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How the Trump Administration Can Improve Medicare Physician Payment

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Doctors face a fundamental transition in the Medicare payment system as they struggle to comply with rules[1] issued in 2016 by the Obama Administration to implement a 2015 law[2] that overhauled the system. The rules, which took effect on January 1, 2017, created an overly complex and burdensome regulatory regime. Surveys of the medical profession show that most physicians are either unprepared to comply with these rules or profoundly dissatisfied with the regulatory product.[3]

U.S. Department of Health and Human Services (HHS) Secretary Tom Price should use his broad administrative authority to reverse the Obama Administration's regulatory policies and work to dramatically improve Medicare's physician payment system. Specifically, Secretary Price should:

1. Ease the costly and time-consuming overhead that burdens medical practices by drastically reducing their reporting burden under current law; and

2. Replace the burdensome regime with true payment and delivery reforms that incorporate current private-sector innovations—including those in Medicare Advantage (MA).

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Why Reforms Are Needed

Doctors who participate in Medicare are paid either directly by the government, which reimburses them via Medicare Part B in a fee-for-service (FFS) model, or by insurance companies, which reimburses them via Medicare Advantage. Under the Obama Administration's rules, doctors who participate in Medicare Part B are required to transition to a new payment system called the Quality Payment Program (QPP). The QPP's underlying goal is worthy: transition providers away from the traditional fee-for-service payment model—which compensates doctors for providing services without regard to value—into a system that compensates and rewards doctors for providing value-based care. In short, the new system is intended to encourage doctors to provide better care at lower cost.

However, both the law and the implementing regulations issued by the Obama Administration fall short on this goal. The current approach is overly burdensome and expands the role of the federal government in the practice of medicine.

Under QPP, doctors will have one of two payment options:

1. Remain in FFS and be subject to the Merit-Based Incentive Payment System (MIPS); or

2. Participate in an Advanced Alternative Payment Model (APM).

MIPS is a complex and burdensome pay-for-performance (PFP) system based on traditional fee-for-service payment approaches that have characterized Medicare for decades. Under MIPS, pro-

viders will have their payments adjusted according to how they perform on a number of measures across four categories. In addition, a composite performance score reflecting performance will be publicly reported, affecting not only an individual physician's income but also potentially their reputation and employability.

An alternative is for providers to opt out of MIPS if they can meet Alternative Payment Model participation thresholds and requirements. Such providers will be exempt from the MIPS regulatory requirements and be eligible for a 5 percent bonus. However, the Centers for Medicare and Medicaid Services (CMS) have approved a limited number of Advanced APMs, the majority of which are Accountable Care Organizations (ACO)—a payment structure that was added to the Medicare program by section 3022 of the Patient Protection and Affordable Care Act (ACA) of 2010.[4] Aside from some notable successes, concentrated mainly in a few organizations, Medicare ACOs have yet to consistently generate health care savings; in fact, early results show a net loss to taxpayers in the aggregate.[5] For 2017, the CMS estimates that only 70,000 to 120,000 clinicians (approximately 10 percent–15 percent) will participate in Advanced APMs and qualify for the bonus.[6]

These numbers indicate a real need for expanded access to new and innovative APMs; however, such an expansion will be a lengthy process. While the HHS Secretary has authority to test new models, the Center for Medicare and Medicaid Innovation (CMMI), established by the ACA, is currently the main pathway for testing and implementing new APMs in Medicare. The Congressional Budget Office (CBO) estimates that CMMI models will need to be tested for four to seven years before HHS decides whether to expand them beyond a demonstration phase.[7]

Given these factors, unless changes are made, MIPS will likely make it difficult for doctors to participate in Medicare FFS at a much faster pace than new, viable APMs can be developed and implemented.

What the Administration Should Do

The HHS Secretary has broad regulatory flexibility to ameliorate this situation. Therefore, the Secretary should provide regulatory relief that improves the conditions of medical practice for hundreds of thousands of doctors and medical professionals by reducing government involvement in the practice of medicine and fostering real innovation in health care delivery. Specifically, the Secretary should issue new rules that:

1. Reduce the regulatory burden of physician performance measurement. Physicians and their staff currently spend, on average, 785.2 hours/$40,069 per physician annually to track and report quality measures for Medicare, Medicaid, and private health insurers.[8] In spite of the substantial time and money diverted from patient care, most physicians feel that the current measures do not help them improve the care they provide. According to an October 2016 analysis of the current misalignment of Health Quality Measures, the Government Accountability Office (GAO) concluded:

