VIEWPOINT

Implementing MACRA
Implications for Physicians and for Physician Leadership

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On April 27, the Centers for Medicare & Medicaid Services (CMS) released the highly anticipated 962-page proposed rule[1] for implementing the Medicare Access and CHIP Reauthorization Act (MACRA). MACRA will overhaul Medicare's physician payment system starting in 2019, placing most physicians in the Merit-Based Incentive Payment System (MIPS), a pay-for-performance system that adjusts payments based on measures derived from prior care. Physicians can be exempt from MIPS and receive bonus payments by demonstrating sufficient participation in advanced alternative payment models (APMs), which are intended to support greater flexibility in care delivery alongside greater accountability for efficiency and care improvement.

The broadly bipartisan legislation was intended to align physician payments with better quality of care that avoids unnecessary costs—a better alternative to the perpetual payment tightening under the Sustainable Growth Rate system that it replaced, or to benefit and access reductions that could occur if the payment reforms do not work as hoped. Yet it is uncertain that the reforms will succeed broadly for patients and clinicians, and although the rule provides important details about the MIPS measures and qualifying APMs, the proposal requires further development in many areas. These Medicare reforms are likely to affect payments throughout the entire health care system. Consequently, physicians should take time to understand the key features of the law and the opportunities it presents to shape the future of payment and medical practice.

Payment Adjustments in the MIPS

CMS expects the vast majority of clinicians to participate in MIPS initially. Payment rates will be adjusted positively or negatively for a clinician or group based on a composite performance score, starting at up to 4% adjustment in 2019 (based on 2017 performance) and increasing to up to 9% in 2022. The law bases the composite performance score on 4 components: quality, resource use, advancing care information, and clinical practice improvement activity (**Box**).

The quality, advancing care information, and clinical practice improvement activity categories will likely lead to improvements in measured performance. However, many important aspects of quality are not well captured by existing measures, and differences in patient severity may affect measured performance. Furthermore, there is little evidence that pay-for-performance reduces overall costs. The resource use measures are scheduled to become more important, but measures to date have a poor track record in identifying efficient physicians and practices. For example, 96% of physician practices were scored as "average cost" using similar measures in the 2016 Value-Based Payment Modifier program.[2] Given that the MIPS measures will apply to smaller practices, as well as specialties whose discretionary services are not yet captured by well-developed episode definitions, clinicians can generally expect average scores, which offer little motivation to change.

Advanced Alternative Payment Models

An "advanced" APM requires participants to bear more than "nominal risk" in terms of accountability for quality and expenditure performance, and the statute gives CMS substantial discretion to define nominal risk. CMS set a higher standard than many hoped for, requiring that participants substantially share in losses rather than just gains. Performance benchmarks are envisioned to be patient-focused, for example, at the level of overall expenditures and quality of care for an attributed population in an accountable care organization (ACO), or at the level of expenditures and outcomes for patients requiring care for specialized conditions. Current demonstrations in which physicians are at least partly accountable for outcomes and spending for patients with kidney failure or cancer qualify under this standard.

The law established a special standard for clinicians in certain medical home models. CMS' nominal risk threshold for these models is based on the risk of failing to receive performance bonuses. CMS determined that the recently announced Comprehensive Primary Care Initiative Plus (CPC+) pilot will qualify as an advanced APM.

The eFigure in the Supplement illustrates the consequences of these definitions for Medicare expenditures and physicians under reasonably optimistic assumptions about participation in advanced APMs. Most participants in current CMS APMs, notably those in track 1 of the Medicare Shared Savings Program (MSSP), would not qualify. Although CPC+ qualification is welcome news for primary care clinicians, medical home programs must demonstrate net savings to be expanded—a standard none have yet achieved. Episode bundled payments like the Comprehensive Care for Joint Replacement pilot do not qualify, although CMS requested comments on how that model could be altered to meet requirements.

CMS will receive extensive comments on its standards for nominal risk and APM qualification, with substantial pressure likely coming to qualify participants in MSSP and other "upside" risk payment models. However, savings from APMs to date have been modest, and relaxing the standards would forfeit the agency's strongest lever to move participants into higher-risk APMs that have

Box. The 4 Components of the Composite Performance Score of the Merit-Based Incentive Payment System

Quality (50% Decreasing to 30% in 2021)
Physicians must report on at least 6 quality measures, including 1 outcome measure if available, from an annually updated inventory (example outcome measures include functional improvement following surgery and depression remission).

Resource Use (10% Increasing to 30% in 2021)
These measures will be calculated by CMS using claims, including 2 general measures that assess the total cost of care for beneficiaries during a year or surrounding a hospitalization, as well as 40 clinical episode measures, as a basis for rewarding efficient physicians.

Advancing Care Information (25%)
This category replaces meaningful use measures on health information technology with fewer and more flexible reporting requirements intended to promote interoperability and data flow relevant to a physician's practice, rather than electronic health record capabilities per se.

Clinical Practice Improvement Activity (15%)
Clinicians must attest to several of a wide range of practice-level activities, such as delivery of telehealth services, participation in registries, and provision of 24/7 access.

demonstrated more promising results.[3] As formulated, physicians joining large consolidated organizations that are more comfortable bearing population-level risk appear to have the most straightforward pathway into advanced APMs. If that risk-bearing is associated with significant market power, spending outside Medicare may increase.[4]

What Should CMS and Physicians Do?

The proposed rule has begun the historic and complex undertaking of reforming physician payment. Despite its size and scope, the rule leaves many questions unsettled, including certainty about the best pathways forward for many types of physicians, and how much influence the reforms will have on quality of care and spending for Medicare beneficiaries. Physicians now have a critical opportunity to improve the proposal and develop and implement reforms to maximize its effectiveness.

Given that the vast majority of physicians will initially participate in MIPS, professional organizations should develop better utilization measures that are reliable for small practices; some models exist.[5] Utilization and quality measures that are more focused on the patients treated by different kinds of specialists—not the specialist services—would provide a foundation for greater opportunities to improve care while reducing overall costs, and a pathway toward APMs that is not clear for most clinicians today. In addition, the MIPS clinical improvement activities component should receive more attention; evidence demonstrating that particular activities improve care and efficiency should support a greater weighting within the MIPS performance score. To support such efforts, and with appropriate protections, CMS must share more longitudinal beneficiary data with physician associations and practices considering APMs.

Physicians can also help develop additional effective APM opportunities. For some types of patients, for example, those with advanced gastrointestinal or rheumatologic diseases, specialized medical homes with accountability for patient-level quality and spending—like the oncology medical home—may be feasible. But most medical care requires more extensive collaboration across multiple specialties.

As it stands, primary care physicians have 2 distinct alternatives: join an ACO with significant "downside risk" or join a medical home demonstration and hope it succeeds. For most specialists, the only clear advanced APM option is joining a consolidated risk-bearing ACO. Given the limited success of medical home pilots so far, and the potential downsides of very large organizations, another set of options needs to be developed aggressively for primary care physicians and specialists who may be able to practice more effectively without full consolidation, particularly given that small physician-led ACOs have been disproportionately successful in MSSP track 1.[6] Proven medical home models or ACO models akin to MSSP track 1 for smaller physician practices would be well-suited to interact with specialists in advanced episode-based APMs.[7]

Physician organizations should accelerate efforts to identify opportunities for high-value care as the foundation for success under MACRA. The proposed rule offers guidance and test cases for multiple mechanisms including advanced APMs and quality and resource use measures, as well as clinical practice improvement activities—along with a strong appeal for comments and leadership from the physician community.

ARTICLE INFORMATION

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