

New Medicare Payment Rule: a Trojan Horse for Government Takeover

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Promises Betrayed

In 1965, President Lyndon Johnson signed the Social Security Act Amendments into law, creating Medicare and Medicaid with the promise that the federal government would not interfere in any way with the practice of medicine, including compensation, administration, or operation of any institution, agency, or person. In spite of the government's pledge not to interfere with the practice of medicine, the law has been continuously amended to an extent that now places it in violation of Title XVIII SEC. 1801, *The Prohibition of Any Federal Interference*.¹ Our profession, the heart and the art of medicine, is being commandeered, if not lost.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is the antithesis of what government promised when it created Medicare. MACRA massively increases government control over patients, physicians, and the practice of medicine, proving once again that a government pledge is worthless.

Once Congress passes a law such as MACRA, the President signs it and sends it to a federal regulatory agency, such as the Centers for Medicare and Medicaid Services (CMS) in the case of MACRA, to write rules for its implementation. Through this rule-making process, Executive Branch agencies have effectively become a fourth branch of government. On May 9, 2016, CMS published a proposed MACRA rule of 426 pages in the Federal Register.² There are also versions of 625 pages or 962 pages. The table of contents alone spans 12 pages. What is in the MACRA rule CMS has promulgated? And what do the rules portend for the future of medical care in the U.S.? The CMS MACRA rule epitomizes brazen overreach by an Executive Branch agency, including expansion of powers, changing the intent of the law, and violation of Constitutional rights of the people.

Medical care has been criminally politicized. On one side, statist elites regard the citizenry as stupid and incapable, while regarding themselves as wiser, superior, and empowered to conduct our lives. They produce voluminous laws and regulations, dictating all aspects of life, including our personal medical care. This side brought us the so-called Patient Protection and Affordable Care Act (ACA) or "ObamaCare." On the other side, those who were elected on promises to stand against the statist and get rid of ACA succumb to outside influences and fall into line, neutered, inside the Washington, D.C., Beltway bubble. This side also voted overwhelmingly for MACRA. Rarely is anyone heard advocating freedom and for leaving people alone to conduct their own lives. Both sides are inherently self-serving.

The Concepts behind MACRA

MACRA was passed with massive bipartisan support, sold as the Medicare Sustainable Growth Rate (SGR) repeal. In reality, it is a replacement bill that is not a step toward freedom, but rather a Trojan horse. MACRA sets forth the Merit-Based Incentive Payment System (MIPS), Alternative Payment Models (APMs), and the Composite Performance Score (CPS), whereby physicians are scored and either incentivized or penalized based on their performance on the basis of a complex, experimental government rubric.

A false premise of epic proportion is that a carrot-and-stick system tied to a government rubric is necessary to drive physicians toward "quality" performance. This implies that physicians are not providing high-quality, high-value care. This implies that government knows better than physicians, who presumably are motivated only by money or fear of public humiliation. Despite the fact that physicians spend their lives training and serving their patients to the very best of their abilities, it is assumed that they need a government scheme for communicating expectations and evaluating performance.

The MIPS, APMs, and CPS are untested, unproven remedies for underlying medical payment problems born of Medicare, Medicaid, "ObamaCare," and commercial "insurance" that have evolved into pre-paid medical care. The rules further aggravate existing problems by creating layers of new intermediaries with billions of dollars of new expenses, changing the intent of the law, furthering wealth redistribution, and violating people's rights. The money to pay for this does not exist. The MIPS/APM/CPS concepts for scoring and grading physicians through financial incentives and penalties in order to drive behavior would, in other contexts, be called bribery and extortion.

Physicians objected to the MACRA rule in more than 4,000 public comments.³ I submitted nine "Daily Dissents"⁴ regarding MACRA to CMS and traveled to Washington, D.C., to meet with CMS Acting Administrator Andy Slavitt and his MACRA rule-making team. The following is a glimpse into my meeting, dissents, and proposed solutions.

The Effects of MACRA on Small Practices

CMS acknowledges that the MACRA rule will harm small practices and put them out of business in short order. Are we to presume this is the intent of MACRA or the CMS rule? MACRA's own tables and numbers are telling.

