WEB FEATURE

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transition to MACRA

strategic implications of the Quality Payment Program

In requiring physician practices to accept increased risk, MACRA will change the payment dynamics for many providers, including physicians, hospitals and health systems, post-acute care facilities, and clinically integrated networks.

"In times of change, learners inherit the earth, while the learned find themselves beautifully equipped to deal with a world that no longer exists."
—Eric Hoffer, American philosopher and author of *The True Believer: Thoughts on the Nature of Mass Movements*

AT A GLANCE

- The Medicare Access and CHIP Reauthorization Act (MACRA) creates the Quality Payment Program, which starts in 2019, replacing the Centers for Medicare & Medicaid Services' current quality programs for physicians and other clinicians.
- For the first year in this program, all eligible clinicians will receive payment under the Merit Incentive-Based Payment System (MIPS); in ensuing years, the program will place increasing amounts of payment at risk while presenting increasing opportunities for rewards.
- The first performance period for the MIPS begins in 2017, making it incumbent on providers to act now to address MACRA's implications.

The U.S. healthcare industry is on the brink of yet another sequence of profound change. The Medicare Access and CHIP Reauthorization Act (MACRA) will very soon shift the payment dynamics for healthcare providers, including medical groups, hospitals, health systems, postacute care providers, and clinically integrated networks (CINs). Information about MACRA seems to be flowing in a constant stream these days, making it a challenge for providers to keep track of all the details. Yet it is crucial for all providers to understand this information and its often-systemwide implications for health care, because those that are inadequately prepared for MACRA's changes will find themselves lost.

First and foremost, provider organizations should clearly understand the payment options MACRA presents and their financial implications, while bearing in mind that these changes are not looming in the distance future: The first performance period is just around the corner, beginning Jan. 1, 2017.

Our purpose here is to provide an initial overview of some of the more important aspects of MACRA, as outlined in the proposed rule that was published in the *Federal Register* on May 9, and then to explore the specific implications of MACRA for different types of provider organizations, offering tailored guidance regarding steps each should be taking now to prepare for MACRA. The comment period for the proposed rule ended June 26; it therefore is important to note that the points outlined here are subject to change in the final rule.

MACRA Replaces Existing CMS Quality Programs

MACRA is best known for solving the annual dilemma involving the sustainable growth rate (SGR). But it also is known for creating the Quality Payment Program, which replaces the quality programs currently administered by the Centers for Medicare & Medicaid Services (CMS) for physicians and other clinicians. The new program has two tracks: the Merit-based Incentive Payment System (MIPS) and the potential for advanced alternative payment models (APMs).

The MIPS track combines the current themes reflected in the three mandated programs currently affecting physicians and medical practices. These original programs and their associated themes are as follows:

> The Physician Quality Reporting System (PQRS), focusing on quality measurement and improvement
> The Medicare Electronic Health Record (EHR) Incentive Program, focusing on meaningful use to promote sharing of care information
> The Value Modifier (VM) Program, focusing on resource use

The MIPS replaces these programs with a single program that focuses on the following four categories of performance:[a]

> Quality (replaces the PQRS)
> Advancing Care Information (replaces the Medicare EHR Incentive Program and meaningful use)
> Clinical Practice Improvement Activities (a new category)
> Cost (replaces the VM Program)

Under this new system, for the first time in history, payment amounts for services providers deliver to Medicare beneficiaries will vary among the providers, with some providers potentially receiving a more than 30 percent greater payment amount than other providers based on higher performance.

Impending Timelines and Decision Points

One key aspect of MACRA that has not been well advertised is the impending timeline for all medical group practices, whether employed or independent, to address all decision points. In 2019, all practices will transition to the Quality Payment Program, which is revenue-neutral. Under the MIPS, penalty dollars taken from low-performing practices will be distributed to high-performing practices, which may be rewarded with even more dollars (up to 10 percent of Medicare revenue) through an additional $500 million set aside for incentives.

The risk of penalties and opportunity for rewards will increase for the practices under the MIPS over time, unless the practice can qualify to participate in an advanced alternative payment model (APM), thereby qualifying to receive a lump-sum incentive payment of 5 percent of Medicare revenue per year. A practice can avoid any downside risk at the practice level by participating in an advanced APM but will be subject to downside risk within the APM.

This advanced APM alternative is not immediately available, however: For 2019, the first year in the Quality Payment Program, all eligible clinicians will be in the MIPS, and much like every other current Medicare programs, the performance period for 2019 is 2017, as was noted

a. For additional detail about the MIPS and other elements of the Quality Payment Program, see CMS, *Medicare Electronic Health Record (EHR) Incentive Program of 2015: Quality Payment Program*, Notice of Proposed Rule Making, Fact Sheet, April 27, 2016.

previously.[b] This looming date underscores the need for providers to prepare now.

