# Medicare Access and CHIP Reauthorization Act (MACRA)

## An evolution in Medicare physician payment and care delivery

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# What is MACRA?

## Abstract

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is set to change reimbursement for clinicians who receive Medicare Part B payments. MACRA repealed the Medicare physician Sustainable Growth Rate (SGR) formula, historically used to control the growth of physician reimbursement, and replaced it with the Quality Payment Program (QPP). The QPP will affect all health care organizations and providers, as it will change the future of Medicare and the trajectory of the US health care industry's movement to quality-based payments (e.g., risk-based contracting models, payment for quality over volume, population health management). This paper provides an overview of the new legislation, identifies the impacts of the two major pathways, and examines the core capabilities and common pitfalls in value-based care models.

## Background

The passing of MACRA and creation of QPP represent a major change to the way providers will be paid for Medicare services. The need to control rising health care costs while simultaneously improving the quality of care led the Centers for Medicare & Medicaid Services (CMS) to abandon the traditional fee-for-service (FFS) payment model and explore new ways of paying for care. QPP is an actionable step toward achieving a patient-centered health care system that delivers better care, smarter spending, and healthier people and communities by paying for value rather than just volume. The incentive for physicians to redesign their health care practice to deliver value is substantial, with 4%–5% of a provider's annual Medicare payments based on value, starting in 2019, increasing to 5%–9% by 2022.

MACRA is the first major change to the method of Medicare Part B physician payment in nearly two decades. The SGR paid physicians under an FFS model since its enactment in 1997. As stated by CMS, the SGR "does not provide incentives for individual physicians to control volume growth, and is inequitable to those physicians who do not increase volume unnecessarily." The SGF formula drove uncontrollable cost and utilization growth.

In an attempt to rein in health care spending and redirect the health care dollar to better quality care, SGR was repealed and replaced with QPP by the passing of MACRA under the Obama administration in April 2015. Providers will continue to experience a major shift in the payment landscape to one that incentivizes delivery of value over volume. The quest for value will cause providers serving Medicare patients to redesign their systems of care, modernize their health care practices and adopt health care technology.

QPP will affect the vast majority of providers accepting Medicare Part B payments. With a few exceptions, all providers previously being paid under SGR will be paid under QPP starting in 2019, on 2017 performance. In an attempt to protect small, independent practices, providers serving fewer than 100 Medicare B patients a year or those submitting charges less than $30,000 under Medicare Part B will be exempt from participating in QPP. However, it is estimated that approximately 93% of Medicare Part B charges will be eligible under QPP. Clinicians paid under this model include physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified nurse anesthetists and an expanded set of provider groups in later years.

Within QPP, there are two tracks for provider payments:

1. Advanced Alternative Payment Models (APMs)
2. Merit-based Incentive Payment Systems (MIPS)

Eligible clinicians who participate in CMS alternative payment programs such as Next Generation ACOs, Medicare Shared Savings Program and Comprehensive ESRD Care Models will be paid under APMs. Up to 25% of clinicians are expected to participate in APMs by 2018. The remaining 75% of eligible clinicians who do not participate in APMs will, by default, be paid under MIPS.

# Comparing MIPS to Advanced APMs

MACRA is projected to impact 90%–95% of all physicians, including approximately 93% of Medicare Part B charges. As noted above, there are two major options for complying with MACRA and participating in the QPP:

1. Advanced Alternative Payment Models (APMs)
2. Merit-based Incentive Payment Systems (MIPS)

In alignment with other regulatory programs and care models promoted by CMS in recent years, the Advanced APM option incents and rewards providers for participating in value-based reimbursement models with upside and downside risk (e.g., accountable care organizations (ACOs) and other models discussed in later sections).

MIPS is not intended to be a **final destination** … but ultimately, a route to Advanced APMs for providers that are newer to risk-based and value-based contracting.

In contrast, MIPS is the default option. Physicians that are not participating in arrangements that qualify for the Advanced APM option will need to participate in MIPS. It is important to note, however, that MIPS is not intended to be a final destination for physicians, but ultimately, a route to Advanced APMs for providers that are newer to risk-based and value-based contracting.

The following sections will take a closer look at these two options and explain what physicians can expect going forward from each model.

