MACRA and the future of value-based care

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Abstract

The passage of Medicare Access and Children's Health Insurance Program Reauthorization Act of 2015 (MACRA) heralded a fundamental shift from volume-based to value-based payment for health care services in the United States. Beginning in 2019, neurologists will participate in 1 of 2 Medicare pathways: the Merit-Based Incentive Payment System or Alternative Payment Models. Both options represent an important change from the current fee-for-service payment models, and neurologists will need to be prepared well in advance of the MACRA launch. This article reviews the background, structure, uncertainties, and implications of MACRA on the practice of neurology, with recommendations for preparation. *Neurol Clin Pract* 2016;6:459-465

Fee-for-service (FFS) payment in health care has been heavily criticized by some as a contributor to health care cost inflation and fragmentation of care.¹ Among other attempts to control rising US health care costs, in 1997 the US Congress implemented a sustainable growth rate (SGR) cap on provider payments through the Medicare program administered by the Centers for Medicare and Medicaid Services (CMS). Spending limits mandated by the SGR were suspended through a series of temporary funding patches. Meanwhile, overall costs of health care have continued to grow, passing \$3.0 trillion in 2014, with about 20% of those costs attributable to physician payments.² In early 2015, CMS announced its intention to link 90% of FFS payments by 2018 to the quality of services provided.³

What is Medicare Access and Children's Health Insurance Program Reauthorization Act of 2015?

In April 2015, Congress passed Medicare Access and Children's Health Insurance Program Reauthorization Act of 2015 (MACRA)⁴ amid extensive bipartisan and bicameral support for the politically popular, yet vague, principle of "paying for value instead of quantity" of health care services. The changes enacted by MACRA will shape federal health care payment policy

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for the foreseeable future. Through MACRA, Congress repealed the SGR and outlined the structure of new CMS programs that will direct the transition to value-based payment.

MACRA implements an annual 0.5% increase in the Medicare conversion factor (CF) for 5 years (2015–2019). After 2019, there will be no change in the CF adjustments until 2026, during which time all payment adjustments will be determined by providers' Medicare participation pathway. Quality unadjusted payment increases from Medicare will remain low for the foreseeable future, and may easily be outpaced by inflation.

Merit-Based Incentive Payment System pathway

Barring implementation delays, beginning January 1, 2019 all neurologists (and other providers) who participate in Medicare will do so through one of 2 options: the Merit-Based Incentive Payment System (MIPS) pathway or the Alternative Payment Model (APM) pathway. APMs are discussed in more detail in the next section. Collectively, the 2 pathways comprise CMS's Quality Payment Program.

Broadly speaking, the MIPS pathway will be the default mode of Medicare participation in the future, and is a heavily modified form of the current FFS system. Within MIPS, FFS payments will be adjusted for weighted performance in 4 categories (figure 1): Quality, Advancing Care Information (ACI, which replaces the prior Meaningful Use [MU] program), Clinical Practice Improvement Activities (CPIAs), and Resource Use (RU, or cost of care).

The Quality category in MIPS will be similar to the current Physician Quality Reporting System (PQRS) program, in which quality is determined by performance on selected quality measures. Quality measures will include clinical outcome measures, patient-reported outcomes, and measures of appropriate resource use. Performance in the Quality category will comprise 50% of the overall MIPS score and may decrease over time.

The ACI category in MIPS replaces and will resemble the current MU program. Performance in ACI will account for 25% of the MIPS score.

Figure 1 Merit-Based Incentive Payment System (MIPS) performance categories

This chart summarizes the degree to which the various elements of MIPS will contribute to participants' overall MIPS performance scores in the first year of the program.

Broadly defined, APMs are quality- and cost-based payment models in which the provider accepts “more than nominal financial risk” for poor quality performance.

The CPIA category will feel similar to other programs neurologists have encountered, such as Maintenance of Certification Part IV and other practice improvement programs. CPIA performance will comprise 15% of the MIPS score.

The RU category will be similar to the existing Value-Based Payment Modifier (VBPM) program. Costs of services provided will be determined in this category. RU performance will represent 10% of the overall MIPS score and may increase over time.

Weighted performance on the 4 categories in MIPS will be used to calculate a composite score for each reporting provider (or group, if group reporting is used) ranging from 0 to 100. Payment adjustments will begin in 2019 (based on 2017 performance), ranging from +4% bonuses to −4% penalties (table 1). Between 2019 and 2022, the range of potential bonuses and penalties will widen to $\pm 9\%$ (figure 2). In the payment year, the bonus or penalty will be applied equally to all Medicare provider payments during the year. After 2026, MIPS participants will receive an annual 0.25% CF update in addition to their MIPS payment adjustment.

APM pathway

Neurologists and other providers may choose to participate in the APM pathway rather than MIPS. Broadly defined, APMs are quality- and cost-based payment models in which the provider accepts “more than nominal financial risk” for poor quality performance. APMs will also be required to use accepted electronic health record technology. Current APMs include accountable care organizations, patient-centered medical homes, and payments for bundled episodes of care. In their current form, most existing APMs will not satisfy MACRA requirements for 2-sided risk and will likely evolve to meet those standards.

