

# Making Sense of MACRA: The Value of Quality and Cost

**Quality**



**Cost**



## Scoring Quality and Cost of Care

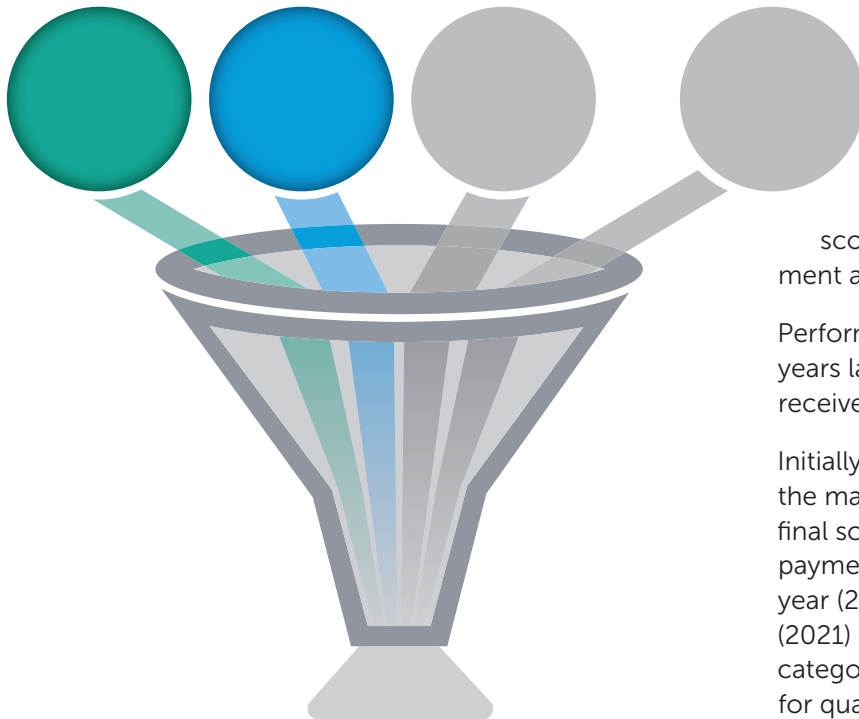
When passed into law in April 2015, the Medicare Access and CHIP Reauthorization Act (MACRA) established two tracks for payment: the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models

(AAPMs). Under MIPS, Medicare Part B payments will be adjusted based on scores from the four performance categories below. This supplement focuses on the quality and cost categories of MIPS to help prepare your practice to enhance the value of care you provide patients.

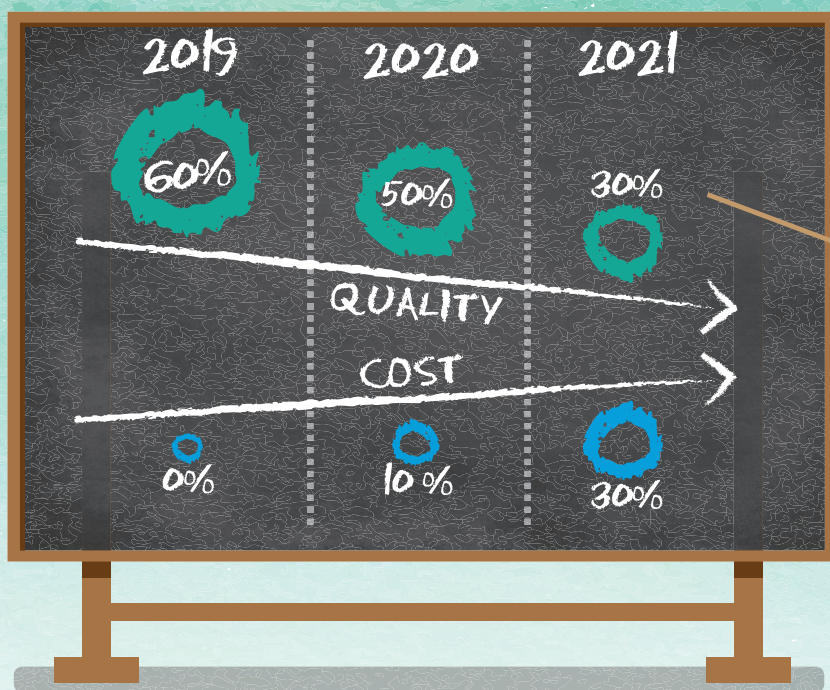
Scores are calculated to determine a final score (1-100), weighted by performance category, and then compared to a performance threshold. Physicians scoring above the threshold receive a positive payment adjustment. Those scoring below the threshold receive a negative payment adjustment.

