

**MACRA AND MEDICARE’S ELUSIVE QUEST FOR FAIRNESS AND
VALUE WITH PHYSICIAN PAYMENT POLICY: SPEEDING UP THE
TRANSITION TO “BIG MED”**

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ABSTRACT

This article traces the evolution of Medicare physician payment policy from the program’s beginning to the passage of the 2015 Medicare Access and CHIP Reauthorization Act (MACRA). Based on interviews, primary data sources, and an extensive review of the secondary literature, the authors provide an analysis of: (1) some of the most significant events, trends and factors that led to the Act’s passage, (2) MACRA’s basic design and the primary options it gives to physicians, and (3) the major concerns many physician representatives and health policy experts have about MACRA. As the majority of physicians will likely feel the need to join big medical groups in response to MACRA’s set of penalties and incentives, the authors conclude that MACRA essentially amounts to a massive gamble on the ability of large health care organizations and pay-for-performance schemes to improve the quality of patient care and restrain the overall rate of Medicare cost growth. MACRA’s contribution to the trend of increased vertical integration—physicians’ alignment with and employment in big health care systems that provide an entire continuum of care—raises concerns noted by many experts over: increased health care prices and total costs, excessive use of medical services, patients’ access to physicians, overall physician autonomy and morale, and decreased competition with the potential for monopolistic or oligopolistic exploitation of market share by larger and larger health care systems.

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I. INTRODUCTION

Part of President Lyndon Johnson's original political deal with the American Medical Association that helped create Medicare in 1965 was for the program to pay physicians based on their own charges, rather than on a standardized fee schedule created by health insurers or the government.¹ At the time, Aetna was using what in private insurance language was called "usual, customary, and reasonable" (UCR) reimbursement.² Under this approach, payments made to physicians were based on the regular, "usual" charge of the physician, assuming the charge to be within the range of "customary" fees in that geographic area for the same service, or if precedent was lacking, to be "reasonable."³ With patients no longer having to pay out of pocket (their Aetna plans paying instead), the UCR payment system was a bonanza for physicians who repeatedly raised their usual charges. Also, "[b]ecause payments were based on historical charges," notes John Iglehart, "there were wide discrepancies in payments to primary care physicians and specialists and to providers who practiced in different geographic areas."⁴

Medicare's leaders instructed the program's administrative intermediary, Blue Shield, to adopt Aetna's method of UCR.⁵ When Medicare began operation in 1966, the terminology changed slightly with "prevailing," replacing "customary," and UCR charges became "customary, prevailing and reasonable" (CPR) charges.⁶ CPR payment quickly proved inflationary. From 1970 through the 1980s, the average annual growth rate of Medicare's spending on physician services was 10.6%.⁷ By "the late 1980s, Medicare's physician expenditures were growing at more than double the rate of its hospital expenditures."⁸ "This divergence in" cost growth "was partly driven by the ... incentives" at the time under Medicare's new hospital reimbursement model (diagnosis-related groups, or DRGs), "which pushed more and more medical services out of inpatient

1. See Steven Findlay, *Health Policy Brief: Medicare's New Physician Payment System*, HEALTH AFF. 1 (2016), https://www.healthaffairs.org/doi/10.1377/hpb20160421.151319/full/healthpolicybrief_156.pdf.

2. Thomas L. Delbanco et al., *Paying the Physician's Fee — Blue Shield and the Reasonable Charge*, 301 NEW ENG. J. MED. 1314, 1315 (1979).

3. See Benson B. Roe, *The UCR Boondoggle — A Death Knell for Private Practice?*, 305 NEW ENG. J. MED. 41, 41 (1981).

4. John K. Iglehart, *Medicare's Declining Payments to Physicians*, 346 NEW ENG. J. MED. 1924, 1924 (2002).

5. Delbanco et al., *supra* note 2, at 1316.

6. *Id.*

7. PHYSICIAN PAYMENT REV. COMM'N, ANNUAL REPORT TO THE CONGRESS 17 (1992).

8. RICK MAYES & ROBERT A. BERENSON, *MEDICARE PROSPECTIVE PAYMENT AND THE SHAPING OF U.S. HEALTH CARE* 83 (2006).

hospital settings and into ambulatory settings, including physician offices.”⁹ “By 1989, Medicare’s Part B spending—most of which was for physician services—had become the single largest domestic program financed from general revenues.”¹⁰ As a result, elected officials and policymakers began looking for an alternative payment system.

