Unpacking MACRA
The Proposed Rule and Its Implications for Payment and Practice

Camille Haycock, MS, APRN, NEA-BC; Michelle L. Edwards, DNP, APRN, FNP, ACNP, FAANP; Christopher S. Stanley, MD, MBA

The Centers for Medicare & Medicaid Services (CMS) has released a proposed rule that details a consolidated pay-for-performance provider payment system within the Medicare Access and CHIP Reauthorization Act. This proposed rule establishes policy for the new provider Merit-Based Incentive System and Alternative Payment Models. While the rule is extremely complex, and not yet finalized, there are significant implications for nursing and advanced practice providers. This proposed rule intends to drastically change the current provider payment system and reward providers who demonstrate better quality outcomes at a lower cost. It also aligns with the current administration’s intention to reform the payment and delivery system to a value-based methodology. Within the proposed rule, there is much at stake and will likely transform the way in which providers are reimbursed for Medicare beneficiaries. There are many strategies that can be deployed to help drive success within this new legislation. Among them are a renewed focus on quality outcomes, knowledge of clinical performance, care coordination, and deploying new models of care that address a lower cost structure. It is imperative that nurses and advanced practice providers are aware of this new legislation and how their practice will be impacted by payment reform. Key words: MACRA, Medicare Payment Reform, payment models, Quality Payment Program (QPP)

On April 27, 2016, the Centers for Medicare & Medicaid Services (CMS) released a proposed rule that details a consolidated pay-for-performance provider payment system within the Medicare Access and CHIP Reauthorization Act (MACRA). This lengthy and proposed rule establishes policy for the new provider Merit-Based Incentive System (MIPS) and Alternative Payment Models (APMs). While the rule is extremely complex, and not yet finalized, the purpose of this article is to simplify the content of the rule and describe the nursing and advanced practice (AP) clinician implications associated with the proposed rule and to provide some strategies for success. This proposed rule intends to drastically change the current provider payment system and reward providers who demonstrate better quality outcomes at lower cost. It also aligns with the current administration’s intention to reform the payment and delivery system to a value-based methodology.

WHAT IS MACRA?

The MACRA of 2015 reforms Medicare payment and makes several changes to how CMS compensates those who are providing care to Medicare beneficiaries. These changes create a Quality Payment Program (QPP). This bipartisan bill was introduced in 2015, passed through the house and senate, and was signed

Author Affiliation: Catholic Health Initiatives, Englewood, Colorado.
The authors declare no conflict of interest.
Correspondence: Camille Haycock, MS, APRN, NEA-BC, Catholic Health Initiatives, 198 Inverness Dr West, Englewood, CO 80112 (camillehaycock@catholichealth.net).
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This new legislation enacts 3 important changes:

1. **Replaces the sustainable growth rate formula that has determined Medicare payments for health care providers for more than a decade.**

2. **Establishes a new framework whereby health care providers are rewarded for providing better care evidenced by quality outcomes, as opposed to more care.**

3. **Combines all existing CMS quality reporting programs into 1 program.**

The QPP within MACRA has 2 separate tracks that allow providers to choose which quality program is best suited for their practice. Both of these programs are designed to accelerate payment for value and are detailed in the following text:

**MERIT-BASED INCENTIVE PAYMENT SYSTEM**

The MIPS is a new program created through MACRA that, by 2019, will collapse the 3 existing QPPs into a single program in which eligible providers (EPs) will be measured. These 3 quality reporting categories include physician quality reporting system, value-based payment modifier, and meaningful use (Medicare Electronic Health Record incentive program). The MIPS has 4 performance categories that will apply to all EPs in 2017 (Figure). These 4 categories, with weighted percentages in year 1 (weighting will adjust over time), are as follows:

1. **Quality** with a 50% weight will require 6 measures to be reported. These measures are chosen from a predetermined list of 300 measures and EPs are able to select which measures they report. In addition, there are population-based measures that require submission of 2 measures for practices up to 9 EPs and 3 measures for practices with greater than 10 EPs.

2. **Resource utilization and cost category** with a 10% weight includes the continued use of measures within the value modifier and total per capita costs and Medicare spend. It is a claims-based measure, and CMS proposes the use of up to 40 episode-specific measures.

