MIPS and MACRA: 
Closer than You Think
EXECUTIVE SUMMARY


MACRA is best known for replacing the sustainable growth rate (SGR) formula that used to require annual Congressional action to avoid draconian cuts to physician payments. But, it with replaces the new Quality Payment Program framework for rewarding value over volume, and combined existing programs including PQRS, VBM and Meaningful Use. The new program has two tracks: the Merit-based Incentive Payment System (MIPS) and advanced alternative payment models (APMs).1

Most eligible professionals will participate in MIPS unless they meet very specific requirements to be an APM participant.

Unless you are already well-entrenched in an ACO or similar arrangement, now is time to get ready for MIPS.

Fortunately, if a group is currently successful with PQRS, VBM and MU, they should find the MIPS transition manageable. However, many groups and physicians are not successful and MIPS will not be easy (despite CMS attempts to streamline some reporting).

According to CMS, MACRA implementation will help achieve the goal of paying for value and better care, in addition to making it easier for health care providers to successfully take part in CMS’ quality programs.

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MGMA has provided this high level summary of the transition:

MACRA BASICS

On April 27th, CMS released its highly anticipated proposal to implement the MACRA physician payment reforms. In July, CMS Acting Administrator Andy Slavitt told the Senate Finance Committee that CMS might consider delaying the start date, currently proposed for January 2017, due to concerns that “some smaller practices may not be ready.” However, it is not clear what a delay would mean. One proposal, from U.S. Rep. Phil Roe, MD, one of the authors of MACRA, is to move the reporting date from January 1 to July 1, 2017. However, on the surface it would appear that delaying MIPS and APMs might leave the existing unpopular programs such as PQRS and MU in place.

In the following, we describe the MACRA implementation as outlined by CMS in its proposed rule since most of the parameters are highly likely to remain, even if the start date for reporting is delayed.
Programs Affected

In addition to repealing and replacing the Medicare Sustainable Growth Rate (SGR), MACRA consolidates and replaces a number of existing programs.

MACRA establishes the new MIPS and APM regimes. It ends payment adjustments for the current Physician Quality Reporting System (PQRS) as of the end of 2018 (2018 PQRS payment adjustments are based on 2016 PQRS reporting). However, the MIPS Quality performance category has many aspects of PQRS including its reporting infrastructure.

Similarly, the Value-Based Payment Modifier (VBM) program is incorporated into the MIPS Resource Use performance category which looks very similar to VBM.

Finally, the Meaningful Use (MU) program/Medicare Electronic Health Records (EHR) Incentive Program has been replaced by “Advancing Care Information” in MIPS. The EHR Incentive Programs for hospitals and for professionals in the Medicaid program remain intact, but the existing Medicare physician payment adjustments for MU end after calendar year 2018.

However, MIPS and APM requirements for 2017 mandate the use of certified EHR technology and require clinicians to choose reporting measures specific to its use, with a particular emphasis on interoperability and information exchange. 25% of an Eligible Clinicians MIPS score will be from the Advancing Care Information performance category. It is based on MU Modified Stage2 measures [for 2014 Edition CEHRT] and MU Stage3 measures [for 2015 Edition CEHRT]. The good news is that reporting will no longer be “all or nothing.”

Providers Impacted

Under the proposal, the traditional term “eligible providers” has been re-named and expanded to include physicians, dentists, chiropractors, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, physician assistants, physical or speech therapists, and hospital-based eligible providers. Any clinician billing for professional services under Medicare Part B is referred to as an “eligible clinician” (EC) under MACRA.

MACRA will also apply to care facilities billing Medicare Part B on behalf of the physicians who see their patients.

MACRA does not apply to those providers who do not bill Medicare, Medicaid providers without Medicare patients, or pediatricians.

MIPS exemptions will made be available for physicians new to Medicare, those billing $10,000 or less in Medicare charges, those with 100 or fewer Medicare patients, and those who significantly participate in an APM.

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Timeline

As it currently stands, MIPS and APMs will go into effect over a timeline through 2021 and beyond. But even with the proposed rule, there are unanswered details. For example, will current MU exemptions for anesthesiologists, radiologists and pathologists be continued? If so, how would that be reflected in their MIPS score?