In designing a new system to try to control the rate of cost growth, policy makers also focused on trying to make Medicare’s payment policy more fair.¹¹ “Under the CPR system, some services were reimbursed much more generously” relative to their costs than other services.¹² William Hsiao, a Harvard University health services researcher, had been studying physician competition under a government contract in the late 1970s, when his research took a detour that proved enormously consequential.¹³ “Most of the physicians I interviewed,” Hsiao said, “told me that the prices of physicians’ services were unfair.”¹⁴ He found that the value of surgical procedures was overstated by as much as four- to five-fold when compared to the value of a basic office visit.¹⁵ Procedures that had become routine or automated as a result of advances in technology were especially profitable, because the rates that had been previously established were never adjusted downward when they became less costly and easier to perform.¹⁶ As Robert Berenson has explained, economists refer to these as “downward sticky” prices.¹⁷ “Over time, Medicare’s CPR method for reimbursement ... effectively ratified” and entrenched these payment distortions.¹⁸

9. *Id.*; Interview with Stuart Altman, Economist and Professor, Nat’l Health Policy, Brandeis Univ. (July 22, 2002); Kathleen Carey, *Cost Allocation Patterns between Hospital Inpatient and Outpatient Departments*, 29 HEALTH SERVS. RES. 275, 275–76 (1994).

10. MAYES & BERENSON, *supra* note 8, at 83; Joseph P. Newhouse, *Medicare Policy in the 1990s* 7 (Nat’l Bureau of Econ. Research, Working Paper No. 8531, 2001).

11. MAYES & BERENSON, *supra* note 8, at 83.

12. *Id.*

13. Rick Mayes, *The Origins, Development, and Passage of Medicare’s Revolutionary Prospective Payment System*, J. HIST. MED. & ALLIED SCI., Jan. 2007, at 21, 24.

14. Telephone Interview by Rick Mayes with William Hsiao, K.T. Li Research Professor of Economics, Harvard Univ. (Oct. 22, 2002) (on file with author); Telephone Interview by Richard Shuster with William Hsiao, Acting Chief Actuary for Medical Programs under the Nixon Administration, Social Security Admin. (Aug. 23, 1995).

15. See William Hsiao & William Stason, *Toward Developing a Relative Value Scale for Medical and Surgical Services*, 1 HEALTH CARE FIN. REV. 23, 23 (1979).

16. See CONG. BUDGET OFFICE, REIMBURSEMENT UNDER MEDICARE: OPTIONS FOR CHANGE 31 (1986).

17. “Downward sticky” means that prices should go down due to increased efficiency or a reduction in input costs, but that they don’t because physicians and the system in which they operate resist it. Robert A. Berenson & John D. Goodson, *Finding Value in Unexpected Places — Fixing the Medicare Physician Fee Schedule*, 374 NEW ENG. J. MED. 1306, 1307 (2016).

18. MAYES & BERENSON, *supra* note 8, at 85.

Based on his team's research, Hsiao concluded that a physician's work "was a function of time spent, mental effort and judgment, technical skill and physical effort, and stress."¹⁹ Congress attempted to translate Hsiao's research into policy by creating the Physician Payment Review Commission (PPRC).²⁰ The PPRC's mission was to provide technical advice for Congress on transforming the conceptual product of Hsiao's research into a new physician payment system for Medicare.²¹

Building on Hsiao's work and adding other sources of data from specialty societies and Medicare administrative charge data, the PPRC ultimately submitted a set of recommendations to Congress in 1989.²² First, it called for a relative-value scale that would raise reimbursement rates to some physicians and lower them to others by basing physician payments on the resources—work, time, and costs—required to provide them.²³ It became known as the Resource-Based Relative-Value Scale (RBRVS).²⁴ "The RBRVS was trying to mimic the competitive market, in which the cost of a product should come very close to the cost for producing that product," according to Hsiao.²⁵ The PPRC's second recommendation was to institute limits or a mechanism that would "restrain the overall growth rate of Medicare's physician expenditures."²⁶ "If total Medicare spending on physician services exceeded this target in one year, payment rates would be adjusted downward the following year."²⁷ Policy makers called this mechanism the Volume Performance Standard (VPS).²⁸ Physicians hated the expenditure targets and VPS, comparing them to "rationing."²⁹

Congress incorporated the PPRC's recommendations into a budget reconciliation bill and "passed the new Medicare Physician Fee Schedule— together with annual expenditure targets—as the Omnibus Reconciliation Act of 1989."³⁰ When the new system finally began operation in 1992, it quickly had a noticeable impact. Annual growth in the volume and intensity of Medicare physician services in the first two years of the new reimbursement system were

