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BEST PRACTICES: PART II

MACRA AND THE QUALITY PAYMENT PROGRAM: A CALL TO ACTION

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The 2015 Medicare Access and CHIP Reauthorization Act (MACRA) led to the creation of the Quality Payment Program (QPP) to adjust physician payments based on "value" over volume. Defining value remains challenging and subjective. Most Medicare physicians receive traditional fee-for-service (FFS) payments and are thus subject to value as defined by the Merit Based Incentive Payment System (MIPS) arm of QPP, which will increase or decrease physician payments based on their performance in four categories: quality, cost, use of certified electronic health records systems, and participation in performance improvement activities.

QPP has been criticized as a flawed system, most notably by the Medicare Payment Advisory Commission (MedPAC) who officially recommended scrapping the QPP and starting over, before it became entrenched.[1] However, short of new congressional legislative action, The Centers for Medicare and Medicaid Services (CMS) is mandated by MACRA to implement the QPP based on the agency's best interpretation of value. QPP is not going anywhere, but it can be altered in CMS' annual rulemaking process. The recently released data on the first year (2019) of payment adjustments[2] reaffirms the numerous concerns about the direction of the program. Based on year one QPP data and on the history of Medicare physician payments, three concerning themes relevant to SGIM members and our patients emerge:

1. There are systematic winners (large, urban medical centers) and losers (practices that care for socially and medically complex patients, small and rural practices).
2. The magnitude of these payment adjustments will become meaningful starting in 2021, as CMS "ramps up" the program. If your practice is not paying attention, now is the time (actually it's already late—payments in 2021 are based off performance in 2019).
3. SGIM members have always cared and advocated for socially and medically complex patients, and for underserved patients broadly, including those in rural areas. Now is the time for our membership to be informed and advocate for change in MIPS/QPP, before systems become fully entrenched, payments to providers who care for these populations go down, and access for these patients worsen.

History Teaches Us Not to Be Complacent

The Physician Fee Schedule (PFS) was introduced in 1992, worsening the existing undervaluation of cognitive/non-procedural evaluation and management (E/M) services (especially for complex care). Significant but insufficient E/M revisions occurred in 1995 and 1997 with no further major adjustments for more than 20 years, and the issue continues to hinder SGIM members and our patients today. The Sustainable Growth Rate (SGR) was created by the 1997 Balanced Budget Act to control growth in Medicare spending on physician services. The SGR model did not adequately incorporate the aging Medicare demographic and the expanding repertoire of interventions and therapeutics. It's potential cuts to physician payments flew under the radar until 2002, when a 4.8% reduction in payments across the board "snuck up" on physicians. Many professional societies welcomed MACRA in 2015, which ended the SGR. However, history is now set to repeat itself, as MACRA/QPP negative payment adjustments remain minor during this ramp up phase and may yet again fly under the radar. By full ramp-up in 2023, when negative payment adjustments will reach -9%, the status quo will be well entrenched and meaningful change perhaps decades away.

What Should SGIMers Know about MIPS Structure and Pitfalls?

Most physicians are reimbursed through FFS Medicare payments, and thus fall under the MIPS arm of QPP. Two significant MIPS structural challenges are worth noting:

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1. MIPS reporting is burdensome and complex. This is one primary reason cited by MedPAC to scrap MIPS and start over. There are 4 domains (3 of which are legacy CMS programs repackaged) in which providers/practices must report data and are scored: quality (Physician Quality Reporting System [PQRS]), cost (Value-Based Modifier), promoting interoperability (Meaningful Use/EHR), and practice improvement activities. The quality domain, weighted most heavily, allows providers/practices to report in multiple formats (5) and choose from multiple measures (more than 65 for internists, of which 6 must be reported). The flexibility offered by this system is outweighed by the administrative burden to providers/practices. Furthermore, CMS will make provider scores publicly available, to allow for beneficiaries to compare when choosing a provider. However, the complexity and variation in reported measures will prevent a meaningful apples-to-apples comparison.
2. While MIPS payment adjustments are currently small, they will get substantially larger. MIPS is ramping up in a well-intentioned but complex fashion over 6 years. In the first payment adjustment year (2019) only 5% of providers will see negative adjustments[2] because the composite performance score (CPS) threshold that must be reached across the 4 domains of MIPS to avoid a negative payment adjustment was set at 3 out of 100 possible points. This will increase to 15, then 30, and eventually to the mean or median score from prior periods (expected to be above 60 points). Fifteen points remains easy to achieve, and CMS estimates low numbers of negative adjustments for payment year 2 in 2020. However, in 2021 and beyond, CMS estimates higher numbers of negative performers. The magnitude of the negative adjustments will also increase, from a maximum of -4% in 2019 up to -9% in 2023 and beyond. The timing of positive payment adjustments for high performers is the same. Due to the MACRA mandate for budget neutrality, the low number and magnitude of negative adjustments in 2019 means that the high number of positive performers will only see very small benefits (maximum 1.88% in 2019). By 2021, the magnitude of positive payment adjustments is expected to reach 5%[3], and in future years is expected to reach double digits, with a theoretical maximum of 37%.[3]

