

2018

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David M. Heller  
*Greenway Health*

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### Recommended Citation

Heller, David M. (2018) "MACRA: Emerging from the Thicket," *Health Law and Policy Brief*. Vol. 12 : Iss. 2 , Article 1.

Available at: <https://digitalcommons.wcl.american.edu/hlp/vol12/iss2/1>

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# MACRA: EMERGING FROM THE THICKET

by David M. Heller\*

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## I. INTRODUCTION

Since the 1990s, healthcare reform has roiled domestic politics in the United States. Issues of insurance coverage, drug pricing, healthcare delivery, and the role of the state deeply divided the country's political parties and living rooms. However, one area of reform maintains broad bipartisan consensus: physician reimbursement reform.

Healthcare expenditures as a percentage of Gross Domestic Product ("GDP") continue to rise at unsustainable levels,<sup>1</sup> leading to serious questions about the sustainability of the Medicare Trust Fund. The Medicare and Medicaid reimbursement system currently operates predominantly through a Fee-For-Service ("FFS") structure, where the government reimburses providers for each individual procedure. FFS is perceived as a major contributor to the exponential increase in healthcare expenditures over recent decades.<sup>2</sup>

In 2015, Congress sought to reign in FFS expenditures and improve physician reimbursement by passing the Medicare and CHIP Reauthorization Act of 2015 ("MACRA"). MACRA leverages multiple policy initiatives and incentivizes providers through a payment structure that is commonly referred to as "value-based care." Value-based care rewards positive clinical outcomes rather than providing payment based on volume. However, as exhibited by similar programs in the past, uneven regulatory implementation threatens to foil MACRA's efficacy.

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\* David Heller is Corporate Counsel at Greenway Health, a leading provider of health information technology to ambulatory healthcare practices. He is also a member of the Executive Committee of the Electronic Health Records Association (EHRA.). The opinions expressed in this Article are solely those of Mr. Heller, and do not reflect the views of Greenway Health, the EHRA, or any other entity or individual. The author would like to thank Debbie J. Alfstad, the practice administrator of the Retina Institute of Texas, P.A. for her contribution to this article with respect to health information exchange and emergency-based specialists. *See infra* note 69.

<sup>1</sup> The Center for Medicare and Medicaid Services (CMS) estimates that healthcare expenditures will account for nearly 20% of GDP by 2020. Spending growth is set to outpace GDP growth by 1.2% each year. Center For Medicaid and Medicare Services, *2016-2025 Projections of National Health Expenditures Data Released* (Feb. 15, 2017), <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-02-15-2.html>.

<sup>2</sup> Writing for the *New England Journal of Medicine*, Dr. Steven Schroeder and Dr. William Frist, who served on the National Commission on Physician Payment Reform, noted that "[c]ontrolling rising expenditures for health care will not occur without changing the way that physicians are paid." They further elaborated stating that "fixing current payment inequities under fee-for-service models will be of the utmost importance." Steven Schroeder & William Frist, *Phasing Out Fee-for-Service Payment*, 368 N. ENGL. J. MED. 2029, 2030 (2013), <http://www.nejm.org/doi/pdf/10.1056/NEJMsb1302322>.

This article explores MACRA’s policy roots and history, analyzes how its current regulatory implementation echoes past reform efforts, and sets forth recommendations for easing the program’s regulatory burden on providers while preserving Congress’s intended implementation of the legislation. It reasons that failure of the Sustainable Growth Rate and other programs designed to control healthcare spending led to MACRA’s passage in 2015, and argues that MACRA’s regulatory implementation suffers from many of the same defects as its predecessors (namely inconsistent implementation and unrealistic expectations of the healthcare delivery and health IT markets). Absent a change from CMS, implementation defects threaten the long-term viability of the statute and undermines its policy goals of improving quality and controlling spending.

## II. MACRA’S AND DELIVERY SYSTEM REFORM’S HISTORY

### A. The Sustainable Growth Rate Becomes Unsustainable

MACRA’s history is rooted in a series of budget debates that took place in the 1990s. The Balanced Budget Act of 1997 sought to balance the federal budget by cutting Medicare expenditures. To do so, the Act implemented the Medicare Sustainable Growth Rate (“SGR”). Designed to hold the growth of Medicare Part B expenditures in line with GDP growth, SGR calculations were based on four factors:

1. Estimated percentage changes in fees for physicians’ services;
2. Estimated percentage changes in the number of Medicare beneficiaries;
3. Estimated change in GDP per capita; and,
4. Estimated percentage change in expenditures due to changes in law or regulations.<sup>3</sup>

As the economy grew through the late nineties, doctors experienced moderate increases in their FFS rates. However, when the economy slowed in 2000 and later years, these increases turned into rate cuts under the SGR. Congress intervened by replacing cuts to providers’ FFS rates with small increases to physician payments. Following Congressional intervention, the gap between the statute’s target expenditures and actual expenditures continued to grow.<sup>4</sup> Between 2003 and 2014, Congress passed 16 laws overriding the SGR’s cuts due to annual physician outcry<sup>5</sup> and the sudden

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<sup>3</sup> Balanced Budget Act of 1997, Pub. L. No. 105-33, §§ 4502-4503, 111 Stat. 251, 432-434 (1997).

<sup>4</sup> Conor Ryan, a statistician and data analyst, provides an excellent overview of the history and math that led to the S.G.R.’s unsustainability, and how the cuts became unintendedly deeper than contemplated. Conor Ryan, *Explaining the Medicare Sustainable Growth Rate*, AMERICAN ACTION FORUM (March 25, 2015), <https://www.americanactionforum.org/insight/explaining-the-medicare-sustainable-growth-rate/>.

<sup>5</sup> For example, in a letter directed at Dave Camp and other members of the House of Representatives, the American Medical Association (AMA) sharply criticized members of the House who did not support a bill to replace the SGR because “limiting growth of physician services to GDP would inevitably lead to sharp cuts in physician reimbursement rates[.]” The AMA further stated “[a]s predicted, the SGR did result in a 4.8% cut in 2002. Congress declined and that cut went into effect. In subsequent years, Congress did step in to prevent additional cuts from occurring. The

negative adjustment on physician reimbursement rates.<sup>6</sup> As Congress continued to delay Medicare spending cuts, lawmakers delivered a series of reforms designed to reward doctors for controlling utilization while maintaining or improving the quality of care. This series of reforms measures clinicians from three aspects: (1) quality, (2) the utilization or cost of patient care, and (3) process and technology. Lawmakers incorporated these elements in three main programs: the Physician Quality Reporting System (“PQRS”), the Value-based Modifier (“VBM”), and the Electronic Health Record Incentive Program, commonly called “Meaningful Use.” Each of these programs adjusted physicians’ reimbursement on Medicare claims based on their performance on the programs’ respective measures.