3. **Advancing care information** (formerly known as meaningful use) has a 25% weight and includes changes from the former electronic health record incentive program. A scale will be used to assess the category, rather than all-or-nothing scoring. Hospital-based providers for whom Advancing care information does not apply will have the other performance categories proportionately increased. There will also be scoring on patient engagement and care coordination that leads to improved outcomes.

4. **Clinical practice improvement** has a 15% weight, with CMS proposing more than 90 activities that would count toward the measurement domain.

![Figure](Merit-Based_Incentive_Payment_System_Performance_Categories.png)

**Figure.** Merit-Based Incentive Payment System Performance Categories. EHR indicates electronic health record. Source: www.cms.gov.
This is a new program, with participants receiving full credit for the establishment of a patient-centered medical home.

Within each of the 4 categories, there are point allocations (Table)\(^5\) with embedded scoring methodology. Eligible providers have the option of participating in MIPS as a group practice or as an individual, and there are a variety of different reporting options. These include qualified registries, electronic health records, administrative claims, and the CMS Web interface. The first performance year in this new rule is CY2017, with the first year of MIPS payment to occur in 2019 (based upon CY2017 results). A MIPS-EP’s payment adjustment percentage is based on the relationship between their composite performance score and the MIPS performance threshold.

**ADVANCED ALTERNATE PAYMENT MODELS**

The second track includes specific requirements for participation with an earning potential of 5% Medicare part B incentive payment and exemption from MIPS. The qualifying APM, however, must meet the following criteria for participation (sourced from the Federal Register)\(^6\):

1. Bear risk for monetary loss. In the proposed rule, CMS requires that financial risk for monetary loss is tied to performance, as opposed to indirect losses related to financial investments. Dimensions of risk will be measured to determine whether the model meets the risk requirement for participation. Full capitated risk will meet the risk requirement.

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### Table. Description of Merit-Based Incentive Payment System (MIPS)\(^a\)

<table>
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<tr>
<th>Performance Category</th>
<th>Percentage of Overall MIPS Score (Performance Year 1—2017)</th>
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<tr>
<td><strong>Quality:</strong> Clinicians choose six measures to report to CMS that best reflect their practice. One of these measures must be an outcome measure or a high-value measure and one must be a crosscutting measure. Clinicians also can choose to report a specialty measure set.</td>
<td>50%</td>
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<tr>
<td><strong>Advancing Care Information:</strong> Clinicians will report key measures of patient engagement and information exchange. Clinicians are rewarded for their performance on measures that matter most to them.</td>
<td>25%</td>
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<tr>
<td><strong>Clinical Practice Improvement Activities:</strong> Clinicians can choose the activities best suited for their practice; the rule proposes over 90 activities from which to choose. Clinicians participating in medical homes earn “full credit” in this category, and those participating in Advanced APMs will earn at least half credit.</td>
<td>15%</td>
</tr>
<tr>
<td><strong>Cost:</strong> CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything.</td>
<td>10%</td>
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Abbreviations: APMs, Alternative Payment Models; CMS, Centers for Medicare & Medicaid Services; MIPS, Merit-Based Incentive System.

\(^a\)From Centers for Medicare & Medicaid Services.\(^5\)
2. Participation in the APM will also require participants to use certified electronic health record technology by at least 50% of providers the first year and increasing to 75% the second performance year.

3. There will be a base payment on quality measures similar to those used in MIPS. This proposed legislation is complex and designed to drive the value imperative. As of this writing (June 2016), CMS is still accepting comment to the proposed policy within MIPS and APMs, and there will likely be some changes to this proposed rule. Some preliminary commentary includes the way that APMs are narrowly defined within the rule. In addition, due to the excessive complexity and requisite analysis, there may be some movement to attempt simplification to reduce the reporting burden that the rule poses for individual or small group practices. Much of the policy within the bill has yet to be finalized. Providers must respond to this legislation by improving quality outcomes and developing advanced care models that mitigate financial risk.

PRACTICE IMPLICATIONS AND HEALTH SYSTEM STRATEGIES

The implications of this new law will be significant for individual clinicians, health systems, and US health care more broadly. As with most transformative changes like this, intended and unintended consequences will take years, possibly a decade, to “play out.” There are, however, several key elements that will impact the nursing profession tactically and strategically that we need to be aware of, and prepare for, starting now.

