

Health Policy Brief

MACRA: Disrupting the health care system at every level

Produced by the Deloitte Center for Health Solutions and the Deloitte Center for Regulatory Strategies



Executive summary

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is poised to drive health care delivery and payment reform across clinicians, health systems, Medicare, and other government and commercial payers. On May 9, 2016, the US Centers for Medicare and Medicaid Services (CMS) published a proposed rule that would implement key features of this law: the Merit-based Incentive Payment System (MIPS), which would apply to eligible clinicians that Medicare pays under the Physician Fee Schedule (PFS), as well as the incentives for clinicians to participate in Advanced Alternative Payment Models (APMs).

The proposed rule's release gives stakeholders more information to assist in planning their MACRA strategies. Among questions facing clinicians and health systems:

- Which payment track will be the best fit for our practice/organization now? In five years? In 10 years?
- *If organizations opt for MIPS:* Do we have the people, processes, and technology in place to accurately collect and report data on the MIPS measures? How can we help clinicians perform well on these measures in order to receive positive payment updates?
- *If organizations choose to invest in APMs:* Given our current payer mix, is it possible for professionals to meet the revenue or patient-count thresholds required to qualify for APM incentive payments and higher payment updates? Are we experienced with and successful at managing risk under these Advanced APMs? What types of Advanced APM arrangements will be most beneficial for us?

Introduction

MACRA is expected to drive care delivery and payment reform across the US health care system for the foreseeable future. Congress intended MACRA to be a transformative law that constructs a new, fast-speed highway to transport the health care system from its traditional fee-for-service (FFS) payment model to new risk-bearing, coordinated care models. It has the potential to be a game-changer at all levels of our health care system. Already, the law is igniting strategic discussions around new care, payment, and delivery models and creating new sources of risk for health care organizations.

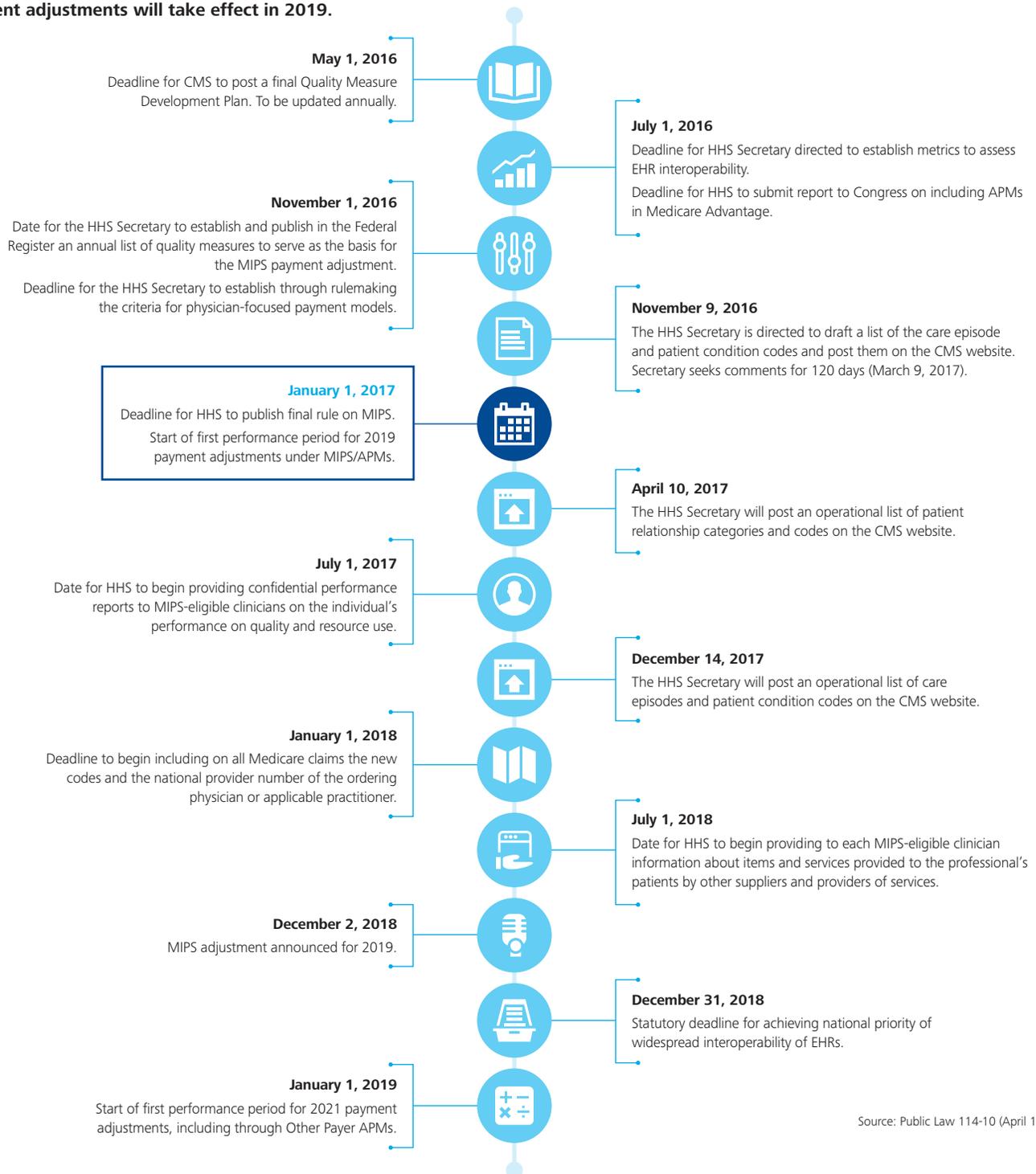
MACRA overhauls Medicare's payments to clinicians by creating strong incentives for them to participate in APMs that require financial risk-sharing for a broad set of health services and that are designed to improve quality. Clinicians who are not counted as participating in these models will need to report and have their performance measured in four categories – quality, resource use, health information technology (HIT) use, and clinical practice improvement. Over time, resource use performance – measuring the costs associated with clinicians' practice and referral patterns – will grow to 30 percent of the performance formula. Together, these policies will encourage much stronger focus on quality and total cost of care.