A key decision facing providers over this impending timeline is whether to plan to remain in the MIPS or to attempt to qualify for an advanced APM track when that option becomes available. The performance year for most APM models is 2019. As CMS notes in the fact sheet for its proposed rule regarding the Quality Payment Program:

> For years 2019 through 2024, a clinician who meets the law's standards for Advanced APM participation is excluded from MIPS adjustments and receives a 5 percent Medicare Part B incentive payment. For years 2026 and later, a clinician who meets these standards is excluded from MIPS adjustments and receives a higher fee schedule update than those clinicians who do not significantly participate in an Advanced APM.

Each option—both MIPS and advanced APM—should be carefully weighed, taking into account considerations such as the provider's readiness to assume risk and to meet administrative requirements (e.g., the submission and tracking requirements for MIPS), and the amount of financial risk and the level of risk (i.e., at the practice level or the APM level) the provider is willing to bear.

Advanced APM Qualifying Requirements

To qualify for an advanced APM, provider participants must meet a number of requirements, including the ability to bear a certain amount of financial risk. This requirement covers three types of risk:

- Total risk, or the maximum amount of losses possible under the advanced APM, which must be at least 4 percent of the APM spending target
- Marginal risk, or the percentage of spending above the advanced APM benchmark (or target price for bundles) for which the advanced APM entity is responsible (i.e., sharing rate), which must be at least 30 percent
- Minimum loss rate—the amount by which spending can exceed the APM benchmark (or bundle target price) before the advanced APM entity has responsibility for losses—which must be no greater than 4 percent

Qualifying advanced APM participants also are required to make use of certified EHR technology.

Payments under an advanced APM are based on quality measures comparable to those used in the MIPS quality performance category.

Advanced APMs options for qualifying practices include the following:

- Comprehensive Primary Care Plus (CPC+)
- Medicare Shared Savings Program Tracks 2 & 3
- Next Generation Accountable Care Organization (ACO)
- Oncology Care Model Two-Sided Risk Arrangement
- Comprehensive End-Stage Renal Disease (ESRD) Care Model
- Expanded Medical Homes

These options are all available starting in 2019, with the exception of the Oncology Care Model, which becomes available in 2018.[c]

Another qualification for the advanced APM lump sum payment is that minimum amounts of the

b. The proposed rule defines *eligible clinicians* as including "physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and groups that include such clinicians."

c. See CMS.gov, "Quality Payment Program: Delivery System Reform, Medicare Payment Reform, & MACRA—The Merit-Based Incentive Payment System (MIPS) & Alternative Payment Models (APMs)."

ALTERNATIVE THRESHOLD PERCENTAGES THAT A PHYSICIAN PRACTICE MUST MEET TO QUALIFY FOR PARTICIPATION IN AN ADVANCED APM

Time Frame	Medicare Threshold or	All Payer Threshold or	Patient Threshold
2019-20	25%	N/A	20%
2021-22	50%	50% with 25% Medicare	35%
2022+	75%	75% with 25% Medicare	50%

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practice revenue portfolio must be in one of these advanced APMs. The current legislation offers alternative thresholds, with increasing percentages over the period of 2019-22. By 2019, for example, a practice (defined by its Tax Identification Number [TIN]) must have at least 25 percent of its Medicare fee schedule revenue in one of these qualifying advanced APMs or as an alternative, it must deliver care to at least 20 percent of its patient population through the APM. The alternative thresholds are as shown in the exhibit on page 3.

There is also a middle ground in which groups can partially qualify as an APM, with the possibility of opting out of the MIPS payment adjustment if the clinicians receive 20 percent of their Medicare payments through an advanced APM or sees 10 percent of their Medicare patients through an advanced APM, with these thresholds increasing in subsequent years. A benefit of being in this middle ground class is more favorable scoring in MIPS categories, including the Clinical Practice Improvement Activities category, in particular. Another benefit is that the provider can choose whether to participate in MIPS. However, a partially qualified APM practice does not receive the 5 percent incentive payment.

Implications for Providers

On the surface, MACRA seems to focus on the physician practice component of the care continuum. Its strategic implications, however, are much deeper, extending to other organizations, including integrated delivery systems (IDSs) and CINs, with potentially significant market consequences. Some IDSs and CINs are purposefully making strategic decisions to enter the qualifying advanced APMs to ensure their employed and affiliated physicians have the option of participating on the APM track. The result is a cohesive strategy for the APM creator and participants, in which market advantages are created for affiliated physicians and financial risks are potentially safeguarded for employed physicians at the practice level. Therefore, each provider type should begin taking steps now to prepare for the act's implementation. Here are some of the key concerns of key provider types, and specific actions each should be taking.

