

Medicare physician payment reform
after two years: Examining MACRA
implementation and the road ahead

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Statement of
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The Medicare Payment Advisory Commission (MedPAC) is a small congressional support agency established by the Balanced Budget Act of 1997 (P.L. 105–33) to provide independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program. The Commission’s goal is a Medicare program that ensures beneficiary access to high-quality, well-coordinated care; pays health care providers and health plans fairly, rewarding efficiency and quality; and spends taxpayer and beneficiary dollars responsibly. The Commission thanks Chairman Grassley and Ranking Member Wyden for the opportunity to submit a statement for the record today.

Background

Physicians and other health professionals billing under Medicare’s fee schedule deliver a wide range of services—office visits, surgical procedures, and diagnostic and therapeutic services—in a variety of settings. The Medicare program paid \$69.1 billion for physician and other health professional services in 2017, or 14 percent of benefit spending in Medicare’s traditional fee-for-service (FFS) program. In 2017, about 985,000 health professionals billed Medicare through the fee schedule—roughly 596,000 physicians and 389,000 nurse practitioners, physician assistants, therapists, chiropractors, and other practitioners (Medicare Payment Advisory Commission 2019).

Medicare’s fee schedule payment rates are based on the clinician work required to provide the service, expenses related to maintaining a practice, and expenses related to professional liability insurance. From 1999 to 2015, updates to these payment rates were governed by the sustainable growth rate (SGR) system, which set updates so that total spending would not increase faster than a target—a function of input costs, FFS enrollment, gross domestic product (GDP), and changes in law and regulation. Because annual spending generally exceeded these parameters, payments to clinicians were scheduled to be reduced by ever-growing amounts starting in 2002. The Congress overrode these negative cuts in all but the first year they were scheduled. Because of these overrides and volume growing in excess of per capita GDP, the resulting scheduled payment rate reduction was expected to be 21 percent in 2015, creating considerable tension for clinicians and the Medicare program. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repealed the SGR system and created a fixed set of statutory updates for clinicians.

MACRA also included two other major provisions—an incentive payment for qualifying participants in advanced alternative payment models (A-APMs) and the Merit-based Incentive Payment System (MIPS). From 2019 through 2024, clinicians who are qualifying participants in an A-APM receive incentive payments of 5 percent of their Medicare-covered professional services revenue each year that they qualify. MACRA’s incentive payments for clinicians participating in A-APMs were intended to encourage clinicians to move toward these models. A-APMs generally require participating entities to assume financial risk for their patients, which creates incentives for providers to improve care coordination and quality while controlling cost growth. Unless otherwise exempted, clinicians who are not qualifying participants in an A-APM and meet certain thresholds for Medicare participation are required to participate in MIPS. MIPS is a system that calculates individual clinician-level or group-level payment adjustments based on four areas: (1) quality and advancing care information, (2) meaningful use of electronic health records, (3) clinical practice improvement activities, and (4) cost. Based on the clinicians’

performance in these four areas, the payments they receive from Medicare can be increased or decreased by varying amounts over time. The basic MIPS payment adjustments are budget neutral, but MACRA also appropriated an additional \$500 million in bonuses for exceptional performance in MIPS each year from 2019 to 2024.

(The Commission has commented extensively on A-APMs and MIPS. For more background on these topics, see the Commission's annual reports and comment letters referenced at the end of this document).

The Commission supports repeal of the sustainable growth rate system

The Commission had long supported repealing the SGR and commends the Congress for doing so (Medicare Payment Advisory Commission 2011, Medicare Payment Advisory Commission 2018b). The SGR failed to restrain volume growth under the fee schedule and, in fact, may have exacerbated it. Although the pressure of the SGR likely minimized fee increases while in effect, it disproportionately affected clinicians who have less ability to increase volume, such as primary care providers. Additionally, both the magnitude of the threatened cuts and the temporary policies to override the SGR engendered uncertainty among clinicians, which in turn may have caused anxiety among beneficiaries. For these reasons, the Commission believes that repealing the volume-based approach to clinician payment was warranted. The MACRA approach of tying payments to clinicians' performance, through comprehensive, patient-centered care delivery models, provides better incentives for clinicians and could ideally result in better care and outcomes for Medicare beneficiaries.

