After the “Doc Fix”: Implications of Medicare Physician Payment Reform for Academic Medicine

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Abstract

The Medicare Access and CHIP Reauthorization Act (MACRA) introduces incentives for clinicians serving Medicare patients to move away from traditional “fee-for-service” and into alternative payment models (APMs) such as accountable care organizations and bundled payment arrangements. Thus, MACRA creates strong reasons for various teaching clinical services to participate in APMs, not only for Medicare patients but for other public and private payers as well. Unfortunately, different APMs may be more or less applicable to the diverse teaching physician roles, academic clinical programs, and patient populations served by medical schools and teaching hospitals. Therefore, this time of transition will complicate the work of academic clinical program leaders endeavoring to sustain the tripartite mission of patient care, health professional education, and research. Nonetheless, payment reforms promoted by MACRA can reward efforts to reinvent medical education to better incorporate value into medical decision making, as well as to give clinical learners the tools and insights needed to recognize their personal financial (and other) conflicts and navigate these to meet their patients’ needs. This post-MACRA environment may intensify the need for researchers in academic medicine to stay independent of the short-term financial interests of affiliated clinical institutions. Health sciences scholars must be able to study effectively and speak forcefully regarding the actual benefits, risks, and costs of health care services so that educators and clinicians can identify high-value care and deliver it to their patients.

Editor’s Note: This New Conversations contribution is part of the journal’s ongoing conversation on the present and future impacts of current health care reform efforts on medical education, health care delivery, and research at academic health centers, and the effects such reforms might have on the overall health of communities.

In an increasingly rare expression of bipartisan agreement, Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA) in April 2015. This legislation (referred to as “the Doc Fix” during its arduous journey through Congress) is the most substantive revision in almost 20 years of how Medicare will reimburse nearly 600,000 physicians (and 300,000 other clinicians) under the “Medicare Physician Fee Schedule” (MPFS). We review the background, rationale, and principal elements of this legislation and comment on the implications of these fundamental changes in Medicare payment for those in academic clinical practice. We then offer considerations for the educators and scholars training and informing clinicians who will care for Medicare beneficiaries under this new paradigm.

Background of the “Doc Fix”

MACRA was designed to replace earlier, failed, attempts by Congress to constrain growth in Medicare “fee-for-service” (FFS) payments for physician (and other clinician) services, and to better reward these professionals for delivering high-value health care. FFS is a long-standing approach to paying for physician services, currently prominent not only in the United States but in many other countries as well. Across these diverse health systems, governments regularly play some role in the setting of physician payments. This is because the traditional market forces that guide pricing and allocating typical goods like shoes, or services like wallpapering, do not apply to most physician services. The physician (or other clinician) as seller of services has access to specialized knowledge unavailable to the buyer, making the buyer unable to fully represent his or her own interests in weighing the seller’s recommendations. Furthermore, in many medical care transactions the buyer of physician services might be a patient distracted by pain, impaired by illness, or even unconscious. Further complicating this market, the patient often does not bear the full price of medical services when insured by private or public payers such as employers or government agencies.

Because of these fundamental problems with setting prices for clinical services, societies have long attempted to regulate physician payments, dating back to the Code of Hammurabi. However, the market failures regarding physician services complicate not only the price for these services but also allocating the correct number and type of them. FFS rewards clinicians for the volume of services they provide, but not for quality or appropriateness, so simply setting prices may be an insufficient solution. Therefore, when
Congress revised the mechanisms for setting the “price” of physician services in 1989 by applying the resource-based relative value scale to the MPFS, it also introduced policies to constrain future volume of these services (the “volume performance standard”). Problems with this approach to expenditure targets emerged, so in 1998 Congress imposed the Sustainable Growth Rate (SGR) formula, which adjusted annual updates to the MPFS using a formula that tied the growth of physician spending to the growth in gross domestic product. This mechanism also proved ineffective as well as inequitable, and after years of political struggle was replaced in April 2015 by MACRA.

Key Elements of MACRA

MACRA does not replace the use of FFS reimbursement in Medicare, but attempts to impose value-based purchasing components on top of the current payment system in order to diminish FFS’s deleterious effects. MACRA presents physicians (and other clinicians who bill the Medicare fee schedule) with two payment pathways. In the first pathway, physicians will still be largely paid through traditional Medicare FFS, but subject to a new pay-for-performance program that consolidates three existing Medicare incentive schemes and enhances incentives with larger risks and rewards and a more sophisticated set of performance metrics. This “Merit-Based Incentive Payment System” (MIPS) will measure physician performance along four dimensions: quality, resource use, clinical practice improvement activities, and meaningful use of electronic health records. Starting in 2019, individual physician (and other clinician) Medicare FFS payments will be adjusted upwards or downwards on the basis of relative performance on a composite performance score. By 2022, the MIPS performance can increase or decrease Medicare FFS payments by up to 9%, a much larger financial risk than under the current “Value Based Modifier” (VBM) mechanism in Medicare FFS.