First, MACRA—with limited exceptions—will impact all providers of health care services, notably nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists, starting with performance year CY 2017. Over time, additional nursing professionals may be included in the scope of this law and policies as determined by the CMS. Therefore, any provider who provides billable services to a Medicare beneficiary in 2017 will be in either the MIPS or the APM track. It is important to note as well that if a provider does not align with, and qualify for, the APM track, he or she will be automatically in the MIPS track. In fact, CMS projects that around 90% of providers in the first year of the program will be in the MIPS track, either because they chose MIPS or because they do not qualify for the APM track. Already, many health care and provider systems are organizing through accountable care organizations (ACOs), clinically integrated networks (CINs), integrated delivery networks (IDNs), or similar structures to serve as the vehicle for Advanced APMs to qualify for the APM track. These ACOs, CINs, and IDNs must have significant capabilities to manage downside financial risk—including the ability to analyze clinical and claims data for population health purposes, care pathways, or care models that are focused on episodes of care, chronic condition management, and alignment of providers across the care continuum. We anticipate significant activity through 2016 and 2017, as providers learn more about this law, determine their options, and align themselves with a health system, hospital, provider group, or organize their own practice to be successful within either the MIPS or APM track.

As the proposed rule clarifies, initially, only CMS-based programs that include significant downside financial risk qualify as an Advanced APM—including Tracks 2 & 3 Medicare Shared Savings Program as well as the next generation ACO. In addition, the recently announced Comprehensive Primary Care Plus (CPC+) program, one option of the Oncology Care Model, and some other unique programs qualify for the APM track.

Beyond the implications for individual providers, MACRA clearly demonstrates the central theme of value, which includes quality and resource utilization (cost of care). Legislators and policy makers see value as a critical element to reform the health care industry. While previous reimbursement policies have had some impact on how hospitals or physicians provide care (such as readmission rate
penalties or value-based modifiers), the majority of these programs have “nibbled around the edges” by providing bonuses (upside only) or small reductions in payments spread over many years. In this new transformational law, providers under the MIPS track will face a 4% reduction in part B payments starting in year 1, escalating to a 9% reduction over subsequent years. On the positive side, providers on the MIPS track may receive payment increases of 4% as well (year 1). There will be winners and losers. The key determinant between the 2 (whether one is a winner or a loser) is the ability of providers, groups, or organizations to provide high-quality care at a lower price, paired with the ability to manage their results and report to CMS. Clinically, it is exciting to see that quality of care will be a central component of this reimbursement model. This change aligns with our clinical mission, calling, and professional identity. At the same time, clinicians approach this change with apprehension because of the likely administrative complexity of collecting, managing, and reporting for our patients. This is especially true for patients with social determinants of health that are challenging for a health system or provider to directly influence.

Many, though not all, organized health systems have been on a multiyear journey to advance population health concepts and programs, including development of ACOs, patient-centered medical homes, medical neighborhoods, continuum of care programs, and episodes of care. However, it is fair to say that most organizations have been “dipping our toes in the water” or have felt like “we have had our feet in two canoes” for the past few years. While organizations may be working toward value-based reimbursement models, the majority of health care reimbursement in the United States is still paid on the basis of volume through fee-for-service methods. In fact, the majority of ACOs (who have organized themselves expressly for the purpose of managing populations aligned with the Institute for Healthcare Improvement’s Triple Aim7) have not entered into downside financial risk models or moved away from fee-for-service. This is in part due to immature comprehensive care models, incompletely integrated networks of providers, and lack of capabilities for managing clinical and financial risk. With MACRA, and the clear starting date of Performance Year 2017 (tied to payment year 2019), we must declare now whether we are committed to quality of care, appropriate use of health care resources, and other population health tenets. Now is the time to jump into the water—no more toe-dipping. Whether we like it or not, our decisions (or inaction) now will set the path for both ourselves and clinical professionals for the next generation.

