Understanding the Medicare Access and CHIP Reauthorization Act (MACRA)

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The Medicare Access and CHIP Reauthorization Act (MACRA) is intended to accelerate the transition to a health care system that rewards quality and value, rather than volume, and help ensure that patients experience better care and improved health outcomes. MACRA will bring the biggest change in Medicare reimbursement in decades and offers a critical opportunity to drive health system transformation that results in authentic patient- and family-centered care.

MACRA changes the way Medicare providers are paid to better reward quality and value.

MACRA immediately replaces the Sustainable Growth Rate (SGR) methodology for Medicare payments and provides stability through short-term annual payment updates to providers. Beginning in 2019, providers will choose from one of two pathways that will link payments to the quality of care provided: the **Merit-Based Incentive Payment System** (MIPS) or **Alternative Payment Models** (APMs).

The Merit-Based Incentive Payment System (MIPS)

MIPS builds on the traditional fee-for-service architecture in Medicare but is structured so that payment rewards providers for delivering high-quality care and achieving better health outcomes. MIPS uses the following four performance categories to evaluate quality of care:

- **Clinical quality** will be assessed using measures already in place by consolidating existing Medicare quality reporting programs (including the Physician Quality Reporting System). Over time, additional evidence-based measures will be defined and further developed for MIPS through the traditional rulemaking process, with emphasis on outcomes-based measures.
- **Resource use** will incorporate Medicare's existing Value-Based Payment Modifier, which provides for differential payment based on the quality of care furnished compared to the cost of care, and will add additional measures of cost and resource use over time.
- **Meaningful use of electronic health records** will incorporate measures from the existing "Meaningful Use" Electronic Health Record (EHR) Incentive Program, which rewards providers for specific uses of technology that positively affect patient care.
- **Clinical practice improvement activities** is a new performance category that will include a broad swath of improvement activities, including expanded practice access, care coordination and beneficiary engagement.

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- Providers participating in a certified patient-centered medical home will receive the highest possible score for clinical improvement activities.

Providers in MIPS will earn a composite score between 1 and 100 based on performance in each of the four categories during the reporting period. Payment to providers (bonuses or penalties) will be adjusted up or down by as much as four percent in 2019, five percent in 2020, seven percent in 2021 and nine percent in 2022.

Alternative Payment Models (APMs)

Providers can choose a different pathway from MIPS by participating in an eligible APM. Providers in APMs are excluded from the MIPS payment adjustments. APMs move away from traditional fee-for-service toward value-based arrangements that tie payment for health care services to quality performance, health outcomes and value for a specific population.

Providers in an APM will receive an automatic five percent annual bonus, in addition to any financial bonuses or penalties they receive through the APM itself, such as shared savings or losses in a Medicare Accountable Care Organization (ACO).

Under MACRA, the Centers for Medicare & Medicaid Services will define the specific guidelines for qualifying APMs. APMs will include models such as those implemented through the Center for Medicaid and Medicare Innovation, a Medicare shared savings program, a health care quality demonstration program, or a demonstration project required by federal law. MACRA further specifies that qualifying APM entities must:

- Use quality measures that are comparable to measures under the performance categories established by MIPS;
- Use certified HER technology; and
- Bear at least nominal financial risk, unless providers are part of certain medical home models.

MACRA should lead to better care and better outcomes for patients.

If implemented with a patient- and family-centered approach, MACRA – and APMs, in particular – has the potential to move us toward more comprehensive, coordinated, patient- and family-centered care while driving down costs. To realize the promise of value-based payment, it will be important for APMs to demonstrate not only high performance on quality metrics and cost-savings, but also high performance on patient- and family-centered measures including patient and family experience of care and patient-reported outcomes.

The payment reforms in MACRA are directed toward Medicare providers but are likely to lead to system-wide changes across the public and private sectors as providers gain more experience with value-based payment and the adoption of APMs becomes more widespread.