Ready, Set, Go: Helping Physicians Move to Value as MACRA Begins

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Passed with the broad bipartisan support of Congress in 2015, the Medicare Access and CHIP Reauthorization Act (MACRA) will bring about comprehensive changes to how Medicare pays for physician services. MACRA aims to accelerate the transformation from fee-for-service payment to alternative payment models that require physicians to assume risk for the cost and quality of care. Given the nation’s unsustainable healthcare costs, MACRA is expected to survive regardless of the outcome of the November presidential and congressional elections.

MACRA is critically important legislation for all providers, not just physicians. This column addresses implications and challenges for hospitals and health systems and complements an earlier column by Bosko and Hawkins (2016) that examined implications for physicians and physician groups.

A CATALYST FOR MOVING PHYSICIANS TO VALUE
Replacing the long-contentious Sustainable Growth Rate formula, MACRA rewards physicians for providing value-based care through a two-track framework: The advanced alternative payment model (APM) track incentivizes providers who are taking risk on the basis of the quality and cost of care for particular episodes or defined patient populations and requires use of certified electronic health record (EHR) technology. The Merit-Based Incentive Payment System (MIPS) track is based on the fee-for-service model but is more directly and rigorously tied to performance in four areas: quality, resource use, advancing care information (use of EHRs), and clinical practice improvement.

For most physicians participating in the Medicare program, inclusion in one of the two tracks is mandatory; those who do not select the advanced APMs track will be default participants in MIPS. Implications for both tracks begin imminently; performance reporting by physicians starts January 1, 2017, for payment 2 years later, in 2019. Based on feedback received and to allow physicians time to obtain help and experience before the program affects them, the Centers for Medicare & Medicaid Services (CMS) may consider postponing implementation of portions of MACRA or shortening the reporting periods; but even with these possible changes, the time for physician and hospital and health system leadership teams to prepare is now.
The MIPS track is revenue neutral, so there will be winners and losers. MIPS payment adjustment of up to 9%, plus or minus, is making small practices feel vulnerable, as indeed CMS projects to be the case: Buried in a table on page 215 of the 426-page proposed rule as published in the Federal Register (CMS, 2016), CMS’s estimation is that 87% of eligible clinicians currently in solo practices and nearly 70% in practices with two to nine clinicians will experience a negative adjustment in payment beginning in 2019. In contrast, 81% of clinicians in practices with more than 100 clinicians are expected to experience a positive adjustment in payment (Table 1).

The stakes are high for those who participate in the APM track, which offers physicians and physician groups a 5% incentive payment through 2024. To qualify as an advanced APM, physicians and physician groups must meet financial standards for bearing risk for monetary losses, as well as eligibility thresholds based on Medicare volume or payment standards. The requirements as outlined by CMS are complex (CMS, n.d.), but the aim is clear: to ensure that qualifying APMs assume “more than a nominal amount of risk”—i.e., significant downside risk—for monetary losses under value-based payment contracts.

CMS anticipates that these six models will qualify as advanced APMs in 2017 (Quality Payment Program, n.d.): Comprehensive ESRD Care (CEC)—two-sided risk; Comprehensive Primary Care Plus (CPC+); Next Generation ACO Model; Shared Savings Program—Track 2; Shared Savings Program—Track 3; and Oncology Care Model—two-sided risk. Additional models, such as a new voluntary bundled payment program, a new Medicare ACO+ track, and an amended Comprehensive Care for Joint Replacement (CJR) model, are being evaluated for possible inclusion in 2018 or later years. Medicare Advantage plans, which now cover one in five Medicare beneficiaries, do not qualify as a stand-alone advanced APM.

