MACRA is coming; MACRA is coming!

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The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was passed in 2015 and is scheduled to take effect on January 1, 2017. Final regulations are anticipated in November, 2016 leaving little time for provider implementation. The stated purpose of MACRA was to end the sustainable growth rate formula, establish a new framework for rewarding health care for providing better care and combine existing quarterly reporting programs into one system. These three changes are known as the "quality payment program" ("QPP").

The proposed rule was issued in April, 2016. A prior issue of this Alert released in April, 2015, summarized MACRA's main points. Because of the limited time that will be available for implementation after release of the Final Rule, we wished to provide an interim report on some of the information readers will need to know and we will issue a more detailed Alert when the Final Regulations are issued. Although the collection of data is the main import of the 2017 activity under MACRA, incentive payments for performance are still anticipated to commence in 2019.

Reporting will be a key element of MACRA and the Acting CMS Administrator shared what the reporting options under QPP will be. These reporting options will be selected by physicians and the amount of data required will be based on the option chosen. It appears that negative payment adjustments can be avoided as long as data is submitted under QPP.

There are to be four reporting options:

1. Test the Quality Payment Program. This option requires only that some data be submitted after January 1, 2017 to avoid negative payment adjustment.
2. Participation for part of the calendar year. Physicians can participate for a reduced number of days in 2017 and still

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receive a positive payment adjustment.

3. Participate for the full calendar year. Physicians may submit data for full calendar year 2017 and be eligible for positive payment adjustments.
4. Participate in advanced alternative payment model in 2017. This method allows physicians to forego reporting quality data and still participate in QPP by joining an Advanced Alternative Payment Model.

Although the program has been met with some objections, as of now the implementation will begin on January 1, 2017. It will benefit all practitioners to prepare themselves for this new approach.

The use of health analytics probably maintained in electronic health records is a key starting point. For larger practices obtaining software that can develop predictive risk stratification will help.

WHAT TO DO NOW?

There are some things providers can do now. Knowing which of your patients are at higher risk of hospitalization is a good place to start. These higher risk patients are also likely the highest cost patients.

Once the practice has a handle on its higher risk patients, the practice can begin developing a care model. The American Medical Association has described some things on which the practice will need to focus:

1. Target populations
2. Payers involved
3. Estimate changes on the type and volume of services
4. Benefits to patients and payees
5. Workflows needed to address desired care
6. Staff needs
7. Role of physician
8. Frequency and mode of patient contact
9. Patient visits
10. Transition costs
11. Reorganizing success

The AMA has also recommended looking for partners including other practitioners, hospitals, urgent care centers and others as part of a team approach to care. Further it is necessary to inform patients about appropriate utilization of services. This means helping patients to manage and improve their chronic conditions.

Continually monitor the progress of the practice, so the practice can determine whether patients are being helped and costs are being addressed. To improve quality results will require continuous evaluations. CMS and commercial payers should be able to provide metrics specific to the practice.

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