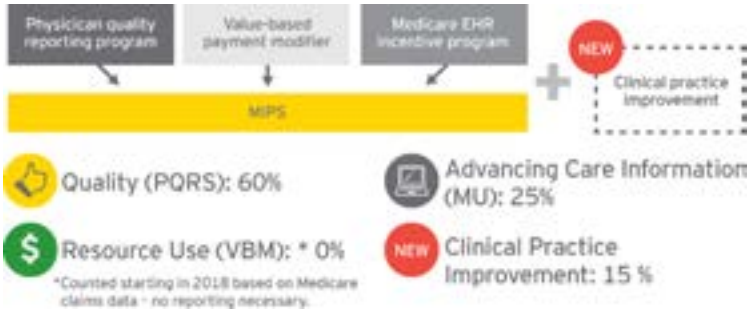
## MIPS

All eligible clinicians who are not able to become involved in an Advanced APM by 2017 will be enrolled into MIPS. Some physician types that will be exempt from MIPS include the following: rural health clinics, Federally Qualified Health Centers, physicians currently in Track 2 of the Shared Savings Program, and small, independent practices that did not meet the threshold of Medicare patient volume or revenue to qualify. After accounting for exemptions, an estimated 500,000 clinicians will be paid under MIPS in 2019.

MIPS presents both a risk and an opportunity for clinicians. Starting in 2019, up to 4% of a clinician's annual Medicare Part B revenue could receive a bonus or a penalty based on the clinician's ability to deliver value, as determined by the MIPS scoring system. The financial incentives for physicians steadily increases each year in the program: 4% in 2019, 5% in 2020, 7% in 2021 and 9% in 2022. The steady ramp-up of financial incentives from 2019 to 2022 provides time for clinicians to learn as the program progresses, receive feedback in the form of payments, and course-correct each year. The intent of this feedback loop and performance measurement system is to hopefully drive better quality care, year after year, for Medicare patients.

The MIPS penalties and rewards program is starkly different from the APM track. In the APM track, participants automatically receive a 5% bonus each year from 2019 to 2022 with the opportunity to receive additional bonuses based on positive performance. Unlike MIPS, APMs are not required to take on downside risk. Why? APMs already have at least 30% upside and downside financial risk outside of MACRA/QPP. Therefore, clinicians are highly incented to eventually transition into APMs.

MIPS is a zero-sum game. For each clinician who wins under the MIPS scoring system, another will lose. Providers will be ranked according to a composite score, with the top quartile receiving a positive performance adjustment, the middle 50% receiving a neutral score adjustment and the bottom quartile receiving a negative performance adjustment. MIPS participating providers will be graded on four factors to determine bonuses or penalties. These four factors will be weighted differentially to determine the composite score: quality measurement, use of a qualified EHR, cost accountability and participation in quality improvement activities. The four corresponding components are: quality reporting, advancing care information, resource use and clinical practice improvement.




## *Quality reporting (60% in 2017)*

The most heavily weighted, and therefore most highly incentivized, aspect of MIPS scoring is quality measurement and reporting, accounting for 60% of the total physician score. This quality program is based on the Physician Quality Reporting System (PQRS). Most clinicians will report up to 6 quality measurements, including an outcome measure, for a minimum of 90 days. Success at this metric will involve not only delivering high-quality care but also the ability to measure and report data.

## *Advancing care information (25% in 2017)*

The next most heavily weighted component, advancing care information, accounts for 25% of the composite score. Advancing care information replaces and simplifies the existing Meaningful Use Program, reducing the number of electronic health record (EHR) reporting requirements from 18 to 5. Providers will be required to report 90 days of data on the 5 key metrics: (1) perform security risk analysis, (2) provide e-prescribing, (3) provide patient access, (4) send summary of care and (5) request/accept summary of care. Additionally, providers can submit 9 additional measures for a minimum of 90 days for additional credit. Advancing care information will require providers to invest in and improve the functionality and interoperability of their EHR systems.

## *Clinical practice improvement (15% in 2017)*

Thirdly, CMS will be attributing 15% of the composite score to participation in practice improvement initiatives. This involves attesting to completion of improvement activities for a minimum of 90 days. These activities may involve participation in qualified and clinical data registry (QCDR), use of telehealth, and assessments relating to maintenance of certification (MOC), among others.