### **B. Quality Reporting Becomes Undermined by Complexity**

In 2006, Congress authorized Medicare incentives for quality reporting through the Tax Relief and Health Care Act of 2006<sup>7</sup> and CMS implemented the statute by creating the PQRS. The program underwent a series of statutory changes over time. The Medicare, Medicaid, & SCHIP Extension Act of 2007 solidified the PQRS with a permanent place in the reimbursement structure.<sup>8</sup> In 2010, the Affordable Care Act (“ACA”) added another layer to PQRS by introducing penalties. Physicians who failed to report quality data to CMS were penalized, and penalties continued to escalate on a yearly basis. In tandem, the ACA ended PQRS incentives, converting the system into a pure penalty program.<sup>9</sup>

From a regulatory perspective, PQRS was complex. At its height, it required reporting on nine separate clinical quality measures.<sup>10</sup> Physicians had to choose a measure that was “cross-cutting,” or broadly applicable to most specialties. There were also guidelines on selecting “high priority measures,” which specifically focused on quality measures that had certain domain designations, such as “population management.”<sup>11</sup> At its start, the program offered 74 total quality measures, a figure that eventually increased to 281 total measures by the program’s end. Further complicating matters,

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Consolidated Appropriations Resolution of 2003, the Medicare Modernization Act of 2003, the Deficit Reduction Act of 2005, the Tax Relief and Health Care Act of 2006, the Medicare, Medicaid, and SCHIP Extension Act of 2007, and the Medicare Improvement for Patients Act of 2008 each provided temporary relief for seniors and their physicians from pending cuts.” Letter from the AMA to Dave Camp, House of Representatives (November 19, 2007).

<sup>6</sup> Jim Hahn lays out these laws tabularly, which includes several continuing resolutions. Jim Hahn, *The Sustainable Growth Rate (S.G.R.) and Medicare Physician Payments: Frequently Asked Questions*, CONGRESSIONAL RESEARCH SERVICE (Mar. 21, 2014), <http://www.ncsl.org/documents/statefed/health/S.G.R.faqs3212014.pdf>.

<sup>7</sup> Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, § 101, 120 Stat. 2922, 2975-2981 (1997).

<sup>8</sup> Medicare, Medicaid, & SCHIP Extension Act of 2007, Pub. L. No. 110-173, § 101, 121 Stat. 2492, 2494 (2007).

<sup>9</sup> Affordable Care Act, Pub. L. No. 111-148, § 3002, 124 Stat. 119, 363 (2010).

<sup>10</sup> Center for Medicare and Medicaid Services, *2017 Physician Quality Reporting System (PQRS): Payment Adjustment Fact Sheet*, 2 (2016).

<sup>11</sup> *Id.*

physicians could report on quality measures using different submission mechanisms.<sup>12</sup> Initially, clinicians could report only on their Medicare claims using codes such as Quality Data Codes (“QDCs”) or G-Codes, and the claim code would have to tie back to the appropriate diagnosis code or procedure code. Depending on the patient’s treatment plan, some measures involved a host of applicable CPT codes, G-codes, or QDCs at the same time.<sup>13</sup>

Later, CMS drastically expanded the available reporting mechanisms in response to the industry’s health information technology (“health IT”) implementation. Eventually, clinicians could opt to report measures via electronic health record (“EHR”) or clinical data registries. However, providers were unable to report each measure via all of the available submission mechanisms. For example, one measure might be reportable only through a registry, and another measure might only be reportable through an EHR.<sup>14</sup> The number of measures available for each mechanism also varied. When CMS introduced EHR-based reporting, there were only ten measures available for that mechanism. The number of measures available for EHR-based reporting eventually expanded to 64 out of 281 total measures.<sup>15</sup> If a provider desired to report on a different measure excluded from the EHR-based reporting mechanism, they were required to select a claims-based measure or purchase a registry connection in addition to the EHR. This could quickly become a rather expensive and complex proposition depending on how a provider wanted to participate.

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<sup>12</sup> Each year CMS published, and still does pursuant to MACRA, a list of quality measures available for physicians to select. For example, for the 2016 performance period, the Physician Fee Schedule listed measures available for Claims, registry, or EHR reporting. Medicare Program: Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016, 80 Fed. Reg. 70,886, 71,216 (Nov. 16, 2015).

<sup>13</sup> CMS maintains a comprehensive list of Quality Measure Specifications and their supporting documents. For a full listing of measure specifications used today, visit <https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Resources.html>.

<sup>14</sup> Physicians “choose” their quality measures through the Quality Payment Program’s website at <https://qpp.cms.gov/mips/explore-measures/quality-measures?py=2018#measures>. There, a physician or practice manager generally filters by specialty to see what quality measures are supported for their specific practice that year. Many fail to take the second step and filter by submission mechanism. A mental health practitioner may filter by specialty and find that his or her practice can choose both the Adult Major Depressive Disorder (MDD): Suicide Risk Assessment measure or Adherence to Antipsychotic Medications for Individuals with Schizophrenia. However, the former can only be reported through an EHR, and the latter can only be reported through a registry. Whether a physician can use both measures depends on what technologies they have purchased or licensed. This can be counterintuitive because the technology used to send measure data to CMS is not clinically relevant, nor is it readily apparent why a clinical quality measure could only be reported in one way.

<sup>15</sup> Center for Medicare and Medicaid Services, *2015 Reporting Experience Including Trends (2007-2015)*, 3 (2017).

