Making Sense of the MACRA Final Rule - Part 1 of 3: Essential Concepts

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On Oct. 14, the Centers for Medicare & Medicaid Services (CMS) published a final rule with comment period implementing the bipartisan Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The nearly 2,400 pages of regulatory text and associated commentary found in the unpublished version submitted to the Office of Management and Budget sets forth CMS' implementing regulations to replace the Medicare sustainable growth rate (SGR) formula with a new system that links Medicare fee-for-service (FFS) payments for physicians and other practitioners to care delivery, quality and value-based variables.

MACRA is viewed by many as a game changer for the delivery and payment of health care services. And since MACRA was a bipartisan piece of health care legislation, those expecting a repeal or major rewrite may be engaged in wishful thinking.

MACRA's implementation begins in earnest on Jan. 1, 2017. This is the first of a three-part series that examines various legal, operational and strategic considerations associated with the law and final rule.

This article examines certain essential concepts related to the "Quality Payment Program" (QPP) established by MACRA and implemented by CMS via the final rule, with attention to the QPP's policy objectives, alternative participation vehicles, and certain operational concerns including what physicians and other "eligible clinicians" will be subject to the law and key participation-related choices.
Separate alerts in this series examine the specific details of MACRA's participation alternatives:

- The Merit Based Payment Incentive System (MIPS); and
- Alternative Payment Models (APM)

Overall, this series examines MACRA and the final rule to provide practical observations and guidance to help position health care organizations for future success.

You can read Part 1 here.

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