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MACRA: Key considerations for health plans

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The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)[1] represents a tectonic shift in how providers are reimbursed for the services they provide to Medicare fee-for-service (FFS) beneficiaries. While on the surface this may seem like it has little to do with health plans in the commercial, Medicare Advantage, or Medicaid space, in reality MACRA has broad and wide-ranging implications for other payers. Furthermore, with MACRA implementation starting on January 1, 2017, payers need to understand how this soon-to-be implemented law will impact the market.

Q: How does MACRA affect providers?

MACRA will have a major impact on the way most providers will be reimbursed for the care provided under Medicare Part B.

- MACRA permanently repeals the Sustainable Growth Rate (SGR).
- Under MACRA, Part B reimbursement will be adjusted. An eligible clinician[2] will see his or her Medicare reimbursement adjusted under one of the three following options.

FIGURE 1: OPTIONS FOR MEDICARE FFS REIMBURSEMENT ADJUSTMENT UNDER MACRA

MIPS	PARTIAL QUALIFYING PARTICIPANT	QUALIFYING PARTICIPANT
▪ Merit-based Incentive Payment System (MIPS) Adjustment to fee schedule (either positive or negative) ▪ Reimbursement through Advanced APMs does not meet threshold	▪ May choose MIPS adjustment or no adjustment to reimbursement ▪ Reimbursement through Advanced APMs meets Partial QP threshold, but falls short of full QP status	▪ 5% lump sum bonus payment ▪ Reimbursement through Advanced APMs meets threshold

- There will be no physician fee schedule updates from 2020 to 2025.[3] Prior to any reimbursement adjustment, this may strain the budget of providers. When fee schedule updates resume in 2026, they will be higher for Qualifying Participants (QPs).

The MIPS adjustment will vary by year, starting with a transition year in 2019 (allowing providers to choose between various levels of participation), full implementation for the 2020 payment year, and increasing to a reimbursement adjustment of -9% to +9% in 2022 onward (actual positive MIPS adjustment will vary to target budget neutrality). While the adjustment is designed to be cost-neutral (and some providers will benefit from the MIPS adjustment) certainly the prospect of a downward adjustment to fees makes the certainty of QP status and the associated bonus all the more attractive. Providers who are not yet in a position to take on the two-sided risk that is a precursor to QP status will want to achieve a positive outcome by focusing on increasing their MIPS adjustment.

Q: Why is QP so desirable, yet so challenging to achieve?

It will be quite difficult to achieve the QP status. To be classified as a QP, two conditions must be met:

1. The eligible clinician must be associated with an *Advanced Alternative Payment Model* (APM). For now, this is limited to a small list of Centers for Medicare and Medicaid Services (CMS) programs that involve two-sided financial risk (among other requirements).
2. The Advanced APM must have a certain percentage of reimbursement or patient counts associated with the attributed members of the Advanced APM. For example, for a Medicare accountable care organization (ACO), the numerator of this ratio might be the Part B reimbursement for attributed members, while the denominator is the Part B reimbursement for all attribution-eligible members.

For 2019, the claim dollar threshold for QP status is 25%, while the patient count threshold is 20%. However, these thresholds increase precipitously in later years. Both because there are relatively few Advanced APMs and the additional criteria

1 You can access the full text of the MACRA draft rule at the Federal Register. https://www.federalregister.gov/articles/2016/05/09/2016-10032/medicare-program-merit-based-incentive-payment-system-mips-and-alternative-payment-model-apm

2 There are exceptions for certain types of providers. Please see the draft rule for more detail.

3 Fee schedule updates will continue from now until 2019.

for QP status are challenging, we expect that there will be relatively few QPs, especially in the early years of MACRA implementation. Furthermore, because Advanced APMs will be trying to meet the twin objectives of achieving shared savings and maintaining QP status, we expect these entities will carefully prune their networks to include providers whose practice patterns promote both organizational goals. Therefore, we expect that providers will be invited to join an Advanced APM rather than being able to elect to be included.

Q: What opportunities might MACRA provide for a health plan?

QP status (and the associated 5% bonus[4]) may be seen as highly desirable. However, in 2023 and beyond, it may prove to be difficult for Advanced APMs to meet the required thresholds through Medicare FFS reimbursement alone.

In 2021 and beyond, QP status can also be obtained through an "All-Payer" option:

- Twenty percent to 25% of patient reimbursement or patient counts must be associated with *Medicare fee-for-service*-attributed members of the Advanced APM.
- Thirty-five percent to 75% of patient reimbursement or patient counts must be associated with *any attributed members of the Advanced APM*, including those associated with payments from commercial payers, Medicare Advantage (MA) plans, or Medicaid managed care organizations (MCOs).

Hospitals and provider organizations will actively seek out risk-sharing arrangements with commercial, MA, and Medicaid plans. Many health plans are already building these arrangements with providers, and MACRA will provide further leverage for the health plan and incentive for the providers to participate.

Q: For a health plan, what are the challenges associated with MACRA?

Providers will not see a fee schedule increase for Part B services from 2020 to 2025. The cumulative effect over this period will be substantial and may put a strain on providers' budgets. In addition to the lack of fee schedule increase, roughly half of providers subject to MIPS will have a negative adjustment.

The next effect is that there may be pressure to shift costs to other payers. This may make contract negotiations for health plans more challenging and may result in increased unit-cost trends. This will be especially true for payers with less negotiating leverage in the marketplace. On the other hand, payers who can continue to index their reimbursement to Medicare may well benefit from the lack of a fee schedule update.

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4 The 5% bonus is available 2019 – 2024.

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