The effect of this complexity is evident in the number of clinicians who successfully submitted data. Initially, only 15% of physicians participated voluntarily.<sup>16</sup> 2015 marked the height of the PQRS program; participation was mandatory at that time.<sup>17</sup> Even then, over 30% of physicians took a penalty to their Medicare revenue instead of participating in the *reporting* program.<sup>18</sup> For providers who chose to participate, success varied based on the method of reporting. Physicians who reported using the EHR successfully submitted nine measures more frequently than those reporting via another mechanism.<sup>19</sup> Varying success rates between mechanisms was potentially attributed to a provider's use of a single set of technology or employ of only one system's workflows.<sup>20</sup> For example, most providers chose to have an EHR installed. Those providers then used the EHR to capture data and used a registry to report the captured data. This process required, at a minimum, multiple logins and portals. In the most extreme circumstances, providers were required to conduct a manual chart review to ensure that the data passing between the EHR and the registry was accurate. Even those using EHR-based reporting experienced setbacks because the number of EHR-based quality measures was severely limited compared to registry measures. In 2017, Medicare's quality reporting only supported 53 EHR-based measures even though there were 216 registry measures available. Overall, low participation rates over the course of the program's lifespan were likely a result of the difficulties that clinicians faced when completing the reporting process.

### **C. Health Information Technology and EHRs Suffer from Complex Measurement**

Congress's incentive program eventually morphed into a penalty program, producing EHRs. In 2009, as part of the American Recovery and Investment Act, Congress enacted the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"). When the law was passed, most patient records were recorded and stored on paper.<sup>21</sup> Physicians appeared particularly resistant to adopting new technology,

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<sup>16</sup> *Id.* at xiv.

<sup>17</sup> *Id.*

<sup>18</sup> *Id.* at xiii.

<sup>19</sup> 96% of physicians reporting through their EHR satisfactorily reported on 9 or more measures, fulfilling the program's requirement. Qualified Clinical Data Registries come in at a close second, with 86% of their users reporting on 9 or more measures. From there, it's a steep drop to 39% via registry reporting. *Id.* at xvi.

<sup>20</sup> Generally speaking, the manual effort involved in reconciling data increases with the number of platforms used to communicate the same basic set of data. The technology platforms may read the data in different ways, or record it using different vocabularies. To illustrate the problem properly, imagine trying to transfer contact lists from one Apple phone to another. It is simple because both phones use the same architecture. However, when migrating the same contact list from an Apple phone to a Google phone, the transfer may result in duplicates, or contacts splitting into discrete entries. Now imagine leaping from Apple, to Google, to Microsoft. Then the list is exported from Microsoft to an Excel file. The fields are bound to be messy without manual manipulation of the data at each transfer. Doctors face the same challenge. However, health information, namely treatment, diagnosis, and payment data, is far more complex than the name, email, and phone number format of a basic contacts list.

<sup>21</sup> In 2009, only 48.3% of office-based physicians had *any* EHR installed. A basic EHR, which computerized patient demographics, patient problem lists, medication lists, clinician notes, orders

particularly because no standardized electronic health record existed. In contrast, Congress aimed to create a modern health IT infrastructure capable of delivering more efficient, transparent, and timely care.

The HITECH Act created the “Meaningful Use” program as an incentive for providers to acquire EHRs.<sup>22</sup> These incentives were calculated as a percentage increase in a provider’s Medicare or Medicaid revenue.<sup>23</sup> As applied to Medicaid, the program was a pure incentive program.<sup>24</sup> CMS was responsible for overseeing the program and defining the guidelines for how to measure Meaningful Use. Over the following years, the Medicare Part B side of Meaningful Use morphed into a penalty program. Physicians who did not “meaningfully use” technology lost a percentage of their Medicare Part B revenue.<sup>25</sup> In application, the Meaningful Use program became mandatory.

Meaningful Use was originally intended to take effect in incremental stages.<sup>26</sup> CMS implemented the system as a pass/fail program with measure thresholds. A provider’s failure on one measure (out of roughly 8-10 total measures) caused the provider to fail entirely. However, the regulatory implementation of Meaningful Use was inadequate, and continued to decline when the program’s penalties took effect. Manifold problems added to the program’s demise. For example, the patient engagement requirements lacked reasonable thresholds.<sup>27</sup> Further, CMS frequently delayed changing requirements, failing to recognize that the original deadlines for participation or thresholds were patently too aggressive in the first place.<sup>28</sup> This scenario continued

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for medications, and viewing lab results, was only present in 21.8% of physician offices. *Office-based Physician Electronic Health Record Adoption*, HEALTH IT DASHBOARD, <https://dashboard.healthit.gov/quickstats/pages/physician-ehr-adoption-trends.php> (last visited Feb. 11, 2018).

<sup>22</sup> HITECH Act, Pub. L. No. 111-5, § 4101, 123 Stat. 115, 467-468 (2009).

<sup>23</sup> *Id.*

<sup>24</sup> *Id.*

<sup>25</sup> *Id.* at § 472.

<sup>26</sup> Specifically, the HITECH act states that “[t]he Secretary shall seek to improve the use of electronic health records and health care quality over time by requiring more stringent measures of meaningful use[.]” *Id.* at § 470.

<sup>27</sup> Meaningful Use Stage 2 originally required that 5% of all unique patients seen by an EP view, download, or transmit their health record (VDT). Many providers expressed frustration with this measure because it penalized providers for actions not always reasonably within their control. The measure was later reduced to just one patient in response to the outcry. Medicare and Medicaid Programs: Electronic Health Record Incentive Program – Stage 3 and Modifications to Meaningful Use in 2015 Through 2017, 80 Fed. Reg. 62762, 62789 (Oct. 16, 2015).

<sup>28</sup> In another example, CMS later released “Modified Stage 2,” which required providers to connect to a public health agency, clinical data registry, or specialty registry. This caused industry-wide panic, as many providers did not plan to attest this way because it was not initially required. CMS later pulled back this requirement, stating that if a provider had not planned to attest to this requirement, they were excluded from the measure. This was done through a fact sheet rather than formal rulemaking. *EHR Incentive Programs in 2015: Alternate Exclusions & Specifications*, CENTER FOR MEDICARE AND MEDICAID SERVICES (2015), [https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2015\\_AlternateExclusionsandSpecifications.pdf](https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2015_AlternateExclusionsandSpecifications.pdf).

to play out through “Modified Stage 2.” Stage 2 contained aggressive timelines that were poorly received by physicians. To accommodate providers, CMS dramatically changed the measure specifications and exclusions for years 2015-2017 through the Modified Stage 2 regulation. However, these accommodations were undermined by their delayed adoption because CMS took action in October of 2015, about 10 months into the 2015 performance period.<sup>29</sup> Finally, CMS consistently introduced incremental flexibility through a series of exclusions from measures or objectives.<sup>30</sup> This flexibility supplemented the complex nature of the program by adding exclusions and different paths for disqualification from certain measures into an already complicated measurement scheme.

