

In their book, [Healthcare Disrupted](#), Jeff Elton and Anne O’Riordan write about three signs of disruption: new language, new economics, and a new future. MACRA fits right into this description. It is big on new language (think of all the new acronyms) and features new economics. Although doctors will still be paid the same way, bonuses and penalties will be based on performance. The new future requires all of us to think about the capabilities needed in this new environment, and the capabilities we already have that need to be reshaped. It’s time to disrupt. But we need to learn more before we get started.

FAQ: THE MACRA BUZZ

After the final ruling was announced, an [article](#) in the Wall Street Journal explained MACRA in very simple terms, describing it as the new rule for how Medicare pays doctors, that it’s a broader push to overhaul federal health spending, and that it includes new bonuses and penalties tied to performance. We’d love to keep the explanation this simple, but there are a lot of important details to discuss and understand. To keep them organized, we’ve taken a FAQ approach based on feedback we’ve received.

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Why is MACRA necessary?

Without the passage of MACRA, physicians could have been subject to negative payment adjustments that varied from year to year under the Sustainable Growth Rate (SGR). Additional penalties of 11 percent or more would have been applicable in 2019 under the [Meaningful Use](#), [Physician Quality Reporting System](#), and [Value-Based Medicine](#) programs. In contrast, under MACRA, with the repeal of the Sustainable Growth Rate, the reimbursement landscape has been stabilized. The largest penalty a physician can experience in 2019 is four percent. MACRA also provides incentives for physicians to develop and participate in different models of health care delivery and payment known as [Alternative Payment Models](#) (APMs).

What are the aims of the Quality Payment Program?

The [Quality Payment Program](#) (QPP) that exists under MACRA unifies several existing policies to support care improvement by focusing on better outcomes for patients, decreasing provider burden, and preserving independent clinical practice. The QPP also promotes adoption of APMs that align incentives across healthcare stakeholders. It advances existing efforts of [Delivery System Reform](#) to ensure a smooth transition to a new system that promotes high-quality, efficient care by unifying these legacy CMS programs.

How do payments work in the two tracks of the QPP?

In replacing the SGR, MACRA built in a modest annual inflationary increase of 0.5 percent until 2019, dropping to 0.25 percent starting in 2026. The base performance year for the QPP is 2017. After that, clinicians must enter the Merit-based Incentive Payment System (MIPS) or become an Advanced Alternative Payment Model (APM) Qualified Provider (QP). MIPS participants will be subject to a four percent bonus or penalty in 2019; five percent in 2020; seven percent in 2021; and nine percent in 2022. APM Qualified Providers will get an automatic lump sum participation bonus of five percent from 2019 through 2024.

Who is required to participate?

The list of eligible participants in the MIPS track extends well beyond physicians. It includes Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, Certified Registered Nurse Anesthetists, and groups that include clinicians who bill under Part B.

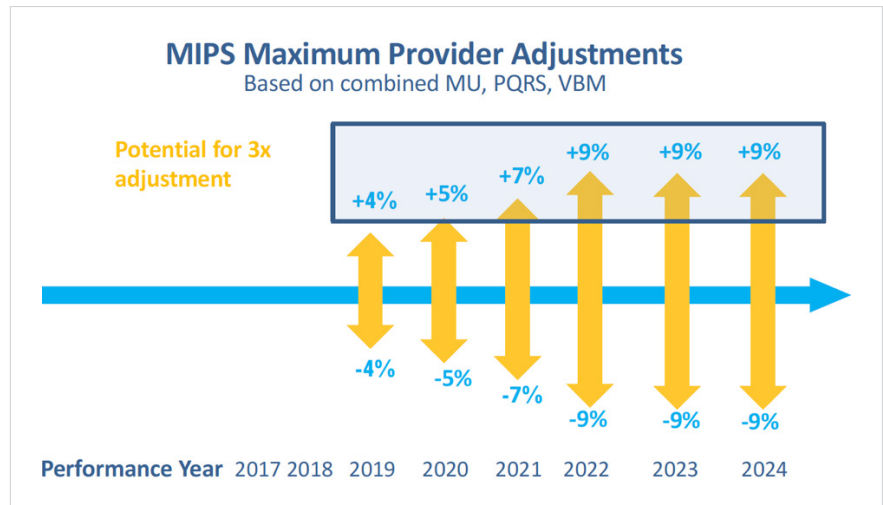


Figure 1: The penalty/bonus structure under MIPS.

