

Victoria Ferenz
Final Draft

MACRA: A New Law, but with what Consequences?

Enacted by the Balanced Budget Act of 1997, the Medicare Sustainable Growth Rate (SGR) was a formula used by the Centers for Medicare and Medicaid Services (CMS) in the United States to control spending on physician services by Medicare.¹ The SGR was introduced to regulate and ensure that the reimbursement rates Medicare would pay to doctors for an average Medicare patient could not grow faster than the economy as a whole.² As the economy slowed and health-care spending skyrocketed, Medicare finances became strained and reimbursements to doctors started to be cut beginning in 2002.³ Almost every year since, the SGR has called for more cuts in physician reimbursements, and each time, Congress blocked those cuts (known as the “doctor fix”).⁴ This repeated task of implementing a “doctor fix” led to the permanent repeal of the SGR in 2015.⁵ Prior to SGR’s repeal, compliance required physicians to pay for, and initiate, Electronic Medical Records (EMR) systems in their offices. These digital medical charts aimed to measure and meet practice quality measurement systems such as Physician Quality Reporting System (PQRS) and Meaningful Use (MU).⁶ Both PQRS and MU were systems used to improve quality, safety, and efficacy in health care while reducing mistakes. In the past, payments to physicians under SGR had been increased if those guidelines were met and if they were not, penalties were assessed.

The SGR cut fees for every service, regardless of potential benefit, for every provider paid under Medicare’s physician fee schedule, and it lacked incentive for improving the quality, appropriateness, and coordination of care. The SGR also failed to address volume and intensity – the factors that drive Medicare spending growth – while penalizing individual providers who did not control their costs.⁷ The Sustainable Growth Rate had failed to controlling Medicare

spending growth over time and ultimately led to a widening gap between Medicare and private payment rates.⁸

President Barack Obama signed the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) into law on April 16, 2015.⁹ MACRA measure replaces the SGR scheme which linked Medicare doctor pay to economic growth, with a new formula that attempts to more closely tie compensation to quality of care.¹⁰

MACRA makes important changes as to how Medicare compensates providers including the implementation of a new framework that rewards healthcare providers for the quality of care, rather than the quantity of care provided.¹¹ MACRA establishes a merit-based incentive program (MIPS) based on the development of, and participation in, alternative payment models (APMs).¹² APMs are projected as value-based payment models that compensate providers based on care quality, cost, and outcomes. By changing the current fee-for-service structure to one in which reimbursement is tied to a value- and/or quality-based measurements, the incentive to perform quality care will theoretically increase.¹³ Health care providers have the option to participate in MIPS or become a qualifying APM participant.¹⁴ By participating in MIPS, health care providers can receive a positive, negative, or zero payment adjustment.¹⁵ Alternatively, an APM participant is eligible to receive five-percent incentive payments for six years, provided certain criteria are met.¹⁶ The established requirements include use of certified electronic health record (EHR) technology and a share of financial risk for monetary loss.¹⁷ Additional criteria are expected, but have not yet been developed.¹⁸ The changes provided by the MACRA legislation, however, come with many concerns regarding both the intended and unintended consequences.

The Intended Consequences of MACRA

The Medicare Sustainable Growth Rate had portions that were poorly constructed and needed an annual “fix,” which was carried out by reversing reimbursement cuts on doctor’s services.¹⁹ MACRA was constructed as a permanent fix for the SGF.²⁰ The main goal of MACRA is to move toward a reimbursement model that compensates physicians based on quality rather than volume.²¹ Quality reporting requirements combine three previous physician-level incentive programs into a single program with less complexity. Current information collection varies, and includes both paper and computer based systems that are typically inaccurate and disorganized due to poor programs and the inability of physicians to comply.²² Another goal of MACRA is to organize data and make it more useful, while improving the overall quality of care. MACRA also aims to decrease health care costs, while lowering the national debt attributable to healthcare costs over time.

