AMGA
Advancing High Performance Health

2016 Issue Brief

Improve MACRA

In 2015, Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA), which repealed the sustainable growth rate payment mechanism and eliminated the annual race to stop significant cuts to Medicare physician payment. The law grants providers stable payments over four years, which allows medical groups to plan, develop budgets, and create care processes that better meet the needs of their patients. During the spring of 2016, the Centers for Medicare and Medicaid (CMS) issued a proposed rule to implement this law with the objective of finalizing these MACRA regulations by the fall of 2016.

AMGA members remain committed to supporting MACRA, which we believe continues the transition of volume to value in the healthcare delivery system. As policymakers prioritize value, our members continue to lead the way in the transition. In preparation for MACRA, AMGA members are developing financial models, implementing successful leadership structures, and creating innovations in population health. A majority of AMGA members have made multi-million dollar investments to improve quality and lower costs and are encouraged that policymakers aim to recognize and incent these actions.

MACRA creates two payment systems that mandate provider risk: The Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (Advanced APMs).

MIPS is a fee-for-service payment system with payment adjustments based upon a composite performance score. Beginning in 2017, providers will be assessed on four components: Quality, Meaningful Use of Health Information Technology, Resource Use, and Clinical Practice Improvement Activities. In 2019, providers will receive a payment update based upon past performance with a potential +/-4% payment eventually growing to +/-9% in 2022 and beyond.

The other option for providers are Advanced APMs, which transitions Medicare physician payments from volume to value by mandating provider payment risk. Beginning in 2019, physicians and medical groups may qualify as an Advanced APM participant and are eligible to receive a 5% bonus if they meet certain requirements. However, these requirements may not attract a substantial number of physicians and medical groups necessary to achieve success.

AMGA Asks Congress to

Adjust Advanced APM revenue thresholds. According to AMGA's risk readiness survey, 22% of AMGA members indicated that no insurers were offering risk-based products in their market, while 48% of our members declared that only 1% to 19% of insurers were offering risk-based arrangements in their market. Consequently, most providers are unlikely to achieve Advanced APM revenue thresholds, which increase from 25% in 2019 to 75% in 2023 and beyond, without increased commercial payer involvement in offering risk-based products. Revising the thresholds to better reflect market conditions is necessary to attract a sufficient number of Advanced APMs. Conversely, Congress could reduce the

threshold requirement if there are insufficient levels of commercial value products in local markets. Medical groups should not be excluded from being an Advanced APM due to lack of commercial payer participation.

Congress also should direct CMS to include Medicare Advantage (MA) as an option in 2019 to meet the revenue threshold required to qualify as an Advanced APM. By excluding MA from the revenue threshold requirements, CMS unnecessarily limits the opportunities to qualify as an Advanced APM for the first two years of the program. CMS should recognize that some potentially qualifying APMs will be excluded until 2021 when they are prepared to make the investments and assume the risk of participating as an Advanced APM in 2019. MA should be considered under the Medicare Option threshold in 2019.

Include APM investments in the definition in nominal downside risk. APM participants will be required to take on more than "nominal" downside risk to be considered an Advanced APM. At a minimum, we believe the definition should include the multi-million dollar investments our members will make in information technology, care process re-design, and staffing needed to develop the competencies necessary to take on more than "nominal" downside risk. Medical groups are at risk for these costs and they should be included in the definition of "nominal" downside risk.

MACRA states that ACOs are APMs. However, it is clear that Track 1 ACOs will not be considered Advanced APMs. CMS preliminarily estimated in 2011 that the average start-up and first-year operating expenses for establishing an ACO is $1.8 million. That figure is five years old and vastly underestimates actual costs. Track 1 ACOs are already at risk for these investments and should be considered Advanced APMs. We further note that of the 433 ACOs currently in the Medicare Shared Savings Program (MSSP), only 22, or 5%, of ACOs are not in Track 1. If policymakers want to ensure that these 411 ACOs continue to participate in quality driven care, participants in these care models must receive the Advanced APM incentives under MACRA.

Provide additional tools providers need to be successful in a value-based payment system. As healthcare financing begins to transition more fully into value or risk-based arrangements, Congress needs to provide clinicians with the tools necessary to succeed in this new environment. The same rules that apply to fee-for-service payments do not apply when taking risk. Most importantly, Congress should require all payers, Federal and commercial, to provide timely access to full administrative claims data. Currently, some payers offer access to this data while many do not. Without this data, however, it is difficult for providers to manage patients or patient populations, especially those with multiple chronic conditions. Also, data sharing between Medicare, commercial payers, and the provider community must be standardized so needless time and money is not spent on collecting and making data actionable. An effective patient attribution policy is also critical. It is difficult for providers to be accountable for cost and quality when they do not know who is under their care. Adequately adjusting for risk and revising quality measures that actually measure healthcare outcomes also are important issues.