Implementing advanced-alternative payment models

MACRA established the A-APM incentive payment to spur reform in the delivery of health care by encouraging clinicians to move toward these models, in which providers take accountability for health care spending and quality. A-APMs are defined in statute based on three criteria:

1. The model requires use of certified electronic health record technology.
2. The model makes payments based on a set of quality measures comparable with MIPS.
3. The model requires the entity to bear financial risk under such alternative payment model in excess of a nominal amount or to be a medical home expanded under Section 1115A(c) (Medicare Payment Advisory Commission 2016b).

The Commission generally supports the establishment of A-APMs and other elements of MACRA that are designed to move clinicians toward comprehensive, patient-centered care delivery models. These models can help counter the incentives in traditional FFS, which reward volume and thus can lead to higher spending for the Medicare program and for beneficiaries. The Commission holds that it is important to encourage providers to take accountability for the cost of health care and for quality outcomes, and it has long recognized the limitations of traditional FFS.

Effective A-APMs should encourage delivery system reform that results in beneficiaries having access to high-quality health care services and a sustainable Medicare program. To help the

Centers for Medicare & Medicaid Services (CMS) implement A-APMs in a way that achieves that goal, in June 2016 the Commission established the following set of principles to help inform how A-APMs should be defined (Medicare Payment Advisory Commission 2016b):

- Clinicians should receive an incentive payment only if the A-APM entity in which they participate (e.g., an accountable care organization (ACO)) is successful in controlling cost, improving quality, or both.¹
- The A-APM entity should be at financial risk for total Part A and Part B spending.
- The A-APM entity should be responsible for a beneficiary population sufficiently large to detect changes in spending and quality.
- The A-APM entity should have the ability to share savings with beneficiaries.
- CMS should give A-APM entities certain regulatory relief.
- Each A-APM entity should assume financial risk and enroll clinicians.

While the statute contains some guidance for the models CMS should consider as A-APMs for purposes of the 5 percent incentive payment, the agency has considerable flexibility in making that determination. CMS began deciding which models qualified as A-APMs beginning in 2017, and the number has increased each year to 13 models in 2019 (Centers for Medicare & Medicaid Services 2018a).

Some A-APMs align relatively well with the Commission's principles for A-APMs. One type of A-APM that the Commission has generally supported is an ACO model that features two-sided financial risk, meaning that providers share in savings or losses based on beneficiaries' actual spending relative to what was expected. The Next Generation ("NextGen") ACO model is an example. It began in 2017, and participating providers agree to take responsibility for the overall cost and quality of medical care for a population of beneficiaries. This model has strong incentives for providers to improve quality and control the overall cost of care for attributed beneficiaries, and it generally aligns with our principles. The most recent evaluation of the program found that in its first year the NextGen program reduced Medicare spending for beneficiaries by 1.7 percent before taking into account shared savings paid to the ACOs (and losses paid to Medicare by ACOs) (NORC at the University of Chicago 2018). After shared savings and losses are taken into account, the NextGen demonstration saved 1.1 percent. Most quality measures did not show statistically significant changes.

Recently the Commission conducted an analysis to measure the performance through 2016 of the Medicare Shared Savings Program (MSSP), the largest ACO program in Medicare. Almost all of the ACOs in the MSSP during this time did not face two-sided financial risk, and thus had weaker incentives than ACOs in the NextGen program. We concluded that the MSSP resulted in spending growth from 2012 to 2016 that was 1 or 2 percentage points lower than spending growth would have been without the program. However, that was before payments to ACOs for shared savings, and actual savings realized by the Medicare program were thus lower. Models

¹ Clinicians are participants in A-APM entities. The A-APM entity is a participant in a qualifying model.

incorporating two-sided risk, like NextGen, have stronger incentives for achieving better cost and quality outcomes and align most closely with our principles.

In contrast, some A-APMs do not align well with our principles. For example, the Commission has expressed concerns about the Comprehensive Primary Care Plus (CPC+) model being designated as an A-APM, in part because providers could join without assuming enough financial risk to change incentives for delivering care (Medicare Payment Advisory Commission 2016a). In CPC+, providers get additional payments in the form of monthly fees and awards based on performance. These additional dollars are intended to help primary care practices coordinate care to improve quality and reduce spending. However, participants in CPC+ only face financial risk for these additional payments, and not on their FFS revenue. The Commission has expressed concern that A-APMs with low standards for financial risk may attract providers interested in gaining the incentive payment and not in changing care delivery.