A general timeline provided by CMS is shown here:

MIPS will begin in the 2017 performance year, which isn’t that far away. With 85% of the MIPS score coming from categories that mimic MU, PQRS, and VBM, physicians and groups are well-advised to continue to improve their performance in these existing programs. If a physician or group is participating in a Medicare ACO or PCMH, it is now critical to understand whether that meets the 25% APM threshold.

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APM Implications

Those wanting to use the APM option can consider achieving PCMH prior to 2017; this is one of the few ways to qualify for an APM. Practices that have achieved PCMH by 2017 will be best positioned to leverage a broad range of incentive options. Providers considering the APM option for 2017 will need to move quickly unless they are already well established with an ACO or PCMH. Those participating in an ACO, PCMH, etc. need to immediately assess if the ACO portion of their business will meet the 25% threshold.

Since providers don’t have to get 100% of their revenue from a qualified APM, physician practices will be able to balance their revenue stream across multiple payment systems and can qualify for APMs while also receiving revenue through other payment systems. Of course, the APM qualifying percentage increases to 75% for 2021. The mechanics each year could pose challenges for practices in terms of exactly where is revenue coming from; e.g. what percent of monthly revenue came from an APM, and is that going to affect whether the group qualifies?

Section 101 of MACRA encourages expansion of the APM options available to physicians, especially specialists, through Physician Focused Payment Models (PFPMs). The law requires the establishment of a Technical Advisory Committee to assess PFPM proposals and make recommendations to the Secretary about which models to consider testing.

Some think the impending changes by Medicare to substantially link payments to performance and incentivize physicians to participate in APMs are likely to cause a dramatic increase in physician-physician consolidation and physician-hospital consolidation and alignment.

MIPS Implications

On the one hand, providers who currently deal successfully with PQRS, VBM and MU should find MIPS reporting to be similar, and perhaps more streamlined. On the other hand, there is a new category of Clinical Practice Improvement and the overall scoring is different.

And there is a new consideration since MACRA requires posting each clinician’s 0 to 100 MIPS score on the CMS “Physician Compare” website where it can be used by patients and others.

Smaller practices may struggle to find the resources to take full advantage of, and manage their performance against MIPS, never mind participate in an APM. Some think this could result in accelerated consolidation into larger freestanding physician practices or integrated delivery systems. The impact that MIPS’s resource utilization will have on hospital reimbursement and health systems may also motivate them to employ physicians to shape incentives appropriately.

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5 "Current Medicare Incentive Programs to be Replaced by New Quality Initiatives – Physicians Must Act Now to Sustain and Grow Fee Schedule," Michigan State Medical Society (MSMS), July 22, 2015
6 Conway, Patrick; Groninger, Tim; Pham, Hoangmai; Goodrich, Kate; Bassano, Amy; Sharp, JP; Falb, Alison; MachHarris, Molly, "MACRA: New Opportunities For Medicare Providers Through Innovative Payment Systems [Updated]," HealthAffairsBlog, September 28, 2015
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Those specialties with little or no in-person patient contact, such as radiology and pathology, may find themselves faced with the challenge of meeting certain requirements. For example, “clinical practice improvement” seeks to engage providers in clinical practice improvement activities, which will be established by CMS in collaboration with professionals. Activities must be applicable to all specialties and attainable for small practices and professionals in rural and underserved areas. This is but one of many issues that remain to be worked.

Physician compensation arrangements, as well as professional services agreements, are expected to evolve to include physician incentives that reflect those being implemented by CMS. Physicians will need to develop a strategic plan to address the evolving performance measures since they will have a significant potential for lower or higher reimbursement rates. Considering the cost associated with ramping up technology capabilities for tracking the quality metrics built into MIPS and APMs, the question of whether the physician or the health system receives the biggest benefit, and incurs the largest costs, will be a prevalent theme.

With the introduction of MIPS, commercial payor contracts containing language that defines reimbursement as a percentage of Medicare may not translate. Many existing contracts do not have sufficient flexibility. Therefore, commercial payor contracts should be reviewed to determine their compatibility with MACRA and language adjusted as necessary.