19. Atul Gawande, *Piecework: Medicine's Money Problem*, NEW YORKER, Apr. 4, 2005, at 44.

20. Consolidated Omnibus Reconciliation Act of 1985 (COBRA), 29 U.S.C. § 9305 (2000).

21. For the best summary and analysis of the PPRC, see Thomas R. Oliver, *Analysis, Advice, and Congressional Leadership: The Physician Payment Review Commission and the Politics of Medicare*, 18 J. HEALTH POL. POL'Y & L. 113, 114, 137 (1993).

22. Iglehart, *supra* note 4, at 1924; see Oliver, *supra* note 21, at 127, 137–38, 150.

23. See Oliver, *supra* note 21, at 125; Iglehart, *supra* note 4, at 1925.

24. Oliver, *supra* note 21, at 125.

25. MAYES & BERENSON, *supra* note 8, at 87.

26. *Id.*

27. *Id.*

28. *Id.*

29. *Id.* at 88.

30. MAYES & BERENSON, *supra* note 8, at 89; Consolidated Omnibus Reconciliation Act of 1985 (COBRA), 29 U.S.C. § 6102 (2000).

the lowest in the program's history.³¹ In the five years after Medicare's fee schedule and expenditure targets went into effect, Part B spending rose at an average annual rate of just 4.4% (less than half the rate from the five-year period before the change).³² Moreover, from 1992 to 2002, payment rates for primary care services increased by forty percent relative to payment rates for all services.³³ This financial redistribution in favor of primary care physicians did not last, however, as specialty societies eventually reasserted their superior influence in both fee schedule recalculations and the adding of new procedure codes.³⁴

II. FROM THE SUSTAINABLE GROWTH RATE TO ANNUAL "DOC FIXES" AND MACRA 2015

In the 1997 Balanced Budget Act, Congress altered the calculation of Medicare's VPS by tying the program's spending-per-beneficiary on physician services to the rate of growth in the national economy, as measured by the gross domestic product.³⁵ This total expenditure limitation of the VPS was renamed the Sustainable Growth Rate (SGR).³⁶ The SGR was initially popular among physicians due to the fact that it resulted in annual payment updates that *exceeded* medical inflation.³⁷

The SGR's popularity did not last long, though. The recession in 2001, coupled with formula recalculations based on new data that had become available, led to an unprecedented 4.9% reduction in physician payments in 2002 (despite physicians' office expenses increasing that year by 2.6%).³⁸ The physician community was shocked; some doctors threatened to stop seeing Medicare patients.³⁹ When total Medicare expenditures for physician services

31. MAYES & BERENSON, *supra* note 8, at 89.

32. U.S. GOV'T ACCOUNTABILITY OFF., GAO-04-751T, MEDICARE PHYSICIAN PAYMENTS: INFORMATION ON SPENDING TRENDS AND TARGETS 5 (2004).

33. Paul B. Ginsburg, *Payment and the Future of Primary Care*, 138 ANNALS OF INTERNAL MED. 233, 233 (2003).

34. See MIRIAM J. LAUGESSEN, FIXING MEDICAL PRICES: HOW PHYSICIANS ARE PAID 35–36, 181–83 (2016).

35. PAUL SHEKELLE ET AL., S. CAL.–RAND EVIDENCE-BASED PRACTICE CTR., TECHNICAL REVIEW: DETERMINANTS OF INCREASES IN MEDICARE EXPENDITURES FOR PHYSICIANS' SERVICES 1 (2003).

36. GOV'T ACCOUNTABILITY OFF., GAO-05-85, MEDICARE PHYSICIAN PAYMENTS: CONCERNS ABOUT SPENDING TARGET SYSTEM PROMPT INTEREST IN CONSIDERING REFORMS 8 (2004).

37. Iglehart, *supra* note 4, at 1926.

38. *Id.*; Paul B. Ginsburg, *Rapidly Evolving Physician-Payment Policy — More Than the SGR*, 364 NEW ENG. J. MED. 172, 172 (2011).

