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MACRA, SGIM's Health Policy Committee, and Alphabet Soup

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Until a few years ago, health policy terms sounded like alphabet soup to me: SGR, RUC, PQRS, CHIP, MVPS, RVRBS, CMS. To be honest, if you work in an academic medical center as I do, we are often many layers removed from the way physicians and hospitals are paid for services. It's easy to lose track of where things stand on the issues of importance to us, our patients, and to SGIM. But then in 2013, I went to my first SGIM Hill Day, an opportunity for SGIM members to gather in DC, brush up on SGIM's health policy advocacy priorities, and "storm the Hill." (Learn more about Hill Day at http://www.sgim.org/communities/advocacy/hill-day.)

At the Hill Day events I attended in 2013, 2014, and 2015 (and for years before that), the SGIM advocacy platform included requesting the repeal of the SGR or the Sustainable Growth Rate. This formula had been created in the Balanced Budget Act of 1997 as a method to control costs by ensuring that Medicare budget increases did not exceed the growth in the gross domestic product. The calculation was such that annually physicians faced substantial potential pay cuts, and Congress passed 16 different "patches" or "doc fixes" to prevent dramatic losses.

The good news is that SGIM advocacy must have worked (!) because in 2015, President Obama signed the Medicare Access and CHIP Reauthorization Act of 2015, or MACRA, which ended use of the SGR.

So what is MACRA? If you don't know, then join the crowd: A recent Deloitte survey found that only half of physicians had even *heard* of MACRA.[1] Twenty-one percent of non-pediatric physicians in private or independent practice were "familiar" with it; only 9% of us—who like most SGIM members are employed by hospitals or large groups—were familiar. Recently, I sat in a faculty meeting where only two or three of the 30 primary care faculty present had heard of MACRA—at least anecdotally confirming the Deloitte results.

Yet MACRA fundamentally changes how we are all paid—or at least how our medical centers and practice plans are paid for our work, assuming we receive Medicare Part B payments—and moves all physicians toward value-based payment and away from payment based on volume. In ending use of the SGR formula, MACRA instead creates a new payment structure (and a different strategy to control costs) by rewarding physicians for providing higher quality care. There are two payment pathways: the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs). Many of us will qualify under APMs because our medical centers or contracting groups have already engaged in accountable care organizations (ACOs). Smaller practices, or those geographically located where APMs have not penetrated, will be paid under MIPS. MIPS creates a single composite quality score that incorporates three existing quality reporting programs (i.e. the Physician Quality Reporting System (PQRS), the Value-Based Payment Modifier (VBPM), and Meaningful Use (MU)) and adds a fourth—the new Clinical Practice Improvement Activities (CPIA) program. Together, the four programs establish a single composite performance score on a scale of 100 used to determine physician payment.

Organizations participating under APMs will get a 5% Medicare bonus as early as 2019; that bonus is in addition to all incentives and payments available through the APM. Five percent more for doing what you are already doing is a powerful incentive for organizations to join APMs. Those participating under MIPS will have performance-based payments beginning in 2019; by 2022, payment will be adjusted as much as -9% or +22% based on the quality score. The year 2019 feels far away; however, the quality reporting period is due to begin in January 2017. (Yes, in three months.) The timeline is presented in Figure 1. Learn more about the quality measurement program for MIPS here: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html.

Mostly, this should be great news for our patients as well as for SGIM members. Medicare's push toward quality-based payment is likely to benefit primary care. We've been advocating for repeal of the SGR for years; MACRA rewards quality over quantity; and there is opportunity for significant gain for high-performing primary care organizations. In fact, Kocher and Chigurupati recently wrote in the *New England Journal of Medicine*, "APMs are designed to distribute savings to PCPs, reflecting the