### Assistance for Physicians

Physician practices will find it difficult to make the investments needed for either of MACRA’s participation tracks without aligning with an entity that has

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**TABLE 1**

<table>
<thead>
<tr>
<th>Practice Size</th>
<th>No. of Eligible Clinicians</th>
<th>Eligible Clinicians With Negative Adjustment, %</th>
<th>Eligible Clinicians With Positive Adjustment, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solo</td>
<td>102,788</td>
<td>87.0</td>
<td>12.9</td>
</tr>
<tr>
<td>2–9 Eligible Clinicians</td>
<td>123,695</td>
<td>69.9</td>
<td>29.8</td>
</tr>
<tr>
<td>10–24 Eligible Clinicians</td>
<td>81,207</td>
<td>59.4</td>
<td>40.3</td>
</tr>
<tr>
<td>25–99 Eligible Clinicians</td>
<td>147,976</td>
<td>44.9</td>
<td>54.5</td>
</tr>
<tr>
<td>≥100 Eligible Clinicians</td>
<td>305,676</td>
<td>18.3</td>
<td>81.3</td>
</tr>
</tbody>
</table>

*Source: Selected data from Table 64 of MACRA proposed rule 42 CFR Parts 414 and 495 (CMS, 2016).*
risk-contracting capabilities and experience, (2) the infrastructure required for performance reporting under risk-bearing arrangements, and (3) the leadership to truly transform the way care is delivered. For the financial viability of their practices, physicians likely will need to partner with larger organizations that have risk contracts for managing the health of defined populations in the community.

Consequently, MACRA can be expected to accelerate the ongoing shift of physicians into large practices and employment by hospitals and health systems. A recent report projects that only 33% of U.S. physicians will remain independent by the end of 2016, a decline from 57% in 2000 (Accenture, 2015). A survey of 1,300 independent physician groups with five or fewer clinicians indicates that 67% of such practices believe their independence will end with MACRA (HealthLeaders Media, 2016). Hospital and physician leaders will need to work together closely to meet MACRA’s value requirements. If your hospital is not prepared to do this, who is?

A Pluralistic Approach

Because physicians have differing needs and their readiness to participate in value-based care delivery and payment may vary, we recommend a multifaceted approach to helping them. Hospital, physician, and health system leaders should consider the following four strategies and related tactical challenges.

**Strategy 1: Invest Further in Physician Practices to Expand the Referral Network, Particularly for Outpatient Care**

In recent years, hospitals have been employing an increasing number of physicians. More than 25% of active medical staff were employed in 2014, up from 22% in 2012, with higher employment levels in the Midwest (33%) and Northeast (30%) than in the South (19%) and West (17%) (Moody’s Investors Service, 2015).

Further investment will bring challenges, including identifying those practices that the organization wishes to acquire, allocating scarce capital to purchase the practices, integrating the newly employed physicians and midlevel clinicians, and sustaining at least initial operating losses. Such losses could include bearing the cost of implementing and complying with MIPS reporting requirements as well as possible adverse payment adjustments (American Hospital Association, 2016). Effective and strong physician leaders and physician quality committees will need to work closely with hospital and health system leaders.

To align employed physicians with organizational cost and quality goals for MACRA participation, hospital leaders should focus on rightsizing the hospital’s delivery network and employed medical groups, building and maintaining a sustainable compensation program for all employed physicians, enhancing the revenue cycle, increasing use of midlevel providers, and implementing a common technology platform (Pizzo, Sullivan, & Ryan, 2015).

A sustainable compensation program in the MACRA environment starts to shift the balance of volume-based productivity measures toward value metrics, such as...
efficiency metrics (e.g., reducing avoidable high-end imaging, emergency department visits, admissions, and readmissions), and applies uniform compensation standards and metrics across physicians, locations, and specialties.

**Strategy 2: Offer Physicians an Advanced APM Model by Building or Purchasing the Capabilities and Infrastructure Required to Assume Risk Contracts With Managed Lives and a Provider Network**

Although some organizations have made major strides in risk contracting, most organizations are in the early stages of building capabilities and infrastructure, and they are not sure how quickly they can or want to enter into risk arrangements.

Hospital and system leadership teams should understand that downside risk is a must with MACRA; upside-only contracts do not qualify for the advanced APM track. MACRA’s long-term goal is to move all providers to advanced APMs. Through advanced APMs, providers will assume downside risk for not meeting targeted population health measures, for not meeting quality standards, and for costs above expenditure targets.

