

The 7 Best Ways to Prepare for MACRA Today

By Bobbi Brown

7 STEPS TO PREPARE

- 1 Outline a Strategy by Q4 2016
- 2 Educate Providers
- 3 Attend Professional Society Meetings
- 4 Identify and Discuss APMs with Thought Leaders
- 5 Identify High-Performance Areas in Quality Measures
- 6 Review Your QRUR
- 7 Evaluate Your Readiness for MACRA

What does the [Medicare Access and CHIP Reauthorization Act \(MACRA\)](#), signed into law in 2015, mean for healthcare organizations and providers? At HIMSS 2016, the CMS Center for Clinical Standards and Quality Director, Kate Goodrich, MD, stated MACRA's goal: "to have a single, unified program with flexibility. The new Merit-Based Incentive Payment System (MIPS) will offer that flexibility and not be a one-size fits all program. The new rule will reimburse physicians based on four factors." Hospitals are not impacted by this regulation.

The proposed regulations published in April 2016 provide more detail on the quality measures and scoring.

MACRA's base year will be 2017—and 2017 is just around the corner. The first payment year will be 2019. This article provides an overview of MACRA and guidance about what health systems should do to prepare for MACRA now.

MACRA Overview

MACRA permanently replaces the unsustainable Sustainable Growth Rate (SGR) formula (created in 1997 to restrict growth in Medicare Part B spending) with a system that attempts to prioritize quality over quantity. It also replaces Medicare's physician quality reporting programs with a Merit-Based Incentive Payment System (MIPS). Several programs such as Accountable Care Organizations (ACOs), bundled payments, and various value-based models exist for hospitals and eligible professionals. These programs will continue and their incentives/penalties are not impacted by MACRA.

Under MACRA, providers will receive a .5 percent annual increase until 2019, at which point they can choose between two value-based payment tracks: MIPS or Alternative Payment Models (APMs). [Meaningful use](#) will be moved under MACRA in both tracks.

Two Value-Based Payment Tracks: MIPS and APMs

Starting in 2019, providers can choose between MIPS and APMs:

MACRA permanently replaces the unsustainable Sustainable Growth Rate (SGR) formula (created in 1997 to restrict growth in Medicare Part B spending) with a system that attempts to prioritize quality over quantity. It also replaces Medicare's physician quality reporting programs with a Merit-Based Incentive Payment System (MIPS).

MIPS

MIPS will be the default system, and consolidates the existing Meaningful Use, Physician Quality Reporting System (PQRS), and Value-Based Payment Modifier (VBM) programs.

Physicians that choose this track face payment increases and or reductions based on performance. In the first year of payment, 2019, there is potential for a maximum plus or minus 4 percent or payments could also have no change or remain neutral. A bonus (not to exceed 10 percent) for exceptional performance is part of this program for the first five years. An overall MIPS score will be calculated according to performance in four measures (weighted by performance, with potential changes in weight by year):

1. Quality (50 percent) Chose six measures to submit.
Example of outcome measure: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery
2. Cost (Resource use) (10 percent) Calculated by CMS to compare resources used to treat similar care episodes and clinical condition groups across practices.
3. Advancing care information (Meaningful use) (25 percent)
Continued focus on interoperability and security
Example: Electronic prescribing
4. Clinical practice improvement activities (15 percent)
General categories include patient access, care coordination. Specifics due later.

APMs

The APMs track reimburses Medicare providers based on value of services rather than service volume. Providers meeting the criteria for this track cannot move to the MIPS track.

Physicians receiving a significant portion of their payments through eligible APMs can be exempt from MIPS—and they receive a lump sum payment of 5 percent of covered services. By 2018, [CMS](#) wants 90 percent of payments tied to quality, with 50 percent under APMs.

The regulations provided more guidance on this track. Criteria include:

- The advanced APM must require use of certified EHR technology.

MACRA will require the continuation of meaningful use for Medicare-eligible professionals, but the incentive program can be modified to achieve the results CMS wants.

- Payment must be based on quality measures.
- There also needs to be financial risk or a medical home that meets certain criteria.

