Approaches to MACRA implementation: Balancing MIPS and A-APMs

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MEDPAC

Outline

- Brief summary of Medicare Access and CHIP Reauthorization Act (MACRA) policies
- Policy considerations
  - Redesigning the Merit-based Incentive Payment System (MIPS)
  - Balance between MIPS and Advanced Alternative Payment Models (A-APMs)
  - Redesigning the 5% A-APM incentive payment
  - Risk-sharing designs
- Discussion

MACRA statutory overview

- Incentive payments and higher updates for clinicians who are qualifying A-APM participants
  - 5% incentive payment on total fee schedule revenue each year they qualify from 2019-2024
  - Higher update in 2026 and later
- A-APMs are models that:
  - Require entities to bear more than nominal risk
  - Require entities to use certified electronic health record technology
  - Base payments on quality measures comparable to MIPS
- Clinicians who are not qualifying A-APM participants subject to new Merit-based Incentive Payment System (MIPS)
  - FFS payments will be adjusted up and down based on clinician-level performance on quality, cost, advancing care information and practice improvement

MACRA final rule

- MIPS
  - 2019 (first year that payment applies): minimal reporting required, most clinicians likely to receive no or very small positive adjustments
  - Reduces reporting requirements from proposed rule
  - ~600,000 clinicians subject to MIPS, 580,000 clinicians exempt
- A-APMs
  - CMS goal: Maximize A-APM participation
  - Defines the "nominal risk" criteria for A-APMs as follows:
    - 3% of the A-APM benchmark (lower than the 4% proposed)
    - Or 8% of the A-APM entity's Medicare revenue
  - Allows mandatory episode payment models (such as comprehensive care for joint replacement) to qualify as A-APMs
  - Describes new Track 1+ ACO model

Redesigning MIPS: Issues

- MIPS payment adjustments will be based on many topped-out process measures of marginal value
- Reporting burden and complexity
- Does not allow equitable comparison across clinicians
- Small number of observations for average clinician

Redesigning MIPS: Policies

- CMS-calculated outcome and patient experience measures
- Eliminate or greatly reduce clinician-reported measures
- Aggregate performance (at a local market area or group level)
- Focus on clinicians with high rates of poor outcomes or extreme utilization

Balance between MIPS and A-APMs

- Remove the MIPS "exceptional performance" fund of $500 million per year (2019-2024)
- Restructure MIPS to limit maximum bonuses
- Increase certainty for clinicians about whether A-APM or MIPS policies apply
  - Clinicians proportionately subject to both, or
  - Clinicians with any involvement in A-APMs are exempted from MIPS

Commission's A-APM principles

- Incentive payment for participants only if entity is successful controlling cost, improving quality, or both
- Entity must have sufficient number of beneficiaries to detect changes in spending or quality
- Entity is at risk for total Part A and Part B spending
- Entity can share savings with beneficiaries
- Entity is given regulatory relief
- A single entity must assume risk

Redesign the 5% incentive payment

- Change the law and apply the 5% incentive payment only to clinician's revenue coming through an A-APM
  - Current law applies incentive to all PFS revenue but clinician must pass threshold
  - Creates uncertainty and payment "cliff;" all or nothing
- Change the law and only award incentive if successful performance in accord with Commission's first principle
- Would be more equitable design and protect Trust Funds

Comparison of benchmark-based and revenue-based nominal risk

Concept: make it possible for small practices to take on risk

Assumptions	
---Beneficiaries	1,000
---Benchmark per capita	$10,000
---Total A&B benchmark	$10,000,000
---Total practice revenue (assumed to be 5% of A&B)	$500,000

Benchmark-based standard: 3% of benchmark	Revenue-based standard: 8% of practice revenue
$300,000	$40,000

Possible 2-sided risk design for small practice entities

Assumptions

---Practice revenue through A-APM	$500,000
---Risk corridor	+/- 20% of revenue

Maximum reward	$100,000 + $25,000 (5% incentive) = $125,000
Maximum loss	– $100,000

- Revenue is revenue through A-APM
- Revenue-based standard for nominal risk (greater than 8 percent) and risk corridor in revenue terms
- Scale shared savings on Part A and Part B performance
- Small entities would need to aggregate to detect cost and quality performance

Summary

- Redesign current system
  - MIPS: minimal or no clinician reporting, outcome-oriented measures, comparability across clinicians
  - Base 5 percent incentive payment only on revenue through A-APM and only if successful performance
  - Create two-sided risk model for A-APM that reflects small practices' ability to take risk
- Two alternatives for payment
  - Pay would be proportionate, A-APM share would get incentive payment, remainder would get MIPS adjustment
  - Or $1 in A-APM, clinician exempt from MIPS

Discussion

- How should MIPS be redesigned?
- Should 5 percent A-APM incentive payment be redesigned?
- Should a two-sided risk model be developed for small practices that can only bear limited risk?
- Other issues?