Medicare overhauls doctor payment rules

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21 October 2016

Last week the Centers for Medicare and Medicaid Services (CMS) unveiled its new rules for how Medicare compensates doctors for services. Under the guise of providing "quality" care, the new rules are part of a cost-cutting strategy that incentivizes doctors to ration care for patients.

In April of last year, President Obama signed the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. The 2,400-page bill had support from both the Democrats and Republicans, reflecting the bipartisan nature of the attack on all remaining "entitlement" programs.

The bill phases out the "fee for service" system, in which doctors were paid based on the volume of services provided, replacing it with a payment structure that provides financial incentives for doctors to cut costs and reduce the volume and frequency of the health care services they provide.

MACRA was presented as a permanent fix to the 1997 law that tied doctors' compensation to the sustainable growth rate (SGR), a formula that rarely kept up with rising health care costs and would have drastically cut their reimbursement rate. Since 2002, Congress intervened and raised physician payment rates 17 times to make up for the shortfall.

According to the new payment schedule, payments to doctors will increase 0.5 percent annually through 2019, then freeze for six years, followed by modest increases. However, starting in 2019 doctors will be eligible to receive larger reimbursements by participating in two new tracks or payment systems that provide financial incentives to provide "quality" care while reducing the volume of services.

CMS estimates that 70,000 to 120,000 clinical practitioners will be in a position to participate in Alternative Payment Models (APM) starting next year. By employing electronic medical records and reporting quality measurements to the government, doctors can earn financial rewards for meeting these standards, or lose money for failing to do so. Providers who are ready to or have already begun making "quality-based" changes can use this track.

In one example of an APM, health care providers and suppliers can voluntarily come together to coordinate health care at lower costs by forming accountable care organizations (ACOs). These will be rewarded for reducing costs while supposedly meeting performance standards on quality of care.

The goal is to eventually move all Medicare providers to the APM track.

In the meantime, an estimated 590,000 to 640,000 clinicians are expected to enroll in the Merit-Based Incentive Payment System (MIPS), where doctors will have lower financial risks and rewards compared to APMs. The purpose of this track is to introduce clinical practitioners to "quality-based" programs, i.e., programs that reduce the quantity of medical services by supposedly improving them.

The performance of clinical practitioners will be rated based on quality standards, making improvements, and employing electronic medical records. In 2018, a cost category will be added to calculate doctors' payment adjustment.

The first performance period begins on January 1, 2017 and closes at the end of the year. Physicians will then submit data on their practices by March 31, 2018. CMS will provide feedback on the doctors' performance, which will determine the payment adjustments made starting January 1, 2019.

Payment adjustments can be increased or decreased by up to 4 percent, and the adjustments will increase annually until a potential maximum adjustment of 9 percent is reached in 2022.

The increase in payments to doctors will be funded by premium hikes to Medicare recipients based upon income.

Another 380,000 clinicians with smaller practices will be exempt from the MACRA because they care for fewer than 100 Medicare patients annually and bill Medicare less than $30,000 a year.

The performance of physicians is based upon the quality measures developed in the CMS's Quality Measure Development Plan (MDP). They include "overuse measures" such as the "overuse" of clinical tests and procedures.

The MDP claims that an underuse of services would be an unintended consequence of clinicians focusing on overuse measures. Actually, however, reducing use of services to the point that patients suffer is a deliberate goal of the policy.

The passage of the MACRA represents a major assault on Medicare. Republican House Speaker John Boehner, who along with Democratic representative Nancy Pelosi drafted the legislation, called the bill the "first real entitlement reform in nearly two decades," since the abolition of cash welfare payments in 1996 by the Clinton administration. When the bill passed, the right-wing *National Review* praised the legislation in an article headlined, "A Medicare Bill Conservatives Need to Embrace."

The Affordable Care Act, which aims to lower health care costs for the government and corporations by rationing care, is substantially reducing Medicare spending. The Congressional Budget Office estimated in 2013 that the ACA would reduce Medicare spending by $716 billion between 2013 and 2022. The ultimate aim of the ruling elite is to transform Medicare, which has improved the health and welfare of millions of seniors since its inception, it into a poverty program with minimal coverage—whether through means testing, some type of voucher program, or through outright privatization.

Medicare, signed into law by President Lyndon B. Johnson on July 30, 1965, was the last major reform issued by the ruling class. Like the reforms pushed by the Roosevelt administration in the 1930s, such as the Social Security Act and the recognition of the industrial unions, Medicare was a concession by the ruling class in the face of major struggles by the working class. Ever since this time, the ruling class has sought to roll back and eliminate these popular programs, a process that has only intensified since the onset of the 2008 economic crisis.