MACRA Introductory Article

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On January 1, 2017, physicians, providers, and health care providers will embark on the era of MACRA, the Medicare Access and CHIP Reauthorization Act of 2015, which will dramatically change how providers are paid by the Centers for Medicare and Medicaid Services. Signed into federal law by President Obama on April 16, 2015, MACRA is a fix for the unsustainable Sustainable Growth Rate formula. As many of you know, the Sustainable Growth Rate (SGR) formula was adopted as part of the Balanced Budget Act of 1997 in order to better control the costs of Medicare payments for physicians. The SGR tied the annual increase in payment for each Medicare beneficiary to the growth in the national economy. For the first few years, Medicare costs did not exceed the annual growth in the economy so physicians received modest increases in their payments. However, amid strong political pressure from physician interest groups around the country regarding a potential 4.8 percent cut in payments for physician services in 2002, Congress quickly passed legislation to avert the payment reduction. These legislative fixes to avert reduced payments, called 'doc fixes,' soon became an annual event as legislators sought to postpone the reduction in payments. Unfortunately, the projected costs of the 'doc fixes' grew to hundreds of billions of dollars. It became clear a permanent legislative solution needed to be adopted. In fact, MACRA's passage into law in 2015 averted a whopping 28 percent reduction in payments to physicians; a cut that would have made it nearly impossible for physicians to continue providing services to Medicare patients.

On May 9, 2016, the Centers for Medicare and Medicaid Services (CMS) published proposed regulations to implement the Quality Payment Program (QPP) creating a flexible system for physicians and other eligible providers to select between two paths connecting quality to payments. This creates a provider payment system more in line with how healthcare is approached today versus 20 years ago. The proposed tracks of the QPP seek to tie an increased percentage of physicians' Medicare fee-for-service (FFS) payments to outcomes through the new Merit-based Incentive Payment System (MIPS) and to encourage the adoption of "alternative payment models" (APMs). While both payment tracks provide more incentive for high quality, efficient care, the main difference between the MIPS and APMs tracks are that APMs require practices to take on more financial and technological risks. According to the proposed MACRA rules, providers will be able to switch between the MIPS and the APM track on a year-to-year basis. It is important to note that these proposed regulations will not be finalized until November 1, 2016 when CMS has reviewed the public comments and concerns about the QPP. In fact, after reviewing the initial public comments, CMS recently created 2 additional options which delay the data submission to allow health care providers more time during 2017 to adjust to MACRA.

Starting on January 1, 2017, the Merit-based Incentive Payment System (MIPS) will annually measure Medicare Part B providers in four weighted performance categories (Quality of Service, Resource Use, Advancing Care Information through Electronic Health Records, and Clinical Practice Improvement). The data collected during 2017 will be utilized to determine payments adjusted in 2019. Thus, payment adjustments will be made on information gathered over one year prior to the first payment year. Based on the MIPS composite performance score, physicians and practitioners will receive positive, negative, or neutral adjustments to their base rate of Medicare Part B payment which is scheduled to increase 0.5% every year from 2016 until 2019. The adjustment rates will

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gradually increase annually from a positive or negative adjustment of 4% in Calendar Year (CY) 2019 to an adjustment rate of 9% positive or negative in CY2022 and beyond. Thus, the MIPs option is designed to greatly reward high quality, efficient care. Beyond the cost-neutral MIPS adjustment, CMS has the ability to further reward providers from a $500 million 'exceptional performance' fund for providers in the top quarter of those that receive a positive MIPS adjustment.

Instead of the MIPS track, providers will also be able to participate in the Alternative Payment Model (APM) track. According to the standards set forth by CMS, a qualifying APM must (1) bear a certain amount of financial risk; (2) base payments on quality measures comparable to those used in the MIPS quality performance category, and (3) require participants to use certified electronic health record (EHR) technology to document and communicate care information. Providers who meet the criteria for APM incentive payments do not receive a payment adjustment under the Merit-based Incentive Payment System (MIPS) and instead receive a 5% lump-sum bonus on their Medicare Part B incentive payments for 2019 through 2024. This bonus will be in addition to the incentive paid through existing contracts with the qualified APM. It is expected all Medicare Part B providers, with a few exceptions such as those who are new to the Medicare B program, have less than 100 Medicare patients, and/or have less than $10,000 in annual Medicare billings, will report their data through the MIPS track in 2017. For 2017, the list of approved Advanced APMs, such as Medicare Shared Savings Track 2 or 3, is expected to be very limited. It is unlikely many sleep providers will be eligible to participate in an Advanced APM initially unless the provider is associated with a large academic center or in a large multi-specialty group setting.

As mentioned earlier, on September 8, 2016, Acting CMS Administrator Andy Slavitt acknowledged the concerns and trepidation of meeting reporting requirements by announcing 2 additional 2017 data submission options to give providers additional time to submit Quality Payment Program data. The first new option, the QPP test option, will allow providers to avoid a negative payment adjustment provided they submit some data to the QPP during 2017 in order to ensure their system is working and prepared for broader participation in 2018 and 2019. The new second option will allow providers to submit their data for a reduced number of days during 2017. Under this option, providers can begin their first performance period later in 2017 and still qualify for a small positive adjustment. Providers will still have the choice to either participate in MIPS for the full 2017 calendar year, where they will receive a modest positive adjustment, or participate in an approved Advanced Alternative Payment Model for 2017.

MACRA and the Quality Payment Program will fundamentally change how providers are paid through Medicare with financial incentives being given for providing high value care. While the implementation of MACRA is a welcome change to the Medicare Part B payment model, as providers will no longer have to worry about payment cuts simply because the population is aging faster than the economy grows, the MACRA era will require a fair amount of more work and more regulations than prior payment models. At the present time, MACRA is a dramatic effort to solve many of the problems and concerns created during the SGR era. That does not mean the MACRA era providers will not experience the system's growing pains as it is implemented over the next few years. For more information, please visit the AASM's Guide to MACRA at Evolve Sleep.

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