Merit-Based Incentive Payment System

To accelerate the move from volume-based to quality-based payment, MIPS will be enacted in 2019 under Section 1848(q) of the Act.²³ This new program that consolidates three existing programs – meaningful use (MU), the Physician Quality Reporting System (PQRS), and the Value-Based Payment Modifier (VBPM) – into a single program.²⁴ The MIPS assesses individual physician performance in four categories: quality, resource use, meaningful use of certified EHR technology, and clinical practice improvement activities, to generate a composite score on a 0- to 100- point scale.²⁵ Physicians participating in MIPS will be eligible for positive or negative Medicare payment adjustments ranging from four percent to nine percent to be phased in over a five-year period.²⁶

Under MIPS and Section 1848(q)(2)(B)(iv) of the Act, a new Health Information Technology (HIT) and EHR system has been designed to increase the portability of medical records and to provide easier transfer of individual health information among health systems.²⁷ EHR, a systematized collection of patient information stored in a single digital format, used HIT to provide health information between consumers, providers, payers, and quality monitors. As a result, unrelated doctors and hospitals would be able to easily communicate and review records when necessary. During medical emergencies when a primary doctor is not available, easily accessible records would provide necessary health information for care, while always remaining HIPAA compliant. An additional goal of the HIT system is to attempt to minimize medical mistakes made due to a lack of necessary information.²⁸

Section 1848(q)(II) of the Act provides for technical assistance to MIPS practitioners in small practices and practices in health professional shortage areas.²⁹ Guidance and assistance will be offered to MIPS practitioners in practices of 15 or fewer professionals, with priority given to such practices in rural areas or medically underserved areas. This would allow small and rural practices which could not typically meet the costly requirements of MIPS to participate in these programs.

Alternative Payment Models (APMs)

Section 101(e) of MACRA promotes the development of, and participation in, APMs for physicians and certain practitioners.³⁰ Alternate Payment Systems create new ways to pay health care providers for the care they provide to Medicare beneficiaries.³¹ Under APM, a health care provider would be paid a five percent lump-sum bonus on their Medicare payments, with the potential of a 0.75% increase in payments per year.³² APM's are required to use EHR systems and quality controls similar to MIPS, along with assuming financial risk for monetary losses in

the treatment of patients. This could be too much risk for individual providers due to inability to meet their overhead cost if the shared losses are too high.³³

The Bundled Payment Care Initiative (BPCI), more recently replaced by a new program called the Comprehensive Care for Joint Replacement (CJR), establishes bundled and episodic care payments to the provider that cover all care for an individual medical problem. CJR was designed by the CMS to establish more efficient care for Medicare patients undergoing surgery. However, this introduces more complexity into the APM system. The lump sum is a single fee that will be paid to the individual provider, hospital, Accountable Care organization (ACO), or Physician Practice Management (PPM). Simple cases with low cost and improved quality will provide profit, while complex cases and those with complications, re-admissions, and unnecessary tests will be penalized by lower reimbursement. This creates risk sharing, where the hospital and physicians share financial risk with the payer based on the care provided.³⁴ Government insurers value these payment models because they establish more stable and predictable costs for medical care, which in turn allows for easier budgeting.³⁵

Beginning in 2019 and for six years thereafter, there will be a five percent incentive payment (five percent of participant's Medicare reimbursements from the previous year) for health care providers who participate in certain types of APMs (not determined yet) and who meet specific payment thresholds.³⁶

MACRA was designed to improve medical care overall by manipulating the reimbursement scheme to encourage higher quality of care.³⁷ It has the potential to limit medical waste and incentivize physicians to move their philosophy of care from a volume based model to one based on quality.³⁸

The Potential Unintended Consequences

Although there will be financial incentives for providers that engage in alternative payment models, there are no clear definitions within the statute that provide details about the incentives specifically. MACRA provides confusing instructions on how healthcare providers must meet the new standards, including requirements and how they will be instituted. To date, CMS has taken a number of unsuccessful and unclear mandates and combined them into a single, still perplexing plan.³⁹

The new systems may lead to increasing frustration as providers attempt to deliver more efficient care at an increasingly lower cost. Although profit for some providers may increase, the intricacies may encourage lesser care being provided to the overall detriment of patients. As bundled care models are introduced, doctors may refuse to take on the more serious and complicated cases. With this system, providers would be forced to assume any extra medical costs not covered in the initial lump sum payment.

