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WE BELIEVE THE MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT (MACRA) AND SPECIFICALLY THE DRAFT RULE AS PROMULGATED IN APRIL 2016 WILL TRULY HAVE A MATERIAL IMPACT ON PHYSICIANS, PHYSICIAN GROUPS AND ON HEALTH SYSTEMS. THIS HEALTH CARE FUTURES DIRECT PROVIDES A SUMMARY OF THE MACRA LEGISLATION AND THE DRAFT RULE. IN ADDITION, HEALTH CARE FUTURES OUTLINES SOME OF OUR THINKING RELATIVE TO THE IMPACT OF THE RULE FOR PROVIDERS INCLUDING HEALTH SYSTEMS. WE WELCOME YOUR REACTION AND COMMENTS. IN ADDITION, IF YOU WOULD LIKE TO RECEIVE AN ELECTRONIC COPY OF THIS ARTICLE, WRITE TO US AT INFO@HEALTHCAREFUTURES.COM

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Be prepared for the Impact of Medicare Access and CHIP Reauthorization Act (MACRA) on Physician Groups, Hospitals and Health Systems.

In April 2016, CMS published the proposed rule to implement MACRA. Even with nearly 1,000 pages, there are many unknowns in the proposed rule that will materially impact the risks and benefits for physicians. CMS has said it is seeking input from providers and others relative to the proposed rule and plans to update the rule later in the fall of 2016. CMS has indicated goals for MACRA are "Better care, smarter spending, better outcomes and healthier people". Measurement of performance as outlined below can be made at the individual physician or the group level. MACRA does consolidate some CMS programs that currently impact physician reimbursement including Physician Quality Reporting Program (PQRS), Medicare EHR Incentive Program (Meaningful Use) and Value Based Payment Modification (VBPM).

Health Care Futures Conclusions on MACRA and Impact on Physician Groups and Health Systems. As noted, there are myriad potential implementation changes that CMS might make to the draft rule. However in our view there are some very likely takeaways for Physician Groups, Hospitals, and Health Systems. These include the following.

- **Health Systems, Hospitals, and Larger Physician Groups need to be prepared for a number of smaller physician practices seeking alignments.** Given the increased complexities of MACRA and the increased unknowns for smaller physician sites, we believe these providers will be increasing seeking alignment with a larger organization. CMS has indicated it believes the brunt of the reimbursement penalties to be imposed on physicians under MACRA will be borne by groups with 10 or less providers.

- **Reimbursement from Medicare will be impacted by how a physician or group performs 18 to 24 months prior.** Much of the determination of how a specific provider is measured in for example 2019 will be based on how he/she measured compared to others in 2017.
- **The evolution of measurement of physician performance will accelerate under MACRA.** No longer will wRVUs or traditional professional fee net revenue generation be the sole determinate of physician productivity.
- **Physician Groups, Hospitals, and Health Systems must adjust their compensation approaches for physician and other providers to meet the new demands of this legislation.** Health Care Futures has prepared a separate Health Care Futures Direct discussing our thoughts relative to the impact of MACRA on physician compensation planning for Physician Groups and Health Systems.

Background on MACRA. MACRA will materially impact how physicians and other related providers will be paid for professional services provided to Medicare recipients under Part B. "The Sustainable Growth Rate (SGR) formula used by CMS to determine the physician payment levels for the subsequent federal fiscal year has been in place since 1997. Many experts have opined that the SGR was not a sustainable program, and there is evidence to support that conclusion given the fact more than 10 times in the nearly 20 years of the SGR model, Congress had to step in at the last minute to pass legislation that included language to avoid material cuts in reimbursement. It is tough to plan for the future of a practice with physicians relying on Congress to come to

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the rescue to avoid material cuts in reimbursements. Like many “pure production” models, the SGR approach has limited incentives for providers to provide quality, high value, and accessible care. One of the proposed benefits of MACRA for physicians is the elimination of this dreaded SGR and the need for Congress to act to avoid large reductions in payments to physicians and related providers. **The SGR concept becomes moot for most providers under MACRA.**

MACRA is designed to help CMS achieve its goal by the end of 2018, of moving to 50 percent of Medicare payments tied to quality or value and 90 percent of the Medicare fee for service payments being tied to quality or value. How many patients one sees in a given day will not be the sole mechanism for how much a physician is paid under this new legislation. MACRA is truly one of the most important pieces of legislation to impact physicians to be passed in recent years. However, one could *not* argue as proposed in the rules, that the process will be streamlined.

CMS has also indicated that by 2019 it hopes to also include other payors. CMS projections indicate 85+- percent of the physicians in the US or about 800k physicians (the Kaiser Foundation indicates there are approximately 900k physicians in the US) will have their Medicare payments fall under this MACRA payment system. CMS further indicates that vast majority of those 800k will utilize the Merit-based Incentive Payment System (MIPS) track (see discussion below).