MACRA puts significant revenue at stake for hospitals, health plans, and other organizations that employ clinicians who are paid through the Medicare PFS. In addition, the law's incentives for clinicians to enter risk-bearing, coordinated care models could create opportunities for health systems

and health plans to enter into new arrangements with clinicians under Medicare; this may set the stage for similar initiatives in other government programs, as well as with employers and commercial health plans.

Deadlines for MACRA implementation are fast approaching

Figure 1. CMS has proposed beginning the first performance period on January 1, 2017. Payment adjustments will take effect in 2019.



Source: Public Law 114-10 (April 16, 2015)

Key provisions of MACRA draft regulations

MACRA repealed the Medicare sustainable growth rate (SGR) methodology, which governed updates to the Medicare PFS and replaced it with fixed, annual payment updates for all future years. CMS' proposed rule establishes MIPS, a new program for clinicians (physicians and certain other professionals paid under the Medicare Part B fee schedule) that consolidates components of three existing programs to create a system that adjusts updates for clinicians based on their performance in four categories of measures. The proposed rule also establishes incentives for clinicians to participate in certain Advanced APMs – whether through Medicare or, in future years, through other payers.

Payment updates, bonuses, and adjustments

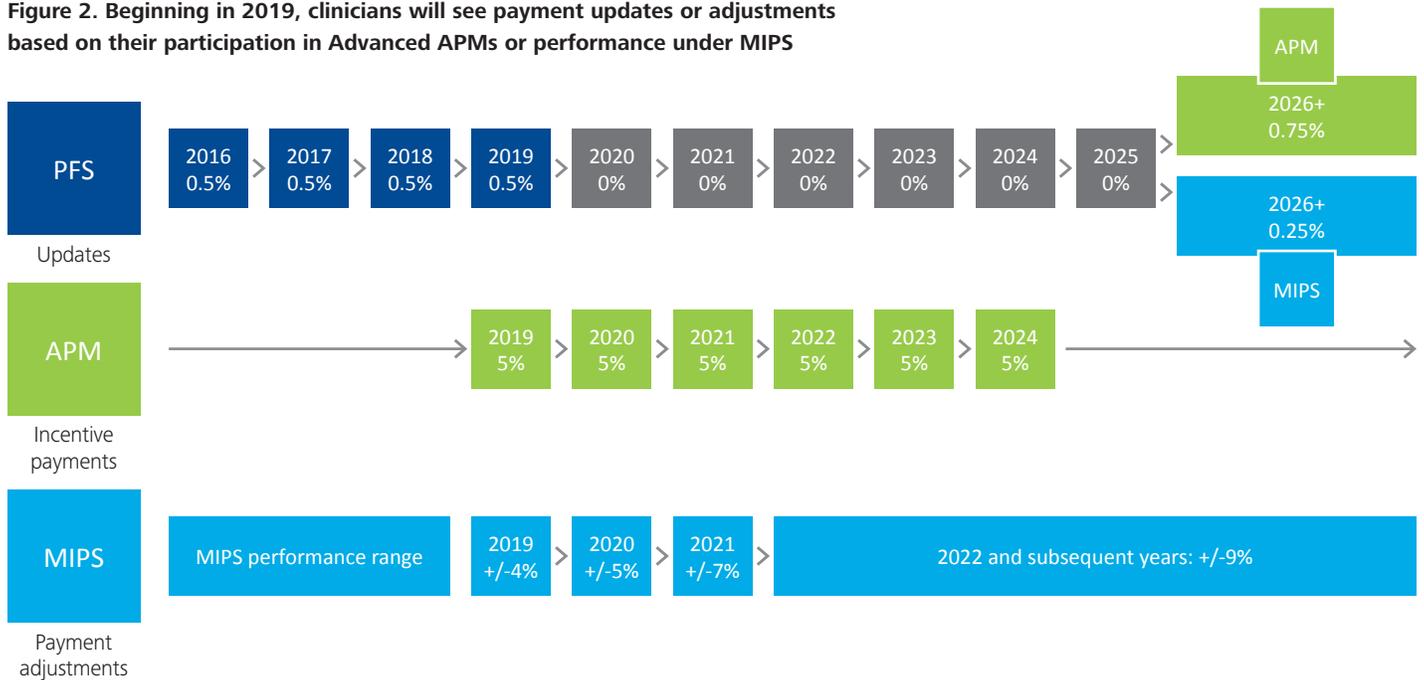
Although MACRA retains the Medicare PFS as the basis for Part B payments to health care professionals, it establishes two separate payment tracks that will more closely align reimbursement with new quality and outcomes measures.

Collectively, these paths are referred to as the Quality Payment Program (QPP).

Only health care professionals who meet or exceed certain revenue or patient-count thresholds through Advanced APMs beginning in 2017 will qualify for temporary financial bonuses and higher updates to the Medicare PFS (five percent beginning in 2019). Health care professionals who do not meet the revenue or patient-count thresholds through eligible APM entities will participate in MIPS. Under MIPS, clinicians who remain in the fee-for-service system will receive lower updates to the Medicare PFS and further payment adjustments determined on an individual or group basis (See Figure 2).