## *Resource use (0% in 2017)*

Finally, starting in 2018, CMS will be measuring cost accountability through the resource use program, using claims data. While resource use does not require any active reporting from physicians and will not become weighted in the composite score until 2018, it is important for physicians to begin assessing their likely outcomes under the program to know how it will affect their composite score. While resource use may remain a small effect on the overall score in the future, providers must invest in and succeed in all four scoring components to be successful.

## *Key takeaways*

With so much at stake for providers in the upcoming MIPS program, it is essential that providers focus on a few key takeaways. First and foremost, MIPS represents a critical change to the way providers will be paid beginning in 2019. Reimbursements in 2019 will be determined by data submitted in 2017. While success at MIPS should be a goal, CMS sees MIPS as a stepping-stone to advanced APMs. Forward-thinking organizations beginning in MIPS should consider their long-term path to APMs.

## APMs

The second option for participating in the Quality Payment Program and complying with MACRA is to participate in an approved Advanced APM. CMS estimates that 70,000 to 120,000 clinicians will qualify for Advanced APMs in 2017. APMs are exempt from participation in MIPS; therefore, the bonus or penalty rates (increasing from 4% to 9% in upcoming years) will not apply. Instead, physicians participating in Advanced APMs will automatically qualify for a 5% annual bonus, on top of rewards, incentives and bonuses earned in the other programs (e.g., ACO shared savings payments would remain and a 5% bonus would be added).

Similar to MIPS, physicians participating in APMs will receive the 0.5% increase in fee updates each year; however, it is important to note that by 2026, physicians participating in APMs will receive a fee update of 0.75%, while physicians still in MIPS will receive an increase of 0.25% in fee updates. This reinforces the notion that MIPS is not meant to be a final destination on the road to value-based care, but it is an easier entry point for physicians who are less experienced and less comfortable with value-based contracting and care models. Physicians should use the next few years to gain the core capabilities of delivering value-based care, while considering which advanced APM to move toward and if it makes sense to collaborate with other groups or entities to form an APM.

In order to be considered part of an Advanced APM, a clinician needs to be in a qualifying APM model.


CMS has already approved quite a few APM models. These pre-approved APM models include:

- Medicare Shared Savings Program (MSSP) ACOs in Track 2 or 3
- Next-generation ACOs
- Comprehensive Primary Care Plus (CPC+) participants
- Comprehensive ESRD Care Model participants

CMS has also indicated a few other models that may qualify for the Advanced APM option by 2018, including ACO Track 1+, the new voluntary bundled payment model, the Comprehensive Care for Joint Replacement (CCJR) Bundled Payment models and the Advanced Cardiac Care Coordination Bundled Payment model.

Additionally, CMS has created a "Design-Your-Own-Advanced-APM" option, known as the Physician-focused Payment Model Technical Advisory Committee, or PTAC. The PTAC was established to review and assess proposals submitted by stakeholders (e.g., payers, providers) for new alternative APMs. Once the PTAC approves of the model, physicians participating in that APM will qualify for the APM option. Some examples of models that are likely to be approved by the PTAC in the near future include Vermont All-Payer Model and oncology care coordination risk-based models.

CMS has created a "Design-Your-Own-Advanced-APM" option, known as the Physician-focused Payment Model Technical Advisory Committee, or PTAC.

The PTAC allows organizations to tailor their APM design to fit their needs, while still creating a framework that APMs must fit within. The following sections identify some of the three key components important to APMs already included in the program and, therefore, provide guidance on what types of components would need to be included in a PTAC submission.

## *Payment or incentives based on quality metrics*

CMS requires that Advanced APMs have quality metrics centered on monitoring and improving patient care. The currently approved Advanced APMs, such as the MSSP ACO, have quality metrics built into the participating programs. The reporting and quality components of these programs focus primarily on process metrics, rather than outcomes-based metrics. Example metrics could include administering an aspirin upon presenting with a heart attack, standard screening for diabetes and pneumonia, and more.

Organizations and physicians seeking to create a new APM model through PTAC will want propose a quality component of the model similar to the bundled payment, ACO or CPC+ models. Additionally, CMS has offered for organizations to mirror the quality component after the PQRS requirements that apply in MIPS.

