

## It was the best of times, It was the worst of times: MACRA in 2017

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### Editorial

As Medicare costs continue to rise fuelled in large part by new devices and pricey drugs, the federal government now spends 50% more on health care than it does to fund the department of defence—a monumental figure [1]. Cardiovascular disease (CVD) remains the largest driver of health care costs in the United States. By 2030 43.9 per cent of Americans are projected to have some form of CVD, driving a more than \$550 billion increase in the total costs of CVD care annually [2]. However, despite how much the United States spends on health care, the American health enterprise continues to rank in the bottom half of developed nations in overall public health [3-5]. The passage of the Medicare Access and Children's Health Insurance Program Reauthorization Act of 2015 (MACRA) was meant to be the dawn of a new day in healthcare to help rectify these disparities. For fellows-in-training (FITs) and early career physicians (ECPs) transitioning from practicing in sheltered fellowship environments into independent practice, understanding these new healthcare delivery models will be vital to providing high-quality care to patients.

The transition from a volume to a value-based system is forcing clinicians to rethink how they provide care. A new presidential administration has only increased uncertainty for both patients and health care providers in how such a monumental transition will take place. The only way for young physicians to prepare for this transition is to arm themselves with as much information about this transition as possible. What follows is a brief overview of MACRA—a very complex bill spanning over 2000 pages—including its history, details of the program as it stands (how it compares to the Affordable Care Act), challenges providers will face, and opportunities for FITs and ECPs to improve the quality of care for patients in this fledgling environment.

The Affordable Care Act's (ACA) primary goal was to mandate health insurance for all citizens (just like automobile insurance is mandatory in most states for all drivers). Several other provisions including those dealing with pre-existing conditions, Medicaid expansion, and allowing young adults to stay on their parents' health insurance plans until twenty-six years of age are other hallmarks of the legislation. The ACA did not fundamentally change the way healthcare was paid for in the US—its primary purpose was to broaden access to

healthcare and to increase insurance coverage to those without. However, the problem of rising healthcare costs remained and every year the threat of a massive Medicare reimbursement cut loomed on the horizon. This was largely in part due to the Sustainable Growth Rate (SGR). The SGR was passed as part of a much larger piece of legislation, the Balanced Budget Act of 1997, signed into law by President Bill Clinton. The SGR was a means to help control healthcare spending by tying Medicare reimbursements to increases in the United States Gross Domestic Product (GDP). However, when healthcare spending and payments to physicians outstripped GDP (to an exponential degree), a perennial cut in payments resulted. Thus, every year almost every organized medicine group lobbied Congress to repeal and replace this law with an alternative; but due to the inability to find sufficient offsets, the SGR was unable to be repealed and a temporary "Doc Fix" measure was passed. However, 2015 was different. In stunning bipartisan fashion, MACRA was passed in April 2015 by a Republican Congress and signed into law by the Democratic President.

MACRA eliminated the flawed SGR formula and set a goal to slowly convert the largely fee-for-service system to one, which focuses on rewarding those who provide the highest quality, most efficient care—bringing new meaning to the hackneyed phrase "volume to value". The federal government originally set a goal that 50 per cent of Medicare payments from the Centre for Medicare Services (CMS—which is the federal regulatory agency primarily in charge of MACRA implementation) should be from value-based models by 2018 (though the implementation of this rule has since been delayed). MACRA and the resulting Quality Payment Program provide the details on how this goal will be achieved.

MACRA contains multiple pathways to help clinicians attain these lofty goals: merit-based incentive programs (MIPS), alternative payment models (APMs), and a blend of the two. The exact formulations of how clinicians may participate in these pathways are still unclear but one thing is for certain—the way physicians interact with patients and their electronic health records will be undergoing significant changes. MACRA became effective on January 1, 2017 and payment updates for clinicians and healthcare systems are slated to take effect in 2019. The government has mandated that healthcare providers participate in this transition by linking provider reimbursements to clinicians' performance in these pathways

but it will be a zero-sum game. Those clinicians providing higher quality care will get payment bonuses whereas clinicians at the opposite end of the spectrum face negative payment adjustments—meaning those that do well will get their bonuses from the money that the government saves by imposing the negative payment adjustments upon those that CMS deems “underperformers”.

Despite the imminent nature of the program, there remain several impediments to its final implementation. It is still unclear to all stakeholders—CMS, physicians, hospitals, patients and insurers—what form the ultimate program will take. Who defines efficient, high-quality care? How is quality measured in this system? Regardless of the final answers to these questions, one thing is for certain: providers and healthcare systems will rely heavily on their ability to abstract data from the electronic health record (EHR); thus, healthcare providers and systems are beholden to the companies and software developers who

create these programs. Another direct requirement of the new health care law is that EHRs be interoperable (to help reduce unnecessary diagnostic testing). However, EHR companies have no fiduciary responsibility in MACRA: they have no “skin in the game” and no incentives to make ensure EHRs are interoperable and provide user’s meaningful data abstraction functionalities. This is one of many challenges providers and healthcare systems will face as MACRA debuts.

With these challenges come opportunities for FITs and ECPs to take a leading role in shaping the final version of the currently amorphous MACRA. Given the plurality of spending in the healthcare sector goes towards treating CVD, the ACC is a national leader in providing guidance to CMS about the best steps forward regarding MACRA implementation. And the ACC has and will continue its outreach to members to educate and inform them about MACRA and ask for their input. Additionally, the ACC has for years kept voluminous data within the National Cardiovascular Data Registry (NCDR) which may provide another avenue for members to submit quality data to CMS.

Many physicians believe that in these turbulent times, the likelihood of any major changes impacting healthcare is

minimal—“the more things change, the more they stay the same”. FITs and ECPs must look at this change not with apathy, not with trepidation, but with an eye for opportunity. The opportunity to create a better healthcare system. The opportunity to provide even better care for our patients. Regardless of the outcome of legislation to repeal the ACA, MACRA will likely remain unscathed; it was passed by a GOP Congress and signed into law by President Obama and is one of the only drivers in reducing healthcare costs in the status quo. FITs and ECPs must continue to find ways to innovate and deliver care more efficiently. Physicians in academic and private practice alike will be impacted equally and will need to work together to navigate these turbulent times.

In many ways, it is “the best of times, it (is) the worst of times, it (is) the age of wisdom, it (is) the age of foolishness.” Charles Dickens poignant opening line from *A Tale of Two Cities* rings true over a century later. But we must remember that residents and fellows are the future of cardiovascular care and that future has never been so bright. With the advent of Trans catheter solutions to valve disease and more advanced pharmaceuticals that hold promise to eradicate CVD, we are at the precipice of a revolution and it is our responsibility to make and keep these technological advances within reach of every patient—not only those who can afford them.

## References

1. Obama BH (2017) Repealing the ACA without a Replacement The Risks to American Health Care. *N Engl J Med* 376: 297-309.
2. Benjamin EJ, Blaha MJ, Chiuve SE, Cushman M, Das SR, et al. (2017) Heart Disease and Stroke Statistics-2017 Update: A Report From the American Heart Association. *Circulation* 135: 146-603.
3. Cardiovascular Disease and Diabetes: Policies for better health and quality of care. Paris: OECD, 2015.
4. Bradley EH, Taylor LA (2013) *The American health care paradox: Why spending more is getting us less*. 1st edn. New York: Public Affairs.
5. US Health Care from a Global Perspective. 2017.