In April 2019, CMS posted performance results from the first year of CPC+. Overall, the evaluation found that practices participating in CPC+ tended to have FFS spending that was 2 to 3 percent higher than comparison practices, after accounting for enhanced payments. These results illustrate the risks to the Medicare program and taxpayers of having A-APMs that are not designed with robust incentives (Centers for Medicare & Medicaid Services 2019).

Ideas for improving A-APMs

A key policy choice is whether to have more A-APM participants in models with weaker incentives, or fewer A-APM participants in models with stronger incentives. The Commission's goal is for Medicare to design efficient A-APMs that create real value for beneficiaries, the Medicare program, and taxpayers, not to maximize the number of providers that can join A-APMs. Thus, it is important for policymakers to continue improving A-APMs in order to increase their likelihood of success. To help in that effort, the Commission has discussed several policies that could improve A-APMs. These policies are focused on strengthening incentives for providers to change practice patterns, reducing burden and uncertainty, and sending consistent signals throughout the Medicare program for how providers and other entities will be measured on cost and quality.

Maintain high standards for financial risk

CMS should only approve A-APMs with high standards for financial risk. As noted above, without high standards for financial risk, A-APMs may attract providers who see the model primarily as a means for gaining incentive payments, and who may be less focused on changing care delivery. This would increase spending for the Medicare program and beneficiaries, without providing real value.

Use prospective attribution in ACOs

Starting in June 2019, MSSP ACOs (some of which are A-APMs) will be given the ability to choose, each year, whether to have their beneficiaries assigned prospectively or retrospectively. This creates risk for the program because it could encourage patient selection. Prospective assignment means that beneficiaries are assigned to an ACO based on which providers they saw in the previous year. Retrospective assignment means that beneficiaries are assigned to an ACO based on the providers they saw in the current year. There are strengths and weaknesses to both

approaches, but, on balance, prospective assignment has several advantages. ACOs know with certainty who their assigned beneficiaries are at the beginning of the year, and thus can better target their efforts to improve care. Also, when an ACO knows in advance who its beneficiaries are, the program is able to relax regulations and give greater flexibility to the ACO (e.g., by allowing a waiver from the requirement that a beneficiary have a 3-day hospital stay before being admitted to a SNF). Prospective assignment also reduces problems of patient selection that may arise through retrospective assignment. Under retrospective assignment, ACOs can take actions during a performance year to influence which patients are assigned to them. For example, toward the end of the year, an ACO could encourage patients with little service use to have an annual wellness visit (AWV) with an ACO clinician so that low-spending patients would be assigned to the ACO. Alternatively, an ACO could encourage patients to see non-ACO doctors if they have an anticipated need for an expensive procedure such as a knee replacement. These selection issues are less of a problem under prospective assignment because it is more difficult to predict a patient's spending in a future year than in the current year, and the ACO is responsible for the patient's spending during the entire year regardless of where the patient gets care.

Measure quality consistently across Medicare

To reward accountable entities and providers for offering high-quality care to beneficiaries, A-APMs should be designed to link payment to quality of care. However, the ACO program used 32 quality measures in 2018, including some process measures with an unclear link to patient health outcomes. Using so many measures is burdensome to ACO participants and makes it difficult to draw comparisons with providers in other parts of Medicare that use different quality measures. The Commission asserts that Medicare quality incentive programs should use a small set of outcomes, patient experience, and value measures to assess the quality of care across different populations, such as beneficiaries enrolled in Medicare Advantage (MA) plans, ACOs, and FFS in defined market areas, as well as those cared for by specified hospitals, groups of clinicians, and other providers (Medicare Payment Advisory Commission 2018a).

A consistent set of population-based measures will allow policymakers to compare quality across different accountable entities and providers in the Medicare program. This would also provide information to the program to better reward high-quality providers, and to beneficiaries to inform decisions of where to get care. Sending consistent signals across the program could also help providers focus their quality improvement activities on improving patient outcomes.

Continue improving FFS

Although A-APMs represent a significant opportunity to encourage delivery system reform and to move the Medicare program to paying for value, it is important to remember that these payment models largely rely on the Medicare FFS system to operate underneath them. That is, in most A-APMs, providers still submit FFS claims and are paid FFS rates. Therefore, it is crucial that the FFS payment systems be continually maintained and improved so that they function smoothly and, to the extent possible, do not create conflicting incentives.