Individuals who bill Medicare more than \$30,000 a year and provide care for more than 100 Medicare patients a year must participate in the QPP. Both requirements must be met. Approximately 14 percent of providers will be low volume and, therefore, not required to participate. Also, eligible physicians who are newly enrolled in Medicare are excluded from reporting in the first year.

Anyone already part of an Advanced APM will also participate. To participate in MIPS, providers must be a physician, physician assistant, nurse practitioner, clinical nurse specialist, or certified registered nurse anesthetist.

CMS estimates that between 592,000 and 642,000 eligible clinicians will be required to participate in MIPS in the 2017 transition year.

If I work in a large organization, do I need to worry about preparing for MACRA?

Reporting will not be automatic and physicians who work for large organizations shouldn't assume that their administration will shoulder this responsibility. There are many reporting requirements and it will behoove physicians to talk to leadership to verify exactly what they are.

What if I don't report at all?

Not reporting has its consequences, in addition to a four percent penalty. All data will be publicly reported through the [Physician Compare](#) website. Anyone contemplating sitting out should consider the potential impact not only on reimbursement, but also on future job search efforts, as well as reputation with prospective patients.

Should I report as an individual or group?

The rule defines a group as a single Taxpayer Identification Number (TIN) with two or more MIPS eligible clinicians, as identified by their individual National Provider Identifier (NPI), who have reassigned their Medicare billing rights to the TIN.

If you or your practice already participates in PQRS, then the election of submitting data as a group or individual has already been determined. Also, it is important to consider how you report. Claims-based quality reporting is allowed only if a clinician uses individual reporting, while only groups of 25 or more eligible clinicians may choose to report using the CMS Web Interface.

Submission requirements are different for groups and individuals. For example, CMS will apply the readmission measure to groups of more than 15 who meet the minimum volume of 200 cases. You must participate in MIPS as a whole, either as a group or an individual—not mixed. Group reporting performance will be assessed and scored across the TIN, and MIPS payment adjustments will be applied to the group level of the eligible clinicians in the group.

You can join virtual groups in the future once CMS has determined that definition. We should know more about this in early 2017.

What about multi-specialty practices? Should they report as a group or individually?

For most practices, it will be beneficial to report as a group. It's relatively easy to achieve measures, such as care coordination, that require effective communication among providers, patients, and specialists. Everybody can participate in this. Individual reporting in a multi-specialty group is an onerous process to address all the issues and will be quite confusing for the staff.

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To get the maximum score for 2017 do I have to report for the full year or can I just report for 90 days?

This depends on the quality of the data being submitted. The higher the data quality, the higher the score. Participants could report for the full year, but with low performance in all measures and still score lower than participants who report for 90 days with high performance in fewer measures.

The 90-day option can begin at any point in 2017. The 90-days must be consecutive and reporting must be submitted by March 2018. This provides flexibility for participants who cannot ramp up in time for the beginning of the year.

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

What are the primary benefits of participating in MIPS?

MIPS offers the first real opportunity for physicians to earn substantial bonuses for providing a higher quality of care. Additional funding is provided for separate bonuses of up to 10 percent for exceptional performance (up to \$500 million per year) from 2019 through 2024.

It's a streamlined performance reporting system, which should be more easily managed than the existing multiple reporting systems. CMS currently allows group practices to report via the [qualified clinical data registry](#) starting in 2017, and MACRA encourages eligible professionals to use these registries for MIPS reporting.

Other benefits of MIPS participation include an improved performance scoring system that features a sliding scale assessment and offers a flexible selection of measures with flexible weighting to accommodate many practice types.

Also, small practices will receive \$100 million in technical assistance, money set aside for training to help them comply and participate in MIPS. From fiscal years 2016 through 2020, \$20 million per year will assist practices of up to 15 professionals to participate in the MIPS program or transition to new payment models.

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Full-year participants will potentially qualify for the four percent bonus, while minimal participation will avoid a negative adjustment. Bonuses and penalties rise in subsequent years. The more you do in 2017, the easier the subsequent years will be.