In aggregate, these shortcomings had notable effects on the market. Physicians across the country developed a distaste for EHRs.<sup>31</sup> Providers expressed frustration and confusion with Meaningful Use’s seemingly ever-changing requirements. Many did not see a practical purpose in their EHR and wished to return to the era of paper charts.<sup>32</sup> Retirements spiked.<sup>33</sup> In the eyes of many clinicians, the program rendered the word “meaningful” meaningless.

#### **D. The Value-Based Modifier and the Cost of Patient Care**

Congress established the Value-based Modifier (“VBM”) through the Affordable Care Act in 2010, one year after the passage of the HITECH Act. VBM represents Congress’s attempt to reward clinicians for controlling the cost of patient care while maintaining quality. Similar to PQRS and Meaningful Use, the VBM plan furnished provider payments two years after the applicable performance period.<sup>34</sup> CMS introduced VBM

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<sup>29</sup> 80 Fed. Reg. 62762, 62787 (Oct. 16, 2015).

<sup>30</sup> The exclusions governing public health reporting are a good example of the complexity involved in a single measure. The “general exclusions” of that measure provided that the measure did not apply if 1) there was no registry in their jurisdiction ready to accept data, 2) if there was no registry at all. Then there was a set of three specific exclusions that applied to the three sub-types of registries, immunization registries, syndromic surveillance registries, and specialty registries. On top of the complexity within this one measure, each other measure out of the 10 objectives in 2016 all had 2-3 specific exclusions. 80 Fed. Reg. 62762, 62820 (Oct. 16, 2015).

<sup>31</sup> According to a 2017 survey by Medical Economics, 63% of users had a negative opinion of their EHR. *2017 EHR Report Card*, MEDICAL ECONOMICS (Oct. 25, 2017), <http://medicaleconomics.modernmedicine.com/medical-economics/news/2017-ehr-report-card>.

<sup>32</sup> The former president of the AMA noted that “[t]he message from physicians is loud and clear: Electronic Health Record (EHR) systems have so much potential, but frustrating government regulations have made them almost unusable.” Steven J. Stack, *Physicians, we hear you: EHR meaningful use isn’t meaningful*, AMA WIRE (July 21, 2015), <https://wire.ama-assn.org/ama-news/physicians-we-hear-you-ehr-meaningful-use-isnt-meaningful>.

<sup>33</sup> While there is a question of causality, the ONC noted that 41% of providers who did not adopt or plan to adopt an EHR cited retirement as their main reason. Office of the National Coordinator for Health IT, *Physician Motivations for Adoption of Electronic Health Records* (Dec. 2014) <https://www.healthit.gov/sites/default/files/oncdatabrief-physician-ehr-adoption-motivators-2014.pdf>.

<sup>34</sup> Affordable Care Act, Pub. L. No. 111-148, § 3007, 124 Stat. 119, 373 (2010).



by phasing the program in over the course of three years and applying it to physician organizations of varying sizes depending on the performance period.<sup>35</sup>

The program included a complex measurement process that leveraged an array of data, including quality data received from the PQRS program, composite measures of hospital admissions for acute and chronic conditions sensitive to ambulatory care, and a measure of 30-day all-cause hospital readmissions.<sup>36</sup> Finally, to calculate cost, the program implemented CMS claims data to calculate six separate measures, including: (1) total per capita costs for all beneficiaries measure and total per capita costs for beneficiaries with specific conditions, (2) diabetes, (3) coronary artery disease, (4) chronic obstructive pulmonary disease, (5) heart failure; and (6) Medicare spending per beneficiary measure.<sup>37</sup>

Because CMS calculated the VBM score through claims data aggregated after the close of the performance period, physicians were largely unable to predict how their cashflow would be impacted in later years because they could not fully assess their performance in the present. Between 2011 and 2015, the administrative and reporting burden ballooned. With the VBM, PQRS, and Meaningful Use combined, ambulatory physicians were subject to no fewer than 25 measures that had different reporting requirements, workflows, reporting deadlines, and portals.

### III. 2015: MACRA USHERS IN A NEW ERA

2015 saw the dawn of a new era in healthcare reform through a rare act of bipartisanship. SGR once again came into play as the politically toxic nature of the program motivated Congress to change or repeal the law. At the same time, representatives received numerous complaints from physician associations and technology vendors stating that the various reporting programs were too complex and burdensome.<sup>38</sup> While Congress desired to replace the SGR, it also wanted to leave in place a simplified regime that could control costs to stabilize healthcare expenditures. Congress addressed these concerns in the Medicare and CHIP Reauthorization Act of 2015.<sup>39</sup> The measure passed overwhelmingly. 92 Senators and 392 Representatives from the House voted in favor of the Act.<sup>40</sup>

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<sup>35</sup> Medicare Program: Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016, 80 Fed. Reg. 70,886, 71,384 (Nov. 16, 2015).

<sup>36</sup> *Id.*

<sup>37</sup> *Id.* at 71,279.

<sup>38</sup> The AMA submitted a detailed letter to CMS in October 2014 that provided a fairly comprehensive view of physician concerns prior to MACRA's passage. While focused on Meaningful Use, it calls out other programs such as PQRS. As a whole, the letter attacks Meaningful Use's measure thresholds, lack of alignment with other reporting programs, lack of flexibility, and complexity. See Letter from the AMA to Marilyn B. Tavenner, et al., Administrator For the Centers for Medicare & Medicaid Services (Oct. 14, 2014).

<sup>39</sup> MACRA, Pub. L. No. 114-10, 129 Stat. 87 (2015).

<sup>40</sup> All Actions HR. 2 – 114<sup>th</sup> Congress (2015-2016) (last accessed Feb. 12, 2018) <https://www.congress.gov/bill/114th-congress/house-bill/2/>.