Moving beyond the Merit-based Incentive System (MIPS)

MedPAC shares Congress's goal, expressed in MIPS, of having a value component for clinician services in traditional Medicare that promotes high-quality care. However, MedPAC believes

that MIPS, as currently structured, cannot achieve this goal and, therefore, should be replaced with a better quality payment program (Medicare Payment Advisory Commission 2018b). The Commission did not reach this conclusion hastily. We first examined options for improving MIPS as it was implemented, and we have provided feedback as CMS established rules for the first three years of the program (Medicare Payment Advisory Commission 2016a, Medicare Payment Advisory Commission 2017). However, as we continued to explore MIPS in a deliberative process laid out in several Commission reports to the Congress, we came to the conclusion that the basic design of MIPS is fundamentally flawed. For a number of reasons, MIPS will not succeed in helping beneficiaries choose clinicians, in helping clinicians change practice patterns to improve value, or in helping the Medicare program reward clinicians based on the value of the care they provide.

First, information collected under MIPS is unlikely to be meaningful because the MIPS measures are variable in application, clinical appropriateness, and association with meaningful outcomes. Under MIPS, each clinician's quality score is based on six measures chosen by the clinician from a set of several hundred predominantly process measures. To measure all or most medical and surgical specialties at the individual level, as the MIPS program is designed, there needs to be a wide variety of clinical process measures, including those relevant to each specialty. Therefore, when clinicians are compared with each other nationally to determine Medicare payments, the comparison is on wholly different measures. This will likely lead to substantial inequities over time and to the ultimate rejection of the program as unfair. The Commission supports providers using additional measures, such as care process measures, to manage their own quality improvement. However, these measures should not be tied to Medicare payments through quality incentive programs.

Second, few individual clinicians manage a sufficient number of discrete beneficiary medical issues and resultant processes of care during a year to produce reliable, statistically significant comparative results (the "small numbers" problem). Although some clinicians may furnish services at volumes large enough to be accurately measured, they are too few to build a comprehensive program that is broadly accurate and equitable across clinicians. In the third year of the program, CMS plans to exclude about 45 percent of clinicians from the MIPS program because they do not meet group eligibility or fall below the low-volume threshold (Centers for Medicare & Medicaid Services 2018b).

Third, adjusting payment based on quality and efficiency measured at the individual clinician level belies the reality of modern medicine. Medicine is increasingly provided by care teams. Although there are clearly examples of how the actions of one clinician alone are critically important to quality outcomes, the preponderance of care experienced by most Medicare beneficiaries is the result of the actions of multiple clinicians and institutions. The Commission believes that coordinating care over time and across settings is one important key to a more effective and efficient Medicare program of the future. Measuring clinicians individually and on their own chosen measures undermines incentives to coordinate care broadly across the Medicare program.

Fourth, requiring clinicians to report annually multiple measures to CMS is burdensome, complex, and expensive. For 2017 (the first year of reporting under MIPS), CMS estimated that the cost for providers to comply with MIPS was more than \$1.3 billion (Centers for Medicare & Medicaid Services 2016). CMS estimated that MIPS would require approximately \$700 million

in reporting costs in 2018 (Centers for Medicare & Medicaid Services 2017). For 2019, CMS did not provide a summary estimate for reporting costs (Centers for Medicare & Medicaid Services 2018b). Clinicians have already spent a substantial amount of financial resources and time to implement MIPS, and they will continue to do so. This is time and money that could be better devoted to patient care.

MIPS is not succeeding

Based on the flaws in the design of MIPS, we expected that MIPS-based payment adjustments would be small in the first years of the program, providing little incentive for clinicians to improve. This expectation was confirmed by CMS's first year MIPS performance data, which showed that the maximum MIPS bonus a clinician receives in 2019 is 0.22 percent. When the exceptional performance bonus is added, the maximum total bonus is 1.88 percent.

