

## HEALTH POLICY CORNER: PART II

**SGIM Responds to the Proposed Implementation of MACRA**

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The changes imposed by MACRA (Medicare Access and CHIP Reauthorization Act) have settled over the physician community as a dark cloud. Though widely hailed by Congress as an innovative response to the combined challenges of an aging demographic and increasingly expensive health care, the implications of the “value-based” paradigm have suddenly jumped into hyperfocus as the regulations proposed by the Centers for Medicare and Medicaid Services (CMS) have been reviewed and digested by the physician community. “High quality” and “cost control” are broad aspirational goals, but the day-to-day work of physicians and their enterprises do not lend themselves easily to rapid change. Furthermore, there has been scant attention to patients and doctors. Will patients buy into a payment model that can penalize their doctors or their site of care on the basis of the tests ordered? How will it feel to know that your work will be watched for every action you take?

Congress passed this “fix” due to the annual failure of the sustainable growth rate—the dreaded SGR—as the volume-based target dictated cuts in physician reimbursement each year. SGIM and physician specialties went hat in hand each year to ask Congress for yet another reprieve from the mandated cuts.

We all cheered in relief last year, but now we know better after sifting through CMS’ almost-1,000-page proposed rule implementing the new payment system. Beginning in 2019, MACRA requires that physicians either participate in the Merit-Based Incentive Payment System (MIPS) or an alternative payment

model (APM). However, 2019 comes more quickly than expected. The first performance period for MIPS and APMs will be based on practice patterns starting in 2017. SGIM and virtually all other professional societies called for a delay, and CMS has created three options for reporting in 2017. However, the first adjustments will start in 2019 unless Congress intervenes. It would be unwise to be complacent.

CMS will issue a final rule on these programs later this year, leaving less than three months to prepare to report either under MIPS or as part of an APM. In our response to the proposed regulations, SGIM addressed key elements of MACRA, outlined below, that demand ongoing attention either within the rulemaking by CMS or by Congress.

**MACRA and the Flawed Physician Fee Schedule**

CMS is building this new payment system using the very same poorly defined and undervalued evaluation and management (E/M) codes that have plagued primary care since the beginning of the resource-based relative value scale (RBRVS) payment in 1992. In our comments, we continued to advocate for CMS to develop new E/M codes based on a strong research base:

*SGIM believes it is critically important that new models of care delivery be built from trustworthy building blocks. CMS must prioritize the reworking of the E/M service codes using a strong evidence base. With a well-constructed and valid representative knowledge-base, new service codes can be defined and provided*

*with appropriate relative valuations that recognize the complexities and demands of current medical practice.*

**Actionable Data**

Physicians cannot make meaningful changes if data are late or unreliable. SGIM made the following suggestion: *It is critical that physicians receive as close to real-time feedback as possible so they have sufficient time to correct any deficits and successfully report before the close of the reporting period. SGIM urges CMS to provide participating providers with a comprehensive feedback report on a quarterly basis and ensure that the final report is provided no later than October 1 of the reporting year. This would provide more regular feedback and also allow those participating to have a more complete picture of where they are succeeding and areas in which they may be subject to penalties. CMS should make these reports available to practice staff designated by the provider, as well as the provider.*

*Feedback reports should allow primary care physicians to see the impact of their own decision making on resource use, as well as how other providers’ decision making influences resource use for their panel of patients. For example, it should enable them as much as possible to look at resource use measures for local specialists so this can be considered in referral decisions. However, it will be essential that all feedback be based on statistically valid measures and that appropriate risk adjustment methods be used to provide meaningful and accurate feedback.*

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### The Case for Risk Adjustment

Appropriate risk adjustment is critical to ensure that physician performance is properly evaluated in quality reporting programs. CMS will not have a new risk-adjustment methodology ready for 2017. We expressed concern that this methodology must be accurate and transparent to prevent physicians from cherry picking their patient panels in an attempt to avoid the sickest patients. Inaccurate, incomplete, or invalid risk adjustment could adversely affect patient access to care and would be especially detrimental in areas where access to care is already limited.

### Attribution of Cost

CMS has been experimenting with patient attribution models in its existing quality programs. SGIM made the following recommendation to CMS:

*...we recommend that MIPS and APMs use a prospective attribution method with a retrospective review process at the end of the payment period to correct for actual utilization patterns. A patient who is prospectively attributed to one provider, but then receives most of their primary care from a different provider, should be attributed to the second provider rather than the first. Patients should be asked to designate their primary care provider, and providers should be able to review their panel at the beginning of each*

*monitoring period. This method would enable primary care providers to have a clear idea of the patients they are responsible for, while not holding them responsible for care they do not participate in. This would also facilitate the use of "population health" and preventive care strategies to proactively intervene to help patients achieve optimal health outcomes. At the same time this would help ensure that patients have a designated source of care while still enabling them to choose freely among providers.*

### The Special Circumstances of Academic Medical Centers

The attribution methodology poses unique challenges for providers in academic medical centers (AMCs). General internists in these settings serve highly complex patients and receive the same MIPS composite score as all of the physicians reporting in that group. How will CMS capture the diversity of care and priorities for quality improvement of many different specialties?

Furthermore, CMS did not address the challenges that attending physicians who supervise residents will face in AMCs. These physicians typically oversee multiple residents who may work under different attending physicians. These shifting supervisory relationships and patient panels will impact performance in these sites, making the

need for improved feedback paramount. SGIM called on the agency to address this issue.

### Small Practice Pressures

CMS estimated that nearly all (almost 90%) practices with fewer than ten clinicians will face penalties. SGIM is extremely concerned about the impact that MACRA will have on the financial viability of these practices, particularly primary care practices, as well as the potentially strong incentives to consolidate or sell a smaller practice to a larger entity. The education, training, and technical assistance promised by CMS is insufficient to support these practices. SGIM recommended amending the low-volume threshold to include more of these practices.

### Next Steps

We await CMS' response to the hundreds of comments they have received. However, much of what physicians fear about MACRA was baked in by Congress, including the 2019 start date, the 9% maximum penalties by 2022, and the high bar for APM participation. We will continue to focus our efforts to achieve better payment for primary care work within the fee schedule to ensure that improvement in payments for primary care services will have a beneficial impact that enables general internal medicine to thrive in the world of MACRA.

SGIM