The Future of Medicare Physician Payment

Congress should take steps now to ensure the long-term stability of MACRA. This includes accounting for the effects of inflation on physician practice, improving MIPS measurement, implementing new APMs and providing opportunities to succeed through innovation and quality improvement.

Effect on Clinical Practice of Anti-Inflationary Medicare Physician Fee Schedule Policies

In 2019, doctors are essentially being paid at the same rate per unit of work as they were in 1998, despite general inflation of more than 50 percent over that period.[1] At the same time, clinical practice has become increasingly complex due to factors such as medical advances, the addition of new treatments, incorporation of electronic health data, new regulations, and growing patient demand for services. This drop in purchasing power cannot be ignored and creates an adverse incentive to increase volume rather than focusing on the quality and value of care. The *Medicare Access and CHIP Reauthorization Act* (MACRA) included legislated updates over the early years of the law's implementation. The following chart shows how these updates have been eroded due to budget neutrality and other factors:

Medicare Conversion Factor Annual Statutory vs. Actual Percentage Increases			
Year	***Statutory Update***	***Conversion Factor***	***Actual % Change Over Previous Year***
2016	+0.5%	$35.8043	**-0.34%**
2017	+0.5%	$35.8887	+0.24%
2018	+0.5%	$35.9996	+0.31%
2019	+0.25%	$36.0391	+0.11%

Unfortunately, Medicare payment rates are about to enter a six-year period of 0% updates, during which early MACRA incentives are also set to expire, meaning many will be faced with lower payment rates based on factors out of their control, not on the quality of care they are providing. The Medicare conversion factor over the next several years is likely to go down due to budget neutrality rules and changes in care patterns as our population ages.

The Merit-based Incentive Payment System (MIPS): Deficiencies in Implementation

For surgeons and their patients, MACRA implementation has failed to deliver on its promise of tying payment more closely to the value of care, typically described as the quality of care received for the cost to produce that care. However, many physicians are not currently assessed on the care they provide nor on the outcomes of the patients they see. Instead, most surgeons have their quality score assessed on broad, primary care focused quality measures that have no bearing on the outcomes of surgical care and provide no means for improvement. There are similar problems with methodology used for cost measurement in MIPS, and the information gathered about both cost and quality cannot be compared over the same patient(s) or the same episode of care.

[1] In 1998 the Conversion Factor was $36.6873. In 2019 despite MACRA legislated updates it was $36.0391.

Additionally, neither the cost nor quality category of MIPS looks at the entire team involved in the care of a given patient. In general, MIPS has failed to provide the opportunity for physicians to be rewarded for improving the value of care to the patient. Despite being of limited clinical value, these reporting programs are also costly to implement.

Few Advanced Alternative Payment Model (A-APM) Options
The Centers for Medicare and Medicaid Services (CMS) has yet to test or implement a single A-APM recommended by the Physician-focused Payment Model Technical Advisory Committee (PTAC), counter to the intent of Congress. This means that many surgeons have no option but to continue participation in the flawed MIPS program. Innovation requires the testing of many options to see what works, and it is becoming apparent that CMS will require additional urging or direction from Congress if the agency is to test physician developed models. Furthermore, as time passes MACRA requirements for A-APM participation continue to become more and more difficult to achieve and incentives to attract early participants into APMs are set to expire in 2024. These factors combined will ultimately close the door for individuals in many specialties from becoming qualified participants (QPs) in an A-APM.

Inflationary pressures continue to weigh on physician practices, yet for the reasons described above, physicians lack the opportunity intended by MACRA to be rewarded based on improving the quality and value of care they provide. Now is the time for Congress and stakeholders to come together to develop solutions.

Congressional Action

Faced with two decades of stagnant payment, looming cuts, and onerous requests for investment in new systems that CMS fails to implement, physicians are understandably frustrated and burned out. With Medicare playing a vital role in the delivery of health care in the United States, Congress must take steps to ensure that Medicare as a payer keeps pace with innovation and inflation by addressing reimbursement in a way that reflects the cost of medical care and the value of services provided to beneficiaries. Congress can do this by taking the following steps:

- Create an inflationary update mechanism for the Medicare conversion factor formula;
- Partner with physicians and other experts to improve the MIPS program;
- Urge CMS to work with stakeholders on measurement that informs patient and physician decisions;
- Extend the A-APM incentive payment beyond 2024 while directing CMS to test PTAC approved models; and
- Review A-APM participation thresholds to ensure surgeons and other can achieve QP status.

The American College of Surgeons will continue to pursue improvements to quality and value in MACRA. However, it is time for Congress to examine physician reimbursement in a way that is fair and incentivizes physicians to continue to take on risk, innovate in care delivery, and provide high quality of care to patients. [i]

[i] Current to April 2, 2019. Please contact ahp@facs.org for an updated version.