2018 Issue Brief

Improve the Medicare Access and CHIP Reauthorization Act (MACRA)

AMGA appreciates Congressional passage of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, which repealed the sustainable growth rate payment mechanism and aimed to bring more stability to Medicare physician reimbursement. The law creates two new payment mechanisms: the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs). MIPS could serve as a viable transition tool to value in the Medicare program. As the MACRA law was intended, AMGA members would have been rewarded for their investments in health information technology (IT), care management processes, and workforce. However, the Centers for Medicare and Medicaid Services (CMS) has not implemented MIPS as Congress intended.

MIPS

CMS has excluded 60% of providers from MIPS requirements in performance year 2018. Because MIPS is budget neutral, these exclusions result in insignificant payment adjustments to high performing providers. For example, high performers are estimated to receive an aggregate payment adjustment in 2019 of 1.1%, compared to a potential 4% allowed under the statute. In 2020, CMS expects a 1.5% payment adjustment for high performers, compared to a potential 5% adjustment provided for in the law.

As implemented, the financial burden associated with MIPS reporting exceeds the financial reward. In 2017, CMS estimated the provider reporting burden to equal $1.3 billion, while payment adjustments would equal less than $700 million. AMGA members now face insignificant payment updates combined with reporting costs that nearly twice exceed their payment adjustments. MIPS no longer rewards providers for superior performance and provides no return on investments AMGA members have made in clinical practice redesign, heath IT upgrades, care management improvements, hiring care coordinators, and more. Unfortunately, MIPS has devolved from a tool to transition to value to an expensive regulatory compliance exercise with little to no impact on quality or cost.

APMs

Also, APMs can serve as another pathway to value under MACRA. While well intentioned, APM requirements need to be revised to ensure it remains a viable option. To qualify for the program, providers must meet or exceed minimum revenue thresholds coming from APMs or minimum numbers of Medicare beneficiaries in these models. For example, in 2019, 25% of a provider's Medicare revenue must come from APMs. In 2021, 50% of revenue must come from an APM. This threshold increases to 75% in 2023. However, these APM requirements are unlikely to be met and will not attract the critical mass of physicians and medical groups necessary to define success.

Absent the changes outlined below, MACRA does not meet Congress' goal of transitioning Medicare to value.

AMGA Asks Congress to:

- **Urge CMS to end the practice of excluding providers from MIPS and preserve the original intent of the MACRA law.** Currently, too many providers are not participating in the program because of the low-volume threshold that excludes clinicians with less than or equal to $90,000 in Medicare Part B allowed charges or less than or equal to 200 Medicare Part B beneficiaries. CMS should no longer exclude providers from MIPS.

- **Synchronize rules across all federal Accountable Care Organization (ACO) tracks.** This will allow each risk track to operate under the same regulatory framework and ensure continuity when ACOs move up the risk continuum.

- **Provide significant regulatory relief to all APMs.** Regulatory relief can further incentivize the transition to value. Congress should suspend Meaningful Use Stage 3 requirements; waive Appropriate Use Criteria; reduce the number of quality measures; and provide relief from Stark laws and other regulations.

- **Revise threshold requirements for APM qualification.** Currently, providers must attain either a patient or a revenue threshold requirement to be in the APM program. The payment thresholds jump from 25% initially to 75% in 2023 and thereafter. These thresholds do not reflect current nor future healthcare markets regarding risk-based payments. It is unlikely most providers, even high performing AMGA members, can meet these thresholds over time.

- **Adjust ACO regional benchmarking so that they are not competing against themselves.** Benchmarks are used to determine if ACOs met expectations related to spending. The "market minus you" approach is a more appropriate regional benchmark. In other words, Medicare Shared Savings Program ACO's should be compared to the market rather than have their own performance factored in.

- **Allow Medicare Shared Savings Program Track 1 ACOs to extend for a third contract period.** Currently, Track 1 ACOs are unable to extend their contract for a third performance period and must move to a downside risk model. Unable to make this transition, many ACOs may drop out of the program altogether. Therefore, Congress should ensure that Track 1 ACOs, if they show improvement, can continue their mission to improve care in this APM model.