Table 64 projects that 87% of "Eligible Clinicians" who are

solo practitioners will receive a negative payment adjustment, as will 70% of those in practices of two-to-nine physicians, and 60% of physicians in practices of 10-to-24 physicians. Combined, 73% of physicians in practices with fewer than 25 physicians will have payments cut, as will 60% of all eligible clinicians practicing in groups of fewer than 100. Loss of these practices would shatter patient care.

What are the ramifications of this for the states?

According to information from the Texas Medical Association,⁵ more than 60% of Texas physicians practice in groups of one to three. Under MIPS, according to Table 64 of the rule, more than 80% of such practices will be forced out of business. Their patients will lose their doctors and access to medical care—and possibly their lives.

A July 2015 AMA article⁶ notes that the majority of America's physicians still work in small practices: "These data show that the majority (60.7 percent) of physicians were in small practices of 10 or fewer physicians, and that practice size changed very little between 2012 and 2014 in the face of profound structural reforms to health care delivery," said AMA's then-president-elect Andrew W. Gurman, M.D.

The CMS response to the expected negative effects of MACRA on small practices is that 1) it represents an improvement over the current situation; 2) the deleterious effects on the vast majority of America's medical practices might not be so widespread as data suggests, and 3) it is offering assistance for small practices.

Based on 2014 data, only 62% of small practices were participating in the Physician Quality Reporting System, but CMS speculates that more will participate and do better participating in MIPS.⁷ (Along with most of my colleagues, I contend that fewer of us will participate in MIPS, and that those who do will fare worse.)

CMS notes⁸ that the negative adjustment factor associated with the MACRA MIPS is only 4% instead of the 9% cut in Part B Medicare payments that would have been imposed for failure to attest to Meaningful Use or report to the Physician Quality Reporting System (PQRS) by 2017. But that partial truth is misleading. First, the 4% cut will be imposed on the lowest quartile of compliers, while the best compliers will get an 8.7% positive adjustment and bonus, for an overall disparity in pay of 12.7%. (See Figure A: Illustrative Example of MIPS Adjustment Factors Based on Composite Performance Scores (CPS).²) This is just for the first year, 2019, based on work done in 2017, just 4 months from now. Each year the penalty and resultant pay disparity will increase, and in a mere 3.25 years, the penalty will be 9% for the lowest compliers, compared to the incentive and bonus of 9.9% for top compliers, for a combined difference of 19%.

Regarding assistance, the rule states that MACRA provides for "Technical assistance to MIPS Eligible Clinicians in small practices, rural areas, and practices located in Health Professional Shortage Areas (HPSA)." The Secretary is required to enter into contracts or agreements with appropriate entities (such as quality improvement organizations, regional extension centers, or regional health collaboratives) to offer guidance and assistance to MIPS eligible clinicians in practices of 15 or fewer.

Details will be addressed in a separate guideline.

The Department of Health and Human Services (HHS) recently approved \$100 million in assistance to small practices of fewer than 15 physicians and rural practices over the next 5 years, at \$20 million per year.⁹ While \$20 million is an attention-getting amount, when one does the math it amounts to an inconsequential amount of help for each small practitioner. According to the now infamous Table 64, there are 761,342 "Eligible Clinicians." This financial assistance amounts to \$26.27 per clinician per year. If the \$20 million is distributed only to those who practice in groups of less than 10, it comes to \$88.31 per clinician per year. Considering the cost of the electronic health record alone, the government assistance of \$26 to \$88 per year has negligible impact, yet is lauded by a poorly informed press. The funds actually go to the "appropriate entities" that have agreements with the Secretary of HHS. These organizations will "help" physicians.

The source of the money is not stated, but clearly it will be diverted from something else. It would be better spent directly on patient care than on expanding new classes of intermediaries to extend government reach into the physician's office. This is a prime example of administrative waste, if not propaganda.

MACRA and Patient Privacy

Implementation of MACRA is tied inextricably to the use of Certified Electronic Health Record Technology (CEHRT).

In his 2016 inaugural address¹⁰ as AMA president, Andrew Gurman, M.D., an orthopedic hand surgeon in solo practice, said, "I don't have an Electronic Health Record." He added that he found it easier to forgo the enhanced payments he would get under the federal Meaningful Use regulations for converting to electronic records. "I just take the penalties," he said.