1. *Federal Register*, Vol. 81, No. 214 (November 4, 2016), pp. 77008–77831.
2. Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Public Law 114–10.
3. See Bernie Monegain, "Providers Still Not Ready for MACRA, Stoltenberg Survey Says," *Healthcare Finance*, March 23, 2017, http://www.healthcarefinancenews.com/news/providers-still-not-ready-macra-stoltenburg-survey-says (accessed June 8, 2017), and Bruce Japsen, "More Doctors to Retire as MACRA and Value-Based Pay Hit," *Forbes*, September 21, 2016, https://www.forbes.com/sites/brucejapsen/2016/09/21/more-doctors-to-retire-as-macra-and-value-based-pay-hit/#18d234609f97 (accessed June 8, 2017).
4. Tianna Tu, David Muhlestein, S. Lawrence Kocot, and Ross White, *The Impact of Accountable Care: Origins and Future of Accountable Care Organizations*, Leavitt Partners and The Brookings Institution, May 2015, https://www.brookings.edu/wp-content/uploads/2016/06/Impact-of-Accountable-CareOrigins-052015.pdf (accessed June 8, 2017).
5. Ashish Jha, "ACO Winners and Losers: A Quick Take," August 30, 2016, An Ounce of Evidence | Health Policy blog, https://blogs.sph.harvard.edu/ashish-jha/2016/08/30/aco-winners-and-losers-a-quick-take/ (accessed June 8, 2017).
6. The Centers for Medicare and Medicaid Services, "The Quality Payment Program Overview Fact Sheet," https://qpp.cms.gov/docs/Quality_Payment_Program_Overview_Fact_Sheet.pdf (accessed June 8, 2017).
7. Congressional Budget Office, "Estimating the Budgetary Effects of Legislation Involving the Center for Medicare & Medicaid Innovation," July 30, 2015, https://www.cbo.gov/publication/50692 (accessed June 8, 2017).
8. Lawrence P. Casalino, David Gans, Rachel Weber, Meagan Cea, Amber Tuchovsky, Tara F. Bishop, Yesenia Miranda, Brittany A. Frankel, Kristina B. Ziehler, Meghan M. Wong, and Todd B. Evenson, "U.S. Physician Practices Spend More than $15.4 Billion Annually to Report Quality Measures," *Health Affairs*, Vol. 35, No. 3 (2016), pp. 401–406, http://content.healthaffairs.org/content/35/3/401 (accessed June 8, 2017).

> Although hundreds of quality measures have been developed, relatively few are measures that payers, providers, and other stakeholders agree to adopt, because few are viewed as leading to meaningful improvements in quality.[9]

In addition, a recent RAND analysis of pay-for-performance initiatives found that "consistently positive associations with improved health outcomes have not been demonstrated in any setting."[10]

Recognizing the substantial burden on physician practices, HHS correctly introduced considerable flexibility in MIPS for 2017, allowing providers to avoid a 4 percent penalty with a minimal reporting requirement.

Therefore, HHS should extend the current flexibility in MIPS to 2018 and beyond, as necessary, to bring performance assessment more in line with the development of meaningful measures and the real goal of measurement: improving quality. Moreover, until the measures can be shown to reflect the true value of the care provided, HHS should not publicly report individual performance scores in MIPS. If HHS is unable to provide physicians the ability to improve their practices with meaningful performance measures, then Congress should re-open the Medicare statute to protect physicians from the imposition of unfair penalties under the law.

2. Replace the burdensome regime with true payment and delivery reforms that incorporate current private-sector innovations which improve patients' quality of care—including those in Medicare Advantage (MA). Current criteria for establishing qualified Advanced APMs are stringent and inflexible. HHS should adjust these criteria to include additional, proven models, including two approaches effectively excluded today.

- *First, existing criteria exclude a number of innovative and successful alternative, private models of delivering and paying for health care.* One example is Direct Primary Care (DPC), a private-sector model in which doctors are paid directly rather than through patient insurance premiums. DPC offers doctors and patients the choice to avoid the bureaucratic complexity, wasteful paperwork, costly claims processing, and growing frustrations with third-party payer systems. It can also cultivate better doctor–patient relationships and reduce the economic burden of health care on patients, doctors, and taxpayers by reducing unnecessary and costly hospital visits.[11]

  Therefore, the Secretary should modify the APM criteria such that if a model has a record of success in the private sector, it can be incorporated into Medicare without an additional four to seven years of testing.