39. Barbara Martinez, *Some Doctors Say They May Stop Seeing Medicare Patients After Cuts*, WALL ST. J. (Jan. 15, 2002), <https://www.wsj.com/articles/SB1011045837267109120> (last visited Feb. 22, 2018).

surpassed the target again the following year (and every year thereafter), the SGR formula generated another proposed cut of approximately 4.7% in Medicare fees for physicians for 2003. Rather than allow this to happen, Congress intervened and *raised* fees by 1.4% instead.⁴⁰ From 2003 to 2015, Congress enacted seventeen similar ‘doc fixes’—some years had multiple temporary SGR overrides—to prevent annual fee cuts from occurring.⁴¹ These ‘doc fixes,’ together with annual increases in the overall volume of patient care, resulted in total Medicare physician expenditures continuing to increase faster than the rate of either inflation or economic growth (*see* Figure 1).⁴²

Repeated Congressional interventions from 2003 to 2015 to block any reduction in Medicare’s physician fee updates compounded long-term budgetary problems.⁴³ These repeated ‘doc fixes’ fed back into the SGR formula, resulting in larger projected cuts in future years.⁴⁴ As a result, financial pressure continued to build year after year. By 2011, the SGR’s formula was calling for a 24.9% reduction in Medicare’s physician fees.⁴⁵ The cost of terminating the SGR altogether—by paying for the accumulated fee reduction projections—had risen to approximately \$300 billion.⁴⁶ As Gail Wilensky notes, “this game of ‘kick the can down the road’ became tiresome to both physicians and members of Congress.”⁴⁷

40. JIM HAHN, CONG. RESEARCH SERV., THE SUSTAINABLE GROWTH RATE (SGR) AND MEDICARE PHYSICIAN PAYMENTS: FREQUENTLY ASKED QUESTIONS 1 (2014), <http://www.ncsl.org/documents/statefed/health/SGRfaq3212014.pdf>.

41. *See* Robert Steinbrook, *The Repeal of Medicare’s Sustainable Growth Rate for Physician Payment*, 313 JAMA 2025, 2025 (2015).

42. MEDICARE PAYMENT ADVISORY COMM’N, A DATA BOOK: HEALTH CARE SPENDING AND THE MEDICARE PROGRAM 90 (2016).

43. Peter W. Carmel, *AMA: A New Opportunity to Fix the SGR*, KEVINMD (Sep. 15, 2011), <https://www.kevinmd.com/blog/2011/09/ama-opportunity-fix-sgr.html> (last visited Feb. 22, 2018).

44. *Id.*

45. *2011 MPFS Final Rule Reduces Pay Rates*, AAPC (Nov. 12, 2010), <https://www.aapc.com/blog/9110-2011-mpfs-final-rule-cuts-pay-rates/> (last visited Feb. 22, 2018).

46. Ginsburg, *supra* note 38, at 172–73.

47. Gail R. Wilensky, *Developing a Viable Alternative to Medicare’s Physician Payment Strategy*, 33 HEALTH AFF. 153, 154 (2014).

