

MACRA and CBOs: New Opportunities for Engagement Abound

While federal policymakers are focused on the potential implications of repealing, replacing and/or reforming the Patient Protection and Affordable Care Act (ACA) in 2017, a bipartisan bill enacted in 2015 is quietly changing the way Medicare providers are paid and opening up new opportunities for community-based organizations (CBOs) to partner with health care entities.

AREA AGENCIES ON AGING (AAAs) and other CBOs deliver valuable, proven and desired services in nearly every community in the country—services that health care providers and payers need to optimize care and lower costs. But CBOs often aren't fluent in the new language of payment reform: MACRA, MIPS, APM and ACO. If understood fully, these acronyms could translate into real opportunity for AAAs and other CBOs.

This fact sheet examines the Medicare Access and CHIP Reauthorization Act (MACRA) and other related Medicare payment reforms and their implications for CBOs that serve older adults and people with disabilities.

Medicare Payment Reform: Evolving Toward Value-Based Incentives

MACRA shifts fee-for-service providers toward a pay-for-performance system under which they will increasingly have



to assume more and more financial risk and accountability for quality, outcomes and cost containment.

MACRA streamlines multiple quality reporting programs under Medicare¹ and establishes just two payment pathways:

- Merit-based Incentive Payment System (MIPS)
- Advanced Alternative Payment Models (Advanced APMs)

MIPS will reimburse clinicians based on their performance in four categories: quality, cost, practice improvement and electronic health record use. For 2016-2018, updates for all clinicians under the fee schedule are 0.5 percent each year. Beginning in 2019 and continuing through 2024, there is a strong incentive for clinicians to switch from fee-for-service/ MIPS to advanced APMs. Beginning in 2019, clinicians who meet the criteria set out in the law as qualifying APM participants receive incentive payments of five percent of their entire Medicare fee schedule revenue each year that they qualify. Even larger updates will be applied from 2026 onward. Clinicians who do not meet the advanced APM criteria will

receive no update from 2019 through 2024 and receive lower updates than clinicians who do meet the criteria in 2016 and beyond. As you can see, MACRA heavily incentivizes clinicians who embrace the advanced APMs.

Advanced Alternative Payment Systems

The term APMs is used broadly to define many types of payment models that are different from the traditional fee-for-service model, but few existing APMs would qualify as advanced APMs under MACRA. The Centers for Medicare & Medicaid Services (CMS) have identified the following as qualifying.² (See box on page 3 for descriptions of each advanced APM.)

- Next Generation Accountable Care Organizations (ACOs)
- Medicare Shared Savings Programs (MSSPs) (Tracks 2 and 3) ACOs
- Comprehensive Primary Care Plus Model
- Comprehensive End-Stage Renal Disease Care—Large Dialysis Organization arrangement
- Oncology Care Model two-sided risk arrangement

As of 2017, the majority of clinicians were participating in APMs that did not qualify as advanced APMs under MACRA because the payments were not linked to quality. These ACO models include MSSP ACOs Track 1 and Bundled Payments for Care Improvements.

Implications and Opportunities for Community-Based Organizations

The shift from fee-for-service to payment-for-value places greater importance on person-centered care and the social determinants of health. As clinicians face strong financial incentives to coordinate care and focus on factors occurring in homes and communities that can improve health outcomes, there is new awareness of the roles that CBOs can play in prevention, education and care management.

The payment reform brought about by MACRA liberates resources from traditional payment systems to allow greater flexibility. Care teams can focus on what each individual needs outside of the doctor's office in order to better manage their conditions and prevent costly hospital admission

Key Terms

ACOs

Accountable Care Organizations were created to change the incentives for how medical care is delivered and paid for in the U.S., moving away from a system that rewards the quantity of services delivered to one that rewards the quality of health outcomes.

Advanced APMs (Alternative Payment Models): one of two payment paths under MACRA for clinicians paid under Medicare's physician fee schedule. Under current CMS regulations, the following Advanced APMs qualify: Next Generation ACOs; Medicare Shared Savings Program (MSSP; Tracks 2 and 3) ACOs; Comprehensive Primary Care Plus Model; Comprehensive End-Stage Renal Disease Care—Large Dialysis Organization arrangement; and Oncology Care Model two-sided risk arrangement.

