Advisory Board

Medicare and the Transition to **Value-Based Care**

Part 5: What is MACRA?

Whether you're a **field sales rep,** an **account executive,** a **medical liaison,** or **customer service manager**, you are expected to know a great deal about the health care delivery system—and it can be complicated. This five-part series introduces key elements that make up our health care system and the transition from fee-for-service to value-based care (also called value-based payment).

In this fifth part, you'll learn about MACRA and the two value-based programs focused on providers (MIPS and APM)—as well as key terms you need to know.

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Introduction to Medicare payment reform	Hospital P4P programs	Bundled-payment programs	Shared-savings programs	MACRA

Key terms

While the other articles in this series have focused on how hospitals are moving toward value-based care, this section will focus on how the CMS holds physicians accountable for the quality of care they deliver. Before we dive in, let's first address the program acronyms and definitions you'll need as you read through this section:

MACRA: The Medicare Access and CHIP Reauthorization Act

CHIP: Children's Health Insurance Program

QPP: Quality Payment Program

MIPS: Merit-Based Incentive Payment System

AAPM: Advanced Alternative Payment Models

PQRS: Physician Quality Reporting System

SGR: Sustainable Growth Rate

VBM: The Value-Based Payment Modifier Program

EHR Incentive Program: The Medicare Electronic Health Record Incentive Program, also known as "Meaningful Use"

What is MACRA?

Passed in 2015, MACRA is arguably the most monumental legislation for Medicare physician payment from the last decade. While there are a lot of parts to MACRA,[1] two important changes include:

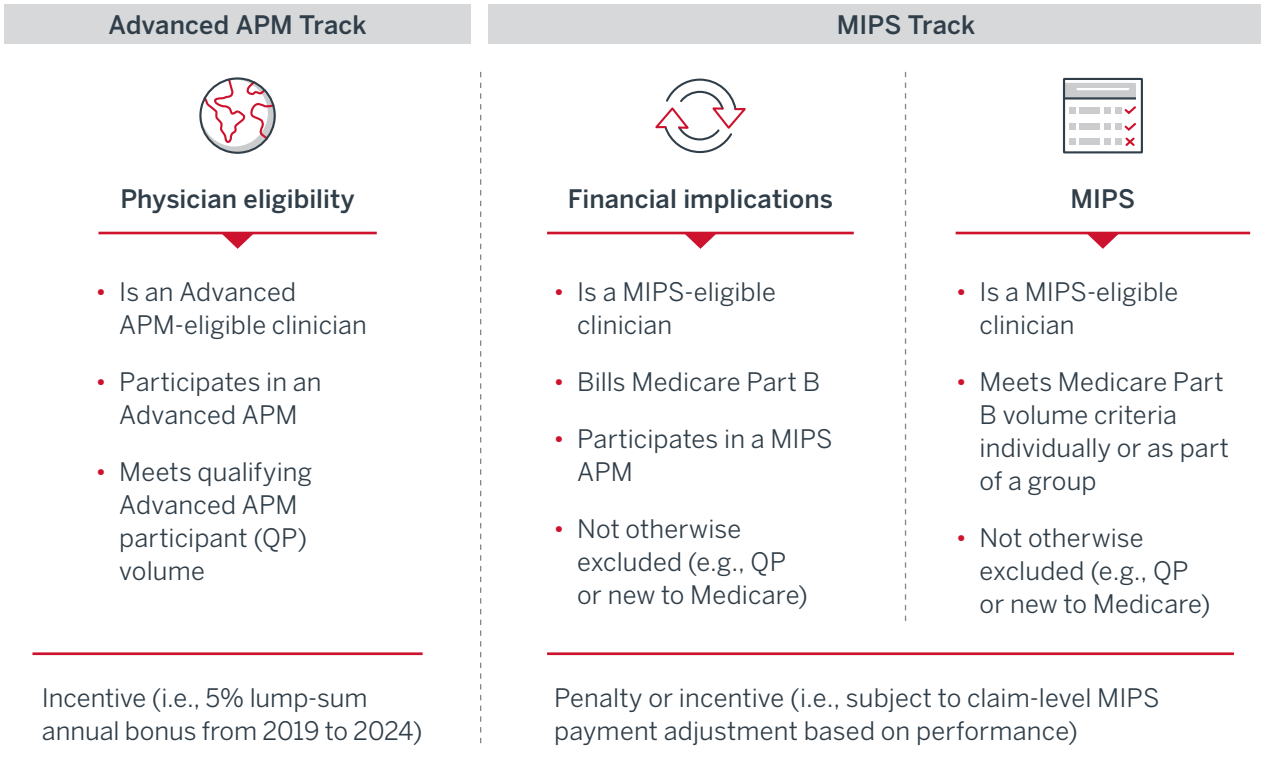
- It holds physician Medicare base payment at near zero growth over the next 10 years, which effectively nullified a series of historic fixes and adjustments to physician reimbursements (such as SGR). This sets the stage for a new physician reimbursement model.
- It authorizes the Department of Health and Human Services (HHS) to implement value-based strategies aimed at improving costs and quality of care to CHIP and Medicare beneficiaries.

