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MACRA: The Past, Present and Future

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Abstract

Introduction: The U.S. health care system is undergoing significant change as demands to improve medical quality and reduce health care costs expand. U.S. health care spending accounted for 16.9% of gross domestic product in 2013, the highest amount compared to other developed countries. On April 16, 2015 the U.S. Congress passed a historical piece of bipartisan legislation, the Medicare Access and CHIP (Children's Health Insurance Program) Reauthorization Act (MACRA). We describe the events leading up to the passage of MACRA, review the various components of MACRA and describe how MACRA will likely impact physician practices. We also suggest how best to prepare for compliance with the Centers for Medicare & Medicaid Services (CMS) MACRA final rule with comment period, which was released on October 14, 2016.

Methods: A literature review of the quality measures defined by CMS before the passage of MACRA was performed as well as a review of the current MACRA final rule (Quality Payment Program) and related CMS commentary. An expert panel of health care consultants provided guidance concerning compliance with the final rule. Furthermore, case studies are described as examples to assist the urological community in meeting the expectations of MACRA.

Results: The Surgical Care Improvement Project process measures (current quality) for urological surgery are reviewed and their impact on surgical site infections is described. Details of MACRA and its Quality Payment Program framework, the Merit-based Incentive Payment System and Alternative Payment Models, are also described. A detailed understanding of and preparation for the implementation of MACRA will help physicians comply with the regulations which offer future opportunities for better reimbursement. Opportunities to comply with MACRA through Advanced Alternative Payment Models may mitigate the complexity of reporting under the alternate Merit-based Incentive Payment System. The development of bundled payment procedures in urology, similar to the Comprehensive Care for Joint Replacement program in orthopedics, may eventually qualify for Advanced Alternative Payment Model status.

Conclusions: Physicians should be proactive, and lead the effort to improve medical quality and control health care related costs, the primary goals of MACRA. Academic and community urologists should collaborate and define optimal quality measures that are meaningful and relevant to the practice of urology, which is currently being done by the AUA (American Urological Association) Quality Registry program. The specialty of urology would benefit from a concerted effort to

Abbreviations and Acronyms

ACI = Advancing Care Information

ACO = Accountable Care Organization

APM = Alternative Payment Model

AQUA = AUA Quality

CEHRT = certified electronic health record technology

CIN = Clinically Integrated Network

CMS = Centers for Medicare & Medicaid Services

EHR = electronic health record

IA = Improvement Activities

IOM = Institute of Medicine

MACRA = Medicare Access and CHIP Reauthorization Act of 2015

MIPS = Merit-based Incentive Payment System

PQRS = Physician Quality Reporting System

QP = qualifying APM participant

QPP = Quality Payment Program

SCIP = Surgical Care Improvement Project

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develop bundled payment models for a variety of urological procedures and seek CMS recognition as qualifying for Advanced Alternative Payment Models.

Key Words: quality of health care; cost control; Medicare Access and CHIP Reauthorization Act of 2015; reimbursement, incentive; health expenditures

On April 16, 2015 Congress passed the Medicare Access and CHIP (Children's Health Insurance Program) Reauthorization Act of 2015 (MACRA), a historical piece of bipartisan legislation.[1] Subsequently on October 14, 2016 the Department of Health and Human Services, Centers for Medicare & Medicaid Services, the regulatory agency in charge of implementing and enforcing MACRA, released a final rule with comment period implementing the provisions of MACRA.[2]

MACRA repeals the highly criticized Sustainable Growth Rate formula and its Medicare Physician Fee Schedule cuts, replacing it with the Quality Payment Program, a new model that focuses on quality and cost measurement, reporting and payment adjustments.[2] For Medicare Part B eligible clinicians, including physicians, physician assistants, nurse practitioners, clinical nurse specialists and certified registered nurse anesthetists, the QPP involves the payment tracks of 1) the Merit-based Incentive Payment System and 2) Advanced Alternative Payment Models (see figure).[2] [F1]

In its current state Medicare assesses provider quality and cost of care using the 1) Physician Quality Reporting System, 2) Medicare EHR Incentive Program (meaningful use) and 3) Value-Based Payment Modifier. The MIPS reimbursement track consolidates these 3 programs into a single framework and eligible clinicians participating in the MIPS track will receive Medicare payment adjustments based on their performance relative to other participating providers.

The second reimbursement pathway under the QPP will be available to clinicians who participate in Advanced APMs. Those who participate in Advanced APMs (qualifying APM participants or QPs) will not be subject to MIPS and will be eligible to receive bonus payments beginning in 2019 (Appendix 1).

In recognizing the wide diversity of clinicians set to participate in the QPP and in an attempt to ease the concerns of certain stakeholders, CMS presented 4 MACRA "pick your pace" compliance options for the first performance year (transitional year) beginning January 1, 2017. Choosing 1 option from among test, partial, full or Advanced APM will ensure that eligible clinicians do not receive negative payment adjustments in 2019.

For the test option, as long as a MIPS eligible clinician submits some 2017 data (1 quality measure or 1 Improvement Activity), s/he will avoid a negative payment adjustment. This option is designed to allow clinicians to test their systems and prepare for broader participation in future performance years. Failing to submit the minimum data will result in a 4% negative adjustment.

With the partial option, MIPS eligible clinicians who submit 2017 data for a reduced period (less than the full 2017 performance year but for at least a full 90-day period) may earn a neutral or small positive payment adjustment.

For the full option, MIPS eligible clinicians who submit 2017 data for a full calendar year beginning on January 1, 2017 may qualify for a modest positive payment adjustment. In addition, those who are deemed exceptional performers will be eligible to receive additional positive adjustments.

Finally, for the Advanced APM option, qualifying Advanced APM participants are eligible for a 5% bonus incentive payment in 2019.

Ultimately MACRA facilitates the objectives of the Department of Health and Human Services to achieve better patient quality and value through 2 important goals. Goal 1 is that 30% of Medicare reimbursement is tied to quality or value via APMs by the end of 2016 and 50% by the end of 2018. Goal 2 is that 85% of Medicare fee-for-service payments is linked to quality or value by the end of 2016 and 90% by the end of 2018.[3]

The Past

The need to improve medical quality and reduce health care expenditures has been the driving force behind the current paradigm shift from a fee-for-service to a value based reimbursement model. There is a growing consensus that current efforts to improve value will be more successful as reform is unavoidable. In addition, technology has the potential to greatly enhance the sharing of information necessary to implement new value based reimbursement models.

Quality

A seminal report published by the IOM in 1999 citing a high rate of medical mistakes, along with other reports suggesting that quality of care in the U.S. has room for improvement, led many organizations (including the U.S. government) to demand improvement in the quality of medical care provided by the U.S. health care system.[4] In a subsequent report

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