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MACRA Implications: Darwin Comes to Medicare Physician Payments

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The Medicare Access & CHIP Reauthorization Act (MACRA) will institute a "survival of the fittest" model of competition for Medicare revenue among physicians.

Physicians will be in one of two payment models: the Merit-based Incentive Payment System (MIPS) or advanced alternative payment models (APMs) that entail downside risk. Both tracks put a portion of Medicare payments at risk, and physicians in MIPS will be evaluated against their peers nationally. This more Darwinian environment will influence decisions by physicians, which in turn will drive accountable care organizations (ACOs) to consider taking on downside risk. These issues will affect health systems and hospitals that employ physicians.

Although the rules are not finalized and MACRA won't affect what physicians are actually paid until 2019, health systems, hospitals, and their physician enterprises will feel the effects much sooner. Performance is scheduled to be measured from the beginning of 2017, so there is little time to prepare (even though the acting administrator of the Centers for Medicare & Medicaid Services recently told Congress the agency may consider delaying the start of the measurement period in response to physician concerns).

MIPS replaces the Physician Quality Reporting System, Value-Based Payment Modifier, and Medicare EHR Incentive programs with a single payment system that pays for performance based on a combined score for:

- Quality
- Cost
- Clinical practice improvement activities
- Advancing care information

Physicians will receive a positive or negative payment adjustment on each Medicare Part B claim in 2019, based on where their score falls on the performance curve in 2017. The adjustments initially will be as much as 4 percent up or down, increasing to as much as 9 percent in 2022. Additional bonus payments can increase this payment differential between higher and lower performers.

The APM track provides for five years of 5 percent lump-sum incentive payments starting in 2019 for physicians who qualify in an advanced APM (e.g., certain ACOs with downside risk and other innovative Medicare payment programs).

STRATEGIC IMPLICATIONS

Beyond the payment mechanisms, we want to consider some key strategic repercussions of MACRA:

- **ACOs face urgent decisions.** Accepting downside risk may make ACOs more attractive to physicians seeking to avoid MIPS by qualifying for the Advanced APM track. Educating ACO physicians about their options, including downside risk, will be critical.
- **More physicians may seek employment by hospitals.** MIPS is going to be hard on independent physicians, whose performance will be compared to that of large physician enterprises with more infrastructure and resources. If independent physicians decide they can't manage the logistics on their own, they may seek employment. Some may rush to be hired before hospitals reach their capacity of employed physicians.
- **Hospital-employed physician networks may benefit.** Larger physician enterprises are better positioned than independent physicians to handle MIPS, although they will still need to prepare quickly to earn bonuses instead of getting saddled with penalties.
- **Physician compensation should be redesigned.** The goal of such an endeavor is to incorporate MACRA payment factors to ensure everyone is pointed toward the same goals.
- **MIPS could improve alignment between Medicare and commercial pay-for-performance efforts.** A single scoring system could make it more likely that commercial payers will adopt a similar methodology.
- **More physicians may drop Medicare.** Although this issue has been relatively limited to date, focused on a small number of markets and specialties, it could become more prevalent.

It takes time to effectively drive change. Planning for MACRA should start now.

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