In addition to repealing the SGR, MACRA created the Merit-based Incentive Payment System (“MIPS”).<sup>41</sup> MIPS rolled PQRS, Meaningful Use, and the Value-based Modifier into a single reporting program. Under MACRA, each category was respectively labelled quality, meaningful use of certified EHR technology, and resource use.<sup>42</sup> Congress also added a new element called Clinical Practice Improvement Activities, which gave physicians credit for making clinical process changes.<sup>43</sup> Under MACRA, Medicare reporting would have one deadline and a single reporting portal. It would also be regulated through a single regulatory stream. All in all, MACRA aimed to simplify the process of reporting quality data to Medicare. In addition to easing the reporting process, the program authorized CMS to give providers significant flexibility in the first two years of the program.<sup>44</sup> Most notably, Congress gave CMS flexibility to set the composite score lower than the mean or median of prior performance scores.<sup>45</sup>

However, consolidation of the various programs came with serious financial consequences. Over time, MIPS is set to become more financially aggressive. In 2017, physicians faced incentives or penalties of 4% of their Medicare revenue.<sup>46</sup> After full implementation occurs, physicians will face incentives or penalties of up to 9% of their Medicare revenue.<sup>47</sup> For organizations whose payer mix consists of predominantly Medicare beneficiaries, the incentives or penalties could represent the organization’s entire profit margin. 9% also presents a three percent increase in the net total financial downside presented by PQRS, Meaningful Use, and the Value-Based Modifier. The program is budget neutral<sup>48</sup> (*i.e.* for every incentive dollar earned, another physician receives a one-dollar penalty). Additionally, providers will be measured against the mean or median of the market’s overall performance.<sup>49</sup>

Congress designed MIPS as a budget neutral program to create a business case for participation in an Advanced Alternative Payment Model (“APM”). Under an Advanced APM, a provider shares the financial risk of the cost of patient care with CMS. If the provider is capable of lowering the cost of care while maintaining quality, CMS rewards the provider with a financial incentive. Alternatively, if the provider fails to lower the cost, or does so by decreasing the quality of care, CMS punishes the provider by imposing a financial penalty. The statute defines an Advanced APM as a payment model based on the organization’s undertaking of “more than nominal risk.”<sup>50</sup> This heightened financial risk usually occurs in the form of shared savings or shared losses. In other words, CMS will share the government’s savings with

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<sup>41</sup> MACRA, Pub. L. No. 114-10, § 101, 129 Stat. 87, 92 (2015).

<sup>42</sup> *Id.* at 96.

<sup>43</sup> *Id.*

<sup>44</sup> *Id.* at 107.

<sup>45</sup> MACRA, Pub. L. No. 114-10, § 101, 129 Stat. 87, 106 (2015).

<sup>46</sup> *Id.* at 106.

<sup>47</sup> *Id.*

<sup>48</sup> MACRA, Pub. L. No. 114-10, § 101, 129 Stat. 87, 108 (2015).

<sup>49</sup> *Id.* at 107.

<sup>50</sup> *Id.* at 119.

healthcare providers who decrease CMS's overall cost of patient care by reducing hospitalizations, preventing health catastrophes, and providing proactive care. Instead, if a provider costs CMS additional funds, the provider will pay a fraction of that cost out to CMS and the broader healthcare system.<sup>51</sup> Designed to be a direct replacement for the SGR, Congress hoped Advanced APMs and the MIPS penalty structure would streamline and improve the reporting process.

Despite Congress's intention to simplify MACRA and remove political uncertainty from physician payments, providers have expressed hostility towards the program. Lamenting about the financial components and the infancy of the program, many physician organizations have resisted the program's implementation at each stage of adoption. Notwithstanding MACRA's simplification in comparison to prior programs, even the Medicare Payment Advisory Commission has now recommended that Congress replace MIPS with a simpler or voluntary alternative.<sup>52</sup> In response, the authors of MACRA indicated their expectation that CMS fully and faithfully implement the statute.<sup>53</sup> Despite widespread pushback, MACRA is bolstered by bipartisan buy-in and general dislike of the fee-for-service system. Relying on this supportive base, it appears that MACRA is here to stay. As CMS proceeds with MACRA, it is increasingly clear that the program's success depends on the details of implementation and physician buy-in. However, inconsistent implementation, initial aggressive and unrealistic programmatic requirements, and late adjustments to those requirements threaten the program's future.

#### **IV. MACRA IN 2017 & 2018: WALKING IT BACK**

##### **A. 2017's Proposed Regulation: Panic in the Market**

On May 9, 2016, CMS released the first in a series of proposed rules implementing MIPS and the other provisions of MACRA. Similar to the implementation of its legacy programs, the rule set out aggressive requirements with significant financial impacts for the first year. To begin, CMS required one full year of reporting.<sup>54</sup> If a physician accepted more than \$10,000 in Medicare revenue and cared for fewer than 100 Part B

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<sup>51</sup> *See id.*

<sup>52</sup> Kate Bloniarz et al., *Assessing Payment Adequacy and Update Payments: Physician and Other Health Professional Services; and Moving Beyond the Merit-based Incentive Payment System*, MedPac (Jan. 11, 2018) <http://www.medpac.gov/docs/default-source/default-document-library/jan-2018-phys-mips-public.pdf?sfvrsn=0>.

<sup>53</sup> A bipartisan group with members from multiple committees wrote that "Congress overwhelmingly passed the bipartisan Medicare Access and CHIP Reauthorization Act (MACRA). We write to express the importance of successful implementation, as intended by Congress, of the reforms included in MACRA and the establishment of the Merit-Based Incentive Payment System (MIPS) and Alternate Payment Model (APM) tracks for physician payment." Letter from Congress to Sylvia Burwell, Secretary of the U.S. Department of Health and Human Services (Sept. 6, 2016), <https://waysandmeans.house.gov/wp-content/uploads/2016/09/09.06.16-EC.WM-MACRA-Letter.pdf>.

<sup>54</sup> 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, 81 Fed. Reg. 28,162, 28,218 (May 9, 2016).

beneficiaries, they were subject to MIPS payment adjustments.<sup>55</sup> CMS summarized the program's costs and benefits, estimating \$833 million in negative adjustments and \$833 million in positive adjustments over the first year; the adjustments would be spread out over a range of 687,000 to 746,000 total "eligible clinicians."<sup>56</sup>

Generally, the statute commands CMS to set the performance threshold each year based on the mean or median of the prior year's score.<sup>57</sup> For the first performance period, CMS proposed an alternative threshold determination based on an analysis of Part B allowed charges, 2014 and 2015 PQRS data submissions, feedback data on cost and quality, and Meaningful Use program data.<sup>58</sup> Though the program took effect on January 1, 2017, providers did not receive their first year target for the 2017 performance period until October-December 2017.

In addition to obvious obstacles such as time compression, physicians also faced the daunting task of understanding and adopting a new and complex MIPS scoring system. CMS proposed a calculation of 50% for Quality, 25% for Advancing Care Information (ACI) (the new regulatory designation for Meaningful Use), 15% for Clinical Practice Improvement Activities, and 10% for Cost. However, each specific category required a different number of total points in order for providers to earn full credit.

