Health Affairs Blog

The Roadmap To Physician Payment Reform: What It Will Take For All Clinicians To Succeed Under MACRA

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As the largest change in Medicare physician payment since the Sustainable Growth Rate formula, the Medicare Access and CHIP Reauthorization Act (MACRA) will affect up to 836,000 clinicians and allocate more than $1.2 billion in payment bonuses and penalties in its first year alone. Reflecting the importance of this policy, the 962 page proposed rule for its implementation generated thousands more pages of comments, with nearly 4,000 organizations and individuals submitting formal comment letters to the Centers for Medicare and Medicaid Services (CMS).

The proposed rule has been summarized by CMS, and there have been several *Health Affairs* Blog posts on MACRA. A major focus of the proposed rule is on the two main pathways for physician payments: the Merit-Based Incentive Payment System (MIPS), which adjusts fee-for-service (FFS) payments based on a composite measure of quality and value, and alternative payment models (APMs) that move away from FFS payment. How these features of the legislation are implemented will have a major impact not only on clinician payment but also on further developments in health care organizations, the way that they deliver care, and potentially the cost of care.

In this post, we highlight several big-picture policy questions raised by the proposed rule. More details on these topics are included in our

comment letter to CMS.

What Alternative Payment Models Will Be Available To Clinicians?

One of the law's key goals is to encourage movement from the traditional fee-for-service payment system to alternative payment models (APMs) focused more directly at the patient and population level. As an incentive for this shift, MACRA provides a 5 percent bonus to providers who participate in "advanced" APMs. The legislation sets a bar that envisions most clinicians would not qualify without significant payment change — it requires eligible providers to bear more than "nominal" financial risk for the costs of care they provide, to use quality measures similar to MIPS, and to use electronic records to coordinate and improve care.

There are few existing Medicare APMs that meet these criteria. If implemented as proposed in the rule, less than 10 percent of eligible clinicians would be participating in an advanced APMs. Several of the advanced APMs are accountable care organization (ACO) models with significant downside risk on total cost of care, which effectively limits availability to large consolidated provider organizations with substantial financial capital. Another is the Comprehensive Primary Care Plus (CPC+) pilot, which will be available to only some primary care providers and may not be permanent. The original CPC model also still needs to demonstrate overall program cost savings and quality improvement to be expanded nationally.

Some new options for certain specialists have become available since the MACRA rule was published. CMS proposed a larger set of mandatory episode bundles for hospital-based procedures and conditions, which expands the initial joint replacement bundled payment pilot to bypass surgery as well as heart attack and hip fracture care. CMS noted that physicians who provide enough of their care in collaboration with hospitals implementing these bundles can also qualify for advanced APM status.

Even with these new options, many clinicians in smaller practices (particularly clinicians not affiliated with a hospital system) will have few options to qualify for advanced APM status. Small or medium sized practices typically have small reserves, limited access to insurance against financial losses, and thus less capacity to meet the proposed advanced APM financial risk requirements. Moreover, advanced APMs may have administrative requirements beyond the practice's capabilities, such as longitudinal electronic data integration and advanced quality measure reporting.

These factors may accelerate current trends toward provider consolidation, which has generally not led to measurably better care outcomes. While consolidated organizations should be better able to reduce costs through better care coordination and a wider base to spread fixed costs, consolidation also drives up prices since the larger organizations have greater market power and ability to negotiate higher prices with private insurers. Studies have also suggested that small practices may be able to more quickly improve care, with researchers finding independent practices succeeding in prominent payment reforms.

Clinicians not participating in advanced APMs will be in the fee-for-service-based MIPS track, which may also put greater pressures on smaller practices. According to the preliminary analysis presented in the proposed rule, almost 90 percent of solo practices and 70 percent of very small practices will likely receive a payment penalty in MIPS, compared to 20 percent of large practices. While CMS officials have noted that many steps will mitigate these concerns ahead of implementation, it further highlights the challenges that independent, non-hospital based physicians may face under MACRA.

What Could Help More Clinicians Succeed With Alternative Payment Models?

First, there is a need for more evidence on what works for clinicians to succeed in payment reform. While there are some promising pilots underway, experience and evidence remain limited.

For example, the pilots that undergird the largest eligible primary care models demonstrate how much effort is required to reengineer care processes and workflows, as well as how long it takes for a health care organization to show an impact on quality and cost. More evidence is needed to identify best practices and core competencies for clinicians to advance and succeed in new delivery and payment models.

