THE MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015: INCENTIVIZING VALUE OVER VOLUME

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was signed into law on April 16, 2015. MACRA fundamentally changed the methodology for how Medicare pays for physician services to provide greater system stability and promote value-based care principles. MACRA also created incentives for physicians to move into alternate payment models (APMs), further bolstering the importance of the CMS Innovation Center (CMMI), as well as a Technical Advisory Committee chartered to evaluate proposed APMs submitted by private sector parties.

This bipartisan legislation made critical advancements to transform care delivery by further shifting the Medicare payment paradigm from fee-for-service (FFS) to a modernized, value-based payment system.

Congress directed CMS to reward high-value, high-quality Medicare clinicians with payment increases while still reducing payment to clinicians who are not meeting performance standards. The prior physician quality reporting system, value-based modifier, and Meaningful Use programs were retired, and CMS established a new Quality Payment Program that encourages participation in value-based health care models that link physician payments to the value - rather than volume - of services provided.

Quality Payment Program

The Quality Payment Program (QPP) offers eligible clinicians two tracks: 1) the Merit-based Incentive Payment System (MIPS), and 2) the Advanced Alternative Payment Models (AAPMs) track.

1. **The Merit-based Incentive Payment System (MIPS):** MIPS was designed to tie payments to quality and cost efficient care, drive improvement in care processes and health outcomes, increase the use of Health Information Technology, and reduce the cost of care. MIPS resembles the traditional FFS Medicare payment methods in that relative payment rates for each service are determined by the Relative Value Scale. MIPS adjusts Medicare Part B payments based on clinician-reported data in four performance categories: (1) quality, (2) promoting interoperability, (3) improvement activities, and (4) cost. Performance categories are weighted to calculate a final score and the weightings are designed to change over time increasing the emphasis on quality and cost. The final score for each eligible clinician is compared to a performance threshold to determine payment adjustments.
2. **Advanced Alternative Payment Models (Advanced APMs or AAPMs):** Advanced APMs offer physicians incentives to provide high-quality, cost-effective care and transition away from fee-for-service (FFS). To qualify as an Advanced APM, APMs must meet three criteria: (1) require participants to use certified electronic health record (EHR) technology, (2) provide payment for

covered professional services based on quality measures comparable to those used in the MIPS quality performance category, and (3) either be an entity that is a Medical Home Model expanded under CMMI authority or bears financial risk through another APM.

Qualifying as an Advanced APM is just the first step. The APM's eligible clinicians also must meet increasing participation thresholds – determined by the percent of Medicare Part B payments or patients seen through an Advanced APM entity – to become Qualifying APM Participants (QPs). Physicians have several incentives to join the APM track and achieve QP status, including an annual incentive payment from 2019-2024 equal to 5 percent of the QPs prior year aggregate Medicare Part B payments for professional services, higher annual payment rate updates beginning in 2026, and exclusion from MIPS reporting requirements and payment adjustments.

MACRA goes beyond just encouraging participation in AAPMs in the Medicare program. The Quality Payment Program Advanced APM track also includes the All-Payer Combination Option, which considers a clinician's participation in AAPMs with Medicare and other payers. The Other Payer Advanced APMs are payment arrangements that meet certain criteria with Medicaid, Medicare Health Plans, such as Medicare Advantage (MA), payers in CMMI Multi-Payer Models, and other commercial payers.

The Evolution of the Qualifying APM Participant (QP) Threshold

CMS' evaluation of whether eligible clinicians and APM entities meet thresholds are determined using a combination of two methods: (1) the Payment Amount Method, and (2) the Patient Count Method.

1. **Payment Amount Method:** Considers the percentage of Medicare Part B payments made to all clinicians in the AAPM entity that were for Medicare beneficiaries attributed to the AAPM entity.

Payment Amount Method			
Payment Year	Medicare Option	All-Payer Combination Option	
	Medicare FFS	Medicare FFS	All Payers
2019-20	25%	Medicare Option only in these years	
2021-22	50%	25%	50%
2023 and subsequent years	75%	25%	75%

2. **Patient Count Method:** Considers the percentage of attribution-eligible beneficiaries who are attributed to the AAPM entity.

