



Medicare Access and Children's Health Insurance Program Reauthorization Act (MACRA) of 2015

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) makes sweeping changes to how Medicare pays for physician services. The legislation repeals the sustainable growth rate (SGR) formula. Beginning in 2019, physicians will receive annual payment adjustments based on whether they qualify to participate in one of two tracks described below.

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Starting in payment year 2019 (based on performance year 2017), MACRA consolidates features of existing quality programs into the MIPS and sunsets existing penalty structures. Under the MIPS, an increasing percentage of Medicare fee-for-service (FFS) payments will be tied to a physician's composite score on four weighted performance categories:

- **Quality (30%*):** Must include existing Physician Quality Reporting System (PQRS) measures, including those used by Qualified Clinical Data Registries (QCDRs), plus newly solicited measures. MACRA provides CMS with \$15 million for each of five years for measure development. CMS must give priority to outcome, patient experience, care coordination, appropriate use and electronically-specified measures.
- **Resource Use (30%*):** May include existing Value-Based Payment Modifier measures, but also encourages CMS to adopt episode-based cost measures with more accurate risk adjustment and attribution methodologies.
- **Meaningful Use of Certified EHR Technology (25%):** Must align more closely with other categories and better reflect flow of clinical practice.
- **Clinical Practice Improvement Activities (15%):** Recognizes participation in activities such as expanded practice access, population management (e.g., registry participation), care coordination, beneficiary engagement, patient safety and practice assessment (e.g., MOC), and participation in an APM.

**Note: In 2019 and 2020, the weight of Resource Use must be 10% and 15%, respectively, with commensurate increases in the Quality weight.*

Composite performance scores will determine up or down payment adjustments, which will be capped at +/- 4.0% in 2019 and rise to +/- 9.0% in 2022 and subsequent years. High performers may be eligible to receive up to 3x the upward adjustment amount. Also, from 2019-2024, the Secretary may spend up to \$500 million each year on bonus payments to reward "exceptional performance."

ALTERNATIVE PAYMENT MODELS (APMs)

Starting in 2019, "qualifying" APM participants who receive a significant and increasing share of revenues from an eligible Medicare or all-payer APM will be exempt from MIPS and instead receive a 5.0% lump sum bonus on their previous year's aggregate Part B services. Eligible APMs must involve "more than nominal" financial risk, quality measurement comparable to MIPS, and the use of federally-certified EHR technology.

It is not yet known which specific Medicare and private payer APMs will qualify for the APM track. By November 2016, CMS must establish specific criteria for determining which APMs will qualify. A Physician-Focused Payment Model Technical Advisory Committee (PTAC) will review and provide recommendations to CMS on whether certain physician-focused payment models meet established criteria, although CMS has no obligation under MACRA to test any models recommended by the PTAC.

WHAT'S NEXT?

Many critical details related to these new payment policies will be shaped through rulemaking and other direct stakeholder engagement. NASS continues to engage in proactive advocacy to ensure that the Congressional intent of MACRA is preserved throughout this process and that federal quality mandates more meaningfully and accurately evaluate physician quality, appropriately incentivize higher value care, and minimize administrative burden.