The result is the creation of two new payment tracks for all physicians who bill through Medicare Part B.

> ▶ To learn more about the various parts of Medicare, please refer to Part 1 of this series: **Introduction to Medicare payment reform.**

These two tracks, called the Merit-Based Incentive Payment System (MIPS) and the Advanced Alternative Payment Model (Advanced APM) determine the rate of increase for physician base payment (figure 1). More importantly, they determine whether a provider is eligible for certain **bonuses** or **penalties**.

Figure 1: Overview of Advanced APM and MIPS tracks under MACRA



What is the Merit-Based Incentive Payment System?

Introduced in 2017, the Merit-Based Incentive Payment System (MIPS) is a physician-focused reimbursement program designed to move Medicare Part B providers from an FFS-based system to a value-based system.[2] **MIPS is a points-based program that consolidates three historic Medicare Programs—the Physician Quality Reporting System (PQRS), the Value-Based Payment Modifier Program (VBM), and the Medicare Electronic Health Record (EHR) Incentive Program (also called Meaningful Use)—into a single, points-based system.**

Physicians' reimbursement under MIPS largely follows a traditional fee-for-service structure. CMS adjusts this pay based on how physicians score in four categories of metrics: quality, cost, improvement activities, and promoting interoperability (figure 2).

Based on providers' performance, CMS assigns a positive, neutral, or negative payment adjustment on a two-year lag. For instance, eligible professionals who participate in MIPS in 2019 may be eligible for a 5% bonus in 2021, while those that do not report at all receive a 7% reduction to their claims in 2021.

Although health care professionals in the MIPS track are not required to participate in Advanced APMs, such as BPCI Advanced, a special rule applies to those who do so.

▶ For more information on BPCI Advanced, please refer to Part 3 of this series: **What are bundled-payment programs?**

Under the MIPS APM track, providers are exempt from the cost category, receive favorable scoring under the improvement activities category, and receive any potential incentive payments from the Advanced APMs themselves.

While bonuses can be significant for high achievers, MIPS also poses a challenge to current operations. To participate, providers are required to significantly invest in infrastructure to report on the requested metrics. These efforts are hampered by paperwork, and many providers have to hire staff to handle new administrative needs and comply with MIPS requirements. However, some relief is in sight. Earlier this year, CMS unveiled a framework to reduce the reporting burden, which is expected to launch in 2021.[3]

Figure 2: Category weights for MIPS in 2019

	PERFORMANCE CATEGORY AND DESCRIPTIONS	SUBMIT DATA TO CMS?	MIPS ADVANCED APM WEIGHT	2019 MIPS WEIGHT
Quality	Clinical quality measures, like how well patients with diabetes achieve proper blood sugar control	x	50%	45%
Cost	Claims data to compare how much services cost compared to benchmarks	N/A	N/A	15%
Improvement activities	Activities to encourage practice improvement, such as using disease registries	x	20%	15%
Promoting interoperability	Assesses measures focused on use of certified EHRs; previously named Advancing Care Information/Meaningful Use	x	30%	25%

What is the Advanced Alternative Payment Model Track?

Like MIPS, the Advanced Alternative Payment Model (AAPM) Track is aimed at moving Medicare Part B providers to a value-based care system. What's the difference? The Advanced APM track is considerably more restrictive to participate in, but it provides potentially significant and immediate bonuses.

Qualifying for the Advanced APM Track is difficult (figure 3). In fact, very few providers do. They must use certified EHR technology, report on clinical quality measures, and most importantly, participate in an alternative payment program that involves them taking on considerable downside risk. Further, providers must meet and increase certain payment or patient volume thresholds (figure 4).

While this may seem like a lot to take on, this is still an attractive track because from 2019 to 2024, participants in the Advanced APM Track are exempt from MIPS payment adjustments and will automatically receive a 5% bonus.