Summary of Reporting Options				
No Reporting	Minimal Reporting	Partial Reporting	Full Reporting	Advanced Reporting
Maximum negative adjustment of 4% in MIPS.	Report some data in 2017 to the Quality Payments Program (QPP)	Participate for part of 2017	Participate for all of 2017	Participate in an Advanced APM
	Protected from negative payment adjustment in MIPS, but no positive payment adjustment available either	Eligible for positive payment adjustment	Doctors who begin reporting data on January 1st 2017 will be eligible for a “modest” pay increase in 2019	Doctors who begin reporting data on January 1st 2017 will be eligible for a “modest” pay increase in 2019
	The specific measures have defined what “some data” actually means	Protected from negative payment adjustment	Data on quality measures, use of technology and practice improvement must be reported	Data on quality measures, use of technology and practice improvement must be reported
	CMS considers this a test of how doctors will be ready for more intense reporting requirements in the following years	Participants will be testing their systems for future MACRA compliance and may end up with a small Medicare pay increase		

Table 3 A summary of the reporting options under the new MACRA rule.

How would scoring look with minimal participation under MIPS in year one?

In this example, Individual A submits one quality measure with low performance (max possible points = 60), no Improvement Activity data (max possible points = 40), and no Advancing Care Information data (max

Partial QPs are eligible to select the MIPS track, but Advanced APM QPs are not obligated to MIPS and they receive the five percent incentive payment for 2019.

FINANCIAL ASSISTANCE FOR TRAINING AND EDUCATION IS AVAILABLE

The intent of MACRA is not to save money just for the sake of saving money, but to incorporate financial incentives in order to take care of patients in a more efficient way and to give them the benefit of a quality clinical experience.

As mentioned earlier, MACRA will provide \$100 million to fund training and education (\$20 million each year for the next five years), beginning December of 2016. Individual or small group practices of 15 or fewer clinicians, and those working in underserved areas, are eligible to receive this training. This education will be conducted through local, experienced organizations that will use the funding to help small practices select appropriate quality measures and technology to support their unique needs, train clinicians about the new improvement activities, and assist practices in evaluating their options for joining an Advanced APM.

More information is available from several organizations:

[American Medical Association](#)

[American Hospital Association](#)

[American Academy of Family Physicians](#)

[Office of the National Coordinator list of certified vendors](#)

[CMS Quality Payment Program](#)

Focus on Strategic Planning in Four Key Areas

To start preparing for MACRA today, focus on evaluation and strategic planning in four key areas:

Financial – For 2017, stabilize and optimize your revenue stream to make sure your practice isn't leaving money on the table. Make sure you are conducting self-audits and GL management to help plug any revenue leaks. Scrutinize your [reimbursements](#).

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Clinical – 60 percent of your MIPS score is based on Quality targets, so pay attention to this scoring category and take advantage of all the measures spread across multiple domains. Also, focus on the measures on which you already report. Remember that [population health](#) and care coordination are at the heart of the QPP, so focus on expanding communication with your beneficiaries, patient care teams, and specialists.

Technical – Success here is key to MACRA, so make sure you can access information through your EHR templates, that your workflow is customized, and create dashboards for easy visualizations.

Staff Training – To help shoulder this burden, practices may need to align with partners that have expertise in program implementation, staff training, and educating stakeholders along the continuum.

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FOLLOW THROUGH WITH SEVEN STEPS TO PREPARE FOR MACRA

With the strategic plan in place, follow through with these seven steps to ensure a smoother transition to the new payment structure.

#1: Determine Your Status

Use the American Medical Association's [payment model evaluator](#) to find out if you qualify for the MIPS or Advanced APM tracks, or are exempt.

#2: Decide on Individual Vs. Group Reporting

If you practice with more than one eligible clinician, decide whether it's more beneficial for you to report individually or as a group. If you report as a group, you will have less flexibility on which measures to report.

#3: Determine Accommodations

Determine whether you meet the requirements for small, rural, or non-patient-facing physician accommodations.

#4: Target Specific Improvement Areas

Access and review the 2014 annual PQRS feedback reports to see where you can make improvements. If you don't have data on certain measures or you haven't reported on them before, then it will be difficult to start reporting on them for 2017. Pick measures on which you are already reporting.



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