An additional component of MACRA is the implementation of EHR. This may require extensive upgrades for hospital and office computer systems, driving up overhead costs. Many hospital and provider networks are currently not compatible with one another and could require the purchase of entirely new systems to achieve standardization. EHRs also create a risk of hacking and exposure of personal health information to the public. Recently, Hollywood Presbyterian Medical Center in Los Angeles fell prey to a cyber-attack, and the hospital only escaped its plight by paying the hackers a \$17,000 ransom.⁴⁰ The hackers gained access to all of the Medical Center's EHRs.⁴¹ Fortunately, there was no evidence that any patient or employee information has been subject to unauthorized access, but this problem is not uncommon.

Implementation of the complex quality control reporting systems may drive up practice costs upward without actually helping physicians to improve medical care. More time may be directed toward detailed data collection and entry, and less devoted toward patient care.

The execution of MACRA may increase the costs of medical care. This could limit access to care for the indigent, and patients in underserved areas, due to lack of compliance by the doctors with limited practice resources. This system could especially drive physicians away from providing care for complex problems, expensive cases, and limit health care access depending on the geographic region.

If these pathways become too burdensome or punitive, they could drive doctors away from Medicare completely. This will limit care for the elderly and disabled. However, these pathways are still being adjusted and more fully developed, as this system will not be implemented until 2019.⁴² As of now, providers are being left in the dark as to how they will be expected to accomplish these quality goals.

Conclusion

The SGR was a poorly constructed bill that led to potential large reductions in payment to physicians each year. With the threat of annual cuts in Medicare reimbursement, physicians began to limit their care of Medicare patients, which subsequently led to lack of availability to medical care. As a result, Congress was forced to create the “doctor fix” each year.

MACRA was passed in 2015 to replace and reform the SGR. It greatly expanded reporting and quality requirements for physicians and hospitals, revised payment models, increased governmental regulation for reimbursement, and established new monitoring methods.

Two basic pathways were established: MIPS and APM. These pathways will change the way that physicians presently practice medicine and how hospitals provide access and care for

patients. Bundled payment programs will pay physicians, hospitals, ACO's, and PPM's a set fee for global and complete care of a patient, from the beginning to end of the episode of care. Additionally, complications requiring readmission, extra ancillary care, revision surgery, or excess medical visits will decrease payment and profit to that group. Further, the introduction of bundled payments to hospitals and providers will not only affect Medicare patients but could also spill over to privately insured and uninsured patients who will be required to compensate for financial losses by paying higher rates for physician and hospital services. This may provide incentive for physicians and hospitals to limit availability to indigent patients in order to cut losses.

The introduction of new guidelines is intended to improve the quality of care and portability of medical records while decreasing medical costs. However, a large part of these costs will be transferred to physicians and hospitals in order to upgrade EHR systems, hire additional staff for data collection and entry, and to fulfill reporting requirements. EHR systems will be required to store and transfer medical records, and these can become expensive and complex. In theory, this should be extremely beneficial for all patients. However, many systems are presently not compatible and will need to be modified. Advances in technology are required before EHR can move forward. Security and HIPAA compliance are also major concerns. At the present level of computer technology, everyone's valuable medical information is at risk for theft.

The result of APM is to push physicians into large practices managed by hospitals, PPM's, ACO's, or eventually the federal government. If physicians have a shared financial risk, there is a possibility for cost containment and the streamlining of care. This could also

incentivize the physician to limit appropriate care for financial gain, and reduce access to care for patients with complex cases.

MACRA has multiple aims, including to repair the problems that existed with SGR and to establish portable EHRS. Doing so is intended to decrease medical mistakes and improve overall care. MACRA creates a way to monitor and pay for exceptional care, encourage quality and cost effective care, and weed out poor and inefficient care. MACRA also decreases budgetary costs for the federal government. However, MACRA may bring with it some unintended consequences as well. Doctors and hospitals may limit or alter care as a result of the new regulations, believing that less is now more. Complex cases and unreliable patients may be avoided as they will increase the cost of care and decrease profit. Providers may manipulate data in order to meet the requirements, limit penalties, and maximize profits. EHR data may be hacked and personal health information may not be protected. Because the government wants to remain budget neutral, it could lead to draconian reimbursement cuts similar to SGF, causing doctors to eventually drop out of Medicare completely.

