The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
“Stabilizes” fee updates

• Repeals the SGR, averting a 25% cut in fees, with a schedule of fixed, annual updates
• July 2015-2019: annual fee update 0.5%, 2020-2025 0%
  – Payment increases (and decreases) take place through the MIPS (Merit-based incentive payment system)
• Before 2025, 5 percent bonuses and exemption from MIPS for physicians who qualify as participating in AAPMs (advanced alternative payment models)
• After 2025, 0.25% annual update; 0.75% if in an AAPM
• These fixed, stable fee updates will likely produce an increasing gap between practice costs and revenues (given fairly flat service use in recent years)
The Merit-based Incentive Payment System

• Combines the 3 current incentive programs:
  – Physician Quality Reporting System (PQRS) – quality
  – Value-Based Modifier (VBM) – quality & resource use
  – Meaningful Use (EHR), which CMS relabeled as Advancing Care Information

• And adds a fourth, into a combined 4-part MIPS program
  – Clinical Practice Improvement Activities

• Applies to payments after January 1, 2019 – the current programs are in use till then. Note that the increased financial impacts are delayed compared to prior law

• Excludes physicians:
  – In their first year
  – With < 100 Medicare beneficiaries
  – With < $30,000 in Medicare allowed charges (was $10,000 in proposed rule)
  – The result is that almost 400,000 physicians are not initially subject to MIPS penalties (and bonuses)
MIPS assessment categories
(percentages when fully phased in in 2022)

- Quality -- 30%
- Resource Use -- 30%
- Advancing Care Information -- 25%
- Clinical Practice Improvement Activities -- 15%
  - Such as expanding practice areas, population management, care coordination, beneficiary engagement, patient safety
- For year 1, 2019, (with data collection starting 2017), CMS will not include any resource use rather than the 10% called for in statute, so instead will increase the quality component to 60%
MIPS payment adjustments

• Negative adjustments capped
  – Those at 0-25% of threshold get maximum negative adjustment
    • 2019: - 4%
    • 2020: - 5%
    • 2021: - 7%
    • 2022: - 9%

• Positive adjustments
  – Maximum: 3 X annual cap for the negative adjustment – so theoretically as much as 27% more if >25% above performance threshold
    • But total extra is funded at $500 million/year going forward
    • The negative adjustments + the $500 million fund the bonuses – providers have to decide whether they are better off in MIPS or AAPMs – the prospect of as much as 27% upside is quite enticing. BUT …..
## CMS/LAN APM Framework

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HHS Jan 26, 2015 Announcement of Goals and Timeline for Value Payments

• 30% of traditional Medicare payments *tied to* value thru APMs (categories 3,4) by the end of 2016, and 50% by 2018

• 85% *tied to* value (categories 2-4) by 2016 and 90% by 2018

• Note that these assessments of value-based payment do not reflect the percentage of spending related to value, just whether any part of the payment approach has performance measurement and incentives for reducing spending -- even upside only
A few observations about the CMS/LAN Framework

• Emphasizes theoretical incentives in payment methods, mostly ignoring the design and operational issues that determine whether payment models work as intended
• Assumes that value derives only from 1) use of quality measures and 2) “non-nominal” risk-bearing
• In short, the LAN Framework that classified 28 distinct payment models is useful for presenting a logical taxonomy based on structural features (measures and risk) but errs in implying that value follows the same continuum
• Any payment method can be designed to produce more or less value – and that includes classic fee-for-service, in this case, the Medicare Physician Fee Schedule