MedPAC June 2016 Report to Congress: Medicare’s proposed rule on MACRA

On June 15th, 2016 the Medicare Payment Advisory Commission (MedPAC) released a statement on Medicare’s new framework for paying clinicians (i.e., The Medicare Access and CHIP Reauthorization Act of 2015 [MACRA]) as part of its June 2016 Report to the Congress: Medicare and the Health Care Delivery System. Their assessment provides feedback and recommendations on how to best implement and modify MACRA in order to help move the Medicare program from its current orientation around fee-for-service (FFS) payments to a value-delivery-based payment system, while improving overall quality in Medicare. The proposals presented attempt to solve problems with the current version of MACRA that have been classified into three main categories: defining and designating Advanced Alternative Payment Models (Advanced APMs), Merit-based Incentive Payment System (MIPS) considerations, and general implementation issues. All recommendations look to target both design and function, while drawing on the lessons of existing performance incentive programs, in order to make the indirect spending controls of MIPS and APMs as effective as possible.

The core advice related to Advanced APMs is that clinicians should only receive the APM incentive payment (for 2019 through 2024) if the Advanced APM, in which they are participating Qualified Practitioners (QPs), is successful in controlling cost and/or in improving quality. MedPAC does not want Medicare payments to be determined by the status of the provider alone, but instead to be a reflection of the value of the service provided to the beneficiary. Looking to the future, requiring Advanced APMs be successful from their start as one of the two paths in the Quality Payment Program (QPP), makes it so CMS can avoid the difficult process of rolling back Advanced APMs that ultimately prove to be unsuccessful. The requirement that Advanced APMs be successful in order to receive the APM incentive payment also helps correct for the cases where MedPAC fears that the 5% incentive payment will outweigh the nominal risk that the APM must bear, and hence fail to provide a sufficiently strong incentive to control spending. In order to support the requirement that only APMs successful in controlling cost and/or improving quality receive the incentive payment, MedPAC lays out five interconnected recommendations.

First, designated Advanced APMs should be at financial risk for total Part A and Part B spending. MedPAC believes that such accountability is necessary to 1). Achieve the clinical and financial integration promised by a reformed payment system 2). Reduce the risk of excess spending without added value. Second, designated Advanced APMs should be responsible for a beneficiary population sufficiently large to detect changes in spending and quality. By being responsible for a beneficiary population large enough to detect changes in spending and quality, Advanced APMs will bear financial risk for monetary losses in excess of a nominal amount. This increased financial risk is important for MedPAC because it can help ensure that the 5% incentive payments continue to provide a sufficiently strong incentive to control spending. Moreover, a sufficient number of beneficiaries could make it possible to overcome the noise of random variation and measure spending reliably. MedPAC admits that a minimum beneficiary requirement would make it harder for some APM entities to qualify and subsequently proposed aggregating geographically dispersed clinicians as a solution -- similar to that used for rural MSSP ACOs -- to increase the number of attributed beneficiaries.

Next, MedPAC proposes that designated Advanced APMs should have the ability to share savings with beneficiaries. Their reasoning is that beneficiary involvement helps efforts to control spending and improve quality, while strengthening CMS’ commitment to patient engagement. In order to balance the added requirements and avoid creating unintended incentives, MedPAC states that CMS should grant APMs it designates as Advanced APMs “regulatory relief,” removing certain regulations that are excessive within the proposed framework and impede the
proper function of the incentