FROM THE EDITOR

Should We Fear the Unintended Consequences of MACRA?

MACRA's methods of controlling health care costs could have unexpected results.

The Medicare Access and CHIP Reauthorization Act (MACRA) is upon us. Almost. Beginning this month, our quality performance in 2017 will affect our payments under MACRA when it officially launches in 2019. In this issue (page 12), Amy Mullins, MD, outlines the mind-numbing complexity of the two MACRA payment tracks, called the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (AAPMs), jointly named the Quality Payment Program (QPP). Now that's an acronym that rolls off the tongue.

Much of QPP will seem familiar. MIPS combines four measures into one quality score. Three measures correspond to the current Physician Quality Reporting System, Meaningful Use, and Value-Based Payment Modifier programs. The fourth measure throws in a bit of additional quality improvement.

So the not-so-subtle goal of MACRA over the next 10 years is to push physicians and health systems to take financial risk for the total cost of care.

MIPS has what I consider two serious flaws. First, even if everyone improves their quality metrics way beyond the current benchmarks, there will be winners and losers. Some folks will make more money and others less because MIPS is designed to be revenue-neutral on physician spending. Second, overall, incomes will stagnate under MIPS. This will drive folks to look longingly at the AAPM track, which offers less onerous reporting requirements, an automatic 5 percent bump in income right out of the gate, and a chance for everyone to be a winner. The catch is it involves taking on financial risk, which means that everyone can become a loser too.

So the not-so-subtle goal of MACRA over the next 10 years is to push physicians and health systems to take financial risk for the total cost of care. This is essentially a return to global capitation. Will that work to control costs? Remember how much patients hated HMOs? With providers trying to be good stewards of the health care dollar, will patients come to distrust us? Will they question whether we are still their advocates, committed to putting their interests before our own? Will systems that take on risk and fail cause serious damage to our delivery system? Will nonadherent patients be dismissed from practice after practice? Will focusing on a narrow set of quality metrics cause providers to ignore other perhaps even more important drivers of quality?

Sure, we want to believe we're doing it better this time. We aren't cutting costs. We're eliminating "waste." And we're doing it while maintaining or improving quality.

But is eliminating "waste" by reducing clinical variation and shifting costs to less expensive locations and providers going to do enough to control runaway health care costs?

MACRA fails to address many other drivers of health care spending such as the ever-spiraling costs of medications and new technologies, the public's insatiable desire for the "best" and the "latest," fear of malpractice that leads to defensive medicine, high profit-taking and administrative costs of non-government insurers, hospital consolidation that leads to monopolistic higher prices, and, perhaps most important, a huge imbalance of specialists to primary care physicians.

Policy makers tell us that primary care physicians are the solution to our cost and quality problems. It is commonly acknowledged that we should move from our nation's roughly 75/25 specialist/primary care split to the 50/50 split we see in parts of Europe and Japan, regions that appear to have equal or better outcomes at lower costs. Yet I see nothing in MACRA that will motivate medical students to go into primary care, when as specialists they can typically reap two to three times the income.

Yes, MACRA is well-intentioned. It has some sensible parts. But we'll need to be vigilant that it doesn't lead us to a number of disturbing unintended consequences. FPM

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