- *Second, existing criteria exclude Medicare Advantage (MA) health plans, in which at least one-third of Medicare beneficiaries are currently enrolled.* According to a CMS report to Congress on the feasibility of integrating APMs in the Medicare Advantage payment system, the plans currently use multiple alternative payment approaches concurrently or over time, providing flexibility and an on-ramp to more advanced models. Current APM provisions lack such qualities, requiring providers to make the leap from traditional FFS to complex, risk-based models—a leap that is unreasonable for many, if not most, physician practices.[12] An analysis by the Health Care Payment and Learning Action Network reported that a substantial percentage of MA health care dollars in 2016 were in

9. U.S. Government Accountability Office, *HHS Should Set Priorities and Comprehensively Plan Its Efforts to Better Align Health Quality Measures*, GAO-17-5, October 2016, http://www.gao.gov/assets/690/680433.pdf (accessed June 8, 2017).
10. Aaron Mendelson, Karli Kondo, Cheryl Damberg, Allison Low, Makalapua Motúapuaka, Michele Freeman, Maya O'Neil, Rose Relevo, Devan Kansagara, "The Effects of Pay-for-Performance Programs on Health, Health Care Use, and Processes of Care: A Systematic Review," *Annals of Internal Medicine*, Vol. 166, No. 5 (March 2017), pp. 341–353, http://annals.org/aim/article/2596395/effects-pay-performance-programs-health-health-care-use-processes-care (accessed June 8, 2017).
11. For a full discussion of the DPC model, see Daniel McCorry, "Direct Primary Care: An Innovative Alternative to Conventional Health Insurance," August 6, 2014, Heritage Foundation *Backgrounder* No. 2939, http://www.heritage.org/health-care-reform/report/direct-primary-care-innovative-alternative-conventional-health-insurance.
12. The Centers for Medicare and Medicaid Services, *Alternative Payment Models & Medicare Advantage*, Report to Congress, https://www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/Downloads/Report-to-Congress-APMs-and-Medicare-Advantage.pdf (accessed June 8, 2017).

more advanced payment models, suggesting that MA could serve as a laboratory for truly innovative payment reform without additional risk to taxpayers.[13] In addition, counties with a high penetration of MA health plans have seen a spending reduction "spillover effect" that secures savings in fee-for-service Medicare.[14]

Therefore, the Secretary should leverage existing innovation in MA by allowing provider participation in MA to count toward the APM thresholds beginning in 2019. This will incentivize true innovation in Medicare and greatly expand physician access to successful APMs.

Conclusion

Secretary Price has broad discretion to promote efficiency, foster innovation, and give physicians and patients alike needed regulatory relief.

In the long term, Congress can expand these reforms by enacting policies to expand consumer control in Medicare and reduce government control. Today, provider payment decisions often reflect the impact of politics rather than the natural supply and demand requirements of the market. To curtail this politicization, Congress should fully replace government-run Medicare with premium support for private insurance, so that Medicare enrollees can exercise personal and direct control over the flow of health care dollars.[15] With the resulting decentralization of Medicare decision making, millions of consumers would be able to choose their plans, and providers and doctors would be paid primarily through privately negotiated contracts offered by health plans chosen by the enrollees themselves. In other words, the decentralization would create a system of free-market medical pricing.

Absent such reforms, physicians and the patients they treat will continue to be at the mercy of government regulators whose policy course transitions with each new administration.

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13. Health Care Payment Learning and Action Network, *Measuring Progress: Adoption of Alternative Payment Models in Commercial, Medicare Advantage and State Medicaid Programs*, The MITRE Corporation, 2016, http://hcp-lan.org/workproducts/apm-measurement-final.pdf (accessed June 8, 2017).
14. Garret Johnson, José F. Figueroa, Xiner Zhou, E. John Orav, and Ashish K. Jha, "Recent Growth in Medicare Advantage Enrollment Associated with Decreased Fee-for-Service Spending in Certain U.S. Counties," *Health Affairs*, Vol. 35, No. 9 (2016), pp. 1707–1715, http://content.healthaffairs.org/content/35/9/1707 (accessed June 8, 2017).
15. For an overview of this approach to reform, see Robert E. Moffit, "The Second Stage of Medicare Reform: Moving to a Premium Support Program," Heritage Foundation *Backgrounder* No. 2626, November 28, 2011, http://www.heritage.org/health-care-reform/report/the-second-stage-medicare-reform-moving-premium-support-program.