MACRA: Quality Payment Program

Educational Briefing

Executive Summary

In April 2015, the Medicare Access and CHIP[1] Re-Authorization Act (MACRA), was signed into law. MACRA mandates several critical updates to Medicare provider payments that take effect January 1, 2019. The Act repealed the Sustainable Growth Rate (SGR) formula and stipulates the development of two new payment tracks under the Quality Payment Program (QPP): the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APM). These new payment tracks incentivize clinicians to move away from fee-for-service payment models to a value-based payment structure.

Why is MACRA a key issue for providers?

MACRA sets annual Medicare Physician Fee Schedule payment rate updates at near-zero growth (i.e., 0.5% update from 2015 to 2018, 0.25% for 2019,[2] and 0% through 2025). Starting 2026, payment rates will be updated either by 0.25% annually for MIPS participants or by 0.75% annually in the APM track.

Except in limited circumstances, all providers reimbursed under Medicare Part B are subject to either MIPS or APM payment policies starting in the 2019 payment year. CMS applies a "two-year lookback" policy to associate providers' performance to their payment (e.g., payment adjustments in 2019 are based on performance in 2017).

The MIPS track consolidates three legacy CMS reporting programs–the Medicare EHR Incentive Program for Eligible Professionals (i.e., Meaningful Use [MU]); the Value-Based Payment Modifier (VBPM); and the Physician Quality Reporting Program (PQRS)–into a single program, and includes a fourth Improvement Activities component. Alternatively, providers may qualify for the APM track if they participate in risk-based payment models and meet certain payment and/or patient volume thresholds.

How does the MIPS track work?

The MIPS track scores providers (referred to as MIPS Eligible Clinicians [ECs]) on four performance categories: Quality, Cost, Promoting Interoperability (i.e., EHR use, and also previously named Advancing Care Information), and Improvement Activities (IA).

MIPS performance is weighted across these categories, and the category weights changes over time. Figure 1 to the right shows the default category weights that apply to the majority of MIPS ECs. Additionally, CMS offers alternate weights under the MIPS APM Scoring Standard for ECs that participate in particular types of APMs.

A MIPS EC can participate as an individual or as part of a group. MIPS participants receive a MIPS performance score (i.e., final score) of 0 to 100 on an annual basis. This score is compared to a performance threshold (PT) that is set by CMS each year. MIPS participants that fall above the PT receive bonuses (i.e., a positive payment adjustment rate to their future Medicare Part B reimbursements), whereas those that fall below the PT face penalties (i.e., a negative payment adjustment).

It is critical for participants to score well under MIPS, as their reimbursement will depend on their performance. Figure 2 to the right shows the maximum MIPS penalties. MIPS is a budget-neutral program, where the penalties CMS collects from low performers and non reporters will be paid out as bonuses to high performers. For example, the maximum penalty for the first year of the program is -4% and the incentive for ECs who earned the 100-point MIPS score is 1.88%, which is based on the amount of penalties CMS expects to collect. An additional $500 million is also available to reward exceptional performers in the first six payment years of the program (i.e., 2019 – 2024).

Figure 1. Weights of MIPS Score Components

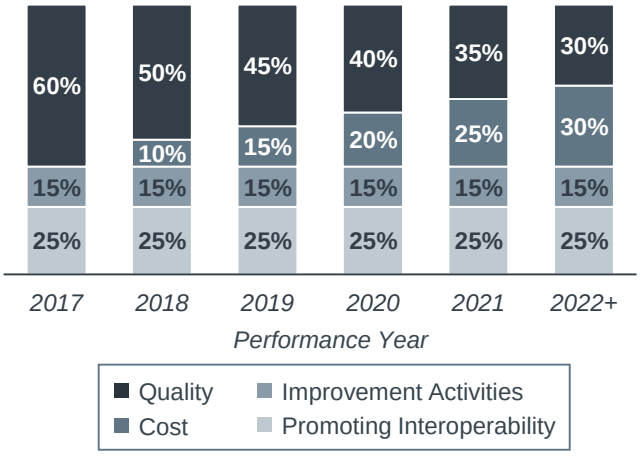

Figure 2. Maximum MIPS Penalties

Payment Year	2019	2020	2021	2022+
Maximum Penalty	-4%	-5%	-7%	-9%

1) Children's Health Insurance Program; 2) The 2018 Bipartisan Budget Act further reduced the 2019 update down to 0.25%.

