additionally, physicians are not required to report on cost, as CMS will calculate that data independently. Physicians are measured on a sliding scale approach, which means that they need not obtain full achievement for every measure.

However, MIPS also presents significant drawbacks for solo and small practitioners. CMS anticipates that due to the nature of the new MIPS reporting system, many solo and small practices will initially experience a financial loss as they struggle to adhere to new criteria and reporting requirements. The new payment models will be budget-neutral, which means that there will be financial winners and losers. In fact, CMS estimates that over 87% of solo practitioners will experience a negative financial adjustment and only 12% will receive financial rewards. CMS anticipates an estimated loss of $300 million for solo practitioners alone. In contrast, CMS estimates that only 18% of groups of 100 or more physicians will suffer financial penalties while over 81% will receive rewards. These troubling results are in large part due to physicians having to spend considerable funds on technological upgrades to meet the quality measurements associated with electronic health records and related infrastructure. Further, the mere task of recording, analyzing, and reporting quality data to CMS is likely to pose significant challenges for small physician practices.

CMS recognizes the potential harm to solo and small physician groups and has proposed that they may join “virtual groups” in order to combine and streamline their MIPS reporting. While the concept of “virtual groups” may be promising for some, it is likely that many solo and small physician groups will opt instead to join larger physician groups or explore employment by hospital systems.

Under both payment models physicians will have an incentive to refer patients to those physicians with better performance profiles, since the cost (also known as the “resource utilization” factor) of MIPS measures the cost associated with a physician’s practice and referral patterns, and the APM model is risk-based.

Physicians, large physician groups, and hospital systems with employed physicians are well advised to examine the proposed rules and consider appropriate strategies for achieving success under either model, including the availability of staff and technology to collect and report on the various measures.

DHHS is accepting public comments on the proposed rule until June 26, 2016. Depending on input received from solo practitioners, small physician organizations, and large integrated health systems alike, DHHS may make significant revisions to its proposal.

If you wish to discuss in more detail please contact your regular Verrill Dana attorney, **Gary Rosenberg** (617-274-2846 or **grosenberg@verrilldana.com**) or **Nora Lawrence Schmitt** (617-274-2855 or **nschmitt@verrilldana.com**).

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