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Better Get Ready for MACRA: The Future of Medicare Payment Is Coming

San Diego—The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) made three important changes to the Medicare payment system:

- ending the sustainable growth rate formula;
- establishing a new framework for rewarding value; and
- combining existing quality reporting programs into one system.

Although many of its operational details are unknown, one thing is certain, according to Sharon Merrick, MS, CCS-P, director of Payment and Practice Management at the American Society of Anesthesiologists (ASA): Physicians around the country must recognize the need to plan for a changing future.

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Sharon Merrick, MS, CCS-P

"It's time to prepare for change," said Ms. Merrick. "We've been hearing about change coming for a long time, but at some point the rubber meets the road, and all the indications are that MACRA is for real. … It's the law of the land."

As Ms. Merrick explained at the 2016 ASA Practice Management meeting, the legislation is intended to advance the Centers for Medicare & Medicaid Services' (CMS) goal of value-based payment. Dubbed by CMS as the "Path to Value," MACRA allows health care providers to participate in one of two new payment programs.

Merit-Based Incentive Payment System

CMS quality improvement programs, including the Physician Quality Reporting System (PQRS), Value-Based Modifier (VM) and Electronic Health Record (EHR) Incentive Program ("Meaningful Use" [MU]), will continue until the start of 2019. Separate applications of payment adjustments under PQRS, VM and EHR-MU will end on Dec. 31, 2018.

Although the latter may be sunsetting as separate programs, they are returning under the Merit-Based Incentive Payment System (MIPS) in the form of performance categories.

"Fee-for-service as we know it now serves as the chassis; the MIPS program will build upon that with a composite score that will adjust your payments," Ms. Merrick explained.

Beginning Jan. 1, 2019, CMS must assess performance for measures and activities in the following four performance categories: Quality (PQRS), Resource Use (VM), Meaningful Use (EHR-MU) and clinical practice improvement activities (CPIA). The composite performance score will then be used to determine and apply a MIPS adjustment factor for 2019 onward, which adjusts as the program progresses (Table).

Table. Composite scores are weighted differently as the program progresses. Categories are weighted:

	2019	2021
Quality	50%	30%
Resource Use	10%	30%
EHR/MU	25%	25%
CPIA	15%	15%

EHR, Electronic Health Record; **MU,** Meaningful Use; **CPIA,** clinical practice improvement activities

"It's almost like Olympic figure skating: You're going to be scored, and your composite score will ultimately result in a positive, negative or neutral adjustment to your payment based on comparison to [an] established threshold," said Ms. Merrick, who noted that the threshold—determined by the secretary of the U.S. Department of Health & Human Services—will change each year of the program.

Initially, said Ms. Merrick, the largest payment adjustment that providers can sustain in the first year of MIPS is 4%, but this changes as the program grows. By 2022, just a few years into the program, providers can lose up to 10% of their allowed charges if they score poorly in comparison with the threshold.

"The farther away you are from the threshold," said Ms. Merrick, "the bigger your payment adjustment.

"Just like PQRS," she added, "it's a budget-neutral program where the losers pay the winners. The money that's available to the winners—those above the threshold—is dependent on how much is taken from those losers."

Regarding resource use, Ms. Merrick expressed concern about how patients are going to be attributed to each professional involved in the care.

"We want to make sure that patients can be attributed to anesthesiologists in this new program," said Ms. Merrick. "We also want to make sure that any savings that anesthesiologists contribute to the overall cost of care are recognized and that anesthesiologists receive the rewards of that contribution."

Alternative Payment Models

MACRA's second payment program is for eligible providers who derive a significant portion of their payments and patients from Alternative Payment Models (APMs) that include both risk for financial losses and quality measurement. Accountable care organizations (ACOs), patient-centered medical homes and bundled payment models are a few examples of APMs.

"CMS clearly wants everyone to move into this mechanism," said Ms. Merrick. "The conversion factor for those in APMs is going to be a little bit higher than those not in APMs, and those who are in it are going to get a 5% bonus in those first years."

Does Your APM Qualify?

As Ms. Merrick reported, proposals must be created and submitted to CMS, which has the authority to determine whether an APM qualifies under MACRA.

"You can't assume by default, just because you're in some sort of bundled payment system or some kind of [ACO], that it's necessarily going to qualify under MACRA," said Ms. Merrick.

However, Ms. Merrick noted the following exceptions: “If it’s your first year in the Medicare program, if you’re a new provider and don’t have any history, or if you don’t meet a low-volume threshold of Medicare payments, there are still opportunities for financial incentives.”

Staying Ahead of the Curve

Although the MACRA program itself begins in 2019, some of the performance periods may start before then. In the meantime, said Ms. Merrick, there could be several changes between what is proposed this spring and what is finalized later in the year. Despite this uncertainty, she said, anesthesiologists can rely on the vigilance of the ASA to monitor the situation.

“The ASA will be analyzing everything that is coming down the pike,” she concluded, “looking for every opportunity to advocate for our members and for the patients that you serve.”

Peter A. Goldzweig, DO, board-certified anesthesiologist and regional medical director of TeamHealth Anesthesia, commended Ms. Merrick’s presentation for highlighting what is at stake for physicians around the country.

“Now that we know what’s at stake,” said Dr. Goldzweig, “we need to figure out how we can stay ahead of the curve.”

—Chase Doyle

The interviewees reported no relevant financial disclosures.