Medicare Access and CHIP Reauthorization Act (MACRA)

Overview of the Quality Payment Program

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MACRA – What is it?

The Medicare Access and CHIP Reauthorization Act (MACRA) was passed into law with overwhelming congressional support (more than 90% of Senate and House votes) on April 16, 2015. MACRA created the Quality Payment Program (QPP), which ties more payments to value, while simplifying reporting for eligible clinicians. This is an overview of the QPP and what it means for you.

WHAT IS THE QUALITY PAYMENT PROGRAM?

Simplification

MACRA created the QPP which has two tracks for participation: The Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). Before the QPP, eligible clinicians participated in several overlapping Medicare programs.

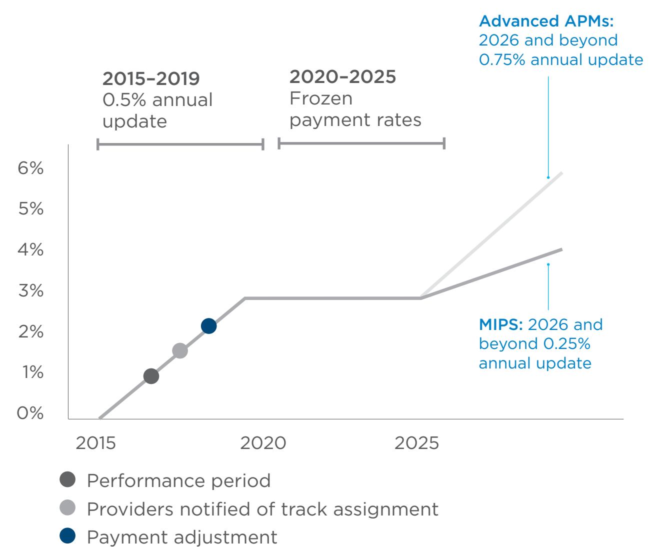
- Electronic Health Records Incentive Program (Meaningful Use)
- Physician Quality Reporting System (PQRS)
- Value-based Payment Modifier

The QPP streamlines these programs into MIPS. It consolidates, better aligns and simplifies these programs to make it easier for eligible clinicians.

MIPS also adds a new improvement activities component, with more than 100 activities from which eligible clinicians can choose to receive credit for providing high-value services.

An Alternative Payment Model (APM) is a payment approach that gives added incentive payments for providing high-quality and cost-efficient care. The QPP also provides incentives for providers to develop and participate in different models of health care delivery and payment (identified as Advanced APMs).

TWO TRACKS FOR ELIGIBLE CLINICIANS



Less penalty

Passed with broad bipartisan support, MACRA replaced the Sustainable Growth Rate (SGR) formula and its piecemeal approach to Medicare payment adjustments. In addition to ushering in a new era of value-based reimbursements, MACRA also warded off a looming 21% Medicare payment cut that was scheduled for mid-2015 under the SGR.

1 MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Most eligible clinicians will be paid under the QPP through this modified fee-for-service model.

- Streamlines PQRS, Value-based Payment Modifier and Meaningful Use programs to work as one, adding flexibility.
- Adds a fourth component to promote and reward practice improvement and innovation.

MIPS

TWO TRACKS IN THE QPP

2 ADVANCED ALTERNATIVE PAYMENT MODEL (APM)

An annual bonus payment is available for eligible clinicians participating in payment models specifically approved by the Centers for Medicare & Medicaid Services (CMS).

ADVANCED APM

1. MERIT-BASED INCENTIVE PAYMENT SYSTEM

MIPS

MIPS adjusts traditional fee-for-service payments upward or downward based on the new reporting program, integrating PQRS, Meaningful Use and Value-based Payment Modifier.

MIPS applies to Medicare Part B clinicians, including:

- Physicians
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Registered Nurses
- Anesthetists
- Physical and Occupational Therapists
- Clinical Social Workers
- Clinical Psychologists

MIPS scoring

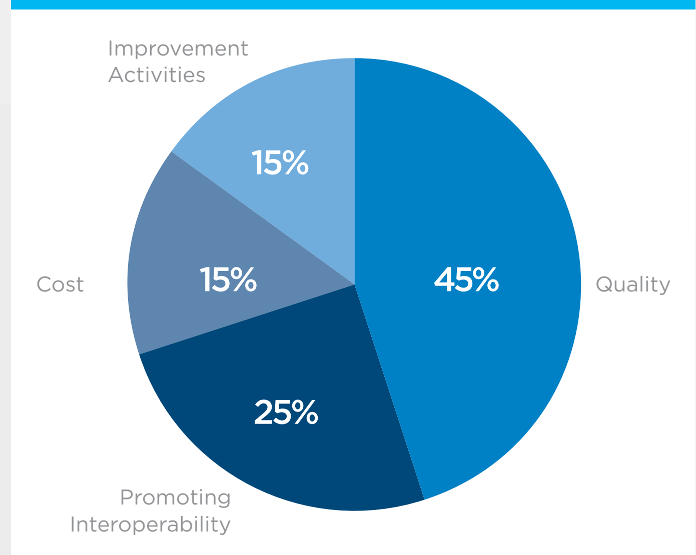
Four components are scored individually and then combined for a composite score. Each eligible clinician score will result in a positive, negative or neutral payment adjustment.

