Macranomics: Summary and timetable

**First in a series*

Michael A. Cassidy, Esq.

The Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS) issued final regulations Oct. 14, 2016, regarding the implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) health care reimbursement reform, and there has been an accompanying deluge of news and announcements advising health care providers to prepare for MACRA implementation beginning Jan. 1, 2017. Most physicians understand MACRA contains three major components that aim to, once again, reform and restructure the country's health care system to reduce costs, improve efficiency and enhance quality – which sounds suspiciously like the Triple Aim philosophy first espoused by Donald Berwick in his "Triple Aim" article while at the Institute for Healthcare Improvement and then later in 2010 as administrator of CMS.

However, there is abundant confusion about the timing, content and impact of MACRA and the Allegheny County Medical Society thinks it would be advisable to:

1. Summarize the major components of MACRA;
2. Identify the timetable; and
3. Provide specific information about the various components based upon the timetable of the role out.

This article will provide a summary of the components, identify the timetable and set the stage for future articles on the substance of MACRA health care reform, which is newly combined and enhanced quality reporting and the development of Alternative Payment Mechanisms (APMs).

Major components of MACRA

MACRA contains the following three major initiatives:

1. MACRA repeals the sustainable growth rate (SGR) physician fee calculator and replaces it with a fixed one-half percent (that's right – one-half percent) increase on "regular" Medicare, i.e., the Medicare physician fee schedule established as part of RB-RVS, which will apply from 2016 through 2025.

2. MACRA combines the existing three quality reporting programs into the new Merit Based Incentive Payment System (MIPS). The new quality reporting begins Jan. 1, 2017, for calendar year 2017 (CY 2017) but it will not effect physician payments until Jan. 1, 2019 (CY 2019).

3. MACRA establishes the foundation for new APMs, which are intended to be the future of health care reform, but which will not be operative until 2019 and thereafter, assuming everything goes according to plan.

SGR repeal

We can assume most physicians are familiar with the Standard Growth Rate (SGR) methodology that has generated ever-increasing proposed reductions in the Medicare Physician Fee Schedule for the last 10 years. As you recall, the proposed reduction for 2015 was 21.5 percent. In the past, the traditional SGR fix was simply new legislation postponing the proposed increase until future years without actually fixing the problem. The results were similar to those you would personally experience if you failed to pay the minimum payment on your credit card statements; the next statement would be double the last statement, resulting in ever-escalating minimum payments.

MACRA enacted a permanent SGR fix by completely repealing the SGR formula and replacing it with specifically stated "regular" Medicare physician fee schedule updates as follows:

1. One-half percent (0.5 percent) per year for calendar years 2016, 2017, 2018 and 2019.

2. Zero percent (0 percent) increases for calendar years 2020, 2021, 2022, 2023, 2024 and 2025.

3. A supposedly permanent one-fourth percent (0.25 percent) increase thereafter.

The Pennsylvania Medical Society has established a website for MACRA tools and information: https://www.pamedsoc.org/tools-you-can-use/topics/macra

Merit-Based Incentive Payment System

The future for regular Medicare payments and increases was transferred to the Merit-Based Incentive Payment System (MIPS). MIPS has two structural components:

1. A combination of the three existing quality reporting mechanisms into one reporting program; and

2. The establishment of merit-based percentage increases or decreases as follows:

- Plus/minus 4 percent for 2019
- Plus/minus 5 percent for 2020
- Plus/minus 7 percent for 2021
- Plus/minus 9 percent for 2022 and thereafter

The MIPS positive/negative adjustments are a zero-sum game, so that any potential bonus payments must be offset by payment decreases to the physicians who do not qualify for the bonuses generated by MIPS reporting.

Combined quality reporting

Until now, CMS has operated three quality reporting programs:

1. PQRS – Physician Quality Reporting System

2. VBPM – Value-Based Payment Modifier

3. MU – Meaningful Use Attestation

These programs will be combined into a new quality measurement tool which will have four components:

1. ACI – Advanced Care Information (the replacement for Meaningful Use Attestation)

2. Resource Utilization (which is the cost factor)

3. Quality

4. CPIA – Clinical Practice Improvement Activities

The new reporting process will begin Jan. 1, 2017, for CY 2017 and will be extremely complex. This process is too complex to describe in the remaining space allotted for this first article, but just allow me to hint at the complexity and uncertainty by quoting the CMS summary:

"Within MIPS, the second pathway of the Quality Payment Program, we believe that the unification into one Quality Payment Program can best be accomplished by making connections across the four pillars of the MIPS payment structure identified in the MACRA legislation – quality, clinical practice improvement activities (referred to as "improvement activities"), meaningful use of CEHRT (referred to as "advancing car information"), and resource use (referred to as "cost") – and by emphasizing that the Quality Payment Program is at its core about improving the quality of patient care. Indeed, the bedrock of the Quality Payment Program is high-quality, patient-centered care followed by useful feedback, in a continuous cycle of improvement. The principal way MIPS measures quality of care is through evidence-based clinical quality measures which MIPS eligible clinicians can select, the vast majority of which are created by or supported by clinical leaders and endorsed by a consensus-based process. Over time, the portfolio of quality measures will grow and develop, driving towards outcomes that are of the greatest importance to patients and clinicians. Through MIPS, we have the opportunity to measure quality not only through clinician-proposed measures, but to take it a step further by also accounting for activities that physicians themselves identify: namely, practice-driven quality improvement. The MACRA requires us to measure whether technology is used meaningfully. Based on significant feedback, this area is simplified into supporting the exchange of patient information and how technology specifically supports the quality goals selected by the practice. The cost performance category has also been simplified and weighted at zero percent of the final score for the transition year of CY 2017. Given the primary focus on quality, we have accordingly indicated our intention to align these measures fully to the quality measures over time in the scoring system."

The takeaway is that CYs 2017 and 2018 will be measurement years with no payment impact until 2019. However, learning the quality reporting program over the next two years will be of paramount importance. Thus, the next article in this series will be a summary of the quality reporting process, to attempt to make some sense of the language quoted above. Thereafter, the next articles will deal with the development of APMs. The articles will be curated on the ACMS website. In addition, the Pennsylvania Medical Society has established a website for MACRA tools and information as follows: https://www.pamedsoc.org/tools-you-can-use/topics/macra.

Just as an aside, note that MACRA is not part of the Affordable Care Act and is unlikely to be impacted by the repeal initiatives likely to be forthcoming following the Republican presidential victory.

Mr. Cassidy is a shareholder at Tucker Arensberg and is chair of the firm's Healthcare Practice Group; he also serves as legal counsel to ACMS. He can be reached at (412) 594-5515 or mcassidy@tuckerlaw.com.