FROM SGR TO MACRA TO MIPS: WHAT YOU SHOULD KNOW

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When President Obama signed the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) into law, the 12-year battle to repeal the Sustainable Growth Rate (SGR) formula—the method that determined Medicare's payment for physician services—came to a close. Once fully implemented, MACRA has been projected to be the most consequential driver of how healthcare is organized, delivered, and reimbursed since the development of DRGs. The aim of this article is to explain why indeed this may be so and to provide a primer on key elements of this legislation.

FROM SGR REPEAL TO MACRA

First, what was SGR and why did most in the medical community want it repealed? To begin, note that since Medicare's inception in 1965, determining a workable method for paying physicians for their services has proved problematic. Original payment methods reimbursed physicians at rates equaling their local 'usual and customary charges.'[1] This provided no guardrails to curb spending, and predictably, spending increased. Subsequent attempts to rein in spending yielded little success. Ultimately in the Balanced Budget Act (BBA) of 1997, increases in physician and other provider reimbursement became linked to the overall U.S. per capita GDP growth. The logic: an overall increase in the Medicare spending on provider reimbursement would be ***sustainable*** so long as it matched the overall growth of the economy at large. At the time, the U.S. economy was expanding rapidly, and for the next few years provider payments increased.

But the logic of the BBA was flawed. By 2002 the U.S. economy had cooled, yet provider payments continued to increase. This led to an historic 4.8% reduction in the Medicare physician fee schedule and resulted in public outcry. For the next 12 years—until MACRA was signed—the medical community found itself, at the end of each fiscal year, lobbying Congress to postpone the payment reductions stipulated by SGR. Each year Congress acceded. Yet the stakes grew, as each of these reprieves merely stalled but did not reset the mandated reductions in provider payments. This created greater degrees of financial jeopardy with each passing year. At the time MACRA was signed, providers were facing a 21% across-the-board decrease in reimbursement.

By offering relief from the yearly face-off with Congress, MACRA was initially greeted with broad support. In MACRA, (1) legacy SGR-mandated provider payment reductions were repealed for good; (2) a yearly 0.5% increase in the physician fee schedule was to be enacted for the four years (2016-2019); then (3) payment was to be held constant for six years thereafter (2020-2025). This so called 'doc fix' legislation was hailed as offering both clarity and stability for provider payments for the next decade – or so it seemed.

THE QUALITY AGENDA

Although most of the concern regarding provider reimbursement has centered on base rates for payment, it is important to point out that since passage of the Patient Protection and Affordable Care Act of 2010 (aka 'Obamacare'), a number of payment modifiers have been introduced to secondarily adjust provider reimbursement based upon quality measures. Today, the Physician Quality Reporting System (PQRS), Meaningful Use of the Electronic Health Record (EHR), and the Physician Value-Based Payment Modifier (VM) programs combine to put 6% of physician reimbursement at-risk; this will increase to 9% in 2017. These programs represent initial legislative attempts to focus attention on the quality of services delivered instead of solely on their volume.

In parallel, Medicare also began developing alternative models aimed at reducing overall cost of care while maintaining the quality. These models are different than traditional fee-for-service arrangements, and Accountable Care Organizations (ACOs) serve as the primary vehicle through which this may be accomplished. In ACOs, providers and facilities work together to coordinate care. So long as specific quality measures are attained, if the ACO provides total cost of care below a predetermined value, the ACO shares in those savings (one-sided risk arrangement). In addition to this 'upside' risk, the ACO may elect also to assume liability for a percentage of costs in excess of benchmarks (two-sided or 'downside' risk arrangement). The percentage of overall shared saving available to the ACO is higher in this downside risk arrangement.

MACRA takes these two approaches to increase quality (i.e., fee-for-service care with quality modifiers vs. ACO care reorganization) and codifies them into two distinct payment tracks: the Merit-Based Incentive Payment System (MIPS) and qualifying Alternative Payment Models (APMs).

