

# The Health Care Payment Revolution

PART 1: The Health Care Payment Revolution

PART 2: Medicare's new direction brings physicians to a crossroad

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**FMA**  
FLORIDA MEDICAL ASSOCIATION





# The Health Care Payment Revolution *Part 1*

By Jarrod Fowler, M.H.A., in conjunction with the FMA Task Force on Alternative Payment Models

The U.S. health care system is in the midst of a revolution. The way providers are being reimbursed is changing, and physicians who aren't already familiar with what's happening now and what's to come run the risk of being overwhelmed or missing opportunities to earn substantial monetary incentives.

The FMA will provide members with a series of articles, starting with this one, that will explain the evolving landscape and provide insight into how to effectively respond.

This article is an overview of the issue that will serve as a starting point for more in-depth discussions.

## **In the broadest terms possible, what's happening?**

Fee-for-service, historically the dominant health care reimbursement modality throughout the United States, is quickly being replaced by “value-based” payment models. These new models, which are being developed with the intent to control health care costs without sacrificing quality, are called Alternative Payment Models (APMs). Both private and governmental payors are rapidly moving in this direction. In fact, a recent AMA survey found that 59 percent of physicians worked in practices that received payment from one or more APMs in 2014. While this doesn't mean that fee-for-service payments are likely to disappear any time soon, it is clear that the reimbursement landscape is rapidly changing, and there is every reason to believe that this trend will accelerate.

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### Why is payment reform occurring?

The impetus for payment reform isn't a mystery. Policy makers, businesses and commercial payors are under tremendous pressure to control health care costs, and experimenting with APMs is viewed as one of the few potentially viable options. That's because APMs can theoretically control health care costs without sacrificing quality. If this theory holds true, APMs may be practical, palatable and sustainable in a way that across-the-board spending cuts aren't.

To get an understanding of why the perceived need to control health care costs has come to a head, take a look at some statistics.

- In 2015, workers contributed an average of \$4,955 in premiums toward employer-sponsored family health insurance policies. Employers paid an additional \$12,591, bringing the total average total premium expense of employer-sponsored family coverage to \$17,545. This represents a 61-percent increase since 2005, when the total premium expense of employer-sponsored family coverage was a "mere" \$10,880. This amount does not include the additional out-of-pocket costs incurred by those who actually used their health insurance.
- Even employer-sponsored high deductible health plans (HDHP), which have gained considerable popularity in recent years, can come with high premiums. The average HDHP family premium was \$15,970 in 2015, including an average worker contribution of \$3,917.
- This trend is hardly new. Since 1999, premiums for employer-sponsored family health insurance have soared 203 percent. Worker contributions toward premiums have increased by 221 percent, and earnings have grown by a comparatively meager 56 percent.
- Major health care programs, including Medicare, are one of the largest, fastest growing components of the federal budget. According to the Congressional Budget Office, federal outlays on major health care programs grew from just over 3 percent of GDP in the year 2000 to 5.2 percent of GDP in 2015. By 2026, spending on major health care programs is expected to reach

6.6 percent of GDP. To provide some dollar figures, the net federal cost of the Medicare and Medicaid programs is projected to be \$891 billion in fiscal year 2015. Exchange subsidies are expected to cost an additional \$37 billion, and CHIP an additional \$9 billion. The CBO also projects that a higher-than-expected growth rate in federal health care spending would substantially increase long-term federal debt. This has created an enormous incentive for U.S. policy makers to "bend the health care cost curve." Even modest reductions in health care spending can free up billions.

### Will APMs be effective?

Even the most fervent supporters of payment reform don't tout APMs as a magic bullet. The long-term effectiveness of APMs has yet to be established, and the overall success of this experiment is not guaranteed. Needless to say, APMs won't fix the underlying structure of the U.S. health care system.

However, again, the prevailing theory among policy makers, businesses and commercial payers is that APMs can make a positive impact. And, as the paragraphs below illustrate, these stakeholders have literally bet billions on this theory.

### HHS: Alternative payment models are the program's future

The Department of Health and Human Services (HHS) recently stated that around 20 percent of all Medicare payments are now made through APMs such as ACOs and bundled payment arrangements, up from almost nothing in 2011. HHS has set a goal of tying 30 percent of Medicare payments to APMs by the end of 2016, and is aiming for 50 percent by the end of 2018. For perspective, in 2014, HHS made \$362 billion in Medicare fee-for-service payments.