Quality scoring required reporting on six measures, including at least one outcomes measure.<sup>59</sup> Providers had to earn a quality score of 60 points to receive a 100% in that category.<sup>60</sup> Thus, earning 30 Quality points would supply a provider with 25% of their MIPS composite score. CMS measured cost using the familiar Medicare Spending Per Beneficiary measure, in conjunction with 14 new episode-based measures.<sup>61</sup>

A new scoring category, Clinical Practice Improvement Activities, measured the implementation of clinical process improvements called "improvement activities." In the proposed rule, each activity was worth a certain number of points. Most practices had to achieve 60 points to receive full credit in the Clinical Practice Improvement Activities category. Small practices, or those with 15 eligible clinicians or fewer, were only required to earn 30 points.<sup>62</sup> Under this category, there were "high priority" activities worth 20 points (e.g. providing 24/7 access to the care team), and "medium priority" activities worth 10 points (e.g. screening patients with certain mental health conditions for depression).<sup>63</sup>

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<sup>55</sup> *Id.* at 28,230.

<sup>56</sup> *Id.* at 28,165.

<sup>57</sup> MACRA, Pub. L. No. 114-10, § 101, 129 Stat. 87, 107 (2015).

<sup>58</sup> 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, 81 Fed. Reg. 28,162, 28,274 (May 9, 2016).

<sup>59</sup> *Id.* at 28,164.

<sup>60</sup> *Id.* at 28,256.

<sup>61</sup> *Id.* at 28,196.

<sup>62</sup> *Id.* at 28,266.

<sup>63</sup> *Id.* at 28,267.

Next, the scoring scheme for Advancing Care Information (ACI) (previously referred to as Meaningful Use) was, and remains, a tangled web of requirements. It was composed of several elements, including a base score, performance score, and bonus score.<sup>64</sup> Although CMS announced that MIPS eliminated the arbitrary pass/fail elements of the legacy programs, the elimination was not fully executed. The base score included a set of 4-5 “required” measures, which consisted of a numerator and denominator.<sup>65</sup> The numerator is the number of times a provider takes a particular action using technology, and the denominator represents the number of encounters where that action is presumably relevant. Under ACI, the provider had to earn a 1 in the numerator for these “base” measures.<sup>66</sup> Providers who did not meet the base measures threshold failed the entire category, echoing the pass/fail structure of Meaningful Use.<sup>67</sup> Because of the low thresholds, CMS elected not to provide for exclusions in 2017.<sup>68</sup> Thus, providers who did not write prescriptions, take referrals or receive transitions of care would fail the entire category.<sup>69</sup> Providers who passed the base score would receive 50% of the ACI score. To reach 100% under ACI (25% of the MIPS composite), providers had to rely on performance score or “bonus score.”<sup>70</sup> The performance measures, which sometimes overlapped with the base measures, were best explained as “the more you do, the more you earn.”<sup>71</sup> Finally, the bonus score rewarded physicians for connecting

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<sup>64</sup> 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, 81 Fed. Reg. 28,162, 28,220 (May 9, 2016).

<sup>65</sup> *Id.* at 28,221.

<sup>66</sup> *Id.* at 28,268.

<sup>67</sup> *Id.*

<sup>68</sup> In Meaningful Use and ACI, exclusions state that a provider does not need to report on the measure because there are not enough relevant encounters for the measure to be relevant. For example, under 2018’s rule, providers who write fewer than 100 prescriptions are excluded from the e-prescribing measure and do not have to report on it. Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year, 82 Fed. Reg. 53,568, 53,680 (Nov. 16, 2017).

<sup>69</sup> Even if a practice does take referrals or transitions of care, the health information exchange measurement can be problematic. Imagine a retinal practice. Retinal medical issues are immediate emergencies; if action is not taken within hours, the patient may become permanently blind. If most patients are having a problem, they generally go to their optometrist or general ophthalmologist before seeking alternative care. If the optometrist or ophthalmologist sees a retinal problem, they will frequently arrange for an immediate evaluation with a retinal specialist, even walking the patient across the street to the retinal specialist for immediate surgery. At no point is the referring physician slowing down to send an electronic summary of care. The retinal specialist is not going to “query” or ask the referring physician’s system for a summary of care. Instead, the retinal specialist will likely ask the physician and patient about the patient’s current medications and potential allergies before whisking the patient away to surgery. Even in the event of a specialist’s request for a summary of care, it may take days for the summary to be completed and delivered. The referring physician’s direct address may also be wrong in the directory, which is generally maintained by a private technology vendor like Surescripts. It is not maintained in NPPES, where all other provider contact information and the NPIs are kept, so there is no universal source of truth.

<sup>70</sup> *Id.*

<sup>71</sup> For example, if a provider gives 3/10 patients access to their electronic health record, that provider receives 3 points under ACI.

to public health registries or reporting improvement activities through an EHR.<sup>72</sup> In aggregate, this amounted to a great deal of complexity to achieve only 25% of a provider's score.

The program's complexity, rapid implementation, and perceived threat to small practices provoked industry outcry. In response to the turmoil, the American Medical Association (AMA) released a 70-page comment letter about the proposed regulation. The letter specifically advocated for a transitional period of reduced thresholds, seeking "a much more progressive and welcoming environment."<sup>73</sup> The American Academy of Family Physicians (AAFP) used stronger language, stating that "we see a strong and definite need and opportunity for CMS to step back and reconsider the approach to this proposed rule which we view as overly complex and burdensome[.]"<sup>74</sup> Both organizations called for an interim rule to scale back many of the proposed rule's provisions. The American Hospital Association (AHA) also weighed in, "urg[ing] CMS to monitor ongoing feedback of the field to implement MACRA, and to be willing to consider additional flexibility in its timeline and other requirements such as quality measure data completeness."<sup>75</sup> Specialist societies lent their voices as well. The American College of Cardiology (ACC) called for CMS to "streamline and simplify" the program,<sup>76</sup> while the American Academy of Orthopaedic Surgeons (AAOS) noted that "it will be burdensome, if not impossible for physicians to get ready for the first performance year of 2017."<sup>77</sup>

Physician organizations were not alone in their criticism of the proposed rule. Technology vendors who supported MACRA's reporting and data collection requirements were equally concerned. The EHRA requested that "CMS take every possible step to dramatically simplify provisions and requirements, and to revise and develop provider-focused communications to reduce remaining perceived complexity."<sup>78</sup> The EHRA further requested 18 months of additional development time to support quality measures.<sup>79</sup> The Healthcare Information and Management Systems Society (HIMSS), representing a broader swathe of the health IT market, noted that the timeline was problematic because vendors supporting the program would need to change measure/

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<sup>72</sup> *Id.*

<sup>73</sup> Letter from the AMA to Andrew Slavitt, Acting Administrator For the Centers for Medicare & Medicaid Services (June 27, 2016).