Many small practices are not going to adopt CEHRT. It is not only very costly; it has numerous other drawbacks. It is not specialty or practice-specific; it makes one less efficient and distracts from patient-focused care; it can "go down," leaving the practice without access to patient records; and so on. A recent study¹¹ showed 89% of surveyed health care providers experienced a data breach in the last 24 months, with ransomware becoming a growing threat.

The most dangerous part of the MACRA rule is the possibility that the ONC (Office of the National Coordinator for Health Information Technology) and its ONC-ACBs (ONC-Authorized Certification Bodies) could be granted unrestricted access to all individually identifiable protected health information in CEHRT without patients' authorization under any circumstance. This constitutes unreasonable search and seizure of patients' most intimate papers and effects, a monstrous violation of our Fourth Amendment rights. Patients' medical records are not lawfully subject to government surveillance. Most Americans will agree. Knowing a federal government agency has attempted to grasp such authority for itself makes it a violation of the physicians' professional code of ethics to even engage in use of CEHRT. Our ethical duty is to keep our patients' data from government, not transmit it to government. The potential for misuse of such information is unacceptable.

Further, there is no way to protect patients' data and prevent ransomware insertion and hacking of patients' demographic data, as well as details of their individually identifiable medical history past, present, and future.

Random CMS audits of such data, including patient medical records, are unacceptable. This would introduce layer upon layer of new administrative costs (and mistrust) and potential data breaches. The fact that CMS wants the data kept, for 10 years at minimum to eternity, with all but a 30-day notice, is very concerning.

With the proposed inclusion of other-payer and all-payer data, CMS is using the rule-making process to expand its scope of power to incorporate commercially insured patients and their data under the agency's control, not just Medicare patients. This unconstitutional power grab paves the way for single-payer socialized medicine.

The collection of MIPS and non-MIPS data by third-party intermediaries, such as the self-nominated Qualified Clinical Data Registries (QCDRs) and Health IT vendors, of all patients and all insurers, is beyond overreach and must be struck down. Third-party entities have no right to collect, buy, and sell American patients' personal data.

Americans also need to ask the projected cost of the massive expansion of third-party intermediaries created to collect, analyze, and report patient data, including the Health IT vendors, qualified registries, and CMS-approved survey vendors. Table 60 from the proposed MACRA rule projects a total gross burden of \$1.33 Billion annually for record keeping and reporting alone. Who bears this cost?

The Effects of MACRA Rubrics

If CMS can continue to modify the definition of Eligible Clinicians (ECs) and Eligible Professional (EPs), it can change the scope of practice for many medical workers. This untested change could result in overuse of resources by mid-level clinicians and increased risk for patients. Such changing of definitions using agency rule-making subjects more and more workers to CMS control, and patients to unproven care by less-trained providers.

The power of the HHS Secretary to re-weight performance categories is risky and should be limited and defined. The CPS rubric is already based on perverse incentives. Allowing the Secretary to re-weight the categories amplifies the potential deleterious effects of this perversity.

For example, consider the resource-use performance category score and Table 21, "Example of Using Benchmarks for One Sample Measure to Assign Points."² Physicians who spend the least on their patients get 10 points, while those who spend the most on their patients get zero. Thus, physicians are incentivized not to spend money and resources on patients. CMS already has access to all resource use; there is no need for physicians to report this data. If the Secretary unilaterally decided to maximally weight the Resource Utilization Category, she could eliminate all physicians except those who spend the least on patients, in other words, who ration the most and deny the most care.

Capitation, proposed for APMs, was tried and rejected in the HMOs of days gone by. What evidence points toward APM success with capitation going forward? Note that many of the "ObamaCare" co-ops and Accountable Care Organizations (ACOs) have already failed, in spite of massive government subsidy.

In order to be deemed an Advanced APM, an APM must assume financial risk. In other words, physicians must act as insurance companies, a role for which they have neither the training nor the financial resources.

Established by Sec. 1115A of ACA to select and test innovative payment and service delivery models, the Center for Medicare and Medicaid Innovation (Innovation Center), works directly with CMS and has collaborated with these federal agencies: Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA), Agency for Healthcare Research and Quality (AHRQ), Office of the National Coordinator for Health Information Technology (ONC), Administration for Community Living (ACL), Department of Housing and Urban Development (HUD), Administration for Children and Families (ACF), Substance Abuse and Mental Health Services Administration (SAMHSA), and "colleagues throughout the federal government" to test new models and execute mandated demonstrations. This broad collaboration exponentially increases risks for data breach, individual targeting, and worse, when considering the army of 90,000 IRS agents and innumerable computer hackers. Patients' data is exposed to intrusion by data seekers, dealers, and manipulators.