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### Commercial payors have embraced payment reform

According to the Catalyst for Payment Reform's 2014 National Scorecard, 40 percent of all commercial in-network payments (in dollars) are now "value-oriented" payments that are "either tied to performance or designed to cut waste." Examples include bundled payments, shared-savings arrangements, shared-risk arrangements and fee-for-service-based pay-for-performance arrangements.

The scorecard also found that 15 percent of commercial health plan members are now attributed to providers who are participating in ACOs, patient-centered medical homes or other delivery models that attribute patients to a provider.

The Catalyst for Payment Reform's National Scorecard is one of many reports illustrating the huge shift away from the traditional fee-for-service environment.

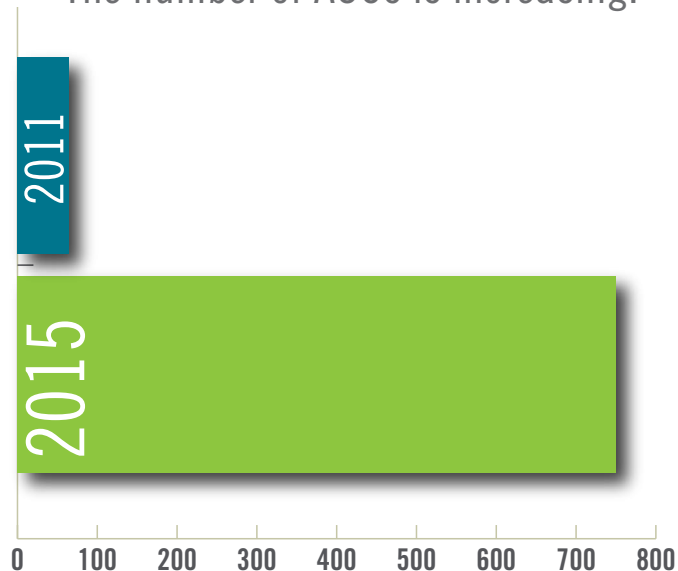
For example, a recent report from the Blue Cross Blue Shield Association (BCBSA) found that one of every five dollars spent by its members is now tied to some type of value-based payment arrangement. That adds up to \$71 billion in claims. The report also highlighted several success stories, including patient-centered medical home programs that have reportedly saved hundreds of millions of dollars while improving quality.

In another report attempting to quantify the impact of this trend, the consulting firm Leavitt Partners found that Cigna, Aetna, Humana, United Healthcare and the BCBSA have collectively established value-based payment arrangements that encompass over 2,000 contracts, more than \$110 billion in payments and close to 40 million covered lives. Leavitt Partners also found that 37 percent of mid and large-sized employers consider APMs to be a "very important" consideration when selecting health plan vendors, and another 40 percent consider it "somewhat important".

### ACOs are everywhere

ACOs are proliferating and growing at an astounding rate. Leavitt Partners estimates there were a mere 64 ACOs nationwide in early 2011. As of late 2015, their latest figures show that

The number of ACOs is increasing.