Physician practices. As noted previously, the Quality Payment System is applied to physician practices at the TIN level. Therefore, each practice, as defined by a TIN, should evaluate its relative readiness for the MIPS and for an advanced APM, including its ability to meet the basic threshold requirements for the latter. The first step is to obtain understanding of the practice's current performance under the PQRS, the meaningful use, and the VM programs. Next, the focus should shift to projecting current performance forward to identify opportunities for improvement and areas for concern. The organization should be motivated in this effort by a recognition of the fact that, ultimately, more risk is coming, and understanding the organization's risk capability will be critical.

A fundamental consideration for a physician practice is whether it wants to bear risk at the practice level or at an organizational level in an advanced APM. Also, the organization should keep in mind is that MACRA also requires posting of scores for each clinician on CMS's Physician Compare website, which means that each provider may have a score from 0-100 posted with associated performance in all MIPS categories available for public viewing.

Physician practices should consider the following key questions as they assess their readiness for MACRA and contemplate next steps:

- How is our practice performing under each of CMS's current quality programs?
- What insights can be gleaned from looking at the practice's current quality and resource use reports?
- To what extent can our practice meet the revenue thresholds for advanced APMs, and which APMs should be considered?
- What impact will APM participation have on our commercial contracts, and how should we broach discussions with commercial payers about APMs?

PREPARING FOR THE MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT (MACRA): PRELIMINARY ACTION STEPS

		Timeline			
	Preliminary Foundational Steps	**2016**	**2017**	**2018**	**2019+ (MIPS)**
1	Develop a MACRA workgroup comprising a cross-section of key stakeholders from throughout the organization, including leadership from strategy, quality, finance, managed care contracting, and clinical areas.	X			
2	Initiate MACRA education sessions for the workgroup to serve as the foundation for evaluating economic and market share impact across the enterprise, and identify that impact by entity. Assign responsibility to an individual from the workgroup to serve as the "point person" for each affected entity.	X			
3	Assess the current market to ascertain how the organization compares with the competition in terms of advanced alternative payment model (APM) participation, quality measures, cost, patient satisfaction, and physician relations.	X	X		
4	Re-imagine organizational strategy considering the increased focus on quality/ preventive care (e.g., expanding outpatient) and the crossover between quality programs.	X	X		
5	For the accountable carenization (ACO), clinicallly integrated network (CIN), and employed medical group, assess current performance in the Centers for Medicare & Medicaid Serives quality programs including the Physician Quality Reporting System, Meaningful Use, and the Value Modifier Program.	X	X		
6	Model scenarios for the Merit-based Incentive Performance System (MIPS) and partially qualifying APM and advanced APM paths and identify the best options for the organization, considering factors such as mission, goals, culture, infrastructure, risk tolerance, and negotiation windows. Create a dashboard that includes relevant measures, targets, and timelines to monitor progress for either path selected.	X	X		
7	Complete a comprehensive review of available data (e.g.., quality and resource-use reports, Medicare spend per beneficiary) to identify areas of opportunity and implement action plans to optimize performance (relevant for MIPS and APM paths).	X	X	X	
8	If a qualified advanced APM path is selected, initiate an APM planning process to work toward accumulating necessary volume to meet thresholds by 2019.	X	X	X	X
9	Incorporate MACRA implications/strategy into managed care contracting strategy focusing on rewarding the Enterprise for 'value'.	X	X	X	X
10	Monitor legislation for changes, because MACRA programs are being created in real time and opportunities for participation in Center for Medicare & Medicaid Innovation initiatives, quality programs, plan design, and more will continue to evolve as CMS evaluates the success and failure of tested initiatives.	X	X	X	X

Source: DHG Healthcare

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> What effect will our MACRA strategy most likely have on our affiliation or alignment strategies?
> How might our group's scores on Physician Compare affect our ability to recruit and retain providers, negotiate contract increases, and join IDSs, CINs, or ACOs?
> How should our physician compensation calculation be adjusted to account for these new measures, incentives, and penalties?
> What would be the cost of doing nothing?

Hospitals and health systems. MACRA has clear strategic implications for hospitals and health systems whether they employ physician practices or not, given that these organizations will have alignment strategies involving physicians (noted above). Understanding the nuances of MACRA legislation and its impact on both employed and affiliated physicians will likely influence APM decisions at the hospital and health system level. The effect of these decisions on the broader

continuum will be certain to have an impact on the hospital's or health system's commercial contracting decisions. Key considerations include deciding whether the organization should support its employed physicians in meeting advanced APM thresholds of MIPS requirements, and whether it also should provide an infrastructure for affiliated physicians to move in the same direction.