There are exceptions to those who will be covered by this new MACRA payment approach. These include: Rural Health Clinic and FQHCs; Medicare recipients who are part of the Medicare Advantage Programs; and, physicians who see less than 100 Medicare patients a year or have less than \$10k in annual Medicare billings.

Overview of MACRA rules as issued in April 2016.

• **Timing impact on payment to Physicians and other Providers.** The changes to physician reimbursement will begin January 2019. However, the 2019 payments will be based on data that will be required to be submitted on 2017 activity. Thus, the first year of payments under MACRA in 2019 will be based on reporting, outcomes, and activity from 2017. 2020 MACRA payments will be based on 2018 information and so on.

• **Two Payment Tracks.** Physicians will be slotted into one of two payment tracks as described below.

– **Merit-based Incentive Payment System (MIPS).** CMS expects the vast majority of physicians will utilize this track – 750,000+- physicians or 93 percent of the approximate 800,000 physicians that would be impacted by MACRA.

◊ **Impact on Provider reimbursement.** By 2023 (fifth year of MACRA) potential bonuses or penalties of 9 percent (18 percent swing) based on various performance metrics. In addition, exceptional performers will have an opportunity for up to an additional 10 percent bonus on top of the 9 percent noted. *Thus, the swing in reimbursement could be 28 percent.*

– **Advanced Alternative Payment Models (Advanced APM).** CMS expects that in the early years of MACRA, approximately 7 percent of physicians will access the MACRA system from this track. *Health Care Futures believes this estimate might be understated based on the number of Physicians who are part of Health Systems or other organizations that might be able to meet the requirements for the Advanced APM track.*

◊ **Requirements for Advanced APM.** The requirements to be eligible for the Advanced APM track are difficult for many to achieve. There are three main criteria that must be met to be eligible as an Advanced APM.

- **Advanced APM has to bear risk.** Rules describe various potential definitions to meet this criteria but the rules note risk must be more than “nominal” with examples outlined.
- **Technology.** APM participants are required to use Certified Electronic Health Record Technology (CEHRT).
- **Quality.** Quality metrics to measure performance and payments to providers within the APM must be comparable to the MIPS quality criteria (see subsequent discussion).

◊ **Eligible Entities for Advanced APM Track.** Existing or CMS approved planned models that meet the criteria, include the following.

- **Medicare Shared Savings (MSSP) Tracks 2 and 3.**
- **NextGeneration ACOs.**
- **Comprehensive ESRD Care.**
- **Comprehensive Primary Care Plus (CPC+).** Scheduled to begin its rollout in 2017.
- **Oncology Care Model (OCM) – two sided risk**



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track. Emerging oncology model scheduled to become operational in 2018.

◇ **Models not considered Advanced APMs per the rules.**

- **MSSP Track 1.**
- **Comprehensive Care for Joint Replacement Model (CJR).**
- **Bundled Payments for Care Improvement (BPCI).**

◇ **Impact on Provider reimbursement.** Providers must take financial risk (up and down). If various criteria are met the Provider/Group can earn a five percent annual end of year lump sum bonus.

● **Winners and Losers.** MACRA is supposed to be budget neutral for CMS. Bonuses earned are paid for by penalties for other Providers. Providers/Groups are reimbursed in part based on how well the Provider/Group is performing in terms of outcomes and resources used as compared to other Providers/Groups.

– **CMS projections.** CMS data indicates over 85 percent of the “losers” will be groups of physicians under 10 providers. Those who are penalized will fund those who earn bonuses.

● **Brief synopsis of reimbursement processes under MACRA.**

– **MIPS.**

◇ **Base Increase in Physician Fee Schedule.** From 2017 through 2019 the increase is 0.50 annually. From 2020 through 2025 there is no increase. For 2026 and beyond the stated increase is 0.25 annually.

◇ **Adjustments to payment to Providers/Groups under MIPS.** Actual reimbursement is impacted by the Composite Score (scale of 0 to 100) for the Provider/Group that takes into account four components. Penalty or bonus in terms of percentage change in reimbursement is based on performance compared to national numbers. The four components are as follows.

- **Quality.** Minimum of six quality scores (from an approved list). Note: fewer quality measures than that required for PQRS.
- **Advancing Care Information (ACI).** In essence this replaces Meaningful Use. The rules indicate the number of reporting measurements will drop from 18 under Meaningful Use to 11 under ACI. In addition, and this is a material change under MACRA, gradation is allowed as opposed to the all or nothing approach under Meaningful Use. CEHRT is

required and there are other requirements as well.

