From SGR to MACRA: Out of the Frying Pan and Into the Fire?

The new legislation replaces multiple quality reporting systems with a new, single system.

BY GEORGE A. WILLIAMS, MD

This April saw the culmination of a decade-long effort by organized medicine to abolish the sustainable growth rate (SGR) formula. The SGR was a flawed cost control that tied growth in Medicare costs to the gross domestic product, resulting in proposed double-digit cuts (21.2% for 2015) over the past several years. Such cuts would have decimated Medicare beneficiary access and therefore were never implemented, thanks to a yearly game of Congressional overrides. The uncertainty of the SGR process adversely affected practice growth and investment and was a continuing distraction to meaningful payment reform.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was passed by the House of Representatives on March 26 (by a vote of 392 to 37) and the Senate on April 14 (by a vote of 92 to 8) and was signed by President Obama on April 16, 2015.[1] This legislation permanently repeals the SGR formula and stabilizes Medicare payments for physician services with positive updates from July 1, 2015 through the end of 2019, and again in 2026 and beyond.[2]

At a Glance

- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) permanently repeals the sustainable growth rate formula and stabilizes Medicare payments for physician services.
- MACRA replaced Medicare's multiple quality reporting programs, electronic health records meaningful use, and the value-based payment modifier with a new single Merit-based Incentive Payment System (MIPS) program.
- The MIPS presents the first real opportunity for physicians to earn bonuses for providing high-quality care.

QUALITY REPORTING PROGRAMS REPLACED

The legislation replaced Medicare's multiple quality reporting programs (the Physician Quality Reporting System [PQRS], electronic health records meaningful use (MU), and the value-based payment modifier [VBM]) with a new, single program, the Merit-based Incentive Payment System (MIPS), which may allow physicians providing high-quality, high-value health care—the actual definitions of which are yet to be defined—to yield financial benefits. The legislation also supports and rewards physicians for participating in new payment and delivery models while preserving fee-for-service as an option. Important for retina specialists, it preserves the current 10-day and 90-day global periods for more than 4000 surgical service codes that Medicare had planned to unbundle.

The law includes annual updates (for Medicare Physician Fee Schedule services) of 0% for January 2015 through June 2015; 0.5% for July 2015 through 2019; and 0% for 2020 through 2025. For 2026 and beyond, the update will be 0.75% for eligible alternative payment model (APM) participants and 0.25% for all others. The required criteria for participating in an APM through an alternative payment entity will be difficult for retina specialists to achieve. However, successful participation in an APM eliminates the need for MIPS. Beginning in 2019, MACRA will provide bonuses to physicians who score well in the MIPS or qualify for an APM.

Current penalties under the PQRS, MU, and VBM will end after 2018. In 2019, the MIPS program will become the only Medicare quality reporting program. Performance and "composite scores" under the MIPS will be based upon four categories: quality (PQRS, 30% of total); resource use (VBM, 30% of total); MU (25% of total); and clinical practice improvement activities (15% of total). The relative contribution of each category to the total score can and likely will change over time at the discretion of the Centers for Medicare and Medicaid Services. The idea is to improve the current quality measures and concepts in PQRS, MU, and VBM. Important for retina specialists, reporting quality measures through qualified clinical data registries such as the American Academy of Ophthalmology's Intelligent Research in Sight (IRIS) registry is encouraged. Participation in a qualified clinical data registry will also qualify as a clinical practice improvement activity.

POTENTIAL ADVANTAGES

In many respects, the MIPS program should be better for physicians than current quality programs. It presents an opportunity for high-performing physicians to earn substantial bonuses and for all physicians to avoid penalties if they meet prospectively established quality thresholds. Several new aspects of the MIPS program should allow physicians to score better and receive more credit for their efforts than under current programs.