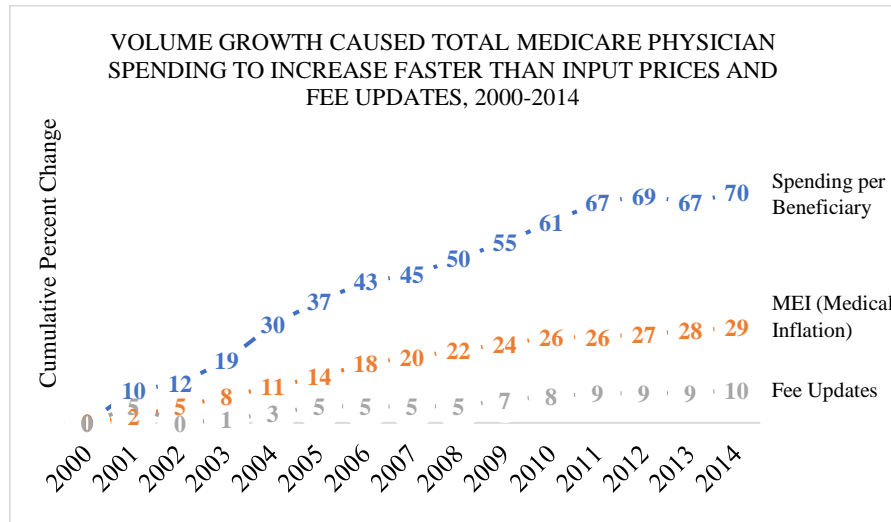


Figure 1. Yearly Medicare Spending Compared to MEI and Fee Increases⁴⁸

Besides being a blunt approach to trying to restrain total cost growth, the SGR also created unintentional and “perverse incentives for individual physicians to increase” the volume of care they provided.⁴⁹ These perverse incentives made the system more unfair. In other words, the SGR’s formula-driven, mandated fee cuts (which Congress simply postponed) were to be applied evenly to all physicians even though certain physicians in some specialties in a few states contributed disproportionately to the excessive Medicare expenditures.⁵⁰ For example, compared to physicians in Vermont, Maine, and North Dakota, physicians in New York, Florida, and Texas overshot their per capita SGR targets by eighty percent between 2003 and 2009.⁵¹ During this same period, cardiologists as a group overshot their SGR target by seventy-nine percent compared to general surgeons who undershot their estimated target by 106%.⁵²

Finally, in 2015, the SGR’s growing unpopularity with physicians, Democrats, and Republicans intersected serendipitously with two events, the first of which was a surprise. The annual rate of overall health care cost growth slowed considerably following the passage of both the Patient Protection and

48. MEDICARE PAYMENT ADVISORY COMM’N, A DATA BOOK: HEALTH CARE SPENDING AND THE MEDICARE PROGRAM 89 (2016).

49. See Robert A. Berenson, *Interactions Between the SGR and RBRVS: Making Sense of Alphabet Soup*, HEALTH AFF.: BLOG (Feb. 13, 2008), <http://healthaffairs.org/blog/2008/02/13/interactions-between-the-sgr-and-rbrvs-making-sense-of-alphabet-soup/> (last visited Mar. 4, 2018).

50. See Ali Alhassani et al., *Perspective, The Sources of the SGR “Hole”*, 366 NEW ENG. J. MED. 289, 289 (2012).

51. *Id.* at 290–91.

52. *Id.* at 291.

Affordable Care Act in 2010 and the Budget Act of 2011, the latter of which included sequestration (an automatic, across-the-board two percent reduction in Medicare payments to medical providers).⁵³ These developments led to the Congressional Budget Office dramatically reducing the estimated budgetary cost of terminating the SGR from roughly \$300 billion to around \$136 billion.⁵⁴ Second, funding for the Children's Health Insurance Program (CHIP), which provides subsidies to cover children in low-income families who are not poor enough to qualify for Medicaid, was set to expire in 2015.⁵⁵ As a result, in a rare display of bipartisanship, Congress voted overwhelmingly—392 to 37 in the House and 92 to 8 in the Senate—to scrap the SGR, to extend CHIP funding for two years, and to transition to a new physician payment system with the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) on April 14, 2015.⁵⁶

III. MACRA BASICS AND PHYSICIANS' OPTIONS

MACRA made a number of major changes to physician reimbursement. First, it locked in provider payment rates at near zero growth until next year (2019).⁵⁷ Second, most health care professionals who see Medicare patients are expected to participate in one of two separate Quality Payment Programs (QPPs): Merit-based Incentive Payment System (MIPS) or advanced Alternative Payment Models (APMs).⁵⁸ Both programs strive to reward health care professionals who provide high quality, efficient care instead of a higher quantity of services. MIPS streamlines the Physician Quality Reporting Program (PQRS), Value-Based Payment Modifier (VM), and Medicare Electronic Health Records (EHR) Incentive Program into a single composite score based on

53. STACEY MCMORROW & JOHN HOLAHAN, URBAN INST., *THE WIDESPREAD SLOWDOWN IN HEALTH SPENDING GROWTH: IMPLICATIONS FOR FUTURE SPENDING PROJECTIONS AND THE COST OF THE AFFORDABLE CARE ACT 6* (2016), https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf429930.

54. Henry J. Aaron, *Three Cheers for Logrolling — The Demise of the SGR*, 372 *NEW ENG. J. MED.* 1977, 1977 (2015).

55. Elisabeth Wright Burak, *Medicare Access and CHIP Reauthorization Act of 2015: Summary of Key Provisions Impacting Children*, *GEO. HEALTH POL'Y INST. CTR. FOR CHILDREN & FAM.* 1 (2015), <https://ccf.georgetown.edu/wp-content/uploads/2015/11/MACRA-Kids-Brief-October-update.pdf>; Anthony T. Lo Sasso & Thomas C. Buchmueller, *The Effect of the State Children's Health Insurance Program on Health Insurance Coverage*, 23 *J. HEALTH ECON.* 1059, 1059 (2004).

56. Gail Wilensky, *The "Doc Fix" is Over, but Unresolved Concerns Linger*, 313 *JAMA* 2211, 2211–12 (2015).

57. *Id.* at 2212.