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How does the APM track work?

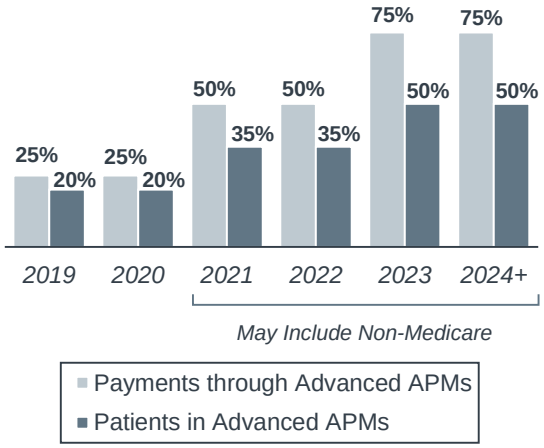
Clinicians who qualify for the APM track earn financial incentives (e.g., a 5% lump sum bonus in the first six payment years of the program from 2019 – 2024), and are exempt from MIPS payment adjustments. The APM track requires two key conditions.

First, clinicians must participate in an Advanced APM, which requires that:

1. The model must incentivize providers to meet quality measures comparable to those in MIPS;
2. The model must require the use of certified EHR technology; and
3. The model must bear more than nominal financial risk for monetary losses or be a medical home model[3] expanded under Center for Medicare and Medicaid Innovation (CMMI) authority.

Second, Advanced APM participants must have a minimum percent of payments or number of patients through the Advanced APM to be considered **Qualifying APM Participants** (QPs). For example, in the first year of the program, under the payment criteria, the QP threshold requires at least 25% of Medicare Part B payments are furnished to attributed beneficiaries. Figure 3 to the right shows how QP thresholds grow over time. Starting in the third year of the program, volumes through non-Medicare Advanced APMs can be included (in addition to Medicare Advanced APMs) for providers to earn QP status through the "All Payer Combination Option."

Figure 3. QP Thresholds by Payment Year



In most cases, the QP threshold is assessed collectively across all providers who participate in a given Advanced APM arrangement together (i.e., the APM Entity). The QP threshold may also be assessed individually under some circumstances.

What does it mean to be a Partial QP?

If Advanced APM participants have slightly less than the required percentage of payments or number of beneficiaries, they may become Partial QPs. For example, under the payments criteria, the Partial QP threshold requires at least 20% (but less than 25%) of Medicare Part B revenue to be furnished to attributed beneficiaries in the first year of the program.

Partial QPs do not qualify for the APM track, and thus do not earn 5% APM payment bonus, but can opt out of the MIPS track and its associated payment adjustments. Partial QPs that opt into the MIPS track will be subject to the penalties and bonuses under MIPS, and many types of Advanced APMs also qualify for special policies under the MIPS APM Scoring Standard.

Questions That Hospital Executives Should Ask Themselves

1. How do we optimize provider performance in MIPS?
2. What is the potential financial impact of MIPS and/or APM tracks based on a provider's projected Medicare volume?
3. Does my organization qualify for the APM track, and if not, do we endeavor to participate in that track in the future?

How might MACRA's QPP affect IT?

Certified EHR Technology (CEHRT)

- Ensure that CEHRT is implemented, as it is required for both MIPS and APM tracks.

Program Monitoring and Alignment

- Leverage IT capability to track providers' performance and compliance performance requirements.
- Plan for future changes for MIPS and APM, as CMS will continue to evolve the Quality Payment Program requirements annually.

Additional Advisory Board research and support is available

If you would like more information on how MACRA impacts your organization, please contact your organization's membership team. To learn more, see our MIPS Toolkit and other MACRA related resources on advisory.com.

3) We note that a Medical Home Model is a type of alternative payment model defined in the MIPS/APM Final Rule, whereas a certified patient-centered medical home is a practice-level designation and does not generally meet the Advanced APM definition.

Sources: Advisory Board Research and Analysis; Department of Health and Human Services.