

Holy MACRA! Will Our Future Be Better or Worse?

Like it or not, value-based payments are here to stay.

For 18 years, physicians labored under the Medicare physician payment formula called the Sustainable Growth Rate (SGR), which annually threatened physicians with cuts, sometimes greater than 20 percent, if physician spending exceeded growth of the Gross Domestic Product – which it always did. Every year Congress came to the “rescue” with short-term patches to head off the cuts. Then, in 2015, lawmakers finally laid the SGR to rest and gave us the Medicare Access and CHIP Reauthorization Act, or MACRA.

In this issue, Amy Mullins, MD, CPE, FAAFP, lays out the Act’s basic principles in “Medicare Payment Reform: Making Sense of MACRA” (see page 12). On the face of it, MACRA makes sense – consolidate the Physician Quality Reporting System, Meaningful Use, and the Value-Based Payment Modifier into a single quality program and further promote value-based care. The Triple Aim, after all, involves achieving higher quality health care for individuals and improving the health of populations while maintaining or reducing the per capita cost. Sounds good, right? But the devil is in the details, and one troublesome detail is how the program pays physicians for quality in a new system known as MIPS (the Merit-Based Incentive Payment System).

MACRA offers two physician payment tracks – MIPS and the Alternative Payment Model (APM). Under MIPS, annual fee increases are frozen between 2019 and 2024, and each physician’s payment rate is increased or decreased based on his or her performance relative to other physicians in the MIPS track. MIPS quality targets are set at the median of all physicians’ performance, which means that half of physicians under this system will see annual pay cuts,

no matter how well their performance might compare to external benchmarks. This approach keeps the system “budget neutral” but ignores the concept that the focus on quality improvement work will likely save the system money.

The overall incentives in MACRA favor the APM track (think “accountable care organization”) and becoming a patient-centered medical home (PCMH). APM physicians will receive a 5 percent pay bump annually between 2019 and 2025 and won’t face the MIPS’ potential performance bonuses and penalties. Plus, a higher fee schedule will take effect in 2026. But APMs have to “take risk,” which is still undefined. The risk requirement will be waived if your practice is a recognized PCMH, another definition that is still pending. Being a PCMH also gets you higher quality points under MIPS.

So what can we do? First, we can challenge MIPS’ approach to quality payments. If the Centers for Medicare & Medicaid Services (CMS) isn’t going to share the savings with the MIPS crowd, it should pay a fair fee-for-service rate but withhold 20 percent to 30 percent of payments for a quality payment pool and then distribute the pool based on performance pegged to reasonable benchmarks. Yes, as more folks achieve quality targets the individual quality rewards will shrink, but that is preferable to penalizing half of physicians for being “below average.”

Second, we can challenge how CMS defines “risk-bearing.” Most accountable care organization owners think the millions of dollars they invest annually with no guarantee of return is risky enough, but CMS hasn’t seen it that way.

Finally, we can carefully evaluate the PCMH requirements when they are spelled out in the regulations. The current National Committee for Quality Assurance approach requires elaborate documentation and rewards form over function, which is not the best approach in my opinion.

Where Medicare goes, other insurers follow. MACRA is our future. Full implementation is almost three years away, but the regulations will unfold this year in the federal rule-making process. Now is the time for physicians to challenge aspects of the law that don’t seem well designed or fair. 

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