CMS expects to pay APM incentives to between 30,658 and 90,000 clinicians in 2019. Between 687,000 and 746,000 eligible clinicians are projected to receive payment adjustments through MIPS in 2019.¹

Figure 2. Beginning in 2019, clinicians will see payment updates or adjustments based on their participation in Advanced APMs or performance under MIPS



*For 2019 through 2024, the highest performing MIPS eligible clinicians who receive a positive payment adjustment will be eligible to share up to \$500 million each year for "exceptional performance" payments. This upside is limited by the statute to +10% of Medicare charges.

Source: Public Law 114-10 (April 16, 2015)

MIPS: Streamlining pay-for-performance

MIPS comprises four categories of measures that reflect quality achievement, clinical improvement, resource use, and electronic health records (EHR) use (See Figure 3). Weighting for the different types of measures changes over time, with resource use measures growing from 10 percent of the total in 2019 to 30 percent in 2021.

CMS estimates that MIPS would distribute payment adjustments to between 687,000 and 746,000 clinicians in 2019, and that these adjustments would be almost equally divided between negative adjustments (\$833 million) and positive adjustments (\$833 million). Additionally, MIPS would distribute approximately \$500 million in exceptional performance payments to MIPS-eligible clinicians whose performance exceeds a specified threshold.²

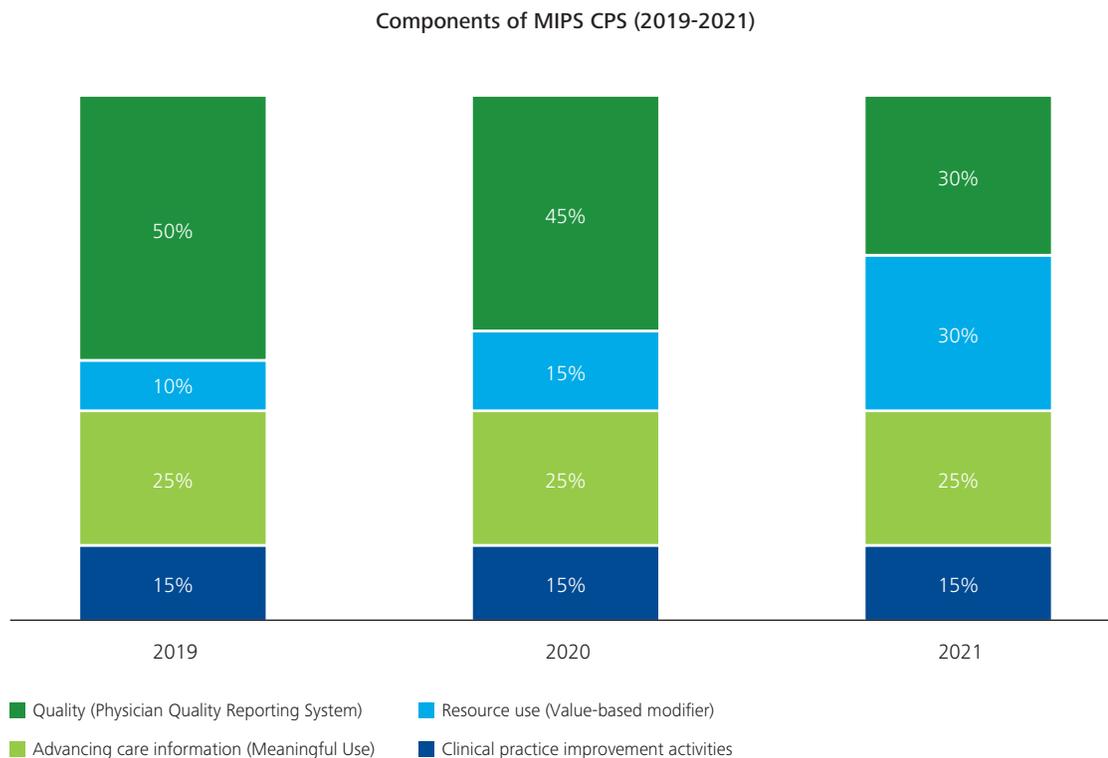
To whom does MIPS apply? MIPS-eligible clinicians include physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and groups that include such clinicians who bill Medicare under Part B.

When does MIPS start? In general, CMS proposes that payment adjustments start in 2019 based on performance measured in 2017. The MIPS performance period is one calendar year for all measures and activities in the four performance categories. Beginning July 1, 2017, CMS proposes to provide performance feedback to clinicians on the quality and resource use measures. The new way of measuring meaningful use of EHRs would start in 2017. The Physician Quality Reporting System (PQRS) and the Value Modifier programs will continue through 2018 and then sunset.

How do clinicians report? Clinicians can report as an individual MIPS-eligible clinician or as part of a group. Some data could be submitted through third-party entities, such as qualified clinical data registries, health IT vendors, qualified registries, and CMS-approved survey vendors.

How would clinicians make sure the data is correct? CMS would have a targeted review process that lets clinicians ask CMS to review the calculation of their MIPS adjustment factors.

Figure 3. Existing incentive programs will sunset in 2018, and performance will be consolidated into a new MIPS composite performance score (CPS)



Source: Public Law 114-10 (April 16, 2015)

MACRA's four categories of performance measures

Quality performance

Similar to PQRS, clinicians would provide information on quality of care, with a choice of which measures to report. A major difference with PQRS is how the information is used. PQRS penalizes clinicians who do not report measures, while the new system increases or decreases payment based on the results compared with other clinicians (See Table 1).