<sup>74</sup> Letter from the AAFP to Andrew Slavitt, Acting Administrator For the Centers for Medicare & Medicaid Services (June 24, 2016).

<sup>75</sup> Letter from the AHA to Andrew Slavitt, Acting Administrator For the Centers for Medicare & Medicaid Services (June 27, 2016).

<sup>76</sup> Letter from the ACC to Andrew Slavitt, Acting Administrator For the Centers for Medicare & Medicaid Services (June 27, 2016).

<sup>77</sup> Letter from the AAOS to Andrew Slavitt, Acting Administrator For the Centers for Medicare & Medicaid Services (June 24, 2016).

<sup>78</sup> Letter from the EHRA to Andrew Slavitt, Acting Administrator For the Centers for Medicare & Medicaid Services (June 27, 2016).

<sup>79</sup> *Id.*

dashboard logic and user interfaces.<sup>80</sup> tenuous response as it became apparent that the market was not prepared for the ambitious proposed rule.

### **B. Walking Back from Full Implementation to the Transition Years**

In response to overwhelming criticism, CMS drastically walked back its implementation of MIPS, echoing the Meaningful Use and EHR Incentive Programs. Most notably, CMS removed most of the program's financial consequences for the 2017 performance period. CMS changed the performance threshold by setting it at 3 points out of 100 instead of basing the threshold on the legacy programs' prior scores. This change had several financial impacts. First, in order to avoid a penalty, providers had to report on fewer measures than in prior years. CMS provided four "Pick Your Pace," reporting options:

1. Do nothing, and receive a 4% penalty;
2. Report on at least one quality measure, the required Advancing Care Information measures, or one improvement activity for at least 90 days to avoid any penalty;
3. Report on more than one quality measure, the required Advancing Care Information measures, or one improvement activity for at least 90 days and earn a small incentive; or
4. Fully report for a full calendar year and earn an incentive.<sup>81</sup>

In addition, CMS significantly expanded the list of providers who would receive an exclusion from the program. Under the new structure, a physician would be excluded from MIPS if they collected less than \$30,000 in Medicare revenue or saw fewer than 100 Medicare patients.<sup>82</sup> Because CMS lowered the performance threshold and expanded exclusions, the total estimate of incentives and penalties for the 2017 performance period was \$199 million spread across at least 592,000 clinicians.<sup>83</sup> The new structure reduced MIPS incentives and penalties to an average of only \$336.15 per clinician program.

The new and improved 2018 MACRA rule continues the trend of expanding exclusions. The rule extends the transition period by another year while adding complexity and untested features to MIPS through the introduction of improvement scoring, virtual group reporting and new exclusions. The rule also raises the performance threshold to 15 points out of 100.<sup>84</sup> To avoid a penalty, providers can take several pathways, including but not limited to:

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<sup>80</sup> Letter from HIMSS to Andrew Slavitt, Acting Administrator For the Centers for Medicare & Medicaid Services (June 27, 2016).

<sup>81</sup> 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, 81 Fed. Reg. 77,008, 77,011 (Nov. 4, 2016).

<sup>82</sup> *Id.* at 77,012.

<sup>83</sup> *Id.* at 77,016.

<sup>84</sup> Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year, 82 Fed. Reg.

1. Report on six clinical quality measures;
2. Report on the required ACI measures and one quality measure; or,
3. Fully participate in Clinical Practice Improvement Activities, which entails one to two process changes to receive full credit.

Despite increasing the performance threshold, CMS further expanded the list of available exclusions to include providers seeing fewer than 200 patients or taking less than \$90,000 in revenue.<sup>85</sup> Under the expanded exclusions, fewer clinicians will be penalized. With fewer providers paying penalties into the program, the total amount of incentive money available to participating providers will decrease to \$118 million.<sup>86</sup> As a result, clinicians who were subject to the program in 2017 may be excluded in 2018.

Moreover, when CMS proposed the 2018 rule, it introduced another element of complexity to the program by permitting virtual group reporting. This technically complex new reporting scheme allows organizations with 10 or fewer eligible clinicians to report as a single entity.<sup>87</sup> While it presumably enables smaller organizations to scale in the same manner as enterprise healthcare systems, different practices in a virtual group will likely use different EHRs. CMS did not release any guidance on how data would be submitted for virtual groups that use different EHRs.

The rule also introduced “improvement scoring,” where an organization could receive extra credit for improving Quality and Cost. However, CMS measures quality improvement at the category level.<sup>88</sup> This means that CMS would measure the improvement a provider made on the average of all measures selected, rather than the individual measures themselves. Given the high level of variance between quality measures, CMS even noted that this could leave improvement scoring open to gamesmanship.<sup>89</sup>

Finally, CMS also reintroduced exclusions for Advancing Care Information, and retroactively applied the exclusions to the 2017 performance period (just 2 months before the closure of that performance period).<sup>90</sup> Introducing new exclusions at this time-sensitive juncture left many developers with insufficient time to support providers, leaving the dashboards of some providers technically unsupported. This regulatory inconsistency and complexity between 2017 and 2018 has set an uncertain stage for the future of MACRA.

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53,568, 53,576 (Nov. 16, 2017).

<sup>85</sup> *Id.* at 53,589.

<sup>86</sup> *Id.* at 53,926.

<sup>87</sup> *Id.* at 53,953.

<sup>88</sup> *Id.* at 53,740.

<sup>89</sup> Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year, 82 Fed. Reg. 53,568, 53,740 (Nov. 16, 2017).

<sup>90</sup> *Id.* at 53,680.