Performance scoring under the MIPS program has several advantages over current quality programs that should benefit retina specialists:

- **Sliding scale assessment.** Performance assessment under the MIPS program will be according to a sliding scale, rather than the all-or-nothing approaches used in PQRS and MU. Credit will be provided to those who partially meet the performance metrics.
- **Flexible weighting.** The law has guidelines for the weighting of the four performance categories, yet it specifically allows administrative flexibility for those in practices or specialties that are at a disadvantage in meeting quality or MU requirements.
- **Credit for improvements.** Physicians can receive substantial credit for clinical practice improvement (CPI) activities and for improving (and achieving) quality of care. Telehealth and remote patient monitoring are to be recognized as examples of CPI activities, along with care coordination, population health management, and monitoring of health conditions. This may be of significant benefit for physicians engaged in management of age-related macular degeneration, diabetic retinopathy, and retinopathy of prematurity.
- **Risk adjustment.** The MIPS will require risk adjustment for patients' "health status and other risk factors," including socioeconomic factors. How this will be done remains to be defined.
- **Timely feedback and defined performance targets.** At the start of each performance period, physicians will know the threshold score for successful performance. The Secretary of the Department of Health and Human Services must issue timely, confidential feedback on physicians' performance on quality and resource use, and this may include CPI and MU. Annual performance targets are based on the mean/median composite score of all MIPS-eligible professionals for a previous period. Exceptional performance is set at the 25th percentile of the highest possible MIPS composite score or of actual scores above the regular target.
- **Group practices can report via a Qualified Clinical Data Registry (QCDR).** MACRA will allow group practices to report via QCDRs starting in 2016, and eligible professionals will be encouraged to use these registries for MIPS reporting. QCDRs will also have access to Medicare claims data to inform and assist their activities. The accruing benefits of IRIS will become increasingly apparent. I expect that IRIS will become the primary mechanism that will allow ophthalmologists to successfully perform under the MIPS program.

"Several new aspects of the MIPS program should allow physicians to score better and receive more credit for their efforts than under current programs."

The MIPS also presents the first real opportunity for physicians to earn substantial bonuses for providing high-quality care. Physicians with composite scores below the performance threshold will incur MIPS penalties on a sliding scale, with maximum penalties of up to 4% in 2019; 5% in 2020; 7% in 2021; and 9% in 2022 and beyond. For exceeding the performance threshold, physicians will be able to earn substantial MIPS bonuses, also on a sliding scale, with the highest bonus at least as high as the highest penalty for that year. Additional funding is provided for separate

bonuses of up to 10% for exceptional performance, up to $500 million per year, from 2019 through 2024. This sounds like a lot, but represents only 0.7% of 2014 payments for physician fee schedule services. However, if all physicians score above the threshold, some will receive incentive payments. Unlike current programs, the MIPS penalties provide greater certainty and have a maximum range in future years.

ARE WE BETTER OFF?

Will retina specialists be better off under MACRA? Certainly the end of the SGR and the hold on surgical global unbundling are positives, but many questions and problems remain. The cumulative scheduled reimbursement updates total less than 3% over the next decade—not exactly a great business model for growth and practice investment.

Although MIPS appears to be better than the current quality and value nonsense, the potential penalties are still considerable, and the ability of retina specialists to achieve bonuses is uncertain. Other unknowns include the mechanisms by which retina specialists will be able to participate in alternative payment models. As currently constructed, there is no apparent way to participate in an APM via a fee-for-service private practice model.

Perhaps the biggest issue for retina specialists remains the unresolved problem of high cost Medicare Part B drugs, which will continue to be attributed to physicians and therefore adversely affect the MIPS resource use score. As new (and likely even more expensive) technologies become available, this may be the proverbial straw that breaks the camel's back.

Will we and our patients be better off with MACRA? I think the answer is a definite maybe. ■

George A. Williams, MD, is a professor in and chair of the department of ophthalmology at Oakland University William Beaumont School of Medicine in Royal Oak, Mich.; director of the Beaumont Eye Institute; and a member of the Retina Today *Editorial Board. He is the delegate for the American Academy of Ophthalmology to the American Medical Association's Specialty Society Relative Value Scale Update Committee and is AAO Secretary for Federal Affairs. Dr. Williams may be reached at gwilliams@beaumont.edu.*

1. H.R. 2. Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). https://www.congress.gov/bill/114th-congress/house-bill/2/text. Accessed August 12, 2015.
2. Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), H. R. 2, Pub. Law 114-10. American Medical Association, May 7, 2015. Accessed at ama-assn.org/ama/pub/advocacy/topics/medicare-physician-payment-reform.page.