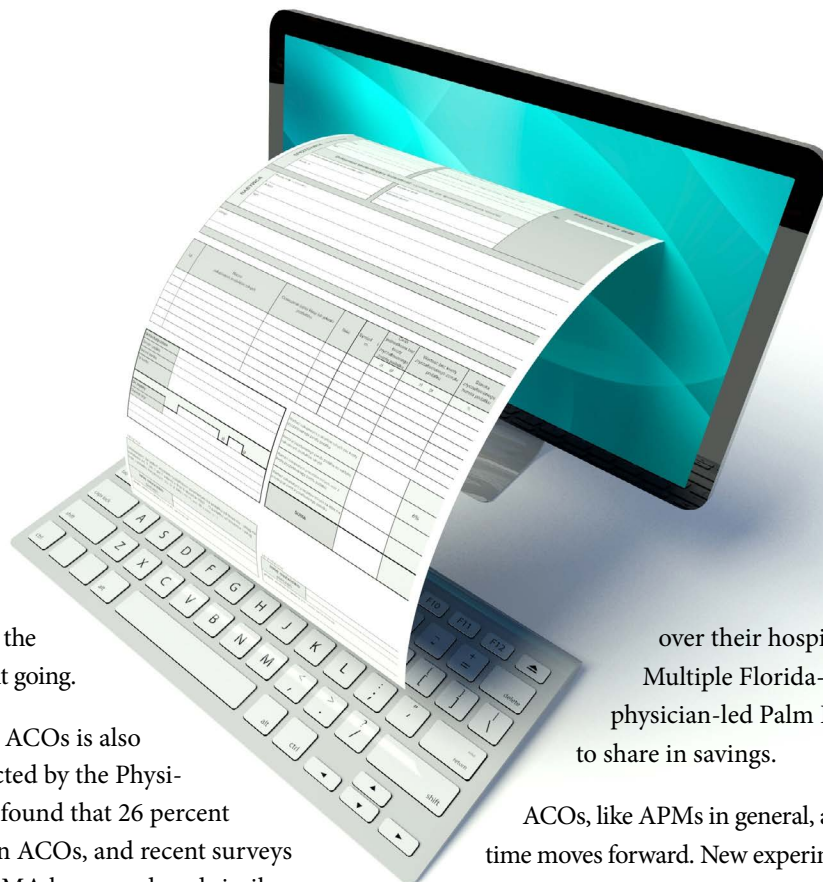


there are now close to 750 ACOs covering around 23.5 million lives. This includes 66 ACOs in Florida alone.

If anything, this estimate is conservative as Leavitt Partners does not double or triple count groups of providers that have multiple ACO contracts. So, if a group of providers forms an ACO under the Medicare Shared Savings Program (MSSP) and then signs two additional ACO contracts with commercial payors, Leavitt Partners would only count the group as a single ACO. Adding up each ACO contract individually, irrespective of whether some are managed by the same groups of providers, produces a much larger figure. Based on data compiled by the Center for Health Care Strategies, there are currently around 528 commercial ACO contracts, 405 MSSP ACOs, 66 Medicaid ACOs and 18 Pioneer ACOs — 1,017 in total.

In addition, Leavitt Partners estimates that ACOs will cover between 41 million and 177 million lives by 2020, depending in part on the financial results they produce. However, even under a worst-case scenario where many ACOs experience negative financial results, Leavitt Partners believes that the total number of lives covered by ACOs will still nearly double by 2020. This is because the incentives to participate in alternative payment models under the Medicare Access and CHIP Reauthorization Act (MACRA) will be strong enough to keep the momentum going. In other words, while strong positive financial results could help drive the adoption of ACOs, Leavitt Partners believes that "negative financial results will not bring the accountable care movement to a halt" anytime in the near future. The incentives under MACRA, which we will talk about more in the next section, will create





enormous pressure to keep the accountable care movement going.

Physician participation in ACOs is also growing. A survey conducted by the Physicians Foundation in 2014 found that 26 percent of physicians participate in ACOs, and recent surveys from Medscape and the AMA have produced similar findings. Interestingly, the survey from the AMA found that roughly a quarter of physicians are unsure if their practices are part of an ACO. This suggests that many physicians have yet to pay much attention to the changing reimbursement environment.

However, while many physician-led ACOs are showing promise, not all ACOs are thriving. For example, so far, only around a quarter of MSSP ACOs have managed to save enough money to share in savings. In addition, nearly half of the original Pioneer ACOs have dropped out of the program. Only around 1 percent of MSSP ACOs have been willing to assume downside financial risk, which suggests that many ACO participants are not entirely confident that they will succeed.

The 2014 Physicians Foundation survey found that only 13 percent of physicians think that ACOs are likely to enhance quality and decrease costs, while more than half of physicians hold a negative outlook on ACOs. Close to a third say they aren't sure about the structure or purpose of ACOs. This suggests that while ACOs are increasingly popular, the medical community isn't sold on their benefits.

Still, ACO participation appears to be growing and, to be fair, some observers appear to view the early results of the program more optimistically than others. There is no dearth of research on how ACOs might be improved. More positive still for physicians, some prominent researchers have suggested that smaller, physician-led ACOs might actually have an edge

over their hospital-led counterparts.

Multiple Florida-based ACOs, including the physician-led Palm Beach ACO, have managed to share in savings.