58. Peggy Eastman, *CMS Proposes Rule on Implementing Quality Payment Program Under MACRA*, *ONCOLOGY TIMES*, Aug. 2017, at 24, 24.

Quality (fifty percent), Clinical Practice Improvement Activities (fifteen percent), and Advancing Care Information (twenty-five percent).⁵⁹

The other option for physicians who receive a significant share of their revenue or patient counts from Medicare is to join an advanced Alternative Payment Model (APM).⁶⁰ Advanced APMs differ from other APMs by allowing providers to earn more by taking on some of the financial risk related to patient care.⁶¹ Specifically:

[a]n APM will qualify as an advanced APM in 2019 and 2020 if the APM entity is (1) at risk of losing 8 percent of its own revenues when Medicare expenditures are higher than expected, or (2) at risk of repaying CMS up to 3 percent of total Medicare expenditures, whichever is lower.⁶² CMS states that it plans to increase the risk standard to 10 or 15 percent of revenues in future years.⁶³

APM participants will be exempt from MIPS and qualify for incentive payments from 2019 to 2024.⁶⁴ Participation in the advanced APM path will lead to a five percent incentive payment in 2019.⁶⁵ Advanced APMs require physicians to use certified EHR technology, use quality measures like those in MIPS, and bear more than a “nominal” amount of risk for monetary losses.⁶⁶ Possible models of eligible advanced APMs include Medicare Shared Savings Programs, Next Generation ACO Models, Oncology Care Model Two-Sided Risk Arrangements, and Comprehensive End-Stage Renal Disease Care Models.⁶⁷

Small physician practices face a threat from MACRA.⁶⁸ Unless major changes are made to MACRA's structure or implementation, many physicians—seeking to avoid the onerous administrative requirements and financial risk of MIPS—will eventually be confronted with having to join either a medical home demonstration project, a large single-specialty practice, or a big accountable care

59. Wilensky, *supra* note 55, at 2212; Jeffrey D. Clough & Mark McClellan, *Implementing MACRA: Implications for Physicians and for Physician Leadership*, 315 JAMA 2397, 2398 (2016).

60. Peter S. Hussey et al., *The Medicare Access and CHIP Reauthorization Act: Effects on Medicare Payment Policy and Spending*, 36 HEALTH AFF. 697, 698 (2017).

61. CTRS. FOR MEDICARE & MEDICAID SERVS., *APMs Overview*, QUALITY PAYMENT PROGRAM, <https://qpp.cms.gov/apms/overview> (last visited Feb. 15, 2018).

62. *Medicare Access and CHIP Reauthorization Act (MACRA) Quality Payment Program Final Rule*, AM. MED. ASS'N 4 (Oct. 19, 2016), <https://www.ama-assn.org/sites/default/files/media-browser/public/physicians/macra/macra-qpp-summary.pdf>.

63. *Id.*

64. Clough & McClellan, *supra* note 58, at 2397; Hussey et al., *supra* note 59, at 698–99.

65. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 60.

66. See *MACRA: Disrupting the Health Care System at Every Level*, DELOITTE, <https://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/macra.html> (last visited Feb. 10, 2018).

67. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 60.

68. Rick Mayes, *MACRA, Physicians, & “Big Med”*, VIEWPOINTS: HEALTH POL'Y BLOG UVA PUB. HEALTH SCI., <https://med.virginia.edu/phs/2018/01/19/mayes-macra-physicians-bigmed/> (last visited Feb. 13, 2018).

organization (ACO) that assumes significant two-sided or “downside risk” of financial losses on patient care.⁶⁹ The Medicare Payment Advisory Commission, which Congress relies upon for independent analysis and advice on Medicare payment policy, wrote in August of 2017 that sensible, good-faith implementation modifications to MIPS to make it more flexible have also made it more complex and likely to “promote only silos of care, not the totality and coordination of patient care.”⁷⁰ Further, the integrity of measuring the quality and costs of individual physicians under MACRA has been called into question given that the patient care provided by 234,000 nurse practitioners (NPs) was connected to physicians due to NPs’ use of “incident to billing” for reimbursement from Medicare.⁷¹ How will the NP’s care affect physicians’ quality scores? Given these and other concerns, Congress should seriously consider repealing MIPS.