Resource use

CMS proposes to use three types of measures for resource use in MIPS; these measures are intended to capture the intensity (volume and mix) of services that clinicians are responsible for, either directly or through referrals. Two measures look at overall resource use: total per-capita costs for all attributed beneficiaries, which measures all Part A and Part B spending for primary care clinicians, and the Medicare Spending per Beneficiary (MSPB) measure, which captures spending around hospitalizations. Lastly, CMS proposes to include episode-based measures around particular types of medical care or conditions. Forty-one episode-based measures are listed in the proposed rule, but CMS indicates that not all of them may be used.

CMS would make adjustments to all the measures for geographic area and beneficiary risk factors. The total per-capita cost of care measure would be adjusted for clinician specialty.

Attribution rules vary by type of measure

- For the total per-capita cost of care measure, CMS would attribute a beneficiary to a primary care clinician (as identified by tax identification number [TIN]) who provided the most or the most recent primary care services.
- For the MSPB measure, CMS proposes to attribute spending to clinicians with the greatest Part B spending (as measured by allowable charges) rendered during an in-patient hospitalization. The MSPB measure would be assigned differently for individuals and groups.
- For episode-based measures, attribution would vary according to whether the episode is acute or procedural.
 - Acute-condition episodes would be attributed to all clinicians who bill at least 30 percent of in-patient evaluation and management visits during the initial treatment or "trigger event" that opened the episode.
 - Procedural episodes would be attributed to all MIPS-eligible clinicians who bill a Medicare Part B claim with a trigger code during the trigger event that opened the episode.

Table 1: Quality performance clinician reporting

| Program | PQRS | Quality performance category |
|-------------------------|--|--|
| Elements | <ul style="list-style-type: none"> • Clinicians receive a negative payment adjustment if they do not report measures. • Clinicians choose which measures they would like to report and the reporting mechanism, which influences the number of measures reported. In general, clinicians had to report nine measures for 2016. | <ul style="list-style-type: none"> • Clinicians will receive a payment increase or decrease depending on their quality measure performance. • Clinicians choose measures, but must report a minimum of six measures with at least one cross-cutting measure (for patient-facing, MIPS-eligible clinicians) and an outcome measure if available. If an outcome measure is not available the eligible clinician would report one other high-priority measure (appropriate use, patient safety, efficiency, patient experience, and care coordination). |
| Updating process | Annual proposal | Annual proposal with final list November 1 |
| Reporting | Medicare Physician Compare indicates whether clinician reports. | Medicare Physician Compare would indicate quality performance. |
| Exceptions | Clinicians for whom measures do not apply | <ul style="list-style-type: none"> • Alternative requirements for non-patient-facing clinicians • New Medicare-enrolled clinicians • APM-qualified participants • Clinicians who bill less than \$10,000 to Medicare Part B and serve fewer than 100 beneficiaries |

Source: Deloitte analysis of US Centers for Medicare and Medicaid Services, Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, Proposed Rule, 2016

CMS would calculate all of these measures from Medicare claims and would not require clinicians to submit data. Although the proposed rule calls for CMS to consider including Part D drug costs in these measures, they will not be part of the first set of resource use measures.

Advancing care information: EHR use

For this MIPS category, physicians and other clinicians must use certified EHR technology. They have some flexibility in the measures they report. The measures are intended to reflect how clinicians use EHR technology in their day-to-day practice, with a particular emphasis on interoperability and information exchange. (See Table 2.) Unlike other parts of MIPS, this aspect would start in 2017.

Clinical practice improvement activities (CPIA)

Clinicians and groups receive points for CPIA based on patient-centered medical home (PCMH) or comparable specialty practice participation, APM participation, and other CPIA activities reported by the clinician in comparison to the highest potential score for a given year. In the proposed rule, CMS regulators say they “generally encourage but are not requiring a minimum number of CPIAs.”³

Key issues and stakeholder reaction

Among key issues that health care stakeholders have raised and are likely formally submit throughout the comment period on the proposed rule are:

Is timing too aggressive or not aggressive enough?

Issues raised are likely to include whether clinicians have sufficient time to prepare, whether CMS provides feedback quickly enough, and whether the two-year lag between measuring performance and reflecting it in payment rates is acceptable.

Is burden too high, especially for small practices?

Stakeholders likely will raise concerns about the cost and effort associated with reporting and whether small practices will be disproportionately disadvantaged by the burden or the results.

Are the measures meaningful, useful, and reflective of care?

Concerns have been raised in the past about too many process measures and not enough outcome measures. CMS indicates it will introduce more outcome measures over time as they become available. Another likely issue is whether there are enough relevant measures for all specialties.

Table 2. EHR use clinician reporting

| Program | Meaningful Use (MU) | Advancing Care Information (ACI) |
|-------------------|---|--|
| Elements | Physicians receive higher or lower payments based on the MU stage they achieved. To receive the maximum payment, physicians must report all objectives and measures. | <ul style="list-style-type: none"> • ACI is rolled into overall MIPS score. • Emphasis is on interoperability, information exchange, and security measures. Clinical Decision Support and Computerized Provider Order Entry are no longer required. • Clinicians can choose which measures best fit their practice; multiple combinations of performance can produce a high score. • There is no separate reporting of quality measures. |
| Exceptions | Clinicians to whom measures do not apply | Clinicians to whom measures do not apply |

Source: Deloitte analysis of US Centers for Medicare and Medicaid Services, Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, Proposed Rule, 2016

Are the measures fair? Stakeholders may raise questions about whether the attribution methodology appropriately matches patients with clinicians, whether the associated quality and resource use is appropriate, and whether the quality and resource measures are adjusted to account for patient complexity and risk, including socioeconomic status. CMS indicates it is studying this issue and will consider it at a later date.