Performance determines your payment adjustment two years later. For example, the payment adjustment you receive in 2019 is based on 2017 performance.

Initially, scoring in quality will be weighted to account for the majority (60 percent for 2019 payment year) of your final score. Cost will account for 0 percent in the first payment year (2019), increase to 10 percent the second year (2020), and rise to 30 percent in the third year (2021) to align with the declining weight in the quality category. The graphic below indicates the sliding weights for quality and cost for the first three payment years.



### Payment Year Weights



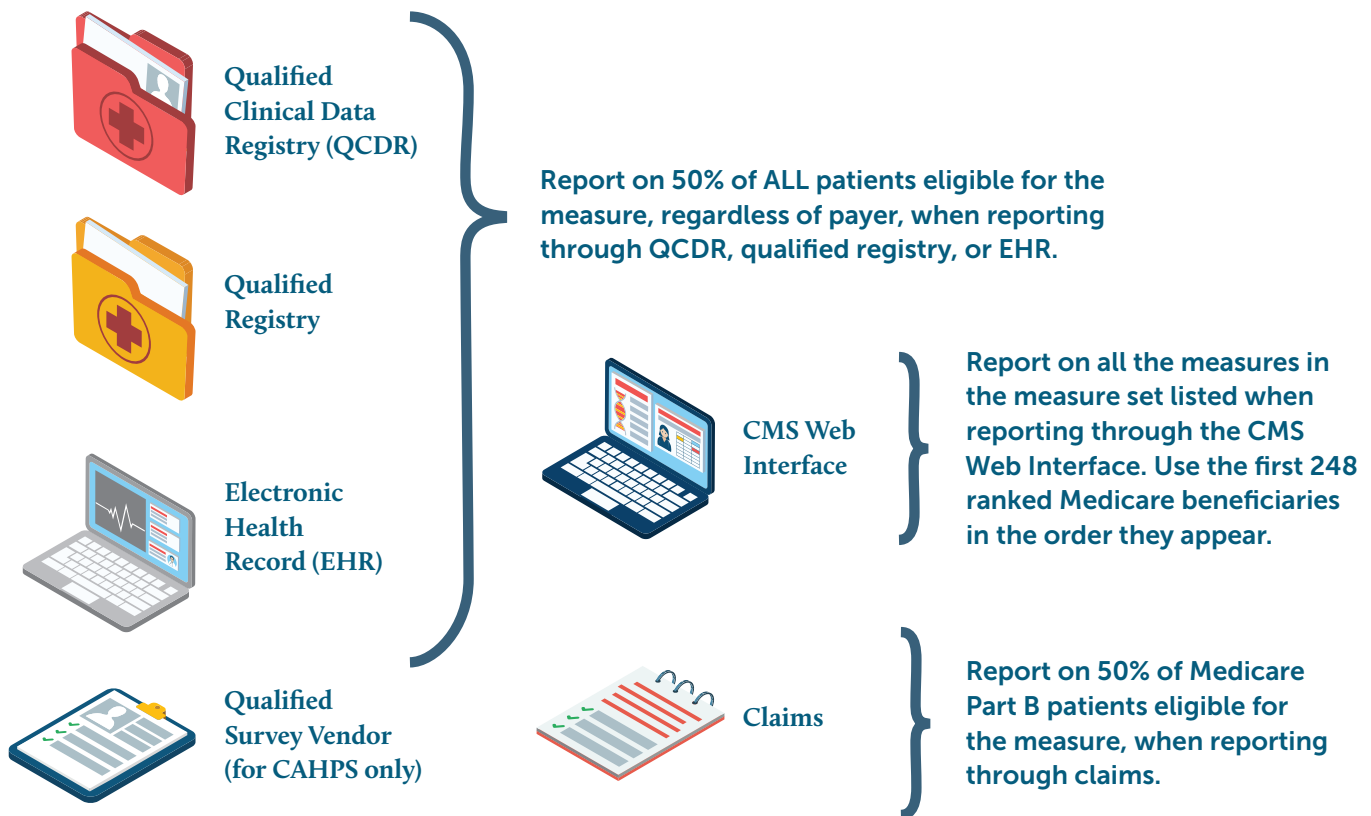


## Quality

Many features of the quality category in MACRA come from the previous Physician Quality Reporting System (PQRS). If you are reporting in MIPS, you are required to report six quality measures (out of 271 possible measures), one of which must be an outcomes measure. If you report more than six measures, CMS will use the six highest-scoring measures to calculate your quality score. In addition, CMS will calculate the all-cause hospital