With the increased administrative costs and financial risk associated with participating in MIPS, hospitals and other large health care delivery systems will probably come to be seen by many physicians as safe ports in the financial storm caused by MACRA.⁷² Estimates from the RAND Corporation are that “MACRA will decrease Medicare spending on physician services –\$35 to –\$106 billion (–2.3 percent to –7.1 percent) and change spending on hospital services by \$32 to –\$250 billion (0.7 percent to –5.1 percent) in 2015-30.”⁷³ The rate of Medicare spending growth on physician care will slow at the same time that the majority of hospitals have been losing money treating Medicare patients (with their overall financial solvency saved by higher payments from private patients).⁷⁴ Moreover, while the explanation of MACRA’s details in this paper may seem complex, they are a very simplified version of the 823-page MACRA final rule.⁷⁵ “Faced with MACRA’s complexity and the financial risk it introduces,”

69. Clough & McClellan, *supra* note 58, at 2398.

70. Medicare Payment Advisory Comm’n, Comments on Proposed Rule, Medicare & Medicaid Services Medicare Program: CY 2018 Updates to the Quality Payment Program, CMS-5522-P 5 (Aug. 18, 2017), http://www.medpac.gov/docs/default-source/comment-letters/08182017_cms5522p_qualitypaymentprogram_comment_v3_sec.pdf?sfvrsn=0.

71. Peter Buerhaus et al., *The Integrity of MACRA May Be Undermined by “Incident to Billing” Coding*, HEALTH AFF.: BLOG (Jan. 8, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180103.135358/full/> (last visited Mar. 5, 2018).

72. *5in5: Hospitals Can Be MACRA Mediators*, OPTUM, <https://www.optum.com/resources/library/manage-MACRA-through-hospital-physician-partnerships.html#main-content> (last visited Feb. 25, 2018).

73. Hussey et al., *supra* note 59, at 697–703.

74. See MEDICARE PAYMENT ADVISORY COMM’N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 84–85 (2017).

75. Quality Payment Program, 82 Fed. Reg. 53,568, 53,568 (Nov. 16, 2017) (to be codified at 42 C.F.R. pt. 414); Lawrence P. Casalino, *The Medicare Access and CHIP Reauthorization Act and the Corporate Transformation of American Medicine*, 36 HEALTH AFF. 865, 867 (2017).

observes Larry Casalino, “many physicians are likely to throw up their hands, [and] say ‘this is the last straw—I can’t take it anymore.’”⁷⁶

IV. SUMMARY ANALYSIS AND DISCUSSION: MACRA AND “BIG MED”

Since the 1980s, Medicare payment policy in general and physician reimbursement reforms in particular have preoccupied many elected leaders, Medicare officials, private insurance executives, and other health care payors. Their primary goals have been increased value for patients and those who pay for care, along with expanded control over the rate of total health care cost growth.⁷⁷ As such, MACRA is just the most recent major reform initiative. It reflects the inescapable reality that “there are many mechanisms for paying physicians; some are good and some are bad,” as James Robinson notes.⁷⁸ Robinson explains further:

The three worst are fee-for-service, capitation, and salary. Fee-for-service rewards the provision of inappropriate services, the fraudulent upcoding of visits and procedures, and the churning of ‘ping-pong’ referrals among specialists. Capitation rewards the denial of appropriate services, the dumping of the chronically ill, and a narrow scope of practice that refers out every time-consuming patient. Salary undermines productivity, condones on-the-job leisure, and fosters a bureaucratic mentality in which every procedure is someone else’s problem.⁷⁹

MACRA, like Medicare Advantage and various physician payment models in the private sector, encourages payment innovations that blend the different payment approaches to mitigate the undesirable dynamics of pure fee-for-service, capitation, or salaried physician reimbursement.

Yet MACRA also amounts to something of a gamble on the ability of big health care organizations to improve the quality of patient care and restrain cost growth. This gamble reflects a belief among many employers, elected officials, and members of the health policy community that (1) pay-for-performance schemes for health professionals work⁸⁰ and that (2) Medicare must shift from a volume-to-value reimbursement model that moves away from fee-for-service payment.⁸¹ Yet the evidence for this belief is “thin, mixed, and preliminary.”⁸² Consistently and accurately measuring quality in health care and then paying for

76. LAUGESSEN, *supra* note 34, at 67.

77. LAUGESSEN, *supra* note 34, at 47–67.

78. James C. Robinson, *Theory and Practice in the Design of Physician Payment Incentives*, 79 MILBANK Q. 149, 149 (2001).