How can data errors be fixed? How can clinicians view and make corrections to their information before it is used for payment or public reporting?

What information will be publicly reported? What information about an individual clinician's performance will be published on Medicare Physician Compare?

Alternative payment models (APMs)

MACRA provides significant financial incentives for health care professionals to participate in risk-bearing, coordinated care models. Clinicians who receive significant shares of their revenue or patient counts through Advanced APM entities beginning in 2017 will be exempt from MIPS and qualify for incentive payments from 2019 through 2024. CMS has proposed two types of eligible APMs: Advanced APMs and Other Payer Advanced APMs.

Clinicians can qualify for the APM incentive track for 2019 and be exempted from MIPS in one of two ways:

- Receive at least 25 percent of Medicare Part B revenue through Advanced APM entities. The threshold increases to 50 percent in 2021 and 75 percent in 2023.
- Attribute at least 20 percent of eligible Medicare beneficiary patients to an Advanced APM entity. The threshold increases to 35 percent in 2021 and 50 percent in 2023.

CMS estimates that between 30,658 and 90,000 clinicians would qualify by participating in Advanced APMs and that they will receive between \$146 million and \$429 million in APM Incentive Payments for CY 2019.

Who qualifies? Not all existing APMs will qualify clinicians for incentive payments under MACRA. CMS differentiates between APMs that meet MACRA requirements (Advanced APMs) and APMs that do not meet the requirements and, thus, will not qualify clinicians for incentive payments. CMS also defines two types of Advanced APMs: Advanced APMs and Other Payer Advanced APMs. Both models require clinicians to use certified EHR technology, use quality measures similar to those in MIPS, and bear more than a "nominal" amount of risk for monetary losses (or be a medical home in the case of Advanced APMs or a Medicaid medical home in the case of the other payer Advanced APM). CMS defined "nominal" risk for this purpose in the proposed rule.

Six current APMs would qualify as eligible Advanced APMs under CMS' proposed rule (See Figure 4).

What is "nominal" risk?

For an APM to be an Advanced APM, it must mandate that participating clinicians and organizations share in potential losses. The arrangements must meet three risk-sharing requirements:

- **Marginal risk levels:** The arrangement must put organizations at financial risk for at least 30 percent of the amount by which actual expenditures exceed expected expenditures.
- **Minimum loss rate:** Many arrangements allow a "cushion" – spending to a certain level over the benchmark would not trigger shared losses. CMS would require risk arrangements to cap this amount at four percent.
- **Total potential risk:** The total amount for which an organization is at risk must be at least four percent of expected expenditures.

Example of nominal risk

Organization X had a benchmark of \$1 million but spent \$1.1 million. This table shows different arrangements that would meet or fail to meet the required risk levels.

| Benchmark: \$1,000,000 | Actual: \$1,100,000 | Marginal risk (sharing rate) | Stop loss (maximum amount at risk) | Are financial risk criterion met? |
|--|------------------------|---------------------------------|------------------------------------|-----------------------------------|
| <p>↓</p> <p>Marginal risk must equal at least 30% In this case, the organization must be at risk for at least \$30,000 (\$100,000 * 0.30).</p> <p>Minimum loss rate cannot exceed 4 percent of expected expenditures In this case, losses greater than \$40,000 (\$1,000,000 * 0.04) would trigger the organization to share in the losses. Losses under that amount would not trigger shared losses.</p> <p>Total potential risk must be at least 4 percent of expected expenditures In this case, the organization must be at risk for at least \$40,000 (\$1,000,000 * 0.04)</p> | | 50% | 15% | ✓ |
| | | 60% | 10% | ✓ |
| | | 40% | 3% | ✗ |
| | | 100% | 5% | ✓ |
| | | 25% | 10% | ✗ |
| | | <p>✗ Risk amount is too low</p> | | |

Source: Deloitte analysis of US Centers for Medicare and Medicaid Services, Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, Proposed Rule, 2016

Figure 4. The term APM is used broadly, but few existing APMs would qualify as Advanced APMs towards the target MACRA thresholds

| Advanced APM? | Model | Number of participating organizations in 2016 |
|---------------|---|---|
| ✓ | Next-generation Accountable Care Organization (ACO) Model | 18 |
| ✓ | Medicare Shared Savings Program (MSSP) Track 3 | 16 |
| ✓ | Comprehensive End-Stage Renal Disease (ESRD) Care (CEC) - Large Dialysis Organization (LDO) arrangement | 12 |
| ✓ | MSSP Track 2 | 6 |
| ✓ | Comprehensive Primary Care Plus (CPC+) | None (available in 2017) |
| ✓ | Oncology Care Model (OCM) two-sided risk arrangement | None (available in 2018) |
| ✗ | MSSP Track 1 | 411 |
| ✗ | Bundled Payments for Care Improvement | 1,522 |

Sources: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-04-18.html>; <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/All-Starts-MSSP-ACO.pdf>; <https://innovation.cms.gov/initiatives/comprehensive-esrd-care/>

Notably, CMS did not include Bundled Payment for Care Improvement initiatives or MSSP Track 1 – the Medicare ACO initiative with the greatest number of participants – in the list of APMs expected to be considered Advanced APMs. MSSP Track 1 features shared savings but no risk for monetary losses. However, in an updated frequently asked questions document published on May 27, 2016, CMS announced that it would allow interested physician practices to dually participate in CPC+ and MSSP. CMS will allow up to 1,500 practices participating in Tracks 1, 2, or 3 of MSSP to sign up to participate in CPC+, giving them access to monthly performance-based payments. This could help to speed up physician adoption of APMs.⁴

Clinicians can qualify for APM incentives through Other Payer Advanced APMs beginning in 2021 based on 2019 performance. To qualify under other payer arrangements in 2021 and 2022, Qualifying APM Participants (QPs) must receive at least 50 percent of the sum of payments by Medicare and other payers through Advanced APMs and Other Payer Advanced APMs. At least 25 percent of Medicare payments for covered professional services must be through Advanced APMs. To qualify in 2023 and subsequent years, QPs must receive at least 75 percent of payments through Advanced APMs and Other Payer Advanced APMs.