APMs

The APM model applies to those providers who are organized into qualifying ACOs that assume downside risk. MACRA then provides for additional financial opportunity. Should the qualifying ACO achieve a certain threshold value for revenue derived from APMs, its providers will receive a 5% bonus on all of their Medicare charges (assessed yearly through 2024). ACO providers are also liberated from reporting on individual quality measures. (See MIPS below.)

While this model may seem attractive, three distinct issues with APMs must be recognized. First, the criteria for qualifying for APM payment are quite stringent. It is expected that fewer than 10% of all Medicare providers will be eligible for APM track payment in 2019, the year that MACRA goes into effect. Second, the 5% APM bonus payment will sunset in after 2024.[2] Third, keep in mind that the ACO may need to deliver up-front financial returns before qualifying for APM bonus payment. APMs are not a business models that can be entered into without considerable expertise in actuarial analysis, operational execution, and financial management.

MIPS

If a provider is not in an ACO, or is in an ACO that does not meet the revenue threshold for APM qualification, the provider will be assigned to MIPS evaluation. It is expected this will encompass 90% of all providers in 2019. Every MIPS provider will be evaluated on performance in four domains: quality, resource use, clinical practice improvement, and advancing care information. Scorecards will be produced and publicly available (https://www.medicare.gov/physiciancompare). Not only are rules complicated as to how performance in each domain will be assessed, but also the burden for reporting in all of these domains is not trivial.

Based on individual performance relative peers, providers will receive ±4% adjustment on all their Medicare payments beginning in 2019, increasing to ±9% in 2022 and beyond.

The MIPS program is essentially self-funded. Those whose performance is deemed to be below the mean will incur financial penalties. These dollars in turn will fund bonuses for those considered to be performing above the mean. While there is additional funding for exceptionally high performers, at its core MIPS is a zero-sum game. The specific rules by which resource use will be allocated and how quality will be assessed are still being developed. Nevertheless, at the time of this writing, MIPS evaluation of physician performance is slated to begin January 1, 2017. It is the performance in 2017 that will dictate the individual 2019 payment modifier for each MIPS provider.

Given the multiple performance dimensions of MIPS, the associated reporting burden, and concern that the achievement thresholds for penalty avoidance will move ever upwards, present consensus is that the APM tract is the safer harbor. However, as pointed out, participation in an APM requires complete reorganization of the infrastructure for care delivery. This is no small undertaking.

LOOKING AHEAD

MACRA is ambitious in its scope and aggressive in its timeline for implementation. So, it is important to highlight that MACRA made its way through the perpetually gridlocked U.S. Congress with tremendous bipartisan support, a phenomenon particularly noteworthy in today's political climate. Passing 392-37 in the Republican-controlled U.S. House, 92-8 in the Republican-controlled U.S. Senate, and then signed into law by a Democratic President, the key elements of this legislation are unlikely to change.

There is justifiable concern over the hydraulics of exactly how to measure, monitor, and award payment for the value of healthcare services rather than their volume. However, movement to some type of value-based payment system is arguably not an imperative but instead an inevitability. Medicare beneficiaries number roughly 54M today, and that number will climb to 82M by 2030. Meanwhile, there were 3.1 tax-paying workers for each Medicare beneficiary in 2015, and that ratio will decrease to 2.3:1 by 2030.[3] The actuarial implications are staggering: ever more beneficiaries needing care and ever fewer taxpayers to support this cost. Even with the projected cost-saving provisions of ACA and MACRA, the Medicare trust fund is projected to be insolvent in 2030. Our present model of care delivery is simply no longer scalable.

Unless we wish to face the prospect of rationing healthcare for lack of resources, we must find new ways to provide healthcare that is of high quality yet delivered at lower aggregate cost. While MACRA does not provide us with this blueprint, it certainly does provide us with the incentive to develop one.

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