MIPS Is a High-Stakes Game, Losers Could Just Vanish

The structure of MIPS is such that certain groups of providers/practices face a disadvantage out of the gate. SGIM draws from the following two most notable groups:

1. Small and rural practices. These practices have historically scored worse on legacy programs such as PQRS.[3] Year 1 QPP data released by CMS confirms the continuation of this trend, with large practices achieving a median CPS score of 90 (of 100 possible) points, 75 for rural practices, and 38 for small practices.[1] The burden of MIPS reporting and the resource constraints faced by small practices contribute significantly. CMS grants some leniency, including a five-point small practice bonus to the CPS score in year 1 (which clearly did not close the 52-point gap) and other provisions. The 2019 final rulemaking alters and shrinks the overall small practice bonus, and CMS explicitly states that the small practice bonus is meant to be temporary.[3] One could read that CMS is determined to force all independent physicians into larger enterprises.
2. Complex patients. Data are not available to compare scores for practices that preferentially care for socially or medically complex patients, but there is significant concern that MIPS scoring methodology does not adequately account for these factors. CMS has finalized its plan to continue a maximum 5-point complex patient bonus, based on Hierarchical Condition Category (HCC) scores (CMS's measure of medical complexity), and Medicaid dual eligible status. CMS states the ongoing need to identify better ways to risk adjust for socially and medically complex patients but chose not to alter their methodology for 2019. While it is not clear how best to account for these factors, what is clear is that the current policy puts providers caring for these patients at a disadvantage. For example, by only using Medicaid dual eligible status to socially risk adjust, there is an obvious disadvantage for practices that care for low-income patients in non-Medicaid expansion states.

The Call to Action for SGIM Members

QPP and MIPS will profoundly influence primary care practice for the foreseeable future. There will be winner and losers. Some of this is already apparent but there will likely be other currently unrecognized unintended consequences. For the sake of our patients, especially those most disadvantaged and vulnerable, and the financial viability of our primary care practices which care for them, SGIM members need to maintain heightened attentiveness to CMS's

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implementation strategy. Specifically, our researchers, advocates and activists must investigate, monitor and report the adverse consequences of MACRA's QPP. Our members have repeatedly demonstrated expertise in teasing out the failures and harms caused by national policies. CMS is very mindful of the published literature. It is not their intention to harm. Like all systems, they need a feedback mechanism.

If nothing changes from the status quo, the cognitively sophisticated clinical care we provide for medically and socially complex patients will take a double hit—from the distortions in the existing Physician Fee Schedule and from the inadequacies of the Quality Payment Program. Access to care for these patients has always been a challenge and will only get worse if reimbursement for providers caring for these populations continues to decline. SGIM members can be a catalyst for change in MACRA's QPP. The time is now to pay attention, ask the tough questions, design the studies, disseminate the results, and advocate for the change needed to protect access to care for our most complex and vulnerable patients.

References

1. MedPac. Report to the Congress: Medicare payment policy, chapter 15: Moving beyond the merit-based incentive payment system. Medicare Payment Advisory Commission, March 2018. http://www.medpac.gov/docs/default-source/reports/mar18_medpac_ch15_sec.pdf?sfvrsn=0. Published March 2018. Accessed April 1, 2019.
2. Verma S. 2017 Quality Payment Program (QPP) Year 1 performance results. Centers for Medicare and Medicaid Services. https://www.cms.gov/blog/quality-payment-program-qpp-year-1-performance-results. Released November 8, 2018. Accessed April 1, 2019.
3. CMS. 2019 Physician fee schedule final rule. Centers for Medicare and Medicaid Services, CMS-1693-F. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1693-F.html. Released November 1, 2018. Accessed April 1, 2019.

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