Physician Response

As burgeoning coercive federal medical care laws and increasing government intrusion into the patient-physician relationship collide head-on with our lives of service, our commitment to our patients, our confidential relationships, and the Oath of Hippocrates, physicians must ask, "If I do this, what will I not do?"

We cannot rely on the American Medical Association (AMA) or specialty societies such as the American College of Physicians (ACP), which no longer represent the will or best interests of physicians and patients. Formerly prestigious organizations like the American Board of Internal Medicine (ABIM), under the American Board of Medical Specialties (ABMS), have come under scrutiny for corruption, questionable lobbying, and unscrupulous financial activities, including a professional testing-for-profit (Maintenance of Certification) scheme that undermines the trust of all physicians. Corporate greed of a growing medical-industrial complex has supplanted patient service, medical ethics, and integrity.

In the era of ObamaCare, ever-rising costs of premiums, deductibles, co-pays, and cost-sharing through the ACA "exchange plans" and all commercial "insurance," accompanied by restrictive networks of physicians and poor patient access to care, have become the norm. Emergence of fourth-party entities such as pharmacy benefits management companies, requiring prior authorizations, step edits, and quantity limits, are denying prescriptions while drug costs explode. Routine

prior-authorization delays and insurer denials subject patients to prolonged pain and suffering.

Despite government subsidies, insurance companies are pulling out of the state ACA Exchanges because of massive financial losses as the insurance death spiral proceeds. According to the 2015 National Health Interview Survey published by the Centers for Disease Control and Prevention (CDC),¹² the same percentage of people remain uninsured now as 10 years ago, but more patients are on Medicaid (government welfare) and fewer on commercial insurance. Medicaid and Medicare are in abysmal financial condition, putting the nation at risk of economic collapse in the not-too-distant future.

The MACRA rule states that its intent is to drive physician behavior, and the numbers published in the proposed rule support this. Apparently, CMS rulemakers mean to end small private practices and drive physicians to large groups. I suggested in my comments to allow practices of fewer than 100 physicians to choose not to participate in MIPS or APMs, and settle for no adjustment factor, in lieu of so much expense and interference. This would save money, resources, and error.

I invited Andy Slavitt and his staff to visit my office, my staff, and my patients in San Antonio. I would love to show, first-hand, a real-life model of quality/value medicine provided with greatest access at a fraction of the cost and, conversely, how top-down intrusion from government is making it more difficult and more expensive for my patients and me.

Physicians in the smallest practices offer an exemplary model. Our patients have our cell-phone numbers. We live and work in the same communities as our patients. Our staffs are well trained, cross-trained, fully employed, and loyal. We have trimmed our budgets, negotiated lower fees, cut waste, paid off equipment, and make things easy and accessible for our patients. The MACRA rubric is an intrusion, an insult, and a sign of lack of insight into that which government seeks to control.

But ultimately, private physicians cannot ethically comply with MACRA. Enabling such a dysfunctional system is unethical, if not inhumane. Without our complicity, their plans will fail. Doctors can care for patients without MACRA; MACRA can't care for patients without doctors.

Many physicians, like me, have opted out of all third-party agreements including Medicare, and we are not subject to malevolent manipulation. We will find a way to care for our patients outside the constraints of the third-party system. If this rule goes forward as promulgated, many more physicians will opt out of Medicare and commercial insurance to pursue successful practice models, providing an alternative for patients also.

Commitment, compassion, trust, responsibility, ownership, and professional ethics cannot be coded by government, nor can they fit into a rubric or information technology (IT) analytic.

Conclusions

The MACRA, MIPS, APMs, and CPS rubrics are convoluted, subject to change on a whim, expensive, experimental, and excessive. Application of this theoretical, untested system

to all patients and all insurers to collect all data, MIPS and non-MIPS, using new levels of intermediaries overseen by ONC and CMS without patient or physician authorization, is a further intrusion and destruction of freedom and privacy.

As Christopher Adamo writes, "Stealth legislation by regulators is an unconstitutional abuse of power, provides no due process, and tramples rights."

The solutions must begin and end with patients and physicians. Medical care is not a proper function of government.

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