▫ **Clinical Practice Improvement Activities (CPIA).**

Points are earned for achieving various metrics in 90+ potential categories. Types of activities included in this component include: care coordination; engagement of the patient; patient safety; enhanced practice/group access (Telehealth is an example); population management; integrated behavioral and practice assessment, etc. Full credit is awarded for this component if the Provider is participating in the Patient Care Medical Home program.

▫ **Resource Use.** CMS will use claims data (no reporting required by the Provider/Group) to assess and compare the resources utilized (cost of care) for episodes of care and clinical coordination groups. Those who provide the care with less resources than the norm will score higher than those who use more resources.

● **Scoring.** As noted, a Composite Score of these four components (with multiple factors and measurements within each component impacting the Composite Score) is compiled on each Provider/Group.

– **Weighting of four Components.** The weighting will change over time per the draft Rule. In 2017 (reminder reporting and scoring of Providers/Groups begins in 2017 for 2019 reimbursement) quality will drive 50 percent of the Composite Score. By 2019, that component drops to 30 percent of the overall Composite Score with Resource Use becoming much more material in terms of the Composite Score.

◆ **2017/2019 Reporting that drives the Composite Score.**

- **Quality** – 50 percent in 2017 and 30 percent by 2019.
- **ACI/Meaningful Use** – 25 percent in 2017 and 2019.
- **CPIA/Practice Improvement** – 15 percent in 2017 and 2019.
- **Resource Use/Cost** – 10 percent in 2017 and 30 percent by 2019.

◇ **Amount of the potential adjustment or Penalty/Bonus of the Physician Fee Schedule.** For reimbursements made in 2019 (again based on 2017 activity and reporting) the range of potential



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adjustment is negative 4 to positive 4 percent. By 2022, that spread shifts to negative or positive 9 percent.

– Advanced APM.

- ◇ **Base Increase in Physician Fee Schedule.** For 2017 through 2025 the increase is the same as MIPS. However, for 2026 and beyond the schedule calls for 0.75 percent annually (as opposed to 0.25 percent annually under MIPS).
- ◇ **Adjustments to payment to Providers/Groups under Advanced APM.** The APM must take financial risk. Thus, the reimbursement to Providers is dependent on how well that financial risk is managed by the Advanced APM.
- ◇ **Quality.** Payments to Providers within the Advanced APM must be based on similar quality measurements as found in MIPS.
- ◇ **Amount of potential adjustment or bonus.** Five percent bonus opportunity for those Providers participating in Advanced APMs – lump sum payment.

Major takeaways of MACRA proposed rule:

- **Time to start to adjust is now.** Reimbursement will be tied to performance 18-24 months in arrears.
- **Not a pure volume generation model.** Provider reimbursement now will include many other factors beyond the number of CPT codes in a given day.
- **Team based care will impact reimbursement.** Physician reimbursement will be much more tied to how a team of professionals manage a patient.
- **Quality will impact Physician reimbursement.** Quality and outcomes will materially impact payments to Physicians and other Providers.
- **Cost of care will be more of a factor.** Resources utilized to manage that care

and achieve the outcomes needed for other bonuses will impact Provider reimbursement and that level of impact will increase substantially over a short duration.

- **Smaller practices will be hurt.** It is fairly clear that CMS and others believe the brunt of the impact in terms of “lost reimbursement” will be borne by those smaller groups and practices that do not have either the infrastructure or capabilities in house. We would suggest as have others that this might be one of the nails in the coffin for small provider groups.
- **Complexities in Physician reimbursement remain.** Granted there is more flexibility relative to certain aspects of the Provider reporting. However, this model is more complex for the Provider as CMS is trying to reward those with great outcomes at a lower cost and penalize those who do not share those attributes.

It would take many more pages of discussion to outline the myriad drivers of physician reimbursement outlined in the proposed MACRA rule. However we believe the proposed rule, recognizing there are many potential modifications (pro and con) that could be made, is a game changer in terms of physician and other provider reimbursement and will have a material ripple effect on physicians, Hospitals, Health Systems, and others. This legislation in our view will lead to material transformation of the physician organizational landscape. There will be winners and losers as with any major piece of legislation. It is clear quality, outcomes, cost of care ability to work in teams will all become a major determinate of how much a provider is paid for care by the largest payor in the US. Those that act proactively to address the impact of MACRA will in our view be more likely to be a winner in the long run.

Physician reimbursement from Medicare could vary nearly 30 percent from provider to provider under MACRA. Efficiency of the care delivery, outcomes, quality, and ability to work in teams will impact which side of that 30 percent physicians will fall. MACRA will make it more difficult for smaller practices to succeed. Other payors will likely follow CMS in some manner.

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