Table 1 Payment adjustments in Medicare Access and Children’s Health Insurance Program Reauthorization Act of 2015 (MACRA)

MACRA participation pathway	2019	2020	2021	2022-2024	2025	2026 and beyond
MIPS pathway, %						
Annual MIPS conversion factor update	0.5	0	0	0	0	0.25
MIPS adjustment factor	−4 to +4 ^a	−5 to +5 ^a	−7 to +7 ^a	−9 to +9 ^a	−9 to 9	−9 to +9
APM pathway, %						
Annual APM conversion factor update	0.5	0	0	0	0	0.75
APM bonus	5 ^b	5 ^b	5 ^b	5 ^b	0	0
Required % Medicare revenue from APM	25	25	50 ^c	50–75 ^c	75 ^c	75 ^c

Abbreviations: APM = Alternative Payment Model; MIPS = Merit-Based Incentive Payment System.

^aDoes not include potential additional bonuses for some high-performing providers. Penalties may not exceed indicated amount.

^bDoes not include bonuses or penalties inherent to the provider’s APM. Bonuses are distributed to the APM entity, and individual providers may receive different amounts.

^cAPM revenue from all payers may qualify if 25% is from Medicare.

Figure 2 Medicare Access and Children's Health Insurance Program Reauthorization Act of 2015 (MACRA) risk corridor

This graph summarizes the potential bonuses and penalties associated with both MACRA participation options, the Merit-Based Incentive Payment System (MIPS) (blue lines) and Alternative Payment Model (APM) (green lines) pathways. After MACRA begins in 2019, the range of bonuses and penalties expands in MIPS, while the APM pathway will provide bonuses from 2019 to 2024. After 2026, each pathway will have separate annual conversion factor (CF) updates (dotted lines). MU = Meaningful Use; PQRS = Physician Quality Reporting System; VBPM = Value-Based Payment Modifier.

There is acknowledgement in MACRA that there are insufficient APM options for most specialists, including neurologists. In late 2015, the newly formed Physician-Focused Payment Model Technical Advisory Committee was charged with recommending new specialty-relevant APM models to CMS. The American Academy of Neurology (AAN) is now developing APMs that will support neurology practices. For example, a neurology-focused APM could consist of a bundled episode of care including all physician visits, phone calls, and EEG testing during the first 6 months of diagnosis and therapy for a new patient with epilepsy. If the protocol is cost-efficient, then the physician and medical plan might share the savings in some proportion. If the care is more expensive than anticipated, then the physician might suffer a loss. The overall success or failure of new payment models will depend largely on CMS's ability to solve the challenges of risk adjustment, attribution of patient outcomes, and other technical factors.

CMS plans an annual 5% bonus payment from 2019 to 2024 for APM entities that receive a substantial portion of their revenue through the APM (table 1). Practices that participate in APMs but fall short of the stated revenue thresholds will be subject to the MIPS program, but will receive favorable scoring on the CPIA portion of the total MIPS performance score. Practices will be subject to separate performance-based bonuses or penalties built into the APM itself, which need to be considered before opting for the APM pathway. After 2026, APM participants will receive a 0.75% annual CF increase, compared to the 0.25% adjustment for MIPS participants.

Lingering uncertainties in MACRA implementation

MACRA is an extensive law in terms of size and scope, and many details regarding its implementation have yet to be clarified. CMS has discretion to make specific determinations on more than 300 elements of the law. The CMS proposed rule for MACRA implementation was released in April 2016, with a final rule anticipated in late 2016. Since 2017 performance

will be used to determine 2019 MIPS payment adjustments, there will be a very short interval between the release of the final rule and when the effect of the law will begin to directly influence neurologists. There remain many uncertainties, which will be clarified over time, in how CMS will calculate the fundamental variables of the value equation: how neurologists are measured on the quality and cost of the care they provide.

Table 2 How should a neurologist prepare for Medicare Access and Children's Health Insurance Program Reauthorization Act of 2015 (MACRA)?