readmission measure for groups of 16 or more clinicians with a minimum measure case size of 200. Find the complete list of quality measures at [qpp.cms.gov/measures/quality](http://qpp.cms.gov/measures/quality).

Once your measures are selected, begin collecting data. Submit your quality data as an individual or a group through these options.



You may use only one method for data submission per category. For example, you cannot submit some quality data through claims and some through a registry. However, you can submit data for one MIPS category (e.g., quality) using one reporting method and data for another MIPS category using a different reporting method.

Additionally, if you submit data as a group in one category, you must submit as a group in all categories. The same is true if you submit data as an individual.

## CALCULATING QUALITY

In order to be scored based on performance, you must submit six measures, the measures must meet the case minimum of 20 unique patients, have a benchmark, and meet data completeness criteria. If you submit a measure not meeting the case minimum or data completeness criteria, it will not be scored on performance, but receive a baseline score of three points.

Benchmarks are set from data two years prior from the performance period (2015 benchmarks determine 2017 performance period scoring), and are broken down into performance deciles for each measure. Performers in the top decile are awarded full points. Those in lower deciles receive fewer points.

## Quality (continued)

Here are the available points in the quality performance category by group size or reporting option (i.e., CMS Web Interface).



### Groups of 15 or fewer clinicians

Points available (without bonus) = 60 (6 measures x 10 points each)



### Submit through CMS Web Interface

Points available (without bonus) = 120  
(11 measures x 10 points, plus all-cause hospital readmissions x 10)



### Groups of 16 or more clinicians

Points available (without bonus) = 70 (6 measures x 10 points, plus all-cause hospital readmissions x 10)

Bonus points are available in the quality category. You can earn two bonus points for additional outcome or patient-experience measures, and one bonus point for reporting certain high-priority measures.

## COST

Many features of the cost category in MACRA come from the previous Value-based Payment Modifier (VBPM) program. You will not receive a score in the cost category for the 2017 performance period (2019 payment year), but it will increase in subsequent years to 10 percent in 2018 (2020 payment year), and 30 percent in 2019 (2021 payment year).

## CALCULATING COST

The Centers for Medicare and Medicaid Services calculates the cost category using claims data, so no submission is required on your part. Most measures in the cost category are triggered by an inpatient evaluation and management (E/M) code or procedure code. There are 10 of these measures in the cost category. They are calculated by CMS if the measure meets the minimum case size of 20 patients.

If you only practice in the ambulatory medicine setting, many of the cost category measures will not apply to the care you provide. The one episode measure that may apply for ambulatory physicians is "colonoscopy and biopsy."

CMS calculates two other measures that must meet minimum case size thresholds. The measures of Medicare spending per beneficiary (35 patients) and total cost of care (20 patients) must meet these minimum case sizes to be scored.

Unlike the quality category (with a two-year look-back period), the cost category will have a benchmark from the actual performance period. Each measure scored will be compared to a benchmark in that same year and potentially awarded up to 10 points each. CMS will average the score of all eligible measures in cost and there are no bonus points available.

Similar to the quality category, benchmarks are broken down into performance deciles for each measure, with points awarded based on where in the decile your performance falls.

## VALUING QUALITY AND COST

Most family physicians will initially participate in MIPS. Therefore, it is important to focus on the quality and cost of care you provide patients now. The balance of quality and cost complement each other and help lead to high-value care under MACRA.

Reviewing quality measures ([qpp.cms.gov/measures/quality](http://qpp.cms.gov/measures/quality)) and determining those to report will help position you for success. Remember, performance in 2017 determines payments in 2019. Collecting quality measure data will help fulfill MACRA requirements now and potentially lead to positive payment adjustments in the future. **FP**

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