Second, CMS should consider a definition of financial risk for advanced APMs that would reflect the unique challenges of smaller organizations. This could avoid further consolidation, which is not essential to achieving better outcomes and lowering health care costs. In particular, a definition of "greater than nominal risk" could be based on total payments at risk as a share of total practice revenues. Practices above a threshold level of risk relative to their total practice revenue would qualify for advanced APMs status if they meet other requirements. The proposed rule notes that having a definition based on a ratio of practice revenue would effectively result in a case-by-case determination. However, it is technically possible to develop clear rules; indeed, CMS must have a way of estimating practice revenue in order to pay the advanced APM bonuses anyway.

For smaller specialty practices, bundled payments for episodes of specialized care in which physicians (not hospitals) are accountable could similarly have a cap on downside risk based on physician group revenue. Medicare's Oncology Care Model provides such a pathway for oncology care and could be an example for patients with other specialized care needs.

While such models have not yet been developed and tested, a short-term step could be an expansion of the "preferred provider mechanism" from the Next Generation ACO model. That is, specialists could receive credit for participating in an advanced APM if they work closely with primary care providers in advanced APMs like physician-led ACOs or CPC+ models — for example, if the specialist receives a significant share of their revenue from caring for patients attributed to those models.

Another short-term approach could be an expansion of the types of clinicians who can serve as the accountable clinician in a physician-led ACO or CPC+ model. For example, the primary provider could be a specialist, such as a gastroenterologist managing the care for a patient with inflammatory bowel disease or a nephrologist managing the care for a patient with advanced renal disease.

Finally, for those clinicians not participating in an advanced APM, there is a need to limit the administrative burden and assist practices in implementing MIPS. These steps can include policies that promote data sharing across organizations, more automated ways of collecting quality data from electronic record systems, and (as we have noted) support for the development of practice capabilities to coordinate care and continuously improve — such as through learning networks and data exchange and analysis in virtual groups. These steps are better, more sustainable directions than simply delaying the implementation of MACRA for smaller practices.

How Can Performance Measures Become Both Less Burdensome And More Meaningful?

MACRA consolidates measures from the Physician Quality Reporting System (PQRS), Value-Based Payment Modifier (VBPM), and Meaningful Use/ Electronic Health Records Incentive Program (MU) programs, and the proposed rule significantly reduces the number of measures that clinicians need to report. For example, clinicians participating in the MIPS program will have to report only six quality measures instead of the nine required under PQRS, and will not have to report any cost or resource use measures (instead CMS will use claims data to calculate these metrics). Additionally, clinicians can self-select which quality and clinical practice improvement activity measures to report. This is a positive development in reducing the measurement burden, but the flexibility may make it more difficult to compare providers and to calculate meaningful and fair payment adjustments.

While lowering the measure reporting burden is important, performance measures also need to become more meaningful. For example, the proposed cost and resource use metrics have not been proven to distinguish between high- and low-cost providers. And as noted by MedPAC's comment letter, many providers will likely max out the clinical practice improvement category because clinicians can self-select which of the 90 activities to report. Better measures need to be implemented and reported consistently.

Finally, to enable success in these payment reforms, clinicians will need more timely information from CMS related to claims-based measures. CMS has proposed providing clinicians with feedback on their measured performance only once a year. But better and more timely data—preferably in the form of preliminary measures or early indicators rather than raw data feeds—is necessary so that clinicians can improve care within the time frame for which they are being evaluated.

CMS has demonstrated the ability to provide more frequent data updates (at least key summary data) in many of its payment reform pilots;

some expansion of these capabilities to all physicians in MIPS and APMs could be a big help for physician efforts to improve performance. While CMS data availability and systems continue to improve, we encourage CMS to seek out public-private partnerships for data analysis and continue to make more data easily available to clinicians and to researchers evaluating the impact of payment reforms.

What's Next?

The proposed MACRA rule, based on strong bipartisan legislation, will make significant changes to how physicians are paid. The law holds great promise in giving clinicians more flexibility in how they practice while in return requiring more accountability for quality and cost. Fulfilling that promise, while avoiding undesirable effects such as price-increasing consolidation, requires further work.

The measurement and provider support mechanisms required for these reforms are still very much in development, and most practices and health care organizations do not have a clear view of how to succeed under these new models. With further work and continued engagement and leadership from clinicians, which CMS has made a priority, MACRA can be transformative.

Authors' Note

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