ACOs, like APMs in general, are likely to evolve as time moves forward. New experiments, such as CMS' Next Generation ACO Model, will test ways to improve upon the accountable care model. Meanwhile, private insurers are testing novel ways to better integrate ACOs with specialty providers such as oncologists.

### MACRA encourages participation in APMs

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repealed the severely flawed sustainable growth rate (SGR) and included several important reforms that will benefit Medicare providers. MACRA also showed that payment reform, and APMs in particular, have extremely strong, bipartisan support in Congress. The bill, which incentivizes physician participation in APMs, passed the House by a vote of 392 to 37 and the Senate by a vote of 92 to 8.

The incentives to participate in APMs under MACRA will be enormous. Physicians who participate in qualifying APMs will be eligible to receive a 5-percent annual Medicare payment bonus from 2019 through 2024. Physicians who forgo participating in APMs and stick with the fee-for-service based Merit-Based Incentive Payment System (MIPS) will also have opportunities to earn bonuses over this period, but those incentives won't be guaranteed.

Then, in 2026 and beyond, qualifying Medicare APM participants will receive a 0.75-percent annual payment update, whereas other physicians will receive a 0.25-percent annual payment update. This significant differential in annual payment updates will continue indefinitely.

### What qualifies as an APM under MACRA?

Generally speaking, eligible APMs under MACRA will be those that base payment on quality, utilize certified EHR technology, and either bear “more than nominal” financial risk for monetary losses or qualify as a medical home as defined by the Centers for Medicare and Medicaid Innovation (CMMI). This definition will encompass CMS Innovation Center initiatives such as risk-bearing Medicare Shared Savings Program ACOs. MACRA will also encourage the creation of physician-focused APMs. Federal regulators are expected to provide more detailed guidance on what will qualify as an APM in the not-too distant future.

### Does participating in an APM mean giving up independent practice?

No. Many physicians who are participating in APMs have been able to thrive and remain independent. Many of those physicians are right here in Florida.

### Is it possible for physicians to forgo dealing with insurers altogether?

Direct primary care (DPC) is an innovative health care payment model that can enable some physicians to eschew participation in insurance networks by financing their practices through direct payments from patients or businesses. While DPC won't qualify for incentives under MACRA, it nevertheless represents a potentially viable way for some physicians to cut through the red tape and bureaucracy associated with third-party payors while remaining financially viable. The FMA supports DPC and plans to offer more education to members who are interested in this model.

### Conclusion: Inevitable doesn't mean unchangeable

The importance of physician comprehension and engagement in these issues cannot be overstated. Payment reform is no longer a unicorn — it is a real live horse with a horn of determination on its head. But that doesn't mean physicians don't get a say in the directions that it goes. Physicians owe it to themselves to stay as informed as possible to ensure physician autonomy and true patient-centered care in the years to come. This means knowing what the options are, and what's coming next. Now and in the years to come, the FMA is committed to serving as an invaluable resource for members as they navigate this changing landscape.