While each provider will need to determine the right path for himself or herself, based upon multiple factors, including tolerance for risk, ability to organize, and many strategic and external market factors, we (the authors) believe that the APM track is ideal for many. This will involve aligning with an organizational structure (ACO or similar) that supports team-based care, the central role for primary care, is dedicated to an emphasis on quality and experience of care and provides the infrastructure support for success (including IT, data, and analytics). Successful providers under the APM track of MACRA will be active participants within the ACO—fundamentally committed to the success of all ACO providers and even more committed to the clinical, functional, and economic outcomes of patients and consumers.

However, this ACO-based organizational structure will not work for all of providers. Some will be in the MIPS track. Successful MIPS participants will also be focused on quality of care, appropriate use of scarce health care resources, and patient experience. These providers must make the time and financial investments to track, manage, and report on data. Certainly, the size and complexity of MACRA and the proposed rule can be overwhelming. The author’s advice is: First, determine whether you should follow the MIPS or the APM track. Then focus on understanding your (or your organization’s) ability to capture quality data. These 2 first
steps will take you at least half of the way to successfully navigating your MACRA path.

ONE STRATEGY FOR SUCCESS: THE ROLE OF APs

The groundbreaking plan MACRA has set into motion is, without a doubt, a game changer for existing health care structures in America. With the start of its first performance period just months away (January 2017), it requires both expedited strategic planning and a fundamental shift in the way leaders of health care delivery systems think about how and by whom services will be rendered in the future.

Not surprisingly, and consistent with historical norms, much of the discussions about MACRA to date have focused largely (and sometime solely) on the role and influence of physicians to ensure operational success within these newly established parameters. While the role of physicians is undeniably important and cannot be underappreciated, this habitual view of health care redesign efforts is far too narrow. As mentioned previously, MACRA applies to all Medicare-billing clinicians, including nurse practitioners, certified registered nurse anesthetists, clinical nurse specialists, and physician assistants. The implementation of an effective organizational strategy should be executed in that light and should ensure that initiatives are developed and deployed with consistent and robust integration of APs. This is crucial for the 56 million beneficiaries currently enrolled in Medicare and the thousands of individuals who become Medicare eligible every day.

The beneficial impact of APs on expanded patient access to care, preserved or enhanced quality, and cost containment is well documented and has been the noteworthy signature attributes of these providers for roughly 50 years. Moreover, these outcomes for which APs have an established track record are among the performance indicators weighted highest in the MIPS performance scoring system and are essential to gauging an organization’s readiness for risk sharing to operate successfully in the APM environment.

Consequently, devising a viable MACRA plan necessitates not only an understanding of the new mandates but also an appreciation for the opportunity to recalibrate the conventional use of physician and AP resources.

REALIZING THE FULL VALUE OF APs IN MACRA

As health care challenges have risen over the years, so has the demand for APs. Advanced practitioners are less expensive to employ and consistently earn high scores on a number of important health care measures, making them an attractive and necessary part of the solution. Although the use of APs has expanded considerably, a greater supply alone is not sufficient to realize their full value. A myriad of internal obstacles, including absence of AP expertise, misinterpretation of state laws, scope of practice myths, individual physician preferences, arbitrary privileging practices, and old fashion turf battles, comprise many organization’s ability to effectively deploy APs. The consequence: variable practice patterns, blunted return on investment, and a “haphazard” workforce strategy, at best.

For example, the potential contributions of APs are often severely underexploited when they function in customary “physician-extender” models under direct supervision of physicians and within overly restrictive organizational structures. Effectiveness and efficiency are greatly enhanced by adopting a truly interprofessional, collaborative model in which APs and other care team members all work to the fullest extent of their professional education, skills, and scope of practice. The key to realizing the full value of APs, whether in a fee-for-service and value-based payment environment, is to deploy them strategically and place them in roles where they practice as autonomously as possible.

CONCLUSION

Within this proposed rule, there is much at stake. This legislation will likely transform the way in which providers are reimbursed for...
Medicare beneficiaries. There are many strategies that can be deployed to help drive success within this new legislation. Among them are a renewed focus on quality outcomes, knowledge of clinical performance, care coordination, and deploying new models of care that address a lower cost structure. Performance in measurement year 2017 will drive the reimbursement in 2019. While the final rule is not expected until the latter part of 2016, all provider practices must be mobilized now to address this new payment structure.

REFERENCES


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