In addition to considering questions like those listed above for physician practices, hospitals and health systems should contemplate the following questions:

> Do our affiliated physicians understand the need for MACRA planning?
> What assistance do the affiliated physicians need, particularly regarding support under the MIPS or qualifying for an advanced APM?
> How far along are our competitors in APM planning and how could our competitors' strategies affect our provider base?
> Which APMs should we be looking into?
> How are our commercial contracts set up to reward the organization for delivering high-value services?
> How will the increased focus on quality and preventive care affect volumes?
> Where should we adapt our strategy as a consequence of the increased physician focus on quality and outcomes? For example, should we expand outpatient services?
> What preparations do we still need to make? How will we know when we are ready for the implementation advanced APMs, and how will we know precisely what we are preparing for? Are we clinically and administratively ready to take on more risk? Given that most APMs require a care focus across the continuum, do we know where our patients go, and do we have the analytics to tell us what our patients spend is and how we can make a difference?
> What happens if we do nothing?

Postacute care providers. MACRA has a clear impact on postacute care providers, given that postacute care typically accounts for a large portion of the spend for patients once they are discharged from the hospital stay and, therefore, is a major point of focus for episodic spend-reduction programs. MACRA also might prompt physicians to change alignment, and it will be essential to anticipate the potential impact of these alignment changes on discharge patterns and care settings. Moreover, as APMs evolve, the emergence of new APMs is likely to have an impact on postacute care pathways.

In prepare for such potential impacts of MACRA, postacute care provider organizations should address the following questions:

> How does our facility compare with the competition in terms of cost and quality?
> How likely are physicians to refer to other settings (e.g., home health), and what impact would such a change have on our discharge patterns?
> How is our facility viewed or ranked by potentially referring physicians (e.g., by orthopedists considering a bundled payment option)?
> How are commercial contracts set up to reward our facility for delivery of high-value services?
> Do we need to consider participation in an advanced APM to remain competitive?
> What preparations do we still need to make? How will we know when we are ready for the implementation advanced APMs, and how will we know precisely what we are preparing for?
> What happens if we do nothing?

CINs. A CIN is in a unique position as MACRA approaches to support physician practices under the Quality Payment Program, given its heavily physician-focused organizational design. However, in light of the potentially tight timelines, CINs have many questions to consider beyond the ones listed above for physician practices. A key consideration is evaluating the CIN's ability to take on risk: The CIN must determine the degree and type of risk it is interested in assuming relative to commercial contracts. This consideration also should prompt other conversations regarding what types of enhanced services the CIN should deliver as the MIPS or advanced APM kicks in.

In addition to considering questions like those listed above for physician practices, CINs should address the following questions:

> How are the CIN's providers currently performing in current CMS quality programs?
> Are there other services we should be offering to assist with our providers' transition to either MIPS, a partially qualified APM, or an advanced APM?
> Which of our providers do we risk losing to another CIN if we can't offer an advanced APM?
> What commercial arrangements should we be considering?
> Should we consider more risk if we are an MSSP Track 1, or in Next Generation or Track 2 or 3?
> What programs do we offer that qualify (e.g., Medicare Shared Savings Track 2), and where should we focus our efforts with respect to making sure we have such programs?
> What types of arrangements should we explore with commercial payers to reach the advanced APM thresholds?
> What preparations do we still need to make? How will we know when we are ready for the implementation advanced APMs, and how will we know precisely what we are preparing for?
> What happens if we do nothing?

Tying It All Together

Ultimately, there is still more to learn about MACRA, but given the far reach of this legislation, it is important to start planning now. The initial goals for each organization should be first to understand its current circumstances and then to evaluate opportunities for improvement in the new Quality Payment Program. Next, if participating in an advanced APM path is the goal, it will be necessary to develop the roadmap for getting there and to identify the risks and rewards that are available. Many of the tenets in the MACRA legislation on which the Quality Payment Program is founded apply to programs across the care continuum.

For example, readmissions are a factor in the VM program currently as well as in CMS's Value Based Purchasing program and in bundled payment programs, in general. As providers work to improve a particular program or area, the impact may be felt in multiple other programs or areas. As providers make improvements, the bar will rise, because every measure improvement has relevance and meaning in terms of peer performance. The speed of optimization is also hugely important, not only because the overall industry needs to be prepared for the impending changes of MACRA, but also improved value is critical to the future integrity of our very healthcare system. Regardless of each organization's status today relative to any of the mandatory or voluntary programs aimed at payment reform, preparing for MACRA will help all organizations identify the critical areas on which they should be focusing in preparation for the Quality Payment Program. ■

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