APMs

CMMI

Center for Medicare and Medicaid Innovation, a division within the Centers for Medicare & Medicaid Services created by the Affordable Care Act to develop new payment and service delivery models, including a few specific demonstrations as defined by Congress.

Sustainable Growth Rate, the payment system that controlled payment updates for clinicians paid under Medicare's physician fee schedule from 1999 to 2015.

SGR

and readmission. CBOs can address many of the social determinants of health such as nutrition, transportation and social engagement.

AAAs and other CBOs should seek out opportunities to work with Medicare physicians and other clinicians as they begin to move toward advanced APMs. These Medicare providers will face declines in reimbursement if they are not able to successfully navigate the new world of advanced APMs. Given the Aging Network's long history of delivering supportive services to older adults, MACRA presents a real opportunity for clinicians and CBOs to work together to provide high-quality, cost-effective care to Medicare beneficiaries. As 10,000 individuals qualify for Medicare each day, finding effective, innovative solutions is more important than ever.

Advanced APMs Criteria

As defined by MACRA, advanced APMs must meet the following criteria:

1

The APM requires participants to use **certified EHR technology**.



2

The APM bases payment on **quality measures** comparable to those in the MIPS quality performance category.



3

The APM either:

requires APM entities to bear more than nominal **financial risk** for monetary losses

OR

is a **Medical Home Model** expanded under Center for Medicare & Medicaid Innovation authority.



MACRA's Advanced Alternative Payment Models

Comprehensive End-Stage Renal Disease (ESRD) Care—Large Dialysis Organization arrangement: a model designed to improve care for beneficiaries with ESRD while lowering Medicare costs.

Comprehensive Primary Care Plus Model: a national advanced primary care medical home model that aims to strengthen primary care through regionally-based, multi-payer payment reform and care delivery transformation.

Medicare Shared Savings Program (MSSP; Tracks 2 and 3) ACO: these ACOs both take on two-sided performance-based financial risk, a requirement under MACRA for advanced APMs. Beginning Jan. 1, 2017, eligible Track 3 ACOs will be able to use the new Skilled Nursing Facility (SNF)

three-day rule waiver under the MSSP, which waives the requirement for a three-day inpatient hospital stay prior to Medicare-covered extended care services for eligible beneficiaries at a CMS-approved SNF affiliate.

Next Generation ACO: This model allows provider groups to assume higher levels of financial risk and reward than are available under the current Pioneer ACO Model and Sharing Savings Programs.

Oncology Care Model two-sided risk arrangement: an innovative new payment model for physician practices administering chemotherapy; aims to provide higher quality, more coordinated oncology care at lower cost to Medicare.



Endnotes

1. Medicare Payment Advisory Commission, *Report to Congress: Medicare and the Health Care Delivery System*. June 2017, 159–172.
2. Centers for Medicare & Medicaid Services, *2016 Fact Sheet: The Quality Payment Program*.

About n4a

The National Association of Area Agencies on Aging (n4a) is the membership organization for the 622 Area Agencies on Aging (AAAs) and a voice in the nation's capital for the more than 250 Title VI Native American aging programs in the U.S. The fundamental mission of the AAAs and Title VI aging programs is to provide services that make it possible for older individuals to remain in their homes, thereby preserving their independence and dignity. These agencies coordinate and support a wide range of home and community-based services, including information and referral, meals, in-home care, transportation, employment services, senior centers, adult day care and more.



advocacy | action | answers on aging

Research and Writing

Nora Super, *Chief, Programs & Services*

Karen Homer, *Research Associate*

Cara Levy, *Intern*

National Association of Area Agencies on Aging (n4a)
1730 Rhode Island Avenue, NW, Suite 1200
Washington, DC 20036
202.872.0888

www.n4a.org
www.facebook.com/n4aACTION
www.twitter.com/n4aACTION