There’s a famous quote, “If you always do what you’ve always done, you’ll always get what you’ve always got.” If you want to change the result, you need to change the way you do things. That appears to have been the mindset when the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) became law in 2016.

MACRA ended the Sustainable Growth Rate (SGR) formula, which threatened participating clinicians with potential payment cliffs for 13 years. Physicians’ billing regularly exceeded Medicare’s expenditure targets. Congress had to pass a SGR “fix” each year to avert cuts in physicians’ Medicare payments. MACRA also reforms Medicare payments to achieve the triple aim of improving quality and outcomes and controlling costs.

WHAT IS MACRA?

MACRA legislation amended section 1848(a) (8) (A) of the Social Security Act and created the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs). The Centers for Medicare and Medicaid Services’ (CMS) response to MACRA was creation of the Quality Payment Program (QPP). CMS calls QPP a “fresh start” and “paying for what works” to stabilize, strengthen and improve Medicare.

The QPP shifts Medicare payments from a fee-for-service, volume-based model to a pay-for-performance, value-based model. The QPP will reform Medicare Part B payments for more than 600,000 clinicians across the country and streamline reporting, standardize evidence-based measures and eliminate duplication. It promotes industry alignment through multipayer models and incentivizes cost-effective, quality care. Clinicians can choose to participate based on their practice size, patient population and specialty. The QPP will bring patients increased access to care, better outcomes and enhanced coordination through the patient-centered approaches to care.

The QPP creates a single system by consolidating components of three legacy programs: the Physician Quality Reporting System (PQRS), Physician Value-based Payment Modifier (VM), and the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals or groups under the physician fee schedule.

YOUR CHOICE: ADVANCED APMs OR MIPS

The QPP features two participation tracks to choose from: Advanced Alternative Payment Models (APMs) and the Merit-based Incentive Payment System (MIPS). Clinicians who choose not to participate in either QPP track in 2017 will receive a 4 percent reduction in Medicare payments beginning in 2019.

For the 2017 MIPS performance period, Medicare Part B clinicians will participate in MIPS if they bill more than $30,000 a year and provide care to more than 100 Medicare patients a year. These clinicians include:

- Physicians who are doctors of medicine, osteopathy, dental surgery, dental medicine, podiatric medicine, optometry and chiropractors
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists

Clinicians who are excluded from MIPS include those newly enrolled in Medicare, below the low-volume threshold (100 or fewer Medicare Part B patients a year, or Medicare Part B allowed charges less than or equal to $30,000 a year), or participants in Advanced APMs at a significant level.

Advanced APMs include accountable care organizations (ACOs), bundled-payment models, patient-centered medical homes (PCMHs) and risk-bearing models. For the 2017 per-
performance year, significant Advanced APM participation means involvement in the following models:
- Comprehensive End-stage Renal Disease Care Model
- Comprehensive Primary Care Plus (CPC+)
- Shared Savings Program Track 2
- Shared Savings Program Track 3
- Next Generation ACO Model
- Oncology Care Model

Participating in an Advanced APM as a qualifying participant provides three benefits: you do not participate in MIPS, you are eligible to receive a 5 percent lump-sum bonus and you will receive a higher Physician Fee Schedule update starting in 2026.

Clinicians have four performance categories in the MIPS track:
- **Quality** (replaces PQRS) includes familiar quality measures such as health screenings, tobacco cessation and medication lists.
- **Cost** (replaces value-based modifier) is based on claims; no reporting is required in 2017.
- **Improvement Activities**, a new category, includes activities such as care coordination, shared decision-making and safety checklists.
- **Advancing Care Information** (replaces Medicare’s EHR Incentive program) includes e-prescribing, providing patient access to their health information, sending/accepting a summary of care and others.

MIPS provides clinicians with the opportunity to choose activities or measures that are best for their practice. Each of the performance categories is weighted on a 100-point scale. For the 2017 transition year, Quality is 60 percent, Improvement Activities are 15 percent and Advancing Care Information is 25 percent. Cost is not weighted in 2017. The total MIPS score translates into a neutral, positive or negative payment adjustment.


For the 2017 transition year, eligible clinicians have the option to pick their pace for participation. At a minimum, practices just need to report some data at any point to avoid negative payment adjustment. Required reporting and payment options for each of the three “pick your pace” levels for 2017 are:
- **Test:** Report at least one Quality or Improvement Activity measure, or report four or five Advancing Care Information measures (depending on CEHRT edition). The test pace results in neutral payment adjustment.
- **Partial-year submission:** Report at least 90 days of data and receive neutral or positive payment adjustment.
- **Full-year submission:** Report a complete year of data and receive a moderate positive payment adjustment.

In 2019, the first year of payments, the maximum adjustment is plus or minus 4 percent, increasing annually to plus or minus 9 percent by 2022 and beyond.

Letters of eligibility were mailed recently to clinicians from their Medicare administrative contractors. Based on the practice’s tax ID number, the letters included the total number of clinicians at the practice, and whether they were eligible to participate in MIPS, non-eligible or exempt. The letters included a Q&A on the program. If you have eligibility questions and cannot locate your letter, search by NPI number on the qpp.com.gov website.

**TECHNICAL ASSISTANCE AVAILABLE**

MACRA is a complex program. CMS has established a network to provide direct, no-cost technical assistance to clinicians to enhance successful participation in QPP, particularly MIPS.

The support network serves all eligible clinicians, regardless of practice size or specialty. The Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs) provide support for large groups of 16 or more clinicians. The QPP-Small, Underserved and Rural Support (SURS) contractors serve small, rural and underserved clinicians, especially those in medically underserved or health-professional shortage areas. The QPP-SURS contractors assist practices with 15 or fewer eligible clinicians with MIPS education, workflows, EHR technology optimization, program structure information, requirements and timelines.

In Arkansas, TMF Health Quality Institute serves as both the QIN-QIO and the QPP-SURS contractor, with AFMC serving as an integral part of both contracts. AFMC is a subcontractor to TMF for both QIN-QIO and QPP-SURS assistance. AFMC can provide one-on-one technical assistance to MIPS-eligible clinicians, tailored to the needs of individual Arkansas practices, at no charge.

For more information about QPP, and how to access educational resources and technical support, visit tmfqin.org/qpp or qpp.cms.gov, or contact TMF directly by emailing QPP-SURS@tmf.org, or phoning 1-844-317-7609. ▲

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