	Action items	Outcome
2016	Continue participation in PQRS (or prepare for implementation in 2017)	2016 PQRS, MU, and VBPM adjustments will be applied in 2018
	Meaningfully use your EHR (or consider steps needed for EHR adoption)	
	Access and understand your Quality and Resource Use Report scores	
	Identify gaps	
	Develop improvement plans	
	Investigate APM and advanced APM options in your community	
	Understand the final MACRA regulations (expected by November 1)	
	Consider implementation of practices to help MIPS scores (e.g., clinical data registry participation, use of telemedicine, or systematic quality improvement initiatives)	
2017	Start of first MACRA performance period	2017 MIPS performance will determine the payment adjustment ($\pm 4\%$) in 2019
	Report under PQRS, MU/ACI, and new CPIAs if you are not in an advanced APM	Qualifying APM participants are exempt from MIPS adjustments and are eligible for 5% bonus in 2019
	Review the new CMS feedback report on July 1	
	To qualify as an advanced APM participant, 25% of Medicare payments must be from an APM	
2018	Report under PQRS, MU/ACI, and new CPIAs if you are not in an advanced APM	2018 MIPS performance will determine the payment adjustment ($\pm 5\%$) in 2020
	Review all CMS feedback reports	Qualifying APM participants are exempt from MIPS adjustments and are eligible for 5% bonus in 2020
	To qualify as an advanced APM participant, 25% of Medicare payments must be from an APM	
	PQRS, MU, VBPM officially sunset at the end of 2018	
2019	Fully participate in MIPS if you are not in an advanced APM	2019 MIPS performance will determine the payment adjustment ($\pm 7\%$) in 2021
	To qualify as an advanced APM participant, 50% of Medicare payments must be from APM	Qualifying APM participants are exempt from MIPS adjustments and are eligible for 5% bonus in 2021
2020	Fully participate in MIPS if you are not in an advanced APM	2020 MIPS performance will determine the payment adjustment ($\pm 9\%$) in 2022
	To qualify as an advanced APM participant, 50% of Medicare payments must be from APM	Qualifying APM participants are exempt from MIPS adjustments and are eligible for 5% bonus in 2022

Abbreviations: ACI = Advancing Care Information; APM = Alternative Payment Model; CMS = Centers for Medicare and Medicaid Services; CPIA = Clinical Practice Improvement Activity; EHR = electronic health record; MIPS = Merit-Based Incentive Payment System; MU = Meaningful Use; PQRS = Physician Quality Reporting System; VBPM = Value-Based Payment Modifier.

What should neurologists do now?

Neurologists will need to decide which MACRA pathway to pursue, MIPS or APMs, based on their individual practice and local market characteristics (see table 2 for an action-oriented MACRA preparation timeline). Many practices that have the option may pursue APM participation given the temporary 5% bonus and higher CF after 2026. However, the MACRA proposed rule released in April 2016 defines qualifying APMs narrowly, and it seems very likely that the large majority of neurologists and other providers will participate in MACRA through the MIPS pathway early on. Practices should examine their options locally to see if available models suit their practice. Many existing APMs are not structured in a way to allow participating neurologists to receive the benefit of current or future APM incentives, so it will be critical for neurologists to watch for new, forthcoming APMs that may better suit their practice. Two important variables to consider with APMs will be (1) the inherent performance bonus/penalty structure of the APM and (2) how the APM entity will allocate its 5% CMS bonus to participants.

While current programs such as PQRS, VBPM, and MU will technically sunset with the start of MACRA, neurologists should strongly consider participating in these programs now for 2 important reasons. First, penalties for failing to participate in these programs will continue to increase until 2019, up to about 10% of Medicare payments. Second, the structures employed in these programs will likely be very similar to MIPS components and certain features of APMs, and participation will be good preparation for the future regardless of each neurologist's chosen MACRA pathway. These potential benefits for practices may outweigh the considerable costs of program participation, which disproportionately fall on small practices.

Finally, participation in a qualified clinical data registry (QCDR) will offer many advantages in the MACRA era, including greater ease of practice quality measurement, reporting to CMS, and more favorable scoring on some elements of MIPS.⁵ The Axon Registry currently in development by the AAN received QCDR approval from CMS in April 2016.

CONCLUSIONS

In terms of payment for health care services, MACRA is the most important piece of legislation in decades and will have an enormous effect on health care delivery and payment for the foreseeable future. The shift from simple FFS models to value-based care will require that we fundamentally reorganize how we deliver care. MACRA is coming soon, and neurologists need to prepare now to ensure their practices remain viable in the era of value-based payment models.

REFERENCES

1. Emanuel EJ, Fuchs VR. The perfect storm of overutilization. *JAMA* 2008;299:2789–2791.
2. Martin AB, Hartman M, Benson J, Catlin A. National health spending in 2014: faster growth driven by coverage expansion and prescription drug spending. *Health Aff* 2016;35:150–160.
3. Burwell SM. Setting value-based payment goals: HHS efforts to improve U.S. health care. *N Engl J Med* 2015;372:897–899.
4. H.R. 2—114th Congress: Medicare Access and CHIP Reauthorization Act of 2015.
5. Sigsbee B, Bever CT Jr, Jones LK Jr. Practice improvement requires more than guidelines and quality measures. *Neurology* 2016;86:188–193.

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AUTHOR CONTRIBUTIONS

L.K. Jones: design/conceptualization of the study, analysis or interpretation of the data, drafting/revising the manuscript for intellectual content. M. Raphaelson: analysis or interpretation of the data, drafting/revising the manuscript for intellectual content. A. Becker: design/conceptualization of the study, analysis or interpretation of the data, drafting/revising the manuscript for intellectual content. A. Kaloides: design/conceptualization of the study, analysis or interpretation of the data, drafting/revising the manuscript for intellectual content. E. Scharf: analysis or interpretation of the data, drafting/revising the manuscript for intellectual content.

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