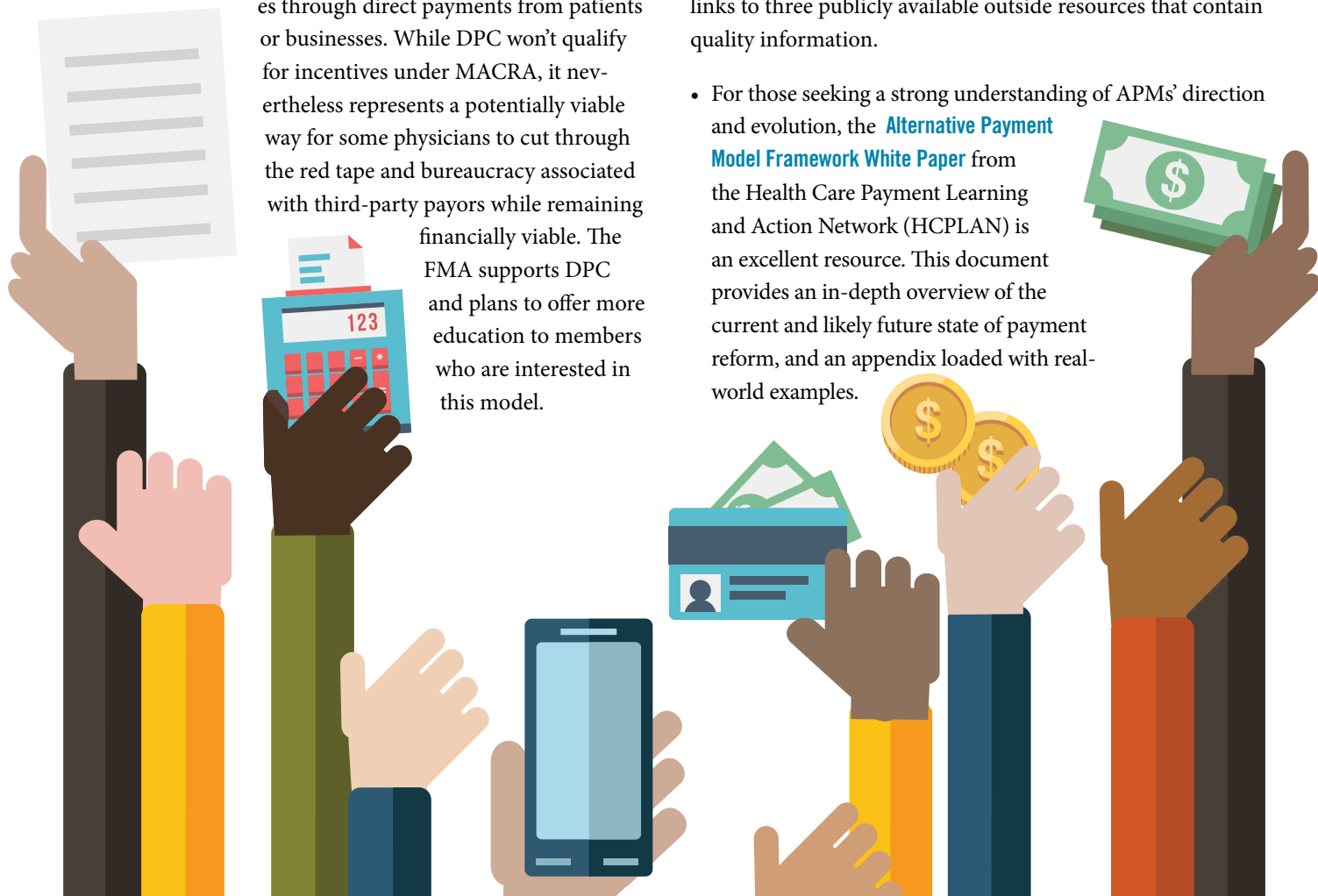
### Can I contact someone?


FMA staff members are available to assist you, and we can help you connect with fellow physicians who have experience with APMs. If you are interested in participating in an APM and need advice from another FMA member, give us a call at (800) 762-0233 and ask to speak with someone in the Payment Advocacy Department.

### Where can I learn more about APMs?

In addition to future FMA updates and white papers, there are several outside resources to consider. Provided below are links to three publicly available outside resources that contain quality information.

- For those seeking a strong understanding of APMs' direction and evolution, the [Alternative Payment Model Framework White Paper](#) from the Health Care Payment Learning and Action Network (HCPLAN) is an excellent resource. This document provides an in-depth overview of the current and likely future state of payment reform, and an appendix loaded with real-world examples.



- The American Medical Association and the Center For Healthcare Quality and Payment Reform have developed an excellent [guide to physician-focused alternative payment models](#). This guide may help physicians in a variety of practice settings qualify for incentives under MACRA.
- For those seeking a better understanding of how implementing APMs can affect day-to-day operations and insight into how physicians are adapting to these changes, the RAND Corporation's "[Effects of Health Care Payment Models on Physician Practice in the United States](#)" study may be a good place to begin. 

