

Overview

This primer provides an overview of the MACRA law and includes questions to help boards, executives and clinical leaders discuss its impact on their organization.

What is the MACRA?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) significantly changes how Medicare pays for physician services. The MACRA repealed the sustainable growth rate (SGR) formula that created physician payment “cliffs” requiring numerous temporary patches from the Congress. More importantly, the MACRA established a new two-track physician payment program that increases the amount of Medicare physician payment at risk for quality and cost performance, and provides incentives to adopt new value-based payment models. The new program began on Jan. 1, 2017; clinician performance during 2017 will impact payment in 2019.

Most clinicians will be paid under the default track of the new program, known as the Merit-based Incentive Payment System (MIPS). The MIPS provides incentives and penalties of up to 9 percent of Medicare professional services payments, based on quality and cost performance. Clinicians are expected to submit a significant amount of data to meet MIPS requirements. An alternative track allows clinicians to earn incentives for participation in certain advanced alternative payment models (APMs). APMs move payment away from fee-for-service reimbursement, and instead pay providers based on the quality and cost of care for particular episodes (e.g., bundled payment), or defined patient populations (e.g., accountable care organizations (ACOs)).

Why Does MACRA Matter for Hospitals and Health Systems?

MACRA will have a significant impact not only on clinicians, but also on the hospitals and health systems with whom they partner. Hospitals may help defray the costs of reporting data for employed or affiliated physicians, and also may be at risk for any payment adjustments. Moreover, hospitals may be asked to participate in advanced APMs to help the clinicians with whom they partner qualify for the advanced APM incentives. Finally, as a larger percentage of clinician payment becomes at risk, there will likely be a continued shift in hospital-clinician relationships, as hospitals and clinicians seek greater collaboration on performance measurement and payment models.

How Does the Physician Payment Program Work?

The attached infographic summarizes the key aspects of the new payment program. Additional detail appears below:

Merit-based Incentive Payment System (MIPS). The MIPS is the default payment track for physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists and practice groups that include these professionals. About 90 percent of eligible clinicians are expected to participate in the MIPS. Physicians and other eligible clinicians will be assessed in the MIPS under four performance categories:

- Quality measures
- Cost/resource use measures
- Participation in improvement activities (e.g., care coordination, patient safety assessments);
- Advancing Care Information (ACI, which assesses the use of electronic health records by eligible clinicians)

For the quality, improvement activity and ACI categories, clinicians are expected to submit data to the Centers for Medicare & Medicaid Services (CMS). Based on their performance in these four categories, physicians and eligible providers will receive a payment adjustment. The payment adjustment will be capped at +/- 4 percent in 2019, rising to +/- 9 percent in 2022 and subsequent years.

Advanced APMs. The alternative advanced APM track allows physicians receiving a significant portion of their payments through advanced APMs to be exempt from most MIPS requirements, and through 2024, to receive a lump sum bonus payment of 5 percent of Medicare professional services payments from the previous year. Advanced APMs must:

- Require the use of certified EHR technology
- Tie payment to performance on quality measures; and
- Require participating providers to bear downside financial risk. Specifically, advanced APM participants must refund Medicare if their spending under the model exceeds a projected amount.

Only a limited number of Medicare advanced APMs qualify for bonuses at this time. These include Tracks 2 and 3 of the Medicare Shared Savings Program, the Next Generation ACO model, the Comprehensive End-stage Renal Disease Care model, and the Oncology Care program. The Comprehensive Primary Care Plus medical home initiative qualifies under special rules set by CMS.

How Can Trustees Help Their Hospitals and Systems Prepare?

Trustees can help their organizations prepare by asking several strategic questions, such as:

- What is our organization's current level of integration with physicians? Would it benefit us to move toward greater integration, such as through increased physician employment or the formation of a clinically integrated network?
- Will our organization assist physicians and other clinicians with required reporting? If so, will we need additional infrastructure, and what is the anticipated cost of implementation and ongoing compliance?
- How can the organization best align measures and incentives among facilities and practitioners across the organization?
- Is our organization prepared to enter into risk-bearing alternative payment models? If so, which models best align with our organizational and clinical priorities? Should we lead these efforts or partner with others?
- How can we best align performance measures and incentives under the new payment program among facilities and practitioners across our organization?
- What impact is this new physician payment program likely to have on our long-range planning (financial and capital, quality and safety, human resource, compliance, risk mitigation, etc.)?
- How should our board continue to monitor the impact of the new payment program on our organization and clinicians (Through periodic reports to the full board, as part of committee oversight such as through the Finance Committee, Quality Committee or Audit and Compliance Committee, etc.)?

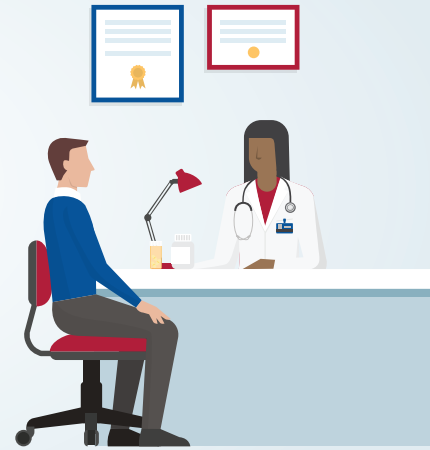
Want to Learn More?

The AHA is working with hospitals, health systems and physician groups to prepare the field for MACRA implementation. Find more resources at www.aha.org/MACRA, which includes webinars, detailed regulatory advisories, and a “MACRA Minutes” video series that provides short discussions of key MACRA issues. We also welcome questions and feedback at MACRA@aha.org.

MACRA

Big changes coming to how Medicare pays clinicians

The Medicare Access & CHIP Reauthorization Act replaced the flawed sustainable growth rate formula with predictable payment increases. Implementation will have a significant impact on physicians and other clinicians, as well as the hospitals and health systems with whom they partner. For more information and educational resources, visit www.aha.org/MACRA.



KEY TAKEAWAYS



Shifts Medicare from fee-for-service to pay-for-performance.



Rewards participation in risk-bearing payment models.

PERFORMANCE MEASUREMENT BEGINS IN 2017

DIFFERENT PAYMENT PATHWAYS

(MIPS or advanced APMs)

MIPS

(Merit-based Incentive Payment System)

APMs

(Alternative payment models)

ELIGIBLE CLINICIANS

Default payment pathway for clinicians, other than those with low Medicare volume or participants in advanced APMs.

Alternative to MIPS for clinicians with significant participation in risk-bearing APMs.

PAYMENT IMPACT

Sliding scale bonuses and penalties ranging from 4% in 2019 to 9% starting in 2022.

Bonus of 5% of Part B professional services payments in 2019-2024.

EVALUATION CRITERIA

Performance evaluated based on:

- Quality
- Improvement activities
- Resource use
- Advancing care information (EHR)

Percentage of care delivered through an advanced APM. Individual APMs incorporate cost and quality metrics, but with no impact to bonus.