Generally, most providers will not meet the criteria for this track. There are some organizations that are automatically qualified:

- Comprehensive ESRD Care Model (large dialysis organization): 12 participants
- Medicare Shared Savings Program—Track 2 and Track 3: 24 participants
- Next Generation ACO Model: 21 participants
- Comprehensive Primary Care Plus (CPC+): Currently regional with payers, available in 2017
- Oncology Care Model Two-Sided Risk Arrangement (available in 2018)

Meaningful Use Is Still Here

In January, 2016, the CMS Acting Administrator, Andy Slavitt, tweeted about the end of meaningful use: “In 2016, MU [meaningful use] as it has existed—with MACRA—will now be effectively over and replaced with something better.” But Slavitt’s tweet was followed up with a speech and blog post in which he softened his declaration: “The focus will move away from rewarding providers for the use of technology and towards the outcome they achieve with their patients.”

Most recently, at the 2016 HIMSS, CMS officials stated that physicians can expect meaningful use to continue to be required. Indeed, MACRA will require the continuation of meaningful use for Medicare-eligible professionals, but the incentive program can be modified to achieve the results CMS wants.

CMS EHR incentive programs (designed to encourage the adoption of new technology and measure the resulting benefits for patients) have paid out \$31.5 billion between January, 2011 and January, 2016. The Eligible Professionals (EP) program received \$12.6 billion for approximately 465,000 unique providers. Nothing has changed in 2016. In January, 2016, more

“The biggest challenge MACRA brings to healthcare organizations and, in particular, physicians, is administrative burden. In particular, compiling quality metrics.”

than 200,000 eligible professionals saw a decrease in their Medicare payments because they failed to meet meaningful use standards in 2014. Meaningful use isn't going away.

Overcoming MACRA's Administrative Burden with an EDW

The biggest challenge MACRA brings to healthcare organizations and, in particular, physicians, is administrative burden. In particular, compiling quality metrics.

A [survey](#) conducted in March, 2016 by Weill Cornell Medical College and the [Medical Group Management Association \(MGMA\)](#) found that physicians spend an average of 15.1 hours every week processing quality metrics. The time physicians spend processing quality metrics translates to an average cost of \$40,069 per physician, per year. These figures emphasize the analytics burden that needs to be offset by clearly defined benefits.

Implementing an [enterprise data warehouse](#) (EDW) and providing physicians with self-service tools to analyze their performance will help providers and systems navigate the administrative burden introduced by MACRA.

The Seven Best Ways to Prepare for MACRA Today

Although 2019 seems far away, health systems need to start thinking about MACRA now. For the most part, health systems and physicians haven't realized the impact of this shift; nor have they determined the right strategies. There are several things health systems can do to start preparing for MACRA now:

1. Outline a strategy for tackling MACRA by Q4 2016.
2. Educate providers and encourage discussion about the new regulation.
3. Attend professional society meetings and use the resources they offer. (Physician groups like the [American Medical Association \(AMA\)](#) and [American Academy of Family Physicians \(AAFP\)](#) are active in their efforts to train and advocate for physicians on MACRA. The [American Hospital Association \(AHA\)](#) provides online resources, including a [webinar](#), to help systems prepare for MACRA.)
4. Identify health system thought leaders and discuss APMs (ACOs, etc.).
5. Take a look at your quality measures and identify high-performing areas.

6. Review your CMS Quality Resource and Use Report (QRUR).
7. If you did not report for PQRS or meaningful use, then evaluate the penalties and your readiness for MACRA.

Although we'll know more about MACRA in the coming months, 2017 will most likely be MACRA's base year, so the best time to start preparing for MACRA is today. We'll provide a follow-up to this blog as new details about MACRA are released. 🔔

About the Author



Bobbi Brown is the Vice President of Financial Engagement for Health Catalyst®. Ms. Brown started her healthcare career at Intermountain Healthcare supporting clinical integration efforts before moving to Sutter Health and, later, Kaiser Permanente, where she served as Vice President of Financial Planning and Performance. Ms. Brown holds an MBA from the Thunderbird School of Global Management as well as a BA in Spanish and Education from Misericordia University. She regularly writes and teaches on finance-related healthcare topics.