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**The references below also contain an enormous amount of information from credible sources.**

- » AMA – Who's using new delivery and payment models – [www.ama-assn.org/ama/ama-wire/post/whos-using-new-delivery-payment-models-1](http://www.ama-assn.org/ama/ama-wire/post/whos-using-new-delivery-payment-models-1)
- » Kaiser Family Foundation – 2015 Employer Health Benefits Survey – [www.kff.org/report-section/ehbs-2015-summary-of-findings](http://www.kff.org/report-section/ehbs-2015-summary-of-findings)
- » JAMA/KFF Info-graphic – Recent Trends in Employer Sponsored Health Insurance Premiums – <http://jama.jamanetwork.com/article.aspx?articleid=2480470>
- » Congressional Budget Office – <https://www.cbo.gov/topics/health-care>
- » Congressional Budget Office Long-Term Budget Projections – <https://www.cbo.gov/publication/45308>
- » HHS News <http://www.hhs.gov/about/news/2015/01/26/better-smarter-healthier-in-historic-announcement-hhs-sets-clear-goals-and-timeline-for-shifting-medicare-reimbursements-from-volume-to-value.html>
- » Catalyst for Payment Reform <http://www.catalyzepaymentreform.org/images/documents/nationalscorecard2014.pdf>
- » BCBS Association – Transforming Healthcare Delivery: A Pathway to Affordable, High Quality Care in America [http://www.bcbs.com/why-bcbs/pathway-to-better-health/transforming\\_healthcare\\_delivery\\_white\\_paper\\_2015.pdf](http://www.bcbs.com/why-bcbs/pathway-to-better-health/transforming_healthcare_delivery_white_paper_2015.pdf)
- » Leavitt Partners – The Impact of Accountable Care [http://leavittpartners.com/wp-content/uploads/2015/05/Impact-of-Accountable-Care\\_Insurers-05.2015.pdf](http://leavittpartners.com/wp-content/uploads/2015/05/Impact-of-Accountable-Care_Insurers-05.2015.pdf)
- » Leavitt Partners – The Impact of Accountable Care: Employer Perspectives [http://leavittpartners.com/wp-content/uploads/2015/05/Impact-of-Accountable-Care\\_Employers-05.2015.pdf](http://leavittpartners.com/wp-content/uploads/2015/05/Impact-of-Accountable-Care_Employers-05.2015.pdf)
- » Health Affairs Blog – The Growth and Dispersion of Accountable Care Organization in 2015 <http://healthaffairs.org/blog/2015/03/31/growth-and-dispersion-of-accountable-care-organizations-in-2015-2/>
- » Center for Health Care Strategies, Inc. Accountable Care Organizations: Looking Back and Moving Forward – <http://www.chcs.org/resource/accountable-care-organizations-looking-back-moving-forward/>
- » Leavitt Partners – Projected Growth of Accountable Care Organizations – <http://leavittpartners.com/?s=accountable+care+organization>
- » The Physicians Foundation – [http://www.physiciansfoundation.org/uploads/default/2014\\_Physicians\\_Foundation\\_Biennial\\_Physician\\_Survey\\_Report.pdf](http://www.physiciansfoundation.org/uploads/default/2014_Physicians_Foundation_Biennial_Physician_Survey_Report.pdf)
- » Health Affairs Blog: Medicare ACOs Continue To Show Care Improvements – And More Savings Are Possible <http://www.ama-assn.org/ama/ama-wire/post/whos-using-new-delivery-payment-models-1>
- » Health Affairs Blog Post – Diving into the pool of ACO quality measures <http://healthaffairs.org/blog/2015/12/21/diving-into-the-pool-of-aco-quality-measures-mssp-year-2-performance-metrics/>
- » HHS Fast Facts – Medicare Share Savings Program ACOs – <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/All-Starts-MSSP-ACO.pdf>
- » Brookings – Adopting Accountable Care – An Implementation Guide for Physician Practices [http://www.brookings.edu/research/papers/2014/11/19-accountable-care-toolkit-physician-aco#recent\\_rr/](http://www.brookings.edu/research/papers/2014/11/19-accountable-care-toolkit-physician-aco#recent_rr/)
- » Health News Florida – FL Doctors Win Medicare Bonuses – <http://health.wusf.usf.edu/post/fl-doctors-win-medicare-bonuses#stream/0>
- » CMS Next Generation ACO Model – <https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/>
- » HealthLeaders Media Florida Blue Launches Oncology ACO – <http://healthleadersmedia.com/page-1/QUA-280059/Florida-Blue-Launches-Oncology-ACO>
- » MACRA Vote Count – <https://www.govtrack.us/congress/bills/114/hr2>
- » AMA Resources – Medicare Alternative Payment Models <http://www.ama-assn.org/ama/pub/advocacy/topics/medicare-alternative-payment-models.page>
- » Heritage Foundation report on direct primary care <http://www.heritage.org/research/reports/2014/08/direct-primary-care-an-innovative-alternative-to-conventional-health-insurance>
- » Kaiser Health News – Fueled By Health Law, 'Concierge Medicine' Reaches New Markets <http://khn.org/news/fueled-by-health-law-concierge-medicine-reaches-new-markets/>