## *Upside and downside financial risk*

In order for a clinician to qualify for the Advanced APM option, they must receive some of their Medicare reimbursement in a qualifying APM with financial risk. Currently, the threshold for fully qualifying for the APM model is that at least 25% claims and 20% of Medicare patients receive care reimbursed in an Advanced APM arrangement. These thresholds were thought to be sufficient to align clinician behavior to the goals of quality improvement and cost containment. Clinicians can receive partial APM status with 20% of claims and 10% of patients receiving care that is reimbursed in an Advanced APM.

The upside and downside risk must be at least 30%. Models such as the MSSP ACO Tracks 2 and 3 easily meet this standard, but for organizations applying for a new model with PTAC, they will need to confirm that this threshold is present in the model. For this reason, MSSP ACO Track 1 is not currently an approved Advanced APM, as it does not require downside risk. CMS has stated that PTAC would likely consider approving an ACO Track 1+ model, where the basic framework for the ACO model is used, but at least some upside and downside risk is introduced at or near the 30% threshold. Since PTAC and CMS are quite familiar with the metrics and operations of the MSSP ACO model, the ACO Track 1+ option would be a favored and likely more successful submission for PTAC approval.

CMS has stated that PTAC would likely consider approving an ACO Track 1+ model … but at least some upside and downside risk is introduced at or near the 30% threshold.

## *Use of certified EHR technology*

Last, APMs must have significant use of certified EHR technology. This is defined by 50%–75% of qualifying participants that accept financial risk using a certified EHR platform and participation at or above the meaningful use requirements found in the MIPS program. Because strong IT and analytics capabilities are required for most APMs to be successful, most existing APMs will already have significant focus on EHR platform use and interoperability. However, for organizations considering the transition to an APM model, the complexity and investments needed for this component should not be underestimated or overlooked. For additional insight into common pitfalls and issues related to IT systems and EHR platforms, please see the next section.

### *Key takeaways*

Advanced APMs incent and reward providers for participating in value-based reimbursement models with upside and downside risk (e.g., ACOs). Physicians participating in Advanced APMs will automatically qualify for a 5% annual bonus, on top of rewards, incentives and bonuses earned in the other programs. There are four main requirements for qualifying as an Advanced APM. Additionally, CMS has created PTAC, which allows organizations to tailor their APM to fit their needs while still creating a framework that APMs must fit within.

## Core capabilities and common pitfalls for value-based care models

As organizations transition from fee-for-service (FFS) reimbursement to value-based care models, they must develop and strengthen multiple capabilities. These capabilities include (1) IT/analytics, (2) integrated operations, (3) finance, (4) clinical improvement, (5) people and (6) patient engagement. The following figure explores and describes these capabilities in more detail:


Many organizations prematurely enter into value-based contracts prior to developing or working toward gaining these capabilities. This becomes particularly dangerous as organizations enter into agreements with both upside and downside financial risk. There are a number of pitfalls and issues clinicians and health systems encounter.

Pitfalls and issues can arise in numerous areas but are particularly common in the six capability areas identified above as necessary for operating successful value-based care models. Providers should conduct or subcontract for a MACRA readiness capability assessment to identify any gaps, pitfalls or issues related to providing value-based care and taking on upside and downside financial risk for physician reimbursement. This assessment is critical for organizations — even if they employ limited or few physicians — as many affiliated providers and clinicians will be evaluating large health systems to determine the best partners with whom to enter into APM contracts in the next two years.

Providers should conduct … a MACRA readiness capability assessment to identify any gaps, pitfalls or issues related to providing value-based care.

One example pitfall or issue would be if an organization had disparate clinical and financial decision-makers and lacked integration between these two functions. Value-based contracts require providers to maintain or improve quality of care, while reducing costs. If finance's cost containment initiatives are not integrated with clinical operations' quality improvement initiatives, the organization will likely see higher up-front sunk costs and investments, and will likely exceed annual expense allocations. A potential solution for this pitfall would include conducting an organizational redesign to create a governance committee and organizational structure that integrates these two functions, as well as other stakeholders that impact quality and costs.