Possible Delays

At a recent panel discussion hosted by the Alliance for Health Reform, numerous trade groups including the American Medical Association and the Blue Cross Blue Shield Association urged CMS to postpone the implementation of MACRA rules. The panel also asked CMS to reduce physicians’ burden of reporting quality data, increase the low-volume threshold to exempt more physicians from MIPS, and preserve the “hardship exemption” offered under Meaningful Use for its replacement, Advanced Care Information.8

CMS Acting Administrator Andy Slavitt responded when testifying before the Senate Finance Committee, that CMS might consider delaying the start date, due to concerns “that some physicians, particularly at small practices, may not be ready for the changes.”9

CMS has received “significant feedback”, Slavitt said. “Some of the things that are on the table, [that] we’re considering include alternative start dates, looking at whether shorter periods could be used, and finding other ways for physicians to get experience with the program before the impact of it really hits them.”

While CMS is considering a possible delay, the direction is quite clear and physicians, hospitals and other providers need to be preparing for a future under MIPS and/or APMs.

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QUALITY PAYMENT PROGRAM OPTIONS

Option 1: MIPS

Positive fee schedule adjustments in the MIPS option will hinge on meeting quality benchmarks, managing resource use, continuously improving clinical practice, and using a certified EHR for MU.\textsuperscript{10} The good news is that those who excel stand to receive a substantial incentive payment—as much as 27 percent!

But this is a “zero sum” process where those incentives come from penalties for lower scoring providers. Providers near the bottom of MIPS scores will initially be subject to a 4% penalty. However, this penalty grows to 9% by 2022! MIPS is a sliding scale as shown in the chart on the next page.

MIPS combines current incentive programs into a single program with four performance categories that together create a score from 0 to 100 points:
- Quality (50% initially declining to 30% or 30 points after 2 years)
- Resource Use (Cost) (10% initially increasing to 30% or 30 points after 2 years)
- Advancing Care Information (Use of Certified EHR Technology) (25% or 25 points)
- Clinical Practice Improvement Activities (15% or 15 points)

\textsuperscript{10} MACRA RFI Posting, "RFI on Physician Payment Reform: External FAQ," CMS-3321-NC, 2015
MACRA requires that the Secretary of HHS develop and provide clinicians with a Composite Performance Score that incorporates performance in each of these categories. Based on this Composite Performance Score, ECs may receive an upward, downward, or no payment adjustment. MIPS allows for ECs to achieve significant financial incentives for providing health care that advances the goals of a better, smarter, and healthier system. This chart summarizes the potential reimbursement impact:

Over time, it is expected (and hoped!) that today’s confusing PQRS quality measures will be replaced with ones that better comport with how each specialty affects patient health. According to a Quality Measure Development Plan (MDP) released by CMS late in 2015, MACRA has five quality domains: clinical care, safety, care coordination, patient and caregiver experience, and population health and prevention. The MDP is intended to be a strategic framework for the future of clinician quality measure development. CMS is required to publish an annual report with progress made during each year, including a listing of the new measures developed.

In the meantime, most observers expect, despite many objections, that 2017 quality reporting will not differ significantly from 2016.

11 Conway, Patrick; Gronniger, Tim; Pham, Hoangmai; Goodrich, Kate; Bassano, Amy; Sharp, JP; Falb, Alison; MacHarris, Molly, "MACRA: New Opportunities For Medicare Providers Through Innovative Payment Systems (Updated)," HealthAffairsBlog, September 28, 2015
Option 2: APMS

APM participants will not be subject to MIPS adjustments and will receive a 5% annual APM incentive payment in 2019 through 2024. Beginning in 2026, ECs in an APM will receive an annual 0.75% fee schedule update (all other EPs will receive a 0.25% fee schedule update). However, it is critical to understand that APMs, by their nature, have expectations of improved quality and outcomes built in. This means that physicians and groups in APMs that don’t meet benchmarks will see reimbursement penalties.

