



MACRA to Cut Medicare Pay to Hospitals Most: Study *Hospital Advocates Anticipate A Macra Rule This Spring* April 4, 2017

Hospitals could face larger-than-expected Medicare payment cuts under the Medicare Access and CHIPS Reauthorization Act (MACRA), a new study in Health Affairs found.

Under three different financial scenarios impacting hospital finances under MACRA, the study predicted Medicare hospital cuts could range as high as \$250 billion by 2030. The authors said that while MACRA ended a contentious “cycle of deep uncertainty about Medicare payment rates for physicians under the sustainable growth rate (SGR) reimbursement formula,” it sparked a different kind of uncertainty.

“It is difficult to predict exactly how care will change” because of “the specific impacts of alternative payment models (APMs) on healthcare delivery.”

Peter Hussey, a senior policy researcher with the RAND Corporation and a co-author of the study, said the losses will result from physicians responding to payment models in ways that reduce the use of hospital care, such as avoiding admissions and readmissions.

“What we found was that physicians will be in a scenario where their Medicare payments are increasing very slowly over the next 10 years,” Hussey said in an interview. “And the only way to increase those reimbursements is through participating in APMs which, if they are successful, keep patients out of hospitals. The biggest effect from MACRA could be a decrease in hospital revenues.”

In 2015, Congress passed MACRA, which eliminated the Medicare Part B SRG formula. Congress frequently intervened to avoid payment cuts required under that formula. MACRA replaced it with a value-based payment program that seeks to tie physician compensation to quality. The replacement, called the Quality Payment Program, offers two options: the Merit-Based Incentive Payment System (MIPS) and APMs.

Hussey said that many hospitals have been preparing for the broader trend of value-based payment.

“MACRA doesn’t change that. But what it has done is to put pressure on that trend by design. If hospital executives weren’t planning to change business models to account for that before, then they should start doing that now,” he said.

Hospital Steps

While hospital inpatient revenues may diminish under MACRA, Hussey said “there are other ways for hospitals to make their margin, through reducing costs, increasing outpatient revenues and improving the management of the health of the populations they serve.”

David Wofford, senior manager at ECG Management Consultants, said in an interview that quantifying the financial impact of MACRA would be “fiendishly difficult. A financial model is only as good as the assumptions creating it. After all, the APMs don’t make decisions, physicians make decisions. It’s important to keep in mind that within MACRA, most physicians will be reimbursed within the MIPs, which includes four different categories of incentives and only one directly related to the cost of care.”

Hospitals need to focus even more on integrating quality of care measures, electronic health records and clinical improvement activities, Wofford said.

“It’s not just about managing cost incentives, but other elements as well. If you’re employing physicians, you do need to determine a MACRA strategy, because being successful on the Medicare Part B side might harm you on the Part A side,” he said.

Melinda Hancock, CFO and senior executive vice president for VCU Health, said her system created a value payment committee to develop a multi-year strategy for building the needed infrastructure to move forward under different payment models.

“Hospitals need to recognize that MACRA is not a standalone reimbursement system, but is a multi-faceted payment model that will affect other payment models,” Hancock, former Chair of HFMA, said in an interview. “The challenge is how we balance our other payment models under it.”

Melissa Myers, senior associate director of policy for the American Hospital Association, said uncertainty clouds the MACRA law, the upcoming rule and how both will play out.

“Hospitals were moving towards value-based purchasing before MACRA,” said Myers in an interview. “MACRA underscores the strong and growing signals that we are moving from a fee-for-services system to a value-based purchasing system. And if people haven’t explored that yet, they need to pay attention.”

AHA has undertaken efforts to educate members about MACRA, including posting a guide on its website at www.aha.org/macra.

MACRA passed with strong bipartisan support and the AHA doesn’t anticipate any major changes, Myers said.

“The game moving forward is on the regulatory side,” she said. “We expect to see an HHS rule on MACRA this spring.”

Long-term Uncertainty

Greg Hagood, senior managing director for SOLIC Capital, said most hospitals aren’t motivated yet to explore MACRA’s long term impact.

“With the Affordable Care Act in flux and new proposed bills, our clients are more interested in what’s happening in the short term, in 2017-2018,” Hagood said. “In the short term we see little change in hospital payments. They kicked the can down the road to allow doctors to participate in the MIPS without incurring the 5 percent penalties.”

Politically, Hagood said, CMS can’t say that it will pay less.

“But this offers a backdoor way to reduce healthcare costs,” Hagood said. “In the next five years we fully expect to reduce the level of reimbursement. The goal is to pay more fixed fees up front and less per procedure and require physicians and hospitals to bear the risk.”

Hagood said hospitals traditionally made their margins on their commercial business.

“Now they need to figure out how to not just profit on their commercial lines, but to re-engineer their operations to make margins on their Medicare business,” Hagood said.

Hospitals increasingly will move patients to outpatient facilities that offer lower cost delivery, embracing ambulatory surgery centers and other appropriate care outside of the hospital, he said.

“To the extent that MACRA affects physician reimbursement in the next few years, hospitals will reorient how they use physicians and physician extenders,” Hagood said.

Rick Gundling, vice president of healthcare financial practices for HFMA, said the study cemented the truism that the futures and fortunes of hospitals and physicians are inextricably linked.

“They are no longer operating in separate silos,” Gundling said in an interview. “What affects physicians affects hospitals. Hospitals now employ at least 250,000 physicians and contract with another 300,000. I think the biggest step that hospitals can take is leveraging their knowledge about APMs and work with physicians to bring those skills into play. It will build greater physician affinity when hospitals provide that kind of guidance and a path forward. It could also offer a competitive advantage with employers and other payers.”

No Predicted Losses

Megan Neuburger, managing director for Fitch Ratings, said she’s seen larger hospitals develop networks of care delivery outside of hospital settings, while improving economic alignment with physicians.

“Many hospitals have seen this coming,” Neuburger said in an interview.

Neuburger said she hasn’t heard of any hospital chains publicly predicting gains or losses attributable to MACRA.

“MACRA is in line with the overarching trends we’ve predicted for hospitals: continuing pressure on high cost services,” she said.

###