Qualifying for incentive payments under Advanced APMs

To qualify for the 2019 and 2020 financial bonuses, clinicians must meet revenue or patient-count thresholds:

- **Revenue:** Clinicians must receive at least 25 percent of Medicare payments under the Physician Fee Schedule through Advanced APMs. The law increases the minimum requirement for Medicare payments through Advanced APMs to 50 percent in 2021 and 2022 and 75 percent in 2023 and subsequent years.
- **Patient count:** Clinicians must have at least 20 percent of Medicare beneficiaries eligible to participate in an Advanced APM attributed to that Advanced APM. The law increases the patient count threshold to 35 percent in 2021 and 50 percent in 2023.

CMS will calculate these numbers each year at the Advanced APM entity level and use the results of whichever calculation is more favorable to the entity.

Because the thresholds rise over time, some clinicians could find themselves moving in and out of MIPS depending on how much revenue they receive through Advanced APMs in any given year. Clinicians who prepare for the MIPS requirements even as they work to increase the revenue they receive through Advanced APMs, and who qualify for the higher payment updates, may fare better than clinicians who choose to focus all of their energy on one path. However, the statute requires quality measures under Advanced APMs to be comparable to those used in MIPS so many clinicians may see efficiencies in running parallel efforts. Furthermore, some clinicians who participate in an APM but do not meet the required revenue thresholds would receive some credit for doing so under MIPS' CPIA measures system.

Key issues and stakeholder reactions

Is the timeline too aggressive and are the quality measures appropriate? The timeline for clinicians aiming for the Advanced APM incentive track does not differ from that of MIPS; clinicians and organizations will have only a few months to prepare for January 1, 2017, the start of the first performance period under the QPP. Advanced APM quality measures must be comparable to those under MIPS, so concerns about having the correct measures still apply under these models.

Would too few qualify for an Advanced APM?

Organizations such as the American Medical Group Association have stated that the narrow definition of Advanced APM means that very few clinicians will qualify in the first few years of implementation. For example, clinicians at the more than 400 organizations that have invested in becoming Track 1 MSSP ACOs will not qualify for APM incentive payments, but will receive higher scores in the CPIA measure.

Is there more to "nominal risk"? Many groups assert that CMS has defined financial risk too narrowly. For example, investments in technology (EHRs), analytics, and population health tools are not accounted for when CMS evaluates an organization's incurred financial risk.

Will CMS allow additional models to qualify as Advanced APMs in the future? MACRA created the 11-member Physician-Focused Payment Model Technical Advisory Committee to advise and evaluate the development of APMs, including specialist physician models. Individuals and stakeholder groups can submit proposals to the committee for physician-focused payment models (PFPMs) that they believe meet the criteria. The committee will review models on a periodic basis and provide comments and recommendations to the US Department of Health and Human Services (HHS) Secretary regarding whether the models meet the criteria. The HHS Secretary will review the comments and recommendations and post a detailed response on the CMS website. Many, but not all, of the PFPMs may be considered Advanced APMs.

How will Medicare Advantage be treated under the law? Many stakeholders wished to see Medicare Advantage (MA) count as an Advanced APM under MACRA. The statute is clear that Advanced APM incentive payments may apply only to Part B payments. However, CMS will evaluate MA payments under the Other Payer Advanced APM requirements. CMS will evaluate MA contracts to determine if they meet the EHR, quality measure, and nominal risk requirements to qualify as Advanced APMs.

An upcoming report could highlight additional considerations for MA plans as they evaluate the potential for participating in Other Payer Advanced APMs. By July 1, 2016, the HHS Secretary will submit to Congress a study evaluating the feasibility of integrating APMs into the MA payment system. In its 2017 MA call letter, CMS added APM questions to MA reporting requirements related to the proportion of payments made to health care providers in four categories of value-based payment developed by HHS.

The MACRA incentives to participate in Advanced APMs and, in future years, Other Payer Advanced APMs, highlight that this law likely will change more than Medicare payments to clinicians. Its emphasis on including other payer options means that health plans – both in MA and commercial lines of business – may see pressure to align payment arrangements with MACRA requirements to help clinicians meet qualifying thresholds for incentive payments.

Implications for health systems and health plans

Although MACRA is directed at physicians and other clinicians who are paid under Medicare Part B, it also could have implications for health systems and commercial health plans.