Providers in MIPS that also participate in non-Advanced APM models, such as Shared Savings Program Track 1 or BASIC levels A–D ACOs, are called MIPS APMs and qualify for preferential scoring, which could positively affect reimbursement.

The adjustment factor

1. Clinicians/groups/MIPS APM entities are assigned a performance score of 0–100.
2. That score is compared with the performance threshold (PT). The PT will either be the mean or the median – as selected by CMS – of the composite performance scores for all MIPS participants.
3. Clinicians/groups/MIPS APM entities that fall above the PT receive bonuses. Clinicians that fall below the PT face penalties.

2019 MIPS SCORING



Many Medicare clinicians are exempt from MIPS

Who is exempt?

Newly enrolled in Medicare

Enrolled in Medicare for the first time during the performance period (exempt until following performance year)

Below the low-volume threshold

Medicare Part B-allowed charges less than or equal to $90,000 a year; see 200 or fewer Medicare Part B patients a year; have less than 200 covered professional services

Note: MIPS-eligible clinicians who meet or exceed at least one (but not all) of the low-volume threshold criteria may choose to participate in MIPS

Advanced APM participation

Receive required percentage of their Medicare payments *or* see required percentage of their Medicare patients through an Advanced APM

1. MERIT-BASED INCENTIVE PAYMENT SYSTEM

MIPS performance categories

Performance category: Quality

This category builds on the PQRS. Shared Savings Program Track 1 and BASIC Level A–D ACOs will automatically be awarded bonus points in the quality performance category for reporting high-priority measures that are already included in the Web Interface measure set. CMS will continue to use claims data to calculate population-based measures, and clinicians or groups that report extra outcome measures or use certified EHR technology will be rewarded with bonus points.

Performance category: Promoting Interoperability (PI)

This category builds on the Meaningful Use component. For performance year three (2019) eligible clinicians under the PI performance category for MIPS must use 2015 Edition Certified EHR Technology (CEHRT).

Non-Advanced APMs (e.g., Shared Savings Program Track 1 or BASIC Level A–D ACOs) are initially required to have at least 50% of their eligible clinicians attest to use of CEHRT, requiring no additional reporting or evaluation caused by this performance category.

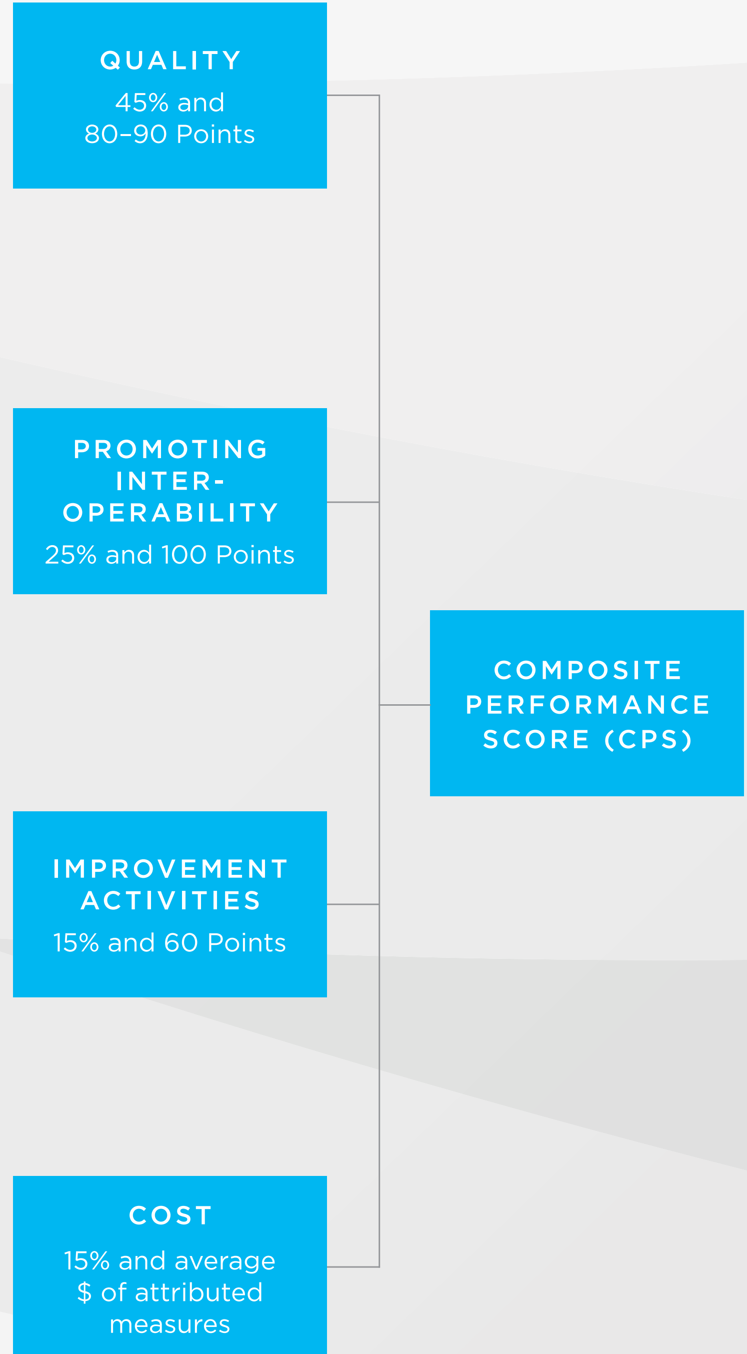
Performance category: Improvement Activities

