The Medicare Access and Chip Reauthorization Act of 2015 (MACRA)\(^1\) repealed the flawed Sustainable Growth Rate (SGR) system of paying for physician services in Medicare. Although the MACRA legislation is conceptually sound, much of the final legislative language is complex and vague. The success or failure of the legislation therefore rests with the decisions concerning the law’s implementation.\(^2\)

In April, the Centers for Medicare and Medicaid Services (CMS) released the 962-page proposed rule regarding the implementation of key provisions of MACRA. The final rule is scheduled to be released in the next several weeks. While the regulators did make some adjustments based on stakeholder input, more work needs to be done. Unless the areas of concern are addressed in the final rule, Congress and the next Administration will need to consider further reducing the reporting requirements in MIPS, setting a more rational timeline, and expanding the scope of qualified advanced alternative payment models to ensure the necessary infrastructure is in place to support the legislation.

**Payment Reform Under MACRA**

MACRA establishes two tracks for the future of physician payment in Medicare: the Merit-Based Incentive Payment System (MIPS) and participation in Alternative Payment Models (APMs).\(^3\) The Quality Payment Program (QPP) is the amalgamation of these two tracks. However, for the foreseeable future, the vast majority of physicians will not have an option of choosing between the two tracks.

**The Increasing Burden of MIPS.** With its substantial reporting burden, MIPS is likely to become increasingly unattractive over the next decade—especially to small, independent practices, the majority of whom are likely to see substantial cuts to reimbursement. In fact, CMS estimates that only 30,000 to 90,000 eligible clinicians would be exempt from MIPS through participation in Advanced APMs. For the rest (between 687,000 and 746,000), based on provider performance, MIPS payment changes would be equally distributed between negative and positive adjustments to ensure budget neutrality.

**Lack of Equity.** Aside from conforming to budget neutrality, little about payment adjustments in MIPS is equitable. In the proposed rule, the CMS estimated that bonuses would be handed out to 81.3 percent of clinicians in organizations with 100 or more eligible clinicians and 54.5 percent of clinicians in organizations of 25–99 eligible clinicians, while penalties would be meted out against 87.0 percent of solo eligible clinicians, 69.9 percent of eligible clinicians in practices of two to nine clinicians, and 59.4 percent of eligible clinicians in practices of 10–24 clinicians. Although the CMS has backed off those estimates and—to its credit—recently introduced considerable first-year reporting flexibility,\(^4\) small, independent practices will likely still be at a disadvantage once MIPS is fully implemented. According to an August 2016 survey, 50 percent of non-pediat-
MIPS is a complex pay-for-performance program. Its administrative burden will be substantial, despite the CMS’s attempts at streamlining the reporting burden in MACRA by incorporating the previously separate Physician Quality Reporting System (PQRS), Electronic Health Record-Meaningful Use (HER-MU), and Value-Based Modifier (VBM) programs into MIPS. Furthermore, there is limited evidence that pay-for-performance programs lead to significant improvements in health care quality.

The Scarcity of APMs. As noted, providers can get out from under the increasing burden of MIPS by participating in an Advanced APM. In addition, from 2019 through 2024, clinicians who have a sufficient share of revenue coming through one or more Advanced APMs will receive a 5 percent incentive payment. From 2026 onward, clinicians meeting the threshold criterion for participation in Eligible Alternative Payment Entities (EAPEs) will receive a higher update (0.75 percent) than clinicians who do not meet that criterion (0.25 percent).

Yet the MACRA proposed rule drastically limits the number of eligible Advanced APMs to models authorized in Section 3021 of the Affordable Care Act. Furthermore, with few exceptions, the models that currently qualify as Advanced APMs are Accountable Care Organizations (ACOs) in tracks 2 and 3 of the Medicare Shared Savings Program (MSSP) or the Next Generation ACO model.

Weak Early ACO Performance. Although a considerable amount of effort has gone into the development and implementation of ACOs, the early results suggest that the CMS should greatly expand the options for APM participation. A recent CMS press release highlighted a combined total program sav-

