Workers' Comp

The Compliance Corner: Understanding MACRA in the P&C Industry: Medicare Access and CHIP Reauthorization Act of 2015

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A change is in the wind, or more like a tornado, when it comes to new healthcare reforms, particularly on the payment side. In 2019, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) will be introduced requiring new quality measurements. In a “be careful what you wish for” scenario, MACRA was put in place after physician groups pushed back on the Sustainable Growth Rate (SGR) formula which lowered payments from Medicare to physicians.

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Since the SGR method of paying physicians is being eliminated, MACRA will be implementing a new payment framework that is based on the quality of care provided to a patient rather than the quantity of care. MACRA consists of two separate payment programs; Merit Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs). As if we didn’t need more acronyms, these programs are loaded with new definitions and more acronyms that will eventually roll off the tongue as part of the new health world terminology in the United States.

Some definitions before moving on to how the components of MACRA are combined. They are:

- **Physician Quality Reporting System (PQRS)** — A reporting system developed by the Center for Medicare/Medicaid Services (CMS) to encourage physicians/practices to report quality. This reporting

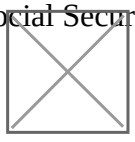
allows providers to quantify how often they are meeting quality metrics. Starting in 2015, providers who did not report these metrics were paid less than those that did through the fee for service schedule (CMS, 2016).

- **Value Modifier (VM or Value-based Payment Modifier)** — This modifier is an indicator to CMS the physician/practices quality of care rating during a performance period of reporting PQRS. This modifier indicates adjustments to payments made to the providers who perform under the Medicare Physician Fee Schedule (PFS). This modifier is connected to the provider's Tax Identification Number (TIN) to be applied to individual physicians and practices (CMS, 2016). This program was being phased in starting in 2015. In 2017, the adjustment will apply to solo practitioners and physicians in groups of two or more and, in 2018, all physicians will be included with the addition of physician assistants, nurse practitioners, clinical nurse specialists and certified registered nurse anesthetists who are solo or in groups of two or more. The performance is rated on what occurred for these providers going back two years (CMS, 2016).
- **Medicare Electronic Health Record (EHR)** — Requirements were established for the capture of clinical data which included providing patients with EHRs. In the second phase, the quality improvement was focused on the point of care and the exchange of information (CMS, 2016). The incentive programs were established as part of the American Recovery and Reinvestment Act of 2009 (ARRA) enacted Feb. 17, 2009.
- **Eligible Professionals (EPs)** — Applies to individual EPs, groups of EPs or virtual groups. The provider types these new quality programs apply to are: physicians, physician assistants, certified registered nurse anesthetists, nurse practitioners, clinical nurse specialists and groups that include these professionals. After 2021 the CMS can add additional EPs. Those that are excluded are qualifying Alternative Payment Model (APM) participants; partial qualifying APM participants; and low volume threshold exclusions (CMS, 2015).

The first model is the MIPS model which combines the PQRS, VM and EHR incentive programs into one single program for the EPs effective in 2019. The measurements will consist of quality, resource use, clinical practice improvements and use of EHR technology. The second model is the APM which from 2019–2024 may pay some participating health care providers one lump sum based on either the covered life or case type (e.g., hip replacement). These lump sum models are intriguing for P&C when we conceptualize the course of care for a workers' compensation injury or auto accident and the possibilities of moving away from fee for service. This is the main reason we are keeping track of these new models as they can be "bell weathers" for future payments through the healthcare continuum.

The American Medical Association (AMA) has been involved in encouraging physicians who are willing to spend the time to develop APMs and work with the system. In addition, they are supporting:

- Identifying opportunities to remove barriers in our existing payment systems in the performance of quality of care
- Identifying unintended consequences of APMs and monitoring the performance
- Maintaining a vigilant and constant attention to realizing the benefits to patients
- Focusing on improving care outcomes for patients, while at the same time achieving savings for payers (AMA, 2016)

Lastly, the payment models and initiatives for quality of care, MACRA contains the "Social Security Number Removal Initiative". This initiative requires SSNs be removed from all Medicare cards.  So what does this really mean for P&C medical payments? To understand that, we simply need to look at how Medicare

affected P&C with just a fee schedule. If we think that value based healthcare is the silver bullet in the payment of medical payments, we need to think again. We still have state laws to contend with and adoption of models and policies. P&C is risky business, not likely where we will attempt to try these new models until we can understand the benefit. Providers are consolidating, physicians are retiring at higher numbers and they're really not that enthusiastic for these changes, according to the 2016 Survey of America's Physicians: Practice Patterns and Perspectives which surveyed over 17,236 physicians (The Physicians Foundation by Merritt Hawkins, 2016). These new models could affect change in P&C specifically in negotiating BI claims. As we did with fee schedule adoption in P&C, the results of the new models will need to be evaluated over time.

References

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