MACRA introduces incentives for physicians and other clinicians to take the other pathway that moves them further away from traditional Medicare FFS and into alternative payment models (APMs) such as accountable care organizations (ACOs) and bundled payment arrangements. To qualify for the APM pathway, physicians must “substantially” participate “in an entity that bears more than nominal financial risk if actual aggregate expenditures exceeds expected aggregate expenditures.” The legislation specifically notes ACA-authorized Medicare “shared savings program” (MSSP) ACOs as a potential model; however, the original MSSP ACOs would not qualify, as they lacked the necessary downside “financial risk.” Other examples currently being tested by the Center for Medicare and Medicaid Innovation (CMMI) include the Oncology Care Model, and several forms of “bundled payment” for specific procedures requiring hospitalization. Under most of these APMs, Medicare continues to pay via FFS, but aggregate payments can be adjusted down or up if patient costs are higher or lower than benchmark values. Furthermore, each APM must have some assessment of quality performance which may also influence payment. Physicians need not be at “financial risk” if the APM model is “a medical home that meets criteria comparable to medical homes expanded under section 1115A(c).” This cryptic legislative language means that if a CMMI-evaluated medical home model (e.g., the Comprehensive Primary Care Initiative or the Independence at Home program) is shown to have cost or quality benefits it can be broadly applied as an APM—and the participating physicians need not have new financial risks imposed.

And these are just the beginning of APMs on the horizon. MACRA specifically encouraged the Centers for Medicare and Medicaid Services (CMS) to test APMs relevant to specialty physician services. The legislation also prioritizes testing of “Risk-based models for small physician practices which may involve two-sided risk and prospective patient assignment…” Anticipating the need to develop and test multiple APMs, MACRA authorizes the recently convened Physician- Focused Payment Model Technical Advisory Committee to provide comments and recommendations to the Department of Health and Human Services (HHS) on physician-focused payment models.

Providers under the APM pathway do not participate in MIPS and are not subject to its reporting requirements. As a further incentive to participate in APMs, those qualifying for the APM pathway will receive a 5% bonus on their Medicare payments from 2019 through 2025. The APM pathway is open to eligible providers who receive a certain percentage of their payments through an eligible APM (the secretary can also develop APM qualification approaches focused on percentages of patients served rather than payments). This percentage starts at 25% of their Medicare payments in 2019 and grows to 75% of either Medicare or all-payer revenues in 2023. It should be expected that this aspect of MACRA will spur already-considerable development of APMs by private insurers and state Medicaid programs. MACRA also rewards APM participation by replacing SGR formula-driven annual fee updates with statutorily set ones; from 2026 onward, the increase is threefold higher for those under the APM pathway (0.75% vs. 0.25% for the MIPS pathway).

Of course, MACRA implementation faces many challenges. First among these is the core question of whether it will achieve the policy goal of moderating spending growth by controlling the growth in the volume of services per patient often seen under FFS payment. The larger potential penalties under MIPS, and the requirement that most APMs include financial risk for provider organizations linked to cost performance, are provisions intended to accomplish this goal in a more targeted fashion than the SGR and VBM mechanisms replaced by MACRA. Nonetheless, years of testing by CMS and CMMI will be required before effective APMs can be identified and the potential impact of MIPS can be observed.

MACRA and Teaching Physician Practice

Care delivery and payment reforms often pose new complications for teaching physicians and the academic institutions endeavoring to sustain the tripartite mission of patient care, health professional education, and research. These challenges may be particularly complex for the network of diverse clinical service collaborations that constitute the modern academic health center (AHC). MACRA creates potent new incentives for various teaching clinical services to participate in APMs both in Medicare and other public as well as private payers. Unfortunately, different APMs may be more or less applicable to the diverse
teaching physician roles, academic clinical programs, and patient populations served by medical schools and teaching hospitals. For example, family physicians could participate in a medical home model supporting enhanced primary care for their Medicare patients, and geriatricians in an “independence at home”-style initiative to support assessment and services for the frail and homebound in their community. Oncologists might be paid for care of cancer patients through the Oncology Care Model, and orthopedic surgeons might participate in the hospital’s bundled payment program for those requiring hip or knee replacement. Cardiologists might also be involved in bundled payment related to acute myocardial infarctions or heart failure patients, or these and many other specialists might participate in an enterprise-wide ACO.

The issues affecting choices among these options, however, may prove daunting for teaching physicians and their institutions. Restructuring the clinical enterprise of an AHC to lead an ACO may seem to be a logical solution given the size of many clinical faculties. However, such an effort may be in conflict with core institutional priorities as well as deeply rooted programmatic strengths. For example, many AHCs lack the strong primary care infrastructure and clinical program focus as well as the population health orientation thought to be keys to successful ACOs. Furthermore, priority academic clinical programs may serve referral populations far larger than those covered by local Medicare (or other) ACOs (e.g., bone marrow transplantation, medical genetics). Other clinical programs may largely care for infants (e.g., neonatology), children (e.g., adolescent medicine), or adults younger than 65 with focused needs (e.g., infertility, cystic fibrosis), rendering Medicare-related APMs irrelevant to their practice. Among the substantive challenges facing academic physicians under MACRA is how diverse AHC clinical faculty can achieve the requisite level of participation in ACOs or other non-FFS payment models to achieve the collective benefits of APM participation.