# The Health Care Payment Revolution

## Part 2

Medicare's new direction  
brings physicians to a  
crossroad

*This is the second article in the FMA's three-part series on the changing health care payment landscape.*

By Jarrod Fowler, M.H.A., in conjunction with the FMA Task Force on Alternative Payment Models

Most physicians know that the Medicare payment system is changing, as the repeal of the Sustainable Growth Rate and the enactment of the Medicare Access and CHIP Reauthorization Act (MACRA) were widely publicized. In addition, nearly all physicians have been affected by Medicare's Meaningful Use and Physician Quality Reporting System (PQRS) programs and as many as 30 percent of physicians are now participating in an accountable care organization (ACO).

However, many physicians are unaware that they will soon face a choice as to how they will be compensated under Medicare Part B. Starting in 2019, MACRA will provide one set of incentives to physicians who derive a substantial portion of their Medicare revenue from an eligible alternative payment model (APM) and another set of incentives for physicians who stick with the more familiar fee-for-service model. Physicians

who stick to fee-for-service will soon be subject to a new pay-for-performance program known as the Merit-based Incentive Payment System (MIPS). Given that these changes will be happening soon, all physicians who accept Medicare should begin the process of educating themselves and preparing for what's to come.

### MACRA Basics

Now is a good time to review the basics of MACRA. Click [here](#) for an overview and [here](#) for an in-depth summary. More information can also be found in our previous article, "The Health Care Payment Revolution, Part 1."

### Fee-for-Service and MIPS or Eligible APMs: Which Path Should I Choose?

There is no right or wrong choice, and switching between these two options will be possible. Physicians may participate in MIPS one year and participate in an eligible APM the next. However, MACRA will offer much stronger financial incentives to physicians who are willing to participate in eligible APMs. A comparison of the two options follows.



*...However, many physicians are unaware that they will soon face a choice as to how they will be compensated under Medicare Part B.*



### Option 1: Fee-For-Service and MIPS

In 2019, nearly all physicians who are not participating in eligible APMs will be subject to MIPS, which consolidates Medicare's current pay-for-performance programs (Meaningful Use, PQRS and the Value-Based Modifier) into a single streamlined program. In other words, the current Value-Based Modifier program, Meaningful Use program and PQRS program will be eliminated and replaced with MIPS after 2018.

MIPS will adjust payment based on performance in four measurement categories: quality, resource use, clinical improvement activities and meaningful use of EHRs. Practically speaking, the only new category here is "clinical practice improvement." The rest of these measures are already encompassed in PQRS, the Meaningful Use program and the Value-Based Modifier program. Potential clinical practice improvement activities include offering same-day appointments for patients with urgent needs and performing care coordination services.

Although MIPS is largely derived from Medicare's existing pay-for-performance programs, MIPS will offer more opportunities for physicians to earn bonuses while making it somewhat easier to avoid penalties. For example:

- Under MIPS, performance in all four measurement categories will be combined into a 100-point composite score. Consequently, physicians who perform well in one category and underperform in another won't necessarily be penalized. For instance, a physician who doesn't meet "meaningful use" requirements won't necessarily be penalized under MIPS if she performs substantial clinical practice improvement activities. Instead, physicians will be able to avoid penalties so long as they achieve a minimum, prospectively established composite score. In theory, this will make it possible for all physicians to avoid penalties under MIPS.
- Risk will be phased in gradually to give physicians and

other eligible professionals time to adapt to the new system. Maximum penalties and bonuses under MIPS will begin at 4 percent in 2019 and gradually rise to 9 percent in 2022 and beyond. From 2019 to 2024, \$500 million in annual funding to award additional bonuses of up to 10 percent for "exceptional performance" will also be available. To put this into perspective, at no point will physicians be required to assume more risk under MIPS than they would have under the current pay-for-performance programs in the absence of MACRA.