- Clinicians can choose the activities best suited for their practice
- More than 100 activities from which to choose
- Clinicians participating in medical homes earn “full credit” in this category
- Participants in non-Advanced APMs, including Shared Savings Program Track 1 and BASIC Level A–D ACOs, will earn at least half credit

Performance category: Cost

This category builds on the Value-based Payment Modifier component.

- CMS will calculate these measures based on claims and the availability of sufficient volume
- Clinicians do not need to report anything
- CMS will not calculate a cost score for Shared Savings Program Track 1 or BASIC Level A–D ACOs under the MIPS APM Scoring Standard



2. ADVANCED ALTERNATIVE PAYMENT MODELS

Advanced APMs

Advanced APMs involve a payment approach that rewards high-quality and cost-efficient care, and involve upside and downside financial risk.

- Medical home models are subject to different (more flexible) standards to become an Advanced APM
- Potential for 5% annual bonus FFS payments

Eligible Advanced APMs

- Shared Savings Program BASIC Track Level E and ENHANCED Track
- Comprehensive Care Plus (CPC+)
- Comprehensive End-stage Renal Disease Care (CEC) two-sided risk arrangement tracks
- Oncology Care Model (OCM) two-sided risk arrangement
- Bundled Payments for Care Improvement (BPCI) Advanced Model
- Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1 – CEHRT)
- Vermont Medicare ACO Initiative
- Maryland All-Payer Model
- Maryland Total Cost of Care Model

Who can participate in an Advanced APM?

Beginning in 2019

If an eligible clinician participates in an Advanced APM, they may become a Qualifying Participant (QP).

Eligible clinicians who are QPs are excluded from MIPS.

2019 through 2025

QPs receive a lump sum incentive payment equal to 5% of their prior year's payments for Part B covered professional services.

Beginning in 2026

QPs receive a higher update under the Physician Fee Schedule than non-QPs.

Advanced APM expansion

2019 and 2020

Eligible clinicians may become QPs only through participation in Advanced APMs.

2021 and later

Eligible clinicians may become QPs through a combination of participation in Advanced APMs and APMs with other payers (Other Payer Advanced APMs).

Other Payer Advanced APMs:

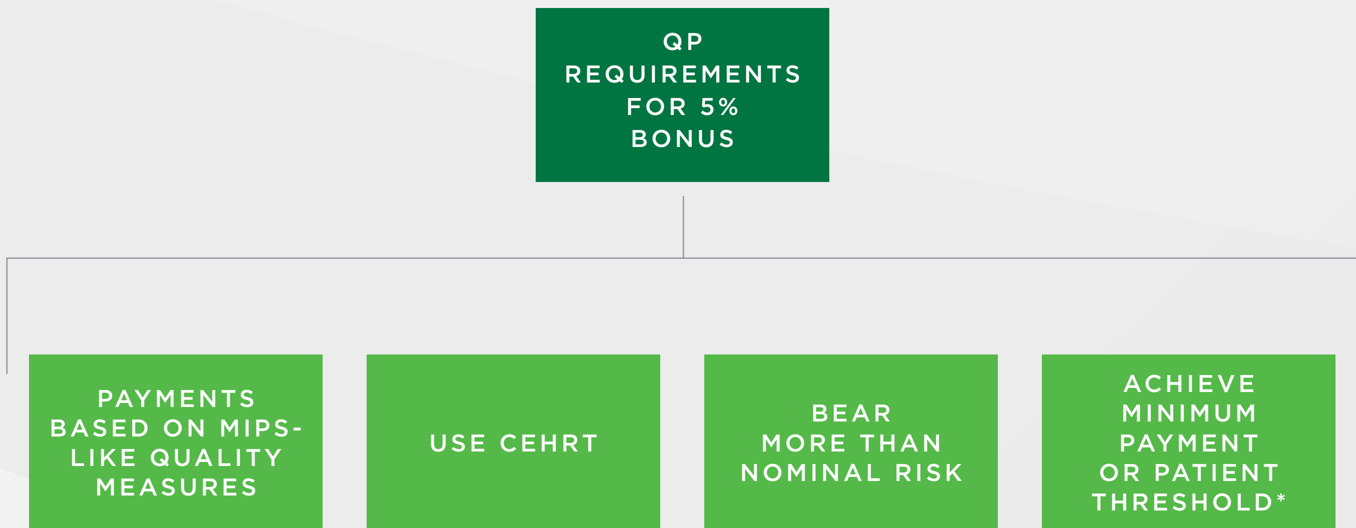
- Are developed by non-Medicare payers, such as private insurers or state Medicaid programs
- Include Medicaid medical home models

2. ADVANCED ALTERNATIVE PAYMENT MODELS

Advanced APM QP requirements

QPs are eligible for a 5% bonus and are exempt from MIPS. QP requirements:

- Provide payment for covered professional services based on quality measures similar to those in the quality performance category of MIPS
- Use CEHRT (at least 75% of eligible clinicians in each Advanced APM entity must use CEHRT)
- Bear more than a nominal amount of risk for monetary losses, or be a medical home model that CMS has expanded
- To qualify for incentive payments, clinicians have to receive enough of their payments, or see enough of their patients, through the Advanced APM*



*Minimum Advanced APM thresholds

Performance Year	2017	2018	2019	2020	2021	2022 and beyond
Payment threshold (percentage of payments through Advanced APM)	25%	25%	50%	50%	75%	75%
Patient threshold (percentage of patients through Advanced APM)	20%	20%	35%	35%	50%	50%

WHAT ARE YOUR OPTIONS?

START HERE

Am I an APM?

YES | NO

YES → Am I an **Advanced** APM?

- YES → Do I have **enough payments or patients** through my Advanced APM?
  - YES → **Advanced APM QP**
    - > Excluded from MIPS
    - > 5% lump sum bonus payment (2019–2024)
    - > APM-specific rewards
  - NO → **SUBJECT TO MIPS WITH FAVORABLE MIPS SCORING**
- NO → **SUBJECT TO MIPS WITH FAVORABLE MIPS SCORING**

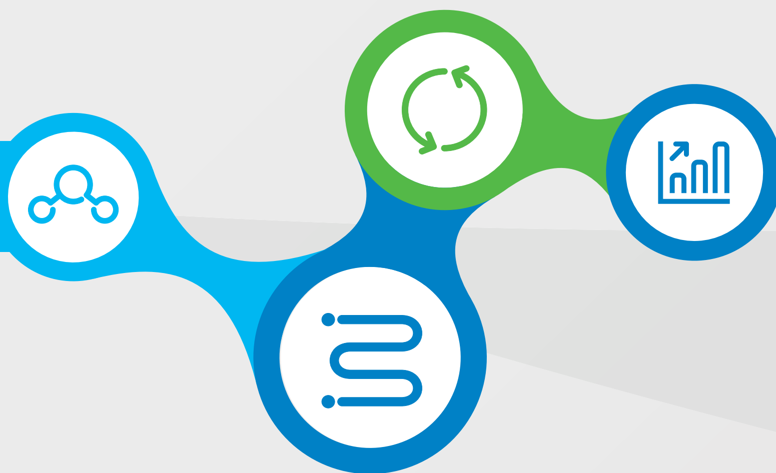
NO → Is this my **first year** in Medicare *or* am I below one of the **low-volume thresholds**?

- YES → Not subject to MIPS
- NO → Subject to MIPS

Those who meet one or two (but not all) of the low-volume criteria may still opt in to MIPS participation.

Bottom line: There will be financial incentives for participating in an Advanced APM, even if you don't become a QP.

HOW WE CAN HELP



CareAllies has the flexibility to help you achieve value-based success.

No matter where you're starting from.

Contact us to learn more.
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1. "The Medicare Access & Chip Reauthorization Act Of 2015: Path to Value," Centers for Medicare & Medicaid Services. 2. Physician Fee Schedule and Quality Payment Program final rule, November 1, 2018.

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