The figure below indicates additional pitfalls and issues, as well as potential solutions commonly found in organizations pursuing value-based care models:

| Capability | Pitfalls and issues | Potential solutions for pitfalls |
|---|---|---|
| IT/analytics | ▸ Lack of data and interoperability<br>▸ Insufficient data warehouse and analytics platforms | ▸ Data management plan<br>▸ Data quality assessment<br>▸ Data warehouse investment |
| Integrated operations | ▸ Obtaining or partnering to provide full care continuum of services needed by a patient<br>▸ Disparate financial and clinical operations and decision-making | ▸ Patient flow diagrams and redesign for end-to-end patient care exp.<br>▸ Marketing compliance plan<br>▸ Organizational redesign; task forces |
| Finance | ▸ Cannibalization of revenue<br>▸ Reduce costs without hurting quality<br>▸ Ability to pay losses<br>▸ Difficulty dividing shared savings/losses<br>▸ Funding up-front sunk costs | ▸ Integrate financial and clinical decision-making functions<br>▸ Request to CMS to withhold savings<br>▸ Analytics platform and modeling |
| Clinical improvement | ▸ Physician autonomy impacting standardization of care and outcomes<br>▸ Size and cost formulary<br>▸ Decentralized supply chain and P&T decisions | ▸ Long-term acute care contracts for high-cost patients<br>▸ Care protocols; centralized formulary<br>▸ Supply chain management |
| People | ▸ Lack of control over and buy-in from physician and staff (alignment)<br>▸ Trouble measuring individual vs. group costs<br>▸ Difficulty identifying high cost or high risk from variations in practice/treatment | ▸ Change management plan<br>▸ Physician champion/leader<br>▸ Build physician metrics into annual contracts<br>▸ Analytics tool to compare treatment chosen to outcomes and cost data |
| Patient engagement | ▸ Patient population too small/large to manage risk and meet care needs<br>▸ Low patient satisfaction<br>▸ Difficulty monitoring patient attribution/leakage<br>▸ Inability to steer or impact patient behavior(s) | ▸ Track/measure patient loyalty and leakage<br>▸ Formalize patient attribution method and periodic adjustments in contracts<br>▸ Increase patient volume; improve market share |

As shown in the table above, there are a large number of potential issues and pitfalls if it is unprepared for APMs. To improve awareness and find solutions, organizations should conduct or contract with a company to complete a MACRA readiness capability assessment. This can allow providers to identify and prioritize investments in systems to avoid these pitfalls and issues and minimize risk of losses for the organization.

# Summary

MACRA is set to change reimbursement for clinicians who receive Medicare Part B payments. MACRA repealed the Medicare physician SGR formula and replaced it with QPP, which will affect nearly all providers in the US. The QPP offers two pathways for reimbursement: MIPS and APMs.

The Advanced APMs option incents and rewards providers for participating in value-based reimbursement models with upside and downside risk (e.g., ACOs). MIPS is the default option. Physicians who are not participating in arrangements that qualify for the Advanced APMs option will participate in MIPS. MIPS is not intended to be a final destination for physicians, but ultimately, a route to Advanced APMs for providers that are newer to risk-based and value-based contracting.

Whether choosing to participate in MIPS or APMs, there are core capabilities that providers and health systems need to develop as they transition to value-based care models. Providers should conduct or contract with a consulting service to complete a MACRA readiness capability assessment to identify gaps, pitfalls or issues related to providing value-based care and taking on up/downside financial risk for physician reimbursement. This assessment is critical for all provider organizations — even if they directly employ few physicians — as many affiliated providers and clinicians will be evaluating large health systems or provider entities to determine the best partners with whom to enter into APM contracts in the next two to three years.

Whether choosing to participate in MIPS or APMs, there are core capabilities that providers need to develop as they transition to value-based care models; [they] should conduct a MACRA readiness capability assessment to identify gaps, pitfalls or issues.

For more information about MACRA, QPP, MIPS, APMs and potential readiness, please contact James King, Principal, Ernst & Young LLP Advisory Services, Performance Improvement — Health.

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## Sources and resources

- CMS education and tools
- MACRA quality payment program
- MACRA QPP and CMS's path to value
- Transforming clinical practice initiative
- MACRA acronyms
- American Academy of Family Physicians (AAFP)
- American Medical Association (AMA)

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