Health system implications:

- Hospitals that own physician practices will need to consider how to succeed under MIPS and whether to pursue an Advanced APM arrangement. This may not be an either/or decision: Even if systems invest in Advanced APM initiatives, not all of an organizations' clinicians may be able to take part in an Advanced APM initiative. Also, smaller physician practices may be more interested in becoming part of health systems if they are not well-positioned to adapt to the new MACRA payment arrangements.
- Both APMs and MIPS will require health systems to invest in technology and business practices. CMS requirements will change over time, so systems and processes will need to change with them. Under MIPS, clinicians and health systems billing on their behalf will need to analyze quality and resource use performance against the national benchmarks and, if needed, change practice patterns to avoid payment reductions and public reporting about substandard performance. Provider organizations also will need to review and appeal inaccurate CMS information and prepare for CMS audit processes to validate clinician-submitted performance data. If organizations have not already accredited their clinicians as PCMHs, they should consider doing so or investing in other practice improvement activities to receive credit under the MIPS clinical practice improvement measures.
- Under Advanced APMs, health systems will need to confirm that their initiatives qualify for and conform to the CMS definition and that the initiatives succeed in managing financial risk. Health systems may need to build or acquire special capabilities to succeed under Advanced APMs. Among these could be managing risk (including reserving capital and purchasing stop-loss coverage); building networks (including post-acute care providers); integrating health information technology across clinicians and the health system to support collaboration; and investing in analytics to identify high-cost enrollees and work efficiently with clinicians to reduce costs and improve quality.

Health plan implications:

- Health plans should consider identifying strategic business opportunities to support clinicians and hospitals as they change the way they practice medicine and adapt to new payment and risk arrangements.
- Health plans may see pressure from clinicians and hospitals to align quality and reduce utilization, and to identify high-performing clinicians using Medicare's new measures. In addition, health plans using narrow-network strategies may see pressure from businesses or consumers to include clinicians that are identified as high-performing based on publicly reported scores.
- Greater consolidation among clinician practices and clinician practices with health systems to meet MACRA requirements may put pressure on health plan payment rates.
- Clinicians may pressure health plans to enter commercial contracts with ACOs and PCMHs that align with programs under MACRA. Doing so may reduce clinicians' burden and qualify them for credit under the Other Payer policies.
- Some health systems may decide to offer MA provider-sponsored plans to gain more control over health care spending and payment, and to avoid some MACRA mandates. This could potentially introduce new competition or a collaborative opportunity for health plans.
- CMS will be considering how to align MACRA with MA in future regulatory activity; this may directly affect MA plans' relationships with clinicians and their investments in APMs.

MACRA is most likely to directly impact clinicians, health systems, and health plans. However, the law may affect other stakeholders along the health care continuum. MACRA's intent is to reduce health care spending and overall utilization by rewarding providers for improved quality and outcomes. Resource use measures and Advanced APMs may increase already heightened scrutiny on inputs: hospitalizations, medical technology and devices, drugs covered under Part A and Part B, and post-acute care. As CMS incorporates Part D spending into resource use measures, organizations may see greater pressure on outpatient drug spending, as well.

Conclusion

Congress passed MACRA with unprecedented bipartisan legislative and stakeholder support. The law has the potential to drive substantial change for clinicians, health systems, health plans, and other payers. In addition to making tactical preparations, organizations should consider holding enterprise-wide conversations to evaluate the strategic choices the law presents.

The MACRA regulations, as drafted, reflect conversations CMS has had with numerous stakeholder groups as the Administration has worked to develop policy and build engagement. The law's details and proposed regulations are numerous, and some requirements remain in flux as CMS accepts comments to prepare the final regulations.

The timeline for stakeholders to prepare for MACRA reporting and compliance is short and there is much to do. To perform well on the quality and resource use measures, many organizations may need to change clinical practice and referral patterns, which could profoundly transform current business models built to maximize revenues. Those organizations which have begun to experiment with innovative payment arrangements that resemble Advanced APMs should consider whether or not to adapt these to Medicare's definitions to make them more acceptable to clinicians and health systems. Finally, payers could see more clinician consolidation and what that may mean in terms of payment negotiations and network design.

Appendix: MACRA-related terminology

MACRA introduces a new vocabulary to Medicare. Below are some of the terms used in the legislation and proposed rules.

Advanced Alternative Payment Model (Advanced APM) – An APM that CMS determines meets the criteria set forth in §414.1415. These criteria include use of certified health information technology, payment based on quality measures, and financial risk.

Advanced APM Entity – An APM entity that participates in an Advanced APM or Other Payer Advanced APM through a direct agreement with CMS or a non-Medicare other payer, respectively.

APM Incentive Payment – The lump-sum incentive payment paid to Qualifying APM Participants. Incentive payments will be available for 2019 through 2024.

Attributed beneficiary – A beneficiary attributed, according to the Advanced APM’s attribution rules, to the Advanced APM Entity on the latest-available list of attributed beneficiaries during the QP Performance Period.

Attribution-eligible beneficiary – A beneficiary who, during the QP performance period:

1. Is not enrolled in MA or a Medicare cost plan
2. Does not have Medicare as a secondary payer
3. Is enrolled in both Medicare Parts A and B
4. Is at least 18 years of age
5. Is a US resident
6. Has a minimum of one claim for evaluation and management services furnished by an eligible clinician in the APM Entity group for any period during the QP Performance Period. For APMs that CMS determines to be focused on specific specialties or conditions or to have an attribution methodology that is not based on evaluation and management services, CMS uses a comparable standard related to the APM-specific attribution methodology for identifying beneficiaries as potential candidates for attribution.

Clinical Practice Improvement Activity – An activity that relevant eligible clinician organizations and other relevant stakeholders identify as improving clinical practice or care delivery and that the Secretary determines, when effectively executed, is likely to result in improved outcomes.

Composite performance score – A composite assessment (using a scoring scale of 0 to 100) for each MIPS-eligible clinician for a specific performance period determined using the methodology for assessing the total performance for a MIPS-eligible clinician according to performance standards for applicable measures and activities for each performance category. The CPS is the sum of each of the products of each performance category score and each performance category’s assigned weight.

Eligible clinician – For purposes of the APM Incentive payment, has the meaning of the term “eligible professional” as defined in section 1848(k)(3) of the Act, is identified by a unique TIN and National Provider Identifier (NPI) combination and, means any of the following:

1. A physician
2. A practitioner described in section 1842(b)(18)(C) of the Act
3. A physical or occupational therapist or a qualified speech-language pathologist
4. A qualified audiologist (as defined in section 1861(l)(3)(B) of the Act).

Episode payment model – An APM or other payer arrangement that incentivizes services furnished to an individual over a defined period of time for a specific clinical condition or conditions.

Group – A single TIN with two or more MIPS-eligible clinicians, as identified by their individual NPI, who have reassigned their Medicare billing rights to the TIN.

Hospital-based MIPS-eligible clinician – A MIPS-eligible clinician who furnishes 90 percent or more of his or her covered professional services in sites of service identified by the codes used in the Health Insurance Portability and Accountability Act standard transaction as an inpatient hospital or emergency room setting in the year preceding the performance period.

Incentive payment base period – The calendar year prior to the year in which CMS disburses the APM Incentive Payment. CMS uses estimated aggregate payments to a QP for Medicare Part B-covered professional services during this period as the basis for determining the Estimated Aggregate Expenditures described in §414.1450(b)(3).

Low-volume threshold – An individual MIPS-eligible clinician or group who, during the performance period, has Medicare billing charges that do not exceed \$10,000 and provides care for 100 or fewer Part B-enrolled Medicare beneficiaries.

Meaningful EHR user for MIPS – A MIPS-eligible clinician who possesses certified electronic health record technology (CEHRT), uses the functionality of CEHRT, and reports on applicable objectives and measures specified for the advancing care information performance category for a performance period in the form and manner specified by CMS.

Measure benchmark – The level of performance that the MIPS-eligible clinician is assessed on for a specific performance period at the measures and activities level.

Medical Home Mode – An APM under section 1115A of the Act that is determined by CMS to have the following characteristics:

1. The APM’s participants include primary care practices or multispecialty practices that include primary care physicians and practitioners and offer primary care services. For the purposes of this provision, primary care focus means involving specific design elements related to eligible clinicians practicing under one or more of the following Physician Specialty Codes: 01 General Practice; 08 Family Medicine; 11 Internal Medicine; 37 Pediatric Medicine; 38 Geriatric Medicine; 50 Nurse Practitioner; 89 Clinical Nurse Specialist; and 97 Physician Assistant.;
2. Empanelment of each patient to a primary clinician; and
3. At least four of the following:
 - i. Planned coordination of chronic and preventive care
 - ii. Patient access and continuity of care
 - iii. Risk-stratified care management

- iv. Coordination of care across the medical neighborhood
- v. Patient and caregiver engagement
- vi. Shared decision-making
- vii. Payment arrangements in addition to, or substituting for, fee-for-service payments (for example, shared savings or population-based payments).

Merit-Based Incentive Payment System (MIPS) – The program required by section 1848(q) of the Act.

MIPS payment year – The calendar year in which MIPS payment adjustments are applied.

New Medicare-Enrolled MIPS-eligible clinician – An eligible clinician who first becomes a Medicare-enrolled eligible clinician within the Provider Enrollment, Chain and Ownership System (PECOS) during the performance period for a year and who had not previously submitted claims as a Medicare-enrolled eligible clinician, either as an individual, an entity, or a part of a physician group or under a different billing number or tax identifier.

Non-patient-facing MIPS-eligible clinician – An individual MIPS-eligible clinician or group that bills 25 or fewer patient-facing encounters during a performance period.

Performance category score – The assessment of each MIPS-eligible clinician’s performance on the applicable measures and activities for a performance category for a performance period based on the performance standards for those measures and activities.

Performance standards – The level of performance and methodology that the MIPS-eligible clinician is assessed on for a MIPS performance period at the measures and activities level for all MIPS performance categories.

Performance threshold – The level of performance that is established for a performance period at the composite-performance-score level. CPSs above the performance threshold receive a positive MIPS adjustment factor and CPSs below the performance threshold receive a negative MIPS adjustment factor. CPSs that are equal to or greater than zero, but not greater than one-fourth of the performance threshold, receive the maximum negative MIPS adjustment factor for the MIPS payment year. CPSs at the performance threshold receive a neutral MIPS adjustment factor.

Qualified Clinical Data Registry – A CMS-approved entity that has self-nominated and successfully completed a qualification process to determine whether the entity may collect medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients.

Qualified registry – A medical registry; a maintenance of certification program operated by a specialty body of the American Board of Medical Specialties or other data intermediary that, with respect to a particular performance period, has self-nominated and successfully completed a vetting process (as specified by CMS) to demonstrate its compliance with the MIPS qualification requirements specified by CMS for that performance period. The registry must have the requisite legal authority to submit MIPS data (as specified by CMS) on behalf of a MIPS-eligible clinician or group to CMS.

QP Performance Period – The period of time that CMS will analyze to assess eligible clinician participation in Advanced APMs and Other Payer Advanced APMs for purposes of making the QP determinations in §414.1425. The QP Performance Period is the calendar year that is two years prior to the payment year.

Small practices – Practices consisting of 15 or fewer clinicians.



Authors

Anne Phelps

Principal
US Health Care Regulatory Leader
Deloitte & Touche LLP
annephelps@deloitte.com

Sarah Thomas, MS

Managing Director, Research
Deloitte Center for Health Solutions
Deloitte Services LP
sarthomas@deloitte.com

Claire Boozer Cruse, MPH

Health Policy Specialist
Deloitte Center for Health Solutions
Deloitte Services LP
cboozer@deloitte.com

Daniel Esquibel

Senior Manager
Deloitte & Touche LLP
desquibel@deloitte.com



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