Almost all (93 percent) of clinicians who participated in MIPS are receiving a small positive adjustment in 2019 based on their 2017 performance (Medicare Payment Advisory Commission 2019). Seventy-one percent of the clinicians qualified for a positive adjustment plus an exceptional performance bonus. CMS estimates that this trend will continue in payment year 2021, with about 90 percent of participating clinicians receiving a MIPS bonus and about 60 percent receiving an additional exceptional performance bonus (Centers for Medicare & Medicaid Services 2018b). Most participating clinicians receive a positive payment because of a number of policy decisions CMS has made to reflect a phased approach to MIPS implementation, which CMS refers to as "Pick Your Pace." Specifically, CMS used its regulatory authority to:

- Set the MIPS performance threshold at 3 points (out of 100) for payment year 2019. Clinicians with a score above 3 are to receive a neutral or positive payment adjustment, and clinicians with a score of 3 or below are to receive a negative payment adjustment. For payment year 2021, CMS has changed the performance threshold from 3 to 30 points.
- Set the MIPS exceptional performance bonus threshold at 70 points (out of 100) for payment year 2019 and 75 points for payment year 2021.
- Permit clinicians to meet the 3-point MIPS performance threshold by reporting minimal information on one quality measure (or attesting to one performance activity) in 2019.
- Weight the cost component at 0 points, so costs (i.e., resource use) do not affect MIPS payment adjustments in the first year. Costs account for 15 percent of the total performance score in year three.

Because clinicians could choose which measures to report, most clinicians had very high performance scores overall in the first year of the program. Specifically, the mean performance score was 74 points, and the median performance score was 89 points, well in excess of the 3-point threshold for a positive adjustment and the 70-point threshold for the exceptional performance bonus.

Under the statute, performance thresholds will eventually be set at the mean or median of clinician performance, and payment adjustments will increase substantially to ± 9 percent. Because clinicians will still be able to select the measures on which they expect to perform well,

MIPS scores will continue to be very high and compressed around a high average. This means that small changes in scores will result in very large and unpredictable swings in payment adjustments, creating greater uncertainty and inequity, and potential rejection of the program by large numbers of clinicians.

The MIPS program is not succeeding in its goals of rewarding and penalizing clinicians based on performance. Subsequent legislation has delayed implementation of the higher performance thresholds to 2022. The Commission urges policymakers to use the intervening years to begin developing an alternative approach to measuring and rewarding value in clinician payment.

A new direction for rewarding clinician quality: A voluntary value program

While the Commission believes MIPS is fundamentally flawed, we do believe that traditional Medicare FFS clinician payment should have a value-based payment component. Thus, we also recommended creating a new clinician value-based purchasing program—a voluntary value program, or VVP—to take its place (Medicare Payment Advisory Commission 2018b). The VVP recommendation reflects a conceptual direction (not yet a detailed design) for rewarding clinician quality in FFS Medicare according to the core quality principles developed by the Commission; future Commission work will explore more detailed specifications for a VVP.

The VVP would incorporate the Commission’s quality measurement principles by measuring groups of clinicians (rather than individual clinicians, to address the “small numbers” problem) on a small set of population-based metrics—that would include measures such as readmission to the hospital and patient experience—that are important to the program and its beneficiaries, can be measured reliably, and can be applied across payment models and providers (Medicare Payment Advisory Commission 2018a). These types of measures would recognize that all clinicians have a role in affecting the health outcomes of their patients. The data required to calculate the measures would be generated from claims or surveys, substantially reducing clinicians’ reporting burden. Moreover, this approach aims to align measures for clinicians with measures we have suggested CMS use in its other quality programs, creating the potential to send clear, transparent, and consistent signals to providers in all sectors. Participation in the program would be voluntary, and clinicians would elect their own group (e.g., independent practice associations, organized hospital medical staffs, or local medical societies), which could include specialists as well as primary care clinicians.

The VVP would encourage clinicians to think about how the care they provide contributes to the overall health outcomes of their patients, while also providing a transition for those who want to join A-APMs. This new direction would encourage care coordination among clinicians, focus quality improvement efforts on measures that are important to beneficiaries and Medicare, and relieve individual providers of the significant reporting burdens they face today and in the future. The VVP would also make quality measurement more equitable across different types of clinicians and improve the transparency of clinician quality of care for both the Medicare program and its beneficiaries.

Conclusion

MACRA made important improvements in how Medicare pays for clinician services. The Commission commends the Congress for repealing the SGR, which created uncertainty in

Medicare payment for many years and contained poor incentives that rewarded volume of services. The Commission supports the elements of MACRA that move toward comprehensive, patient-centered care, including the establishment of A-APMs. However, the Commission urges the Congress to move past MIPS, as it will not accomplish the shared goal of motivating providers to improve performance on cost and quality. The Commission looks forward to continuing to be a resource for the Committee as it deliberates on policies to promote high-quality clinician care at lower costs to beneficiaries and the program.

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