- Penalties and bonuses will be assessed on a sliding scale, so physicians won't automatically be hit with the maximum adjustment (e.g., minus 4 percent in 2019) if their composite score is only somewhat below the threshold. Conversely, physicians will likely need a score that is well above average in order to earn maximum potential bonuses.
- Physicians may be exempt from certain measurement categories if they are not applicable to the physician's specialty. For example, some hospital-based physicians may be exempt from performing "clinical improvement activities." In these instances, the remaining applicable categories would be reweighted.
- Unfortunately, bonuses under MIPS will generally be budget-neutral. The exception to the budget neutrality rule will be from 2019 through 2024, when \$500 million in designated funding will be available to reward "exceptional performance."
- \$100 million in funding will be available from 2016 through 2020 to assist practices of up to 15 professionals participating in MIPS or transitioning to alternative payment models.

Despite making some improvements to the existing pay-for-performance programs, MIPS does have some drawbacks.

- Physicians who elect to stay in MIPS will miss out on the substantial monetary bonuses that are available for physicians who participate in eligible APMs. In addition to being exempt from MIPS, APM participants will also be eligible to receive

an automatic 5-percent Medicare payment bonus each year from 2019 through 2024. This bonus will be in addition to any incentives that physicians receive through the APM itself (e.g., shared savings). Further, in 2026 and beyond, qualifying APM participants will receive a .75-percent annual payment update while physicians subject to MIPS will receive a mere .25-percent update. This substantial payment update differential will continue indefinitely. In the long term, this will create an enormous incentive for physicians to participate in eligible APMs.

- Like all mandatory pay-for-performance programs, MIPS is inconsistent with FMA policy. A combination of potential penalties and low payment updates could make MIPS unsustainable over time.

### Option 2: Eligible APMs

As mentioned above, physicians who participate in eligible APMs can earn substantial monetary incentives. However, participating in an eligible APM will take dedication. Here's what you need to consider:

- Not every APM will be eligible for incentive payments under MACRA. As explained by CMS, eligible APMs will have to use quality measures that are comparable to those under MIPS, require the use of certified EHR technology, and either bear more than nominal financial risk or be a qualifying patient-centered medical home. The APMs specifically referenced in MACRA include CMS Innovation Center models and the Medicare Shared Savings Program. However, until a final rule is published, we won't know precisely what APMs will be eligible.
- In addition, merely participating in an eligible APM will not automatically qualify a physician for the financial incentives offered under MACRA. In order to become qualifying APM participants, physicians will have to receive a certain percentage of their patients or payment through eligible APMs.

- It's important to note that participating in an ineligible APM may still be beneficial. For instance, participating in a non-eligible APM can help increase scores under MIPS. This is because almost all APMs require physicians to perform tasks that are accounted for under MIPS (i.e. resource use management, clinical practice improvement activities, quality improvement activities, etc.)
- To learn more about APMs, including physician-focused APMs, consider reading the first article in this series and its referenced online resources.

### The Short of the Long:

The fee-for-service MIPS program offers some improvements over Medicare's existing pay-for-performance programs, but physicians who are looking to maximize their payment opportunities under Medicare will eventually need to participate in eligible APMs.

### Will Medicare's New Direction Prove Sustainable?

In passing MACRA, Congress essentially took a bet that incentivizing APMs will save the Medicare program money without generating backlash from providers or beneficiaries. However, this theory remains untested and the success or failure of MACRA will likely remain difficult to judge for many years.

It's also worth noting that while MACRA repealed the SGR and offers some improvements to Medicare's existing pay-for-performance program, it is certainly not an ideal law. Low payment updates and a lack of private contracting options are among the issues that need to be addressed in future legislation.

### Why Should I Pay Attention to These Developments Now?

While MIPS payment adjustments won't directly affect physician practices until 2019, those adjustments will be based on performance in 2017. In other words, as is the case with Meaningful Use and PQRS, payment adjustments will be processed two years out from each "performance period." Details will be released very soon. In fact, an RFI has already been released and CMS has estimated that a proposed rule will be issued in June. The rule is also expected to include information on eligible APMs. Rules and proposed rules aside, 2019 isn't far away.

### Where Can I Find More Information About MACRA, MIPS and APMs?

A handy list of resources is included in [our first article](#). You can also call the FMA at (800) 762-0233 to be connected with member physicians who have firsthand experience participating in various APMs.

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