The final effect of this new legislation, whether intended or unintended, may be a forceful shift into a single system that is run by the federal government. Socialized healthcare in America, whether good or bad, is a separate debate.

References:

1. *Sustainable Growth Rates & Conversion Factors*. CENTERS FOR MEDICARE & MEDICAID SERVICES. (Nov. 25, 2014). <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SustainableGRatesConFact/index.html?redirect=/sustainablegratesconfact/>
2. Jacob Goldstein, *Why Medicare Pay Cuts for Doctors Will Be Back*. WALL STREET JOURNAL. (July 10, 2008). <http://blogs.wsj.com/health/2008/07/10/why-medicare-pay-cuts-for-doctors-will-be-back/>.
3. *Id.*
4. *Id.*
5. Ezra Klein *What to do about the doc fix?* WASHINGTON POST. (June 21, 2010). http://voices.washingtonpost.com/ezra-klein/2010/06/what_to_do_about_the_doc_fix.html.
6. Lemeneh Tefera, *Medicare Access and CHIP Reauthorization Act of 2015 Merit-Based Incentive Payment System and Alternative Payment Model Provision*. CENTERS FOR MEDICARE & MEDICAID SERVICES. (September 9, 2015). <http://www.ahqa.org/sites/default/files/images/Understanding%20MACRA.pdf>.
7. Stuart Guterman, *With SGR Repeal, Now We Can Proceed with Medicare Payment Reform*. THE COMMONWEALTH FUND. (April 15, 2015). <http://www.commonwealthfund.org/publications/blog/2015/apr/repealing-the-sgr>.
8. Stuart Guterman, *The 'Doc Fix' – Another Missed Opportunity*. THE NEW ENGLAND JOURNAL OF MEDICINE. (June 12, 2014). <http://www.nejm.org/doi/full/10.1056/NEJMp1401460>.
9. Jeff Mason, *Obama signs bill fixing Medicare doctors' pay*. REUTERS (April 16, 2015). <http://www.reuters.com/article/us-usa-congress-medicare-obama-idUSKBN0N72QM20150416>.
10. *Id.*
11. *The Merit-Based Incentive Payment System (MIPS) & Alternate Payment Models (APMs)*. CENTERS FOR MEDICINE & MEDICAID SERVICES. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-andAPMs/MACRA-MIPS-and-APMs.html>.
12. Stephanie Glover, *Overview of the Medicare Access and CHIP Reauthorization Act (MACRA)*. NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES. <http://www.nationalpartnership.org/research-library/health-care/CBC/npwf-macrawebinar.pdf>.
13. Craig Mahoney et al., *Understanding APMs and MIPS*, AAOS NOW, (March 2016) at 18.
14. Lemeneh Tefera, *Medicare Access and CHIP Reauthorization Act of 2015 Merit-Based Incentive Payment System and Alternative Payment Model Provision*. CENTERS FOR MEDICARE & MEDICAID SERVICES. (September 9, 2015). <http://www.ahqa.org/sites/default/files/images/Understanding%20MACRA.pdf>.
15. *Id.*
16. *Id.*
17. Craig Mahoney et al., *Understanding APMs and MIPS*, AAOS NOW. (March 2016) at 18.
18. *Id.*
19. Jacob Goldstein, *Why Medicare Pay Cuts for Doctors Will Be Back*. WALL STREET JOURNAL. (July 10, 2008).: <http://blogs.wsj.com/health/2008/07/10/why-medicare-pay-cuts-for-doctors-will-be-back/>.