Figure 3: Advanced APM criteria

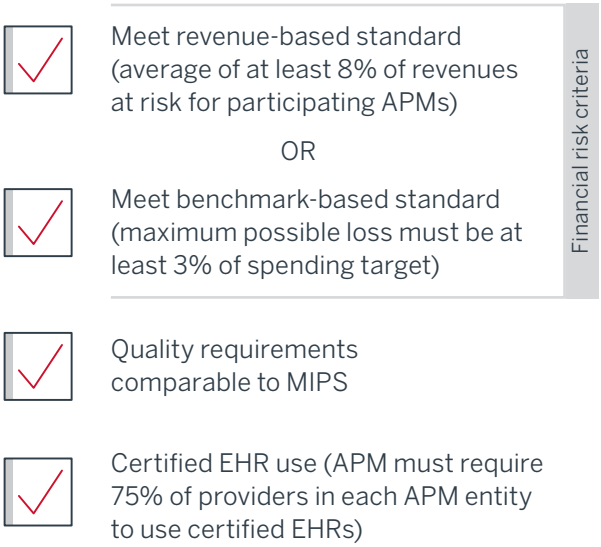
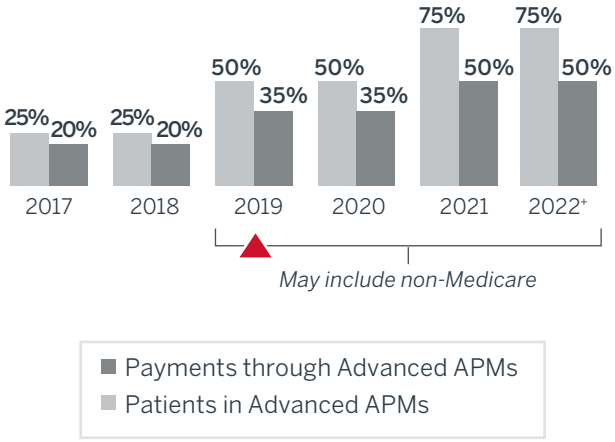


Figure 4: Payment and patient volume thresholds per program year

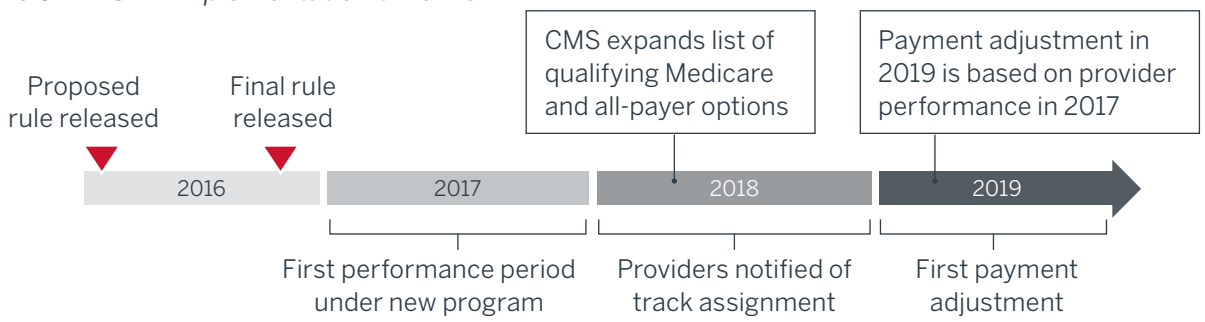


How MACRA continues to evolve

It's important to note that the details of MACRA are not set in stone. It's an active and continuously changing program. Congress can—and has—stepped in to make changes[4,5] (figure 5).

Each year, CMS introduces changes or updates to the program in the form of a "proposed rule." After a period during which providers can review and comment on the changes, CMS will release the final rule. For example, following public comment to the 2016 proposed rule, CMS changed the reporting requirements for the 2017 performance year, making it easier for providers to report. Going forward, be sure to keep an eye out for these types of changes.

Figure 5: MACRA implementation timeline



Let's recap what we've learned:

- MACRA is a piece of legislation that was designed to move Medicare Part B providers from an FFS-based system to a value-based care system.
- MACRA is composed of two value-based programs focused on providers: MIPS and Advanced APM.
- To participate in these programs, providers need to not only deliver quality care, but also report on metrics in an accurate and timely fashion.
- Providers must also manage a growing number of episodes across multiple care settings, which makes cross-continuum support and collaboration essential.
- To fully reap the benefits of MIPS and Advanced APM, providers will need to take on more downside risk and become better population health managers.

▶ Click here to move to Part 1 of this series:
Introduction to Medicare payment reform

ENDNOTES

1. "MACRA," Centers for Medicare and Medicaid Services, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs
2. "MIPS Overview," Centers for Medicare and Medicaid Services, https://qpp.cms.gov/mips/overview
3. "Trump administration's patients over paperwork delivers for doctors," Centers for Medicare and Medicaid Services, July 2019, https://www.cms.gov/newsroom/press-releases/trump-administrations-patients-over-paperwork-delivers-doctors
4. "MACRA," Centers for Medicare and Medicaid Services, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs
5. "Congress recently changed MACRA," Advisory Board, https://www.advisory.com/research/health-care-advisory-board/blogs/at-the-helm/2018/02/congress-macra

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