79. *Id.*

80. See Robert Berenson, *If You Can’t Measure Performance, Can You Improve It?*, 315 JAMA 645, 646 (2016).

81. Berenson & Goodson, *supra* note 17, at 1306.

82. Jonathan Oberlander & Miriam J. Laugesen, *Leap of Faith — Medicare’s New Physician Payment System*, 373 NEW ENG. J. MED. 1185, 1186 (2015).

it appropriately has proven to be exceedingly difficult in the United States.⁸³ Changing physician behavior, as Gail Wilensky has shown, is almost always harder than policy makers assume.⁸⁴ Health care spending varies more across individual physicians than across hospitals,⁸⁵ as some physicians in various forms of practice organization respond better to rules, others to incentives.⁸⁶

Meanwhile, the physician community generally resents what it perceives as non-clinician micromanagement of their behavior.⁸⁷ Until the past two years, the majority of physicians chose to not even submit various quality (Physician Quality Reporting System, or PQRS) data to Medicare and simply accepted a one to two percent penalty in their reimbursement fees due to the expense and onerous work involved in submitting the data.⁸⁸ Physicians already report greater stress and frustration over caring for their patients while spending more time dealing with external quality measures.⁸⁹ Their frustrations are only likely to increase with MACRA's acceleration of the corporate transformation of American medicine.⁹⁰ In addition, if this "once-in-a-generation transformation from a fee-for-service system to alternative payment models" occurs, some specialists stand to lose income and power to primary care physicians.⁹¹ The kinds of shared savings programs that are most likely to qualify as advanced APMS under MACRA aim to reward the chronic disease management and prevention activities of primary care physicians and to reduce the use of imagining services, diagnostic tests, and physician procedures that are the basis of specialist reimbursement.⁹²

Ultimately, policy makers' leap of faith with MACRA may turn out to fit with what Miriam Laugesen has found to be the "long-standing pattern in U.S. health policy: overconfidence in the level of policy disruption occurring and,

83. See Elizabeth A. McGlynn, *Six Challenges in Measuring the Quality of Health Care*, HEALTH AFF., May–June 1997, at 7–8, 17–18.

84. See Gail Wilensky, *Changing Physician Behavior Is Harder Than We Thought*, 316 JAMA 21, 21 (2016).

85. Yusuke Tsugawa et al., *Variation in Physician Spending and Association with Patient Outcomes*, 177 JAMA INTERNAL MED. 675, 679 (2017).

86. Alan L. Hillman, *Managing the Physician: Rules Versus Incentives*, HEALTH AFF., Winter 1991, at 138, 143–46.

87. See *id.* at 138, 146.

88. Robert A. Berenson & Deborah R. Kaye, *Grading a Physician's Value — The Misapplication of Performance Measurement*, 369 NEW ENG. J. MED. 2079, 2079 (2013).

89. Phillip Miller, *The Medical Profession's Future: A Struggle Between Caring for Patients and Bottom-Line Pressures*, 35 HEALTH AFF. 407, 408 (2016).

90. Casalino, *supra* note 74.

91. See Robert Kocher & Anuraag Chigurupati, *The Coming Battle Over Shared Savings — Primary Care Physicians Versus Specialists*, 375 NEW ENG. J. MED. 104, 104–05 (2016).

92. See David J. Nyweide et al., *Association of Pioneer Accountable Care Organizations vs Traditional Medicare Fee for Service with Spending, Utilization, and Patient Experience*, 313 JAMA 2152, 2153, 2158 (2015).

relatedly, underestimation of the potential for strategic adaptation by providers.”⁹³ Most payors see no alternative, however, given that health care now accounts for eighteen percent of GDP and continues to squeeze out spending on other priorities.⁹⁴ A critical question, argues Robert Berenson, is whether physician leaders will be able to actively guide the evolution of large health systems, including APMs, “to increase quality, reduce costs, and reaffirm a (perhaps updated) form of professionalism or, alternatively, passively accept a transformation in the body and soul of American medicine.”⁹⁵

93. Miriam J. Laugesen, *Payment Policy Disruption and Policy Drift*, 40 J. HEALTH POL., POL'Y & L. 839, 839 (2015).

94. See Donald M. Berwick, *Era 3 for Medicine and Health Care*, 315 JAMA 1329, 1329–30 (2016); *National Health Expenditure Data: Historical*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html> (last visited Feb. 27, 2018).

95. Robert A. Berenson, *A Physician's Perspective on Vertical Integration*, 36 HEALTH AFF. 1585, 1589 (2017).