Patient Count Method			
Payment Year	Medicare Option	All-Payer Combination Option	
	Medicare FFS	Medicare FFS	All Payers
2019-20	20%	Medicare Option only in these years	
2021-22	35%	20%	35%
2023 and subsequent years	50%	20%	50%

Attribution under both the Payment Amount Method and Patient Count Method during the QP performance period is based on each Advanced APM's attribution rules. Clinicians who achieve the QP threshold have differences in how they are evaluated under MACRA than MIPS-eligible clinicians. QPs are excluded from MIPS but are required to submit MIPS-comparable reporting measures through their AAPM entity. Measure performance affects the shared savings for each entity. QPs will receive their five percent APM incentive in addition to the payment impact from the APM directly.

The Quality Payment Program Statutory Timeline

The below table incorporates the CMS timeline of the QPP that outlines fee schedule payments, MIPS payment adjustments and the QP 5% incentive payments. After the passing of MACRA in 2015, fee schedule updates continued at 0.5% from 2016-2019 before reducing to 0% from 2020-2025, with APM conversion factors beginning in 2026. For MIPS, the default performance framework in the QPP, the +/- payments adjustments began in 2019 at 4% and will increase incrementally before reaching 9% in 2022 where they will remain. In 2019 QPs also began receiving 5% incentive payments and will continue to receive the lump sum bonus until 2024. Qualifying APM participants are exempt from MIPS scoring and payment adjustments.

<table>
<tr><th>Year</th><th>Medicare Part B Baseline Payment Updates</th><th colspan="2">Merit-Based Incentive Payment System (MIPS)</th><th colspan="2">Qualifying (AAPM) Participants</th></tr>
<tr><td>2016</td><td>+0.5%</td><td>-6%</td><td rowspan="3">PQRS, Value-based Modifier, Meaningful Use***</td><td colspan="2" rowspan="3"></td></tr>
<tr><td>2017</td><td>+0.5%</td><td>-9%</td></tr>
<tr><td>2018</td><td>+0.5%</td><td>-9%</td></tr>
<tr><td>2019</td><td>+0.5%</td><td>+/-4%</td><td rowspan="8">Quality, Cost, Advancing Care Information, and Improvement Activities</td><td rowspan="6">5% Incentive Payment</td><td rowspan="8">QPs Exempt from MIPS</td></tr>
<tr><td>2020</td><td rowspan="6">+0.%</td><td>+/-5%</td></tr>
<tr><td>2021</td><td>+/-7%</td></tr>
<tr><td>2022</td><td rowspan="5">+/-9%</td></tr>
<tr><td>2023</td></tr>
<tr><td>2024</td></tr>
<tr><td>2025</td><td rowspan="2"></td></tr>
<tr><td>2026</td><td>+0.25%*
+0.75%**</td></tr>
</table>

*Non-qualifying AAPM Conversion Factor
**Qualifying AAPM Conversion Factor
***Cumulative maximum penalty for a 10-provider clinic
Source: AAFP MACRA Timeline

Physician-Focused Payment Model Technical Advisory Committee

MACRA also created the Physician-Focused Payment Model Technical Advisory Committee (PTAC), which provides an avenue for private sector entities to propose physician-focused APMs. The Committee is tasked with evaluating and considering model submissions for recommendation to the HHS Secretary for testing by CMMI. To date, HHS has not acted favorably on any PTAC recommendations for testing, which has diminished the intended role of the Committee which was to provide public input to inform CMMI's testing agenda.

Impact of MACRA

MACRA has positively influenced health care delivery reform in the United States since its passage in 2015 and helped solidify the move towards value-based care along with then Health and Human Services Secretary, Sylvia Matthew Burwell, establishing the goal for the majority of Medicare payments to be tied to quality and/or value by 2018.

A study conducted by RAND in 2018 projected that MACRA will slow the rate of growth for Medicare spending on physician services by upward of $106 billion over 15 years. Model evaluations conducted by CMS have shown substantial savings to Medicare from various Advanced APMs, lending support to the underlying concepts on the RAND study.

Clinician participation in Advanced APMs has also continued to grow, with participation increasing from 99,076 to 183,306 clinicians from 2017 to 2018. This nearly two-fold increase shows promising movement in the right direction, with physicians engaging in models that hold them financially and clinically accountable for the care delivered to attributed patients. In rewarding physicians for improving care delivery while transforming payment and care delivery models to reduce cost and total expenditures, MACRA has catapulted value-based payment into the mainstream.