## V. WHAT'S NEXT AND MAXIMIZING PROGRAMMATIC EFFICACY AND EFFICIENCY

Despite MACRA's challenging regulatory implementation, stabilizing programmatic implementation in the coming years will allow CMS to maximize the program's efficacy and gain buy-in from physicians. MIPS has already made several important improvements over its legacy programs, including a single reporting deadline and a reporting portal that displays a provider's live score before the submission period closes.<sup>91</sup> CMS also recently announced two initiatives aimed at gaining provider support. First, the Meaningful Measures project seeks to reorient quality measures to provide less emphasis on process and have a greater focus on clinical outcomes.<sup>92</sup> CMS has also launched Patients Over Paperwork, a program meant to implement President Trump's executive order to "cut the red tape." One of its primary and most laudable goals is to reduce the administrative time physicians spend on compliance with CMS programs, such as MIPS. In a recent newsletter, CMS stated that the new reporting portal and the removal of several quality measures are by-products of that initiative.<sup>93</sup>

Plus, MIPS' scoring is already an improved version of the scoring systems implemented in the legacy programs. One example of this improvement is the fundamental removal of thresholds from Meaningful Use under ACI. Before, Meaningful Use was a pass/fail program with different thresholds for different measures.<sup>94</sup> Today's program is more comparable to a performance category. Additionally, the removal of a cross-cutting quality measure will help specialists more effectively participate, specifically in the Quality category of MIPS.<sup>95</sup>

However, more work remains if CMS wants to regain physicians' confidence that MACRA will be more than just a reporting program where they must memorize a myriad of requirements. Two changes are integral to the program's future: reducing complexity and lengthening the regulatory cycle to the extent permitted by law. Acting with input from the AMA and other provider organizations, Congress has already provided CMS with the vehicle to accomplish these changes<sup>96</sup> by pushing mean and median scoring

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<sup>91</sup> *Id.* at 53,626.

<sup>92</sup> Center for Medicare & Medicaid Services, *CMS Administrator Verma Announces New Meaningful Measures Initiative and Addresses Regulatory Reform: Promotes Innovation at LAN Summit* (Oct. 30, 2017), <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-10-30.html>.

<sup>93</sup> Center for Medicare and Medicaid Services, *Patients Over Paperwork* (Jan. 2018), <https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/JanuaryPoPNewsletter011818.pdf>.

<sup>94</sup> *See id.* at 5.

<sup>95</sup> Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year, 82 Fed. Reg. 53,568, 53,628 (Nov. 16, 2017).

<sup>96</sup> The A.M.A. and other provider organizations requested "to continue the existing flexibility in the MACRA statute that CMS is currently using for an additional three years so that the agency may move forward as the necessary program elements are put in place." Letter from the AMA, *et al.*, to Greg Walden, Chairman of the Committee of Energy and Commerce, (October 2, 2017).

from 2019 to 2022.<sup>97</sup> To accommodate this scoring change and provide a more natural onramp, CMS must gradually increase the performance threshold for the next three years. CMS must release new cost measures by December 31, 2018, with the option to weigh Cost between 10% and 30% (before, it was set to scale to 30% in 2019).<sup>98</sup> In another effort to introduce more simplicity, Congress removed improvement scoring from the program until 2022.<sup>99</sup>

CMS should also take further action to simplify scoring. Under ACI today, providers can earn up to 100%, which then represents 25% of their MIPS composite score. CMS defines full participation in the Quality category as reporting on six quality measures with at least one outcomes measure, a data submission threshold of 60%.<sup>100</sup> The top Quality score is 60 points, and represents 50% of a provider's score.<sup>101</sup> Clinical Practice Improvement Activities contain high priority measures worth 20 points, medium priority measures worth 10 points, and a 40 point or 20 point maximum that, depending on practice size, represents 15% of the provider's total MIPS composite score.<sup>102</sup> This is a tremendously complex scoring scheme that all practices must contend with, regardless of their size or sophistication. Varying the maximum scores in each category and eliminating nuances such as performance scores and base scores would further simplify the program.

CMS should also provide greater consistency and simplicity in terms to aid provider understanding. As noted earlier, ACI contains a reference to a base score, performance score, and a bonus score.<sup>103</sup> For a physician or practice administrator who will not read the entirety of the regulation, the difference between a bonus score and performance score is difficult to understand. CMS's decision to change or replace commonly used terms also presents difficulties to participating providers. CMS adopted the term "eligible clinician," a change from MACRA's statutory use of "eligible provider." Morphing the term Meaningful Use into ACI, while applying identical measure specifications, also caused needless confusion. CMS should avoid unnecessary changes in terminology and consider changing ACI to "MIPS Meaningful Use." This term more accurately describes the category, aligns the category with the terminology in the MACRA statute and allows providers to better understand of the term due to their previous experience with Meaningful Use.

Finally, the broader market would benefit tremendously from extending the regulatory cycle and stabilizing implementation. Allowing some providers to claim an exclusion after participating in 2017 will cause providers to overlook the program based on a belief that it lacks tenacity. Then, if exempt providers become subject to MACRA once

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<sup>97</sup> Bipartisan Budget Act of 2018, H.R. 1892, 115th Cong. § 51003 (2018) (enacted).

<sup>98</sup> *Id.*

<sup>99</sup> *Id.*

<sup>100</sup> Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year, 82 Fed. Reg. 53,568, 53,717 (Nov. 16, 2017).

<sup>101</sup> *Id.* at 53,717.

<sup>102</sup> *Id.* at 53,767.

<sup>103</sup> *Id.* at 53,663.

again, they will be disillusioned and ultimately disinclined to participate. CMS should not implement further raises to the exclusionary thresholds. If CMS chooses to lower the thresholds, the agency should engage in significant education efforts so providers are not “blindsided” by the new exclusion guidelines. Moreover, CMS should start proposing new measures and exclusions eighteen months before implementation (rather than six). This extended implementation period would give providers enough time to familiarize themselves with new concepts. It would also provide technology vendors with additional time to support provider participation in MACRA through development of functionality tools such as updated dashboards and optimized EHR workflows.

## **VI. CONCLUSION**

MACRA is a rare bipartisan achievement that streamlines prior programs while attempting to create a business case for changing the way the federal government pays providers. However, the program’s success ultimately depends on its implementation. If CMS can administer the program in a way that allows physicians to buy in, it stands a much greater chance of success. Prior programs suffered because of inconsistent, uneven, and complex measurement. MACRA’s first two years have echoed those prior reform efforts. Avoiding the historical pitfalls of MACRA’s predecessors will allow the program to succeed. Important improvements that should be integrated into MACRA over the coming year include lengthening the regulatory cycle, simplifying the requirements, and consistent implementation. These improvements will ensure achievement of the legislation’s original intent while also providing for the program’s overall success.