3. Federal Register, Vol. 81, No. 89 (May 9, 2016), pp. 28161-28686.
4. CMS Acting Administrator Andy Slavitt announced that, although the January 2017 start date will not be officially delayed, during the 2017 performance year, eligible physicians and other clinicians will have four options for participation in MACRA and that choosing one of these options would ensure that providers will not receive a negative payment adjustment in 2019. Andy Slavitt, “Plans for the Quality Payment Program in 2017: Pick Your Pace,” The CMS Blog, September 8, 2016, https://blog.cms.gov/2016/09/08/qualitypaymentprogram-pickyourpace/ (accessed October 12, 2016).
8. Section 3021 of the Patient Protection and Affordable Care Act establishes the Center for Medicare and Medicaid Innovation (The Innovation Center).
9. Other options include the Comprehensive End-Stage Renal Disease (ESRD) Care (CEC) Model; Large Dialysis Organization (LDO) arrangement only; the Comprehensive Primary Care Plus (CPC+) Model; and the two-sided Oncology Care Model (OCM).
10. The Next Generation ACO program is scheduled to start in January 2017. Since January 2016, three of the 21 participants have withdrawn from the program.
ings for Medicare ACOs in 2015 of $466 million, but a more detailed analysis, which includes not only the savings achieved by a small number of organizations but also what Medicare paid in bonuses to ACOs and the cost of running the program, shows that the overall impact to the Medicare program in 2015 was actually a net loss of at least $216 million. Moreover, net per capita savings—a more meaningful number than total savings—show a loss to taxpayers for the cohort of participants entering the program in the past three years.\textsuperscript{12}

The goal of any performance measurement system should be to improve patient care, not determine how much physicians are paid. The reporting burden in MIPS should be drastically reduced in order to align with the development of meaningful performance metrics. Physicians should only report on measures that aid them in improving care for the patients they treat, not an arbitrary number of measures in order to “perform” well in MIPS.

- **Expand eligible APMs beyond ACA initiatives.** Under the proposed rule, a payment model can qualify as an Advanced APM in two ways. First, it can be one of the models listed above, all of which are ACA initiatives. Second, it can qualify through the Physician-Focused Alternative Payment Model Technical Advisory Committee (PTAC), which is charged with evaluating proposals for new APMs and, if appropriate, favorably recommending them to the Secretary of the Department of Health and Human Services. Although the PTAC recently released a draft of its Proposal Review Process,\textsuperscript{16} very little is known about the eventual capacity of the committee to evaluate and recommend models. In addition, the Secretary is under no legal obligation to test or implement any model recommended by the committee.

Given the paucity of Advanced APMs and the difficulty of successfully participating in the currently available models, as evidenced by the early results and attrition levels, the incentives for APM participation that were incorporated in the MACRA legislation will be irrelevant to the vast majority of providers unless the pool of available Advanced APMs is greatly expanded. Those incentives were not meant simply to bolster participation in current ACA initiatives; rather, they were intended to encourage payment reform innovation from a


\textsuperscript{13} For some measures, the CMS will use administrative claims data, obviating the need for provider reporting.


wide variety of stakeholders. The APM incentives in the proposed rule reward only those few providers who already have the resources and experience to take on substantial risk while failing to provide a clear glide path to meaningful payment reform for the rest.

- **Extend MACRA incentives to Medicare Advantage.** One way that the CMS could quickly and dramatically accelerate innovation and participation in payment reform is by extending the APM incentives in MACRA to the Medicare Advantage (MA) program. MA enrollment continues to increase in virtually all states. Almost one in three people on Medicare (31 percent or 17.6 million beneficiaries) is enrolled in a Medicare Advantage plan in 2016, with the penetration rate exceeding 40 percent in five states. Evidence suggests that, in areas with a large MA penetration, a spillover effect is contributing to a slowdown in overall Medicare fee-for-service spending.

According to a recent CMS report to Congress, Medicare Advantage Organizations (MAOs) and their network providers have for some time been engaged in payment models that can be classified under every category of the Administration’s Payment Taxonomy Framework and support payment approaches at all levels of the payment continuum. In addition, MAOs often enter into contracts with providers with the intention of moving those providers into more sophisticated risk-based payment arrangements over time, as they become feasible for and acceptable to both parties. This provides an on-ramp for meaningful payment reform without putting taxpayers at additional financial risk, something that is currently lacking in MACRA.

**Conclusion**

The intended goals of the MACRA legislation—to repeal the SGR, stabilize physician payments and foster meaningful payment reform—are sound. However, the final legislative language and the proposed rule have created a situation where MIPS will become increasingly untenable for a large number of providers. At the same time, a scarcity of available Advanced APMs could leave them with nowhere else to go.

Rather than adhere to an arbitrary timeline, MACRA implementation should reflect these realities. Providers should only be assessed on and their payments linked to performance measures that improve patient care, not measures that merely conform to MIPS. In addition, the APM incentives in MACRA need to be extended beyond the current ACA initiatives to foster true innovation from a variety of sources, including Medicare Advantage. If the final rule does not address these issues, then Congress and the next Administration will need to make the necessary changes.

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