Performance measurement in MACRA pertains not only to the evaluation metrics used in MIPS but also to quality metrics used in various APMs which are to include quality measures comparable to MIPS. Issues in performance measurement are no less complex than the challenges within payment models and may pose particular challenges for those in academic medicine. As noted previously, the traditional FFS pathway involves MIPS wherein all clinicians paid through this mechanism will be measured (and their payment adjusted) relative to such dimensions as quality, resource use, and clinical practice improvement. MACRA sets forth ambitious priorities and an aggressive timeline for CMS to implement these new metrics in performance reports and payment adjustments by 2019. A substantive companion paper would be required to reflect on all the implications of MIPS for academic physicians and their institutions, such as the efforts by specialty physicians to develop data registries that can supply information needed for MIPS quality metrics relevant to various procedures and conditions. Suffice it to say that it will be challenging for CMS to devise quality metrics that are well suited to the diverse and very specialized clinical roles common in AHCs. Moreover, absent nuanced risk adjustment and other considerations, assessment of teaching clinicians’ performance on resource use may well conflict with their medical education and health care innovation roles in AHCs.

Accordingly, one interesting aspect of MACRA relevant to MIPS is a new approach to attributing responsibility for patients when assessing the quality and costliness of care for Medicare beneficiaries. Under MACRA, HHS is to “develop patient relationship categories and codes that define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of furnishing an item or service.” MACRA notes as an example a physician who “considers themself to have the primary responsibility for the general and ongoing care for the patient over extended periods of time”; in contrast to one who “considers themself to be the lead … practitioner … during an acute episode”; or one who “furnishes items and services only as ordered by another physician or practitioner.” Of course, these are but a few of the myriad critical patient care roles played by physicians and other clinicians at AHCs. CMS has just begun the complex task of developing these different clinical responsibility constructs in preparation for use in reports and payment by the 2019 deadline. Doubtless, leaders of diverse clinical programs in academic medicine will want to pay close attention to this process.

**Implications of MACRA for Medical Educators**

Inevitably, with health care constituting a large and growing share of government and employer budgets, demands for societal oversight have become intense. Thus, teaching physicians and other medical educators cannot escape the reality that health care spending, and especially payment for physician services, has become a public policy concern, reflected in the ambitious MACRA agenda.

The challenges presented by these payment reforms for AHCs also present opportunities to reinvent medical education to place greater emphasis on considerations of value in medical decision making. Over the 40 years during which U.S. health care has grown to its uniquely high level of societal expenditure, various educators have called for greater emphasis on teaching cost-effective care. The intention of MACRA is to better reward clinicians and delivery organizations that embrace these principles. Thus, broader organizational interests may be aligned to support educational initiatives that emphasize the costs and benefits of diagnostic and treatment choices, the use of evidence in point-of-care decisions, coordination of care with other professionals, and work in interdisciplinary teams to address individual patients’ needs and aspirations.

Sadly, regardless of policy maker aspirations, no performance metric or APM can be relied on to consistently reward more evidence-based, much less more patient-centered, care. As noted in one comprehensive review, “There are many mechanisms for paying physicians … the three worst are fee for service, capitation, and salary.” Thus, educators and clinical program leaders must continue to instill the core principles of medical professionalism, especially the commitment to first serve the patient, regardless of individual or organizational financial interests. At the point of care, patients need professionals they can trust to recommend to them an evidence-based and patient-centered course of action. As payment policies and
Implications for Academic Medicine Scholarship

Perhaps even more challenging in this post-MACRA environment is the need for the intellectual enterprise of academic medicine to remain independent of the financial interests of its affiliated clinical institutions. Because of their tripartite mission, AHCs relying heavily on clinical revenue are a major employer of the scholars who serve as society’s arbiters of health care evidence. Thus, researchers, educators, and program leaders must be alert to the caution succinctly summarized by Upton Sinclair18: “It is difficult to get a man to understand something, when his salary depends on his not understanding it.” As we documented previously,19 various studies suggest that physician practices operated by larger systems cannot be consistently relied on to discern, and to deliver, high-value care. The past success of academic medicine scholars in avoiding conflicts of interest has also been mixed.20 These challenges are unlikely to lessen if MACRA profoundly changes the financing of academic clinical practices and teaching hospitals. Nonetheless, health science researchers must be able to study effectively and speak forcefully regarding the actual benefits, risks, and costs of health care services, regardless of institutional interests such as patents held, clinical centers constructed, programs established, or cyclotrons acquired.

Educators, clinicians, and program leaders in academic medicine will serve their profession poorly if, during this time of transition to alternative payment, they fail in their collective responsibility to identify high-value care and to deliver it to their patients.

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References