20. Lemeneh Tefera, *Medicare Access and CHIP Reauthorization Act of 2015 Merit-Based Incentive Payment System and Alternative Payment Model Provision*. CENTERS FOR MEDICARE & MEDICAID SERVICES. (September 9, 2015). <http://www.ahqa.org/sites/default/files/images/Understanding%20MACRA.pdf>
21. Stephanie Glover, *Overview of the Medicare Access and CHIP Reauthorization Act (MACRA)*. NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES. <http://www.nationalpartnership.org/research-library/health-care/CBC/npwf-macra-webinar.pdf>.
22. Marc Grossman, *Spotlight on Physicians: Meaningful Use 2015*, HEALTHCARE INFORMATICS. (June 5, 2015). <http://www.healthcare-informatics.com/article/spotlight-physicians-meaningful-use-2015>.
23. *Request for Information Regarding Implementation of the Merit-Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models*. FEDERAL REGISTER. (October 1, 2015). <https://www.federalregister.gov/articles/2015/10/01/2015-24906/request-for-information-regarding-implementation-of-the-merit-based-incentive-payment-system>.
24. *FAQ on MACRA and Medicare Payment Reform*. AMERICAN ACADEMY OF FAMILY PHYSICIANS. (September 2015). <http://www.aafp.org/practice-management/payment/medicare-payment/faq.html>.
25. *Id.*
26. *Id.*
27. *Request for Information Regarding Implementation of the Merit-Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models*. FEDERAL REGISTER. (October 1, 2015). <https://www.federalregister.gov/articles/2015/10/01/2015-24906/request-for-information-regarding-implementation-of-the-merit-based-incentive-payment-system>.
28. Sue Bowman, *Impact of Electronic Health Record Systems on Information Integrity: Quality and Safety Implications*. PERSPECTIVES IN HEALTH INFORMATION MANAGEMENT. (2013). <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3797550/>.
29. *Id.*
30. *Id.*
31. *The Merit-Based Incentive Payment System (MIPS) & Alternate Payment Models (APMs)*. CENTERS FOR MEDICINE & MEDICAID SERVICES. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html>.
32. *FAQ on MACRA and Medicare Payment Reform*. AMERICAN ACADEMY OF FAMILY PHYSICIANS. (September 2015). <http://www.aafp.org/practice-management/payment/medicare-payment/faq.html>.
33. Craig Mahoney et al., *Understanding APMs and MIPS*, AAOS NOW, (March 2016) at 18.
34. *Pay-for-Performance (P4P) and the Shifting Reimbursement Paradigm*. AMERICAN BAR. http://www.americanbar.org/content/dam/aba/administrative/healthlaw/18_pay_for_performance.authcheckdam.pdf.
35. Lemeneh Tefera, *Medicare Access and CHIP Reauthorization Act of 2015 Merit-Based Incentive Payment System and Alternative Payment Model Provision*. CENTERS FOR MEDICARE & MEDICAID SERVICES. (September 9, 2015). <http://www.ahqa.org/sites/default/files/images/Understanding%20MACRA.pdf>

36. Sue Glover, *Overview of the Medicare Access and CHIP Reauthorization Act (MACRA)*. NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES. <http://www.nationalpartnership.org/research-library/health-care/CBC/npwf-macra-webinar.pdf>
37. *Fixing the Problems with Attribution, Risk Adjustment, and Episode Groupers*. CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM. <http://www.chqpr.org/>
38. *Id.*
39. Lemeneh Tefera, *Medicare Access and CHIP Reauthorization Act of 2015 Merit-Based Incentive Payment System and Alternative Payment Model Provision*. CENTERS FOR MEDICARE & MEDICAID SERVICES. (September 9, 2015). <http://www.ahqa.org/sites/default/files/images/Understanding%20MACRA.pdf>
40. Justin Moyer, *After computer hack, L.A. hospital pays \$17,000 in bitcoin ransom to get back medical records*. THE WASHINGTON POST. (February 18, 2016). <https://www.washingtonpost.com/news/morning-mix/wp/2016/02/18/after-computer-hack-l-a-hospital-pays-17000-in-bitcoin-ransom-to-get-back-medical-records/>
41. *Id.*
42. Lemeneh Tefera, *Medicare Access and CHIP Reauthorization Act of 2015 Merit-Based Incentive Payment System and Alternative Payment Model Provision*. CENTERS FOR MEDICARE & MEDICAID SERVICES. (September 9, 2015). <http://www.ahqa.org/sites/default/files/images/Understanding%20MACRA.pdf>