All hospitals and health systems will want to ensure that they can address the risks of the chosen APM contracting plan. These include strategic and operating risks (e.g., compliance of network partners) and actuarial and insurance risk (e.g., the ability to meet capital reserve requirements of specific contracts). Also important is the ability to meet financial risks related to capital commitments to build physician networks, enhance technology, and develop care management and evidence-based practice infrastructure.

**Strategy 3: Develop and Implement a Plan for Independent Medical Staff, Including Support for MIPS Compliance, an Effective Clinically Integrated Network (CIN), and an Advanced APM**

For the approximately 75% of active medical staff who are not employed, one key strategy that hospital and system leaders should consider is providing support for MIPS compliance. Such support may include care coordination services and evidence-based clinical pathways that help clinicians meet MIPS metrics, or information technology services such as EHRs and tools that organize data and provide meaningful analytics to drive performance improvement and reporting.

Offering participation in a CIN is another important strategy. CINs are organizations established by hospitals to develop, measure, and incentivize both the hospital and physicians to reduce costs, improve outcomes, and manage a population’s health (Moody’s Investors Service, 2015). CINs offer a solid construct for hospitals to align with both employed and independent physicians for MIPS and advanced APMs through value arrangements such as ACOs and PCMHs. Physicians can and will organize around high-quality care, especially if they are given accurate data. In addition, contracting entities can offer independent physicians such traditional benefits as insurance, billing and collection services, group purchasing, and EHRs.
**Strategy 4: Implement Specific Performance Requirements for All Clinicians Participating in the Network**

Organizations should work with their employed and affiliated physicians to identify the metrics most suitable to the organization’s care delivery and payment goals for both MIPS and advanced APMs, and they should then focus on achieving success with these metrics. Doing so is particularly important for quality metrics because quality represents 50% of providers’ MIPS scores in 2019. MIPS combines performance requirement metrics from three physician reporting programs—the Physician Quality Reporting System, Value-Based Payment Modifier, and Meaningful Use—and offers a choice of quality and clinical practice improvement reporting metrics for providers.

When contracting with payers under advanced APMs, the hospital’s or health system’s CINs should seek to establish incentive payment distribution methodologies that maximize physician cooperation and incentive earnings. Physician quality committees are in the best position to select—on the basis of transparent data—the reporting metrics and targets that clinicians must meet to receive incentive payments.

Hospital and physician leadership teams must ensure that the entities under their direction develop the ability to measure and grade clinician performance. Using a data-driven approach will be critically important to persuade physicians to reduce unwarranted care variation, which is a significant cause of suboptimal patient outcomes and unnecessarily high costs. Physicians who receive reliable data showing unwarranted variation in their own practice—whether related to quality, outcomes, or costs—typically need no further inducement to bring their practices in line with those of their colleagues. However, if they do not, leaders must be willing to exclude or remove clinicians who fall short of the organization’s performance requirements.

**ORGANIZATIONAL READINESS FOR MACRA**

How prepared is your organization to help physicians with MACRA? To assess readiness, hospital and system leaders must ask their management and governance teams six questions:

1. How do you envision helping your independent physicians prepare for MACRA?
2. What alignment strategies are you pursuing with affiliated physicians?
3. How effectively do you work with physician leaders?
4. What steps are you taking toward offering physicians an advanced APM?
5. What investments will be needed to fund MACRA readiness and alignment strategies?
6. Do you have the necessary financial resources to compete for physicians, and, if not, what partnerships or other relationships might be necessary?

While CMS might delay implementation of pieces of the MACRA rule, the march toward value-based payment arrangements, as directed by MACRA, is inevitable.
Organizations whose leadership is proactive in helping physicians meet MACRA’s requirements will be in a better position for success.

REFERENCES
Quality Payment Program. (n.d.). What are alternative payment models (APMs)? Retrieved from https://qpp.cms.gov/learn/apms

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