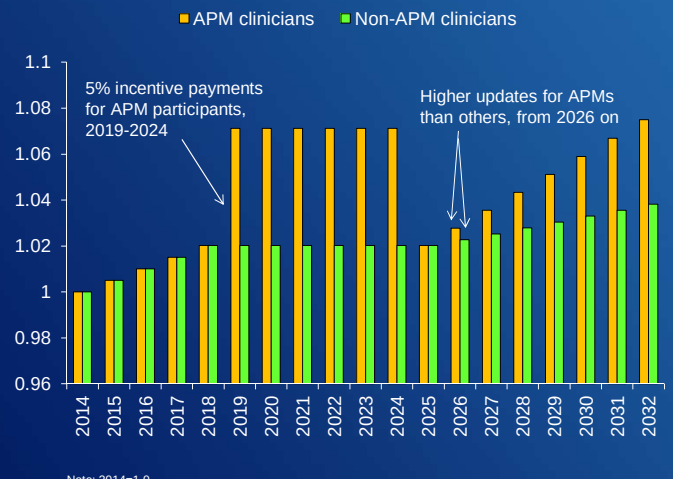
Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

- Repeals SGR and establishes two paths of statutory payment updates for clinicians
- Incentive payments and higher updates for clinicians who participate in eligible Alternative Payment Models (APMs) than for others
- Merit-Based Incentive Payment System (MIPS) for clinicians not meeting APM criteria

MEDPAC 2

Two payment update paths



Note: 2014=1.0

MEDPAC

3

MedPAC 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
- Each entity must assume risk and enroll clinicians

MEDPAC

4

MedPAC approach to A-APMs

- 5% on first dollar
  - Current law applies 5% incentive to all PFS revenue, but clinician must pass threshold; creates uncertainty and payment "cliff"
  - Apply the 5% incentive payment to clinician's revenue coming through an A-APM
  - Only award incentive if successful performance
- Revenue-based risk
  - Make is possible for small practices to take on risk
- Concerns about episode based APMs

MEDPAC 5

MIPS: burden and complexity

- Significant burden on clinicians: CMS estimates over $1 billion in reporting burden in 2017
- MIPS is complex (and CMS emphasis on flexibility and options has increased complexity)
  - Exemptions (~800,000 clinicians exempt)
  - Special scoring and rules (e.g., for facility-based clinicians, clinicians in certain models)
  - Multiple reporting options (e.g., EHR, web interface, registry)
  - Score dependent on actual reporting method (e.g., whether clinician reported through EHR or registry)

MEDPAC 6

MIPS measures and scoring concerns

- Measures not associated with high-value care
  - Process measures
  - Attestation/check the box
  - Minimal information on Physician Compare
- Statistical limitations
- MIPS is structured to maximize clinician scores, leads to score compression, limited ability to detect performance
  - 2019-2020: High scores combined with low performance standard result in minimal reward
  - Later years: Minimal differences result in big payment swings
- Clinicians can choose their own measures, thus resulting MIPS score is inequitable across clinicians

MEDPAC 7

Goals of new approach

- Align quality and value signals across the health care delivery system
- Equitably measure aggregate clinician performance in FFS
- Limit bonuses available in traditional FFS
- Reduce clinician burden

MEDPAC 8

Policy option

- Eliminate the current MIPS and establish a new voluntary value program (VVP) in FFS Medicare in which:
  - All clinicians would have a portion of fee schedule payments withheld (e.g. 2%)
  - Clinicians in voluntary groups can quality for a value payment based on their group's performance on a set of population-based measures
  - Clinicians can elect to join an A-APM (and receive withhold back); or
  - Make no election (and lose withhold)
- A new voluntary value program does not:
  - Revert to the Medicare Sustainable Growth Rate (SGR)
  - Eliminate FFS Medicare
  - Prevent clinicians from using other measures to guide care (process measures, registries, etc.)

MEDPAC 9

Illustrative population-based measures

Clinical quality	Patient experience	Value
• Avoidable admissions/ emergency department visits • Mortality • Readmissions	• Ability to obtain needed care • Able to communicate concerns to clinician • Clinicians coordinated with other providers	• Spending per beneficiary after a hospitalization • Relative resource use • Rates of low-value care

- Calculated from claims (or surveys)
- Aligned with A-APM measures
- Combination of measures to balance incentives

MEDPAC 10