MACRA: A New Alphabet Soup

Is it really simpler? Helpful? Cost-saving? **By Susan Reynolds, MD, PhD**

THE MEDICARE Access and CHIP Reauthorization Act of 2015 (MACRA) became law on April 16, 2015. With its passage the SGR is gone! PQRS is going away! So are meaningful use and the value-based payment modifier!

Under MACRA the Centers for Medicare and Medicaid Services (CMS) says it is simplifying how payments are made for quality care through the new Quality Payment Program (QPP).

QPP has two components: the Merit-based Incentive Payment System (MIPS) and advanced Alternative Payment Models (APMs). Physicians can use either MIPS or Advanced APMs to increase their Medicare reimbursement by beginning to report in 2017.

Confused so far? You may be thinking, "Yikes! Will this affect me? How do I get out of this?" The final rule for MACRA, issued on Oct. 14, 2016, says that you do not have to participate if you bill Medicare $30,000 or less per year or see fewer than 100 Medicare Part B patients per year. Initially, it will affect all other physicians as well as their PAs, NPs, nurse-anesthetists, and clinical nurse specialists. Later on, other providers will be included.

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But there is more. Most physicians will be paid under the MIPS program, which has four components: 1) Quality; 2) Resource Use/Cost; 3) Clinical Practice Improvement Activities; and 4) Advancing Care Information. It should be noted that the new Quality program replaces PQRS reporting, Resource Use/Cost replaces the value-based payment modifier, and Advancing Care Information replaces meaningful use. The Clinical Practice Improvement element is a new category. So four reporting categories will replace three. Is this really getting simpler?

Avoiding Penalties

Under the MIPS program, reporting on these four elements begins Jan. 1, 2017, for payments that will be received in 2019. These payments will include bonuses and penalties of as much as +/- 4%. By 2022 the bonuses and penalties can be as much as +/- 9%, an 18% swing.

The final rule describes how physicians can avoid being penalized in the first year as they gear up for the new system. They can report for only 90 days beginning Oct. 2, 2017. They can report only one quality measure for 2017. If physicians report a full year of data in 2017, they can possibly earn a moderate bonus in 2019. If they decide not to submit any 2017 data, they will receive a negative 4% payment adjustment in 2019. Data for 2017 must be submitted by March 31, 2018.

In 2017 some physicians may qualify to participate in Advanced APMs such as Next Generation ACOs, Medicare Shared Savings Program ACOs Tracks 2 and 3, bundled payment models like the Comprehensive Care for Joint Replacement model, and medical home models. Other possible Advanced APMs in 2017 include the Comprehensive Primary Care Plus (CPC+) model, the Comprehensive End Stage Renal Disease model, and the Oncology Care model. These models are primarily for large groups and have a bonus potential of +5% paid as a lump sum in 2019. The final rule does offer an ACO Track 1 option for smaller groups who would assume lower risk. That option begins in 2018.

Benefits vs. Burnout

Significant payment reform is happening once again. Change is never easy. MACRA is confusing, and QPP at least on the surface may be more complicated for physicians than previous reporting systems. Physicians and their practice managers will have to spend a great deal of time, energy, and money adapting their current reporting systems to QPP. Those physicians who have not done any quality reporting will have to begin or face increasingly significant penalties.

Physician burnout is now occurring in epidemic proportions. More than half of U.S. physicians report being burnt out even before MACRA begins. Documentation-to-care ratios have been reported to be as high as 2:1, meaning that some physicians may spend as much as two hours documenting for every hour of patient care.

I predict that when QPP is fully operational physicians will have to spend more time learning the new system, more time documenting in their EHRs, and less time with their patients. Burnout will only increase. And some physicians will decide it just isn't worth it anymore and seek alternative careers away from the bedside, thereby increasing the physician shortage.

Questions must be asked: Will the new system really save money in the long run? If so, where will the savings occur? Is it worth the cost of the burnout epidemic, with physicians losing passion for their profession and some leaving patient care altogether?

I believe that CMS wanted to make Medicare quality reporting and payment "simpler" as well asreduce the cost of care. QPP will be simpler for them since they will have one reporting program instead of three. But for those in practice trying to adapt to the new system, it will be another hurdle to jump over, a hurdle that may be too high for some to cross.

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