While participants in APMs don’t have to meet the specific MIPS requirements, most APMs will have measures for quality, etc. In the end, the expectations for APM participants could be just as demanding as those for MIPS. In fact, the CMS FAQs say, “Eligible alternative payment entity means ... an entity that: (1) participates in an APM that requires participants to use certified EHR technology and provides for payment based on quality measures comparable to those in MIPS; and (2) either bears more than nominal financial risk for monetary losses under the APM or is a medical home expanded under CMS Innovation Center authority.”

To qualify for APM, providers need to have at least 25% of their Medicare reimbursement from an APM-eligible entity in 2019 and 2020 payment years: i.e. 2017 and 2018 performance years. That increases to 50% for 2021 and 2022 payment years (2019 and 2020 performance) and 75% thereafter.

CMS has discussed an APM exception known as “partial qualifying APM participant”, with a lower percentage threshold. These ECs would not be eligible for the 5% APM incentive, but they would be exempt from MIPS. The exact criteria have not been defined.

CMS offers the following APM examples:

- **Accountable Care Organizations (ACOs)** are groups of doctors, hospitals, and other health care providers who agree to share collective accountability for the quality and cost of care delivered to the patients attributed to their ACO. Payments to ACOs incorporate financial incentives in the form of shared savings or losses for performance on identified spending and quality metrics.

- **Patient Centered Medical Homes** are team-based models of patient care that rely heavily on the primary care practice as the main and central source for delivery and coordination of the majority of health, illness, and wellness care for Medicare beneficiaries. Insurers that support the medical home model typically provide monthly care management fees or other payments in addition to fee-for-service reimbursement for activities related to patient care and coordination.

- **Bundled Payment Models** focus on discrete episodes of care by establishing an overall budget for services provided to a patient receiving a course of treatment for a given clinical condition.

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13 *The Merit-Based Incentive Payment System (MIPS) & Alternative Payment Models (APMs): Delivery System Reform, Medicare Payment Reform, & the MACRA,* CMS, accessed March 2016
14 Baseman, Susan; Boccuti, Cristina; Moon, Marilyn; Griffin; Dutta, Tania, “Payment and Delivery System Reform in Medicare: A Primer on Medical Homes, Accountable Care Organizations, and Bundled Payments,” Kaiser Family Foundation, February 22, 2016
condition over a defined period of time. In contrast to paying for each service individually, bundled payments provide incentives for providers to come in “under budget” for episodes of care.

- APMs aim to provide new ways to pay clinicians for the care they give Medicare beneficiaries. Physicians would be paid differently than today in order to redesign care for higher quality and lower costs and will become accountable for controlling health-care costs, resulting in the payer (Medicare or another health plan) saving money.15

MACRA qualifies a Medicare APM as a CMMI model under section 1115A, a Medicare Shared Savings Program (MSSP), a demonstration under the Health Care Quality Demonstration Program; or a demonstration required by Federal law.16

NEXT STEPS FOR PRACTICES & ECS

MIPS data reporting begins starting January 1st, 2017. Incentives and adjustments will not take place until January of 2019 but they will be determined by the data reported starting January 1st, 2017.17

ECs and practices can prepare for the quickly approaching changes under the new payment law by reviewing current PQRS, VBM and MU results and then evaluating options and opportunities for improvement in the new Quality Payment Program.

The MIPS quality measures to report on, whether workflow supports all of the MIPS requirements, and whether technology supports the workflow and can meet the new reporting requirements are all factors ECs must take into consideration when setting a plan for MACRA implementation.

For those participating in an advanced APM, it will be necessary to develop a cohesive plan of action and to identify the risks and rewards that are available.

By 2017, ECs will have to attest to support for health information exchange and the prevention of information blocking, as well as attest that the EC is cooperating with surveillance and oversight of the practices EHR. ECs must also ensure their practice has obtained a 2014 or 2015 Edition Certified EHR.

Despite some open details and questions about the exact effective date, the major impact of MIPS and APMs mean that it is important to start planning now. Ultimately, preparing for MACRA will help all organizations identify their priorities for the new reimbursement regime on which MACRA is based.