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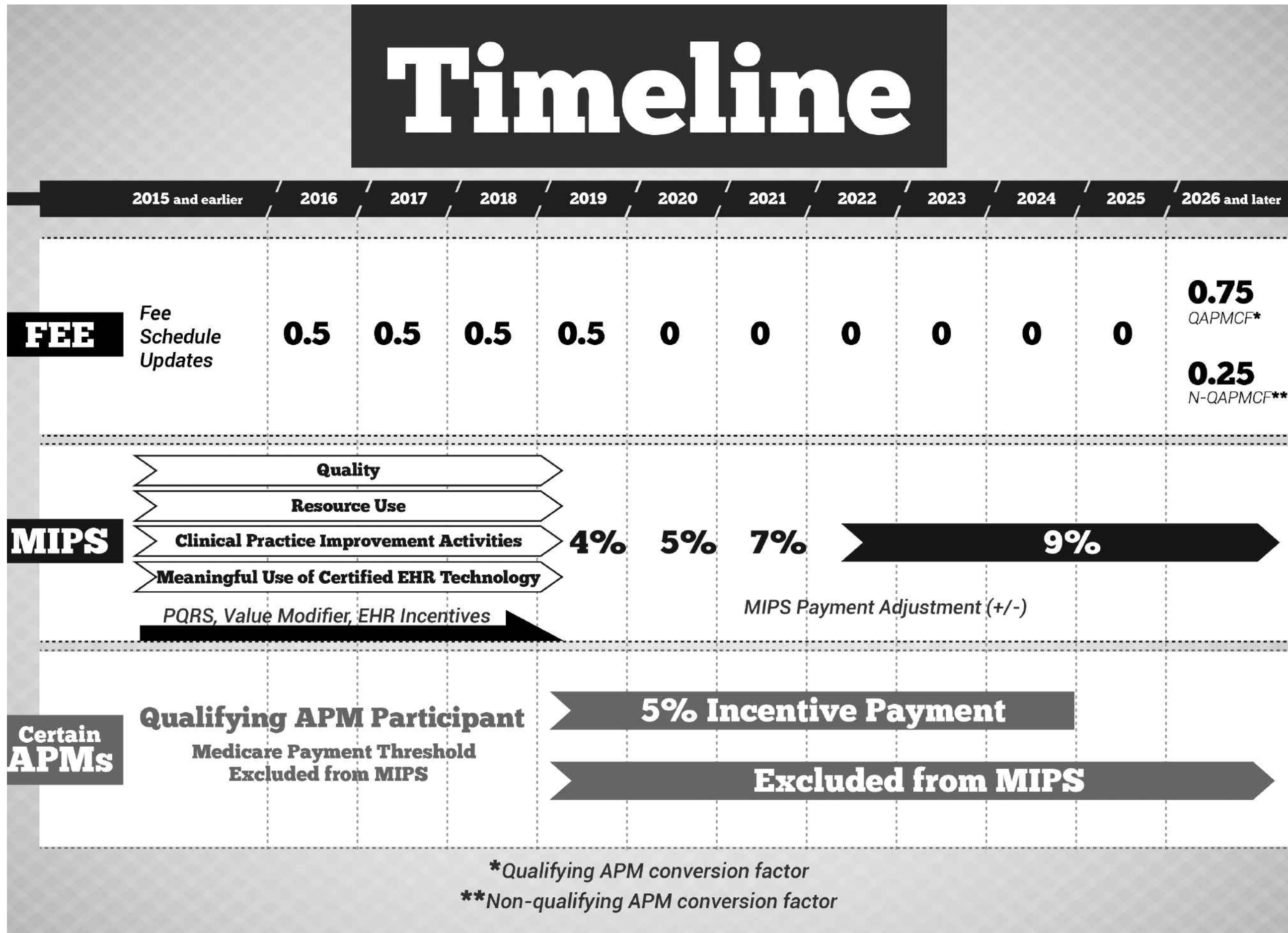
Figure 1: MACRA Implementation Timeline



broader roles for primary care established by MACRA and the Affordable Care Act.... As health care reimbursement shifts from fee-for-service to risk-based payments, PCPs are well positioned economically and strategically. Their incomes are likely to grow substantially over the next decade, at the expense of hospitals and specialists."[2]

While MACRA is overall good for primary care physicians, it's important that we understand some of the complex implications for us and for our patients and that SGIM have a voice in the final rules, which are due out in October. CMS invited public comment about MACRA. You can read the details of SGIM's comments here: http://www.sgim.org/File%20Library/SGIM/Communities/Advocacy/Legislative%20Endorsements/SGIM-MACRA-Letter.pdf. Our response included these suggestions, among others:

1. *True payment reform*. MIPS and APMs are built on a fee-for-service platform: We suggest that the basic value proposition is "unattainable" without transformation of the RBRVS and the reworking of the evaluation and management (E/M) service codes. While Medicare can say that MACRA moves payment from volume to value, the hidden reality is that the new payment system is built on the current E/M service codes and on the RVU system, which inherently undervalues

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care provided by general internists.[3] A cornerstone of SGIM's advocacy for the past many years has been calling for reform of the RUC, E/M coding, and RVUs. In the past year, SGIM and our member John Goodson have led the Cognitive Care Alliance, which was created to advocate for more appropriate E/M service codes that reflect complexity density and for a reduction in required documentation. (Read about this in more detail in the July issue of the *Forum*.[4])

2. *Feedback*. As educators, we know that meaningful and timely feedback leads to performance improvement. Because the final rule for MACRA will not be released until October, we suggest delaying implementation for three months—from January 2017 to April 2017—to allow practices to adapt to the final format. We also request quarterly feedback from CMS to physicians to allow those participating to have a good understanding of their areas of strength and of areas where they are potentially failing. Feedback should be frequent and with enough advance notice to allow time for improvement.
3. *Risk adjustment*. Because MACRA will involve comparing how physicians do on many quality measures, CMS must use a valid and transparent risk-adjustment methodology so that panel comparisons can be apples to apples, instead of apples to… Caesar salad.
4. *Patient attribution*. SGIM recommends a combination of a retrospective and prospective methodology to allow physicians to know which patients will count but also to allow patients the opportunity to choose their own physicians. Attribution is particularly challenging at academic medical centers because residents serve as primary care providers.

There are many more points about the implementation of MACRA to read about in SGIM's letter. Stay tuned, since CMS plans to announce the final "rule" in October.

Has this column been alphabet soup for you, and do you want to learn more? Or are you a health policy nerd looking to take your knowledge and career to the next level? SGIM's Health Policy Committee (HPC) will soon be starting the Leadership in Heath Policy Program or "LEAHP." A year-long opportunity similar in construction to the Association of Chiefs and Leaders in General Internal Medicine's LEAD and SGIM's TEACH programs, LEAHP aims to train the next generation of SGIM leaders in health policy. The program will include a half-day training at the 2017 annual meeting, quarterly webinars, longitudinal mentoring from current SGIM leaders, Hill Day participation, work with CRD Associates, and capstone projects such as white papers on pressing advocacy issues. More is forthcoming in the next issue of *Forum*.

Like all SGIM members, I owe many thanks to our HPC, its leaders, and longtime SGIM HPC staffer Francine Jetton. Even when some of these issues seem like alphabet soup, I know that our HPC will be working hard in the best interests of our patients, our members, and our organization.

References

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