

# 5 Things Everyone Should Know About MACRA

In 2015, Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA), which changes the way that Medicare pays clinicians by establishing two new payment “tracks”—the Merit-Based Incentive Payment System (MIPS) and the Advanced Alternative Payment Model (APM) track. Initially, most clinicians will be paid under the MIPS track, which will adjust clinicians’ Medicare payments up or down based on performance metrics. These new payment adjustments don’t start until 2019, but will be based on performance measurement that begins in 2017. To help you succeed under MIPS, we highlight below five things that health care leaders and clinicians need to know.



## MACRA Is Here to Stay

Partisan battles continue to be fought over many aspects of health policy. But unlike the individual mandate and high-risk pools, MACRA legislation enjoys broad support from both sides of the aisle.

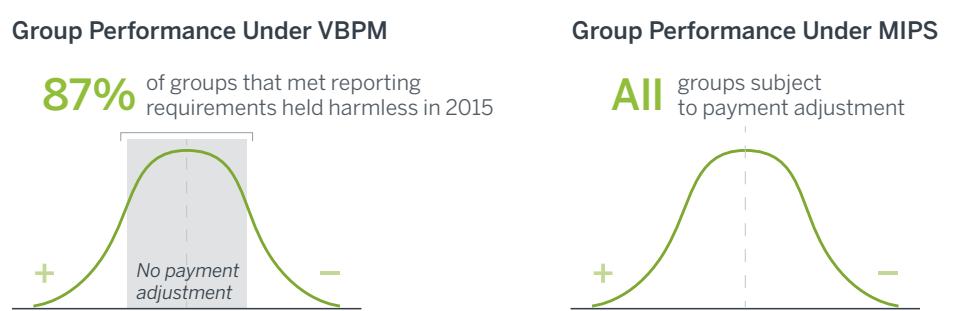
### Congress Passed the Act with Overwhelming Bipartisan Support



## MIPS Ups the Ante on Pay for Performance

Prior to MACRA, group performance standards under the Value-Based Payment Modifier were fairly forgiving. Average performance resulted in no payment adjustment. However, under MIPS, a single point above or below the mean or median composite score will result in a payment adjustment. By 2022, nine percent of clinicians’ Medicare payment will be at risk.

### Average Performance No Longer Enough



## Population Health Is No Longer Optional

In the past, only providers participating in risk-based payment models faced meaningful incentives tied to cost and quality outcomes. In the new MIPS track, outcome metrics—many of which extend beyond discrete patient encounters—will increasingly factor in to clinicians’ pay. While the advanced APM track may encourage more providers to join downside risk programs, MIPS makes population health a reality for everyone.

### MIPS Tracking Quality and Cost Closely

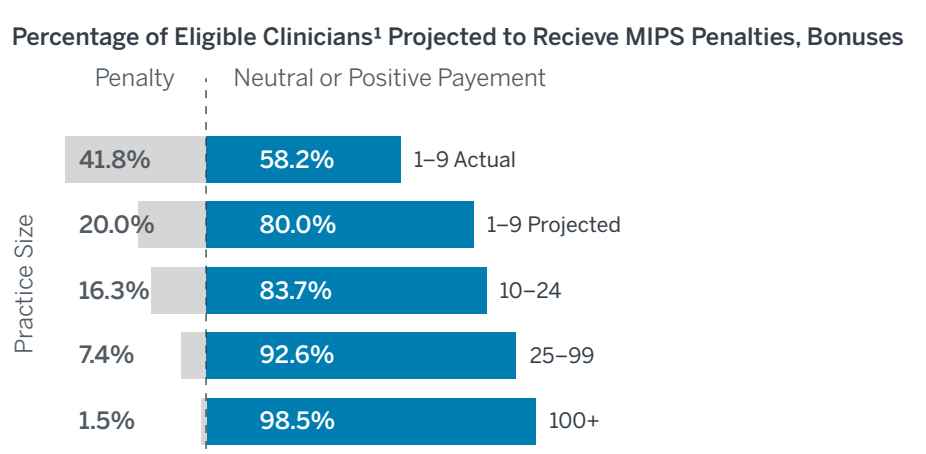
MIPS Performance Category	Top Reporting Takeaways for 2017
Quality <i>(replaces PQRS, VBPM)</i>	<ul style="list-style-type: none"> <li>~300 measures to choose from</li> <li>80% of measures tailored to specialists</li> <li>Eligible Clinicians only required to report 6 measures; in addition, all-cause readmissions will be calculated based on claims</li> </ul>
Cost <i>(expands VBPM cost metrics)</i>	<ul style="list-style-type: none"> <li>Total percapita costs for all attributed beneficiaries and Medicare spending per beneficiary</li> <li>Adds 10 episode-based measures, rather than 41</li> <li>While not factored in to overall MIPS performance in 2017, the weighting rises quickly to 10% in 2018, 30% in 2019</li> </ul>



## You Succeed or Fail as a Team

We anticipate most clinicians will report as a group under MIPS. Hence, scores for all providers in the group will be pulled down by low performers or pulled up by high performers, increasing the incentives for providers and other internal stakeholders to work as a team to achieve ongoing performance improvement.

### Larger Practices Will Fare Better



## Practice Like Everyone Is Watching

The data reported under MIPS eventually will be available to the public on the Physician Compare website. With the rise of consumerism, you can expect patients to use these standardized quality metrics to choose their physicians. This level of transparency will also affect partnerships as hospitals seek out physicians with demonstrated success in MIPS.

### The Future of Physician Compare

<b>MIPS Score</b> Quality Improvement Activities Cost Advancing Care Information	<b>Potential Impacts of Transparency</b> <b>Health System Scrutiny</b> Hospitals on the hook for group physician performance will <b>only partner with physicians demonstrating success in MIPS.</b> <b>Customer Shopping</b> Patients able to compare standardized quality metrics will <b>select highest performing physicians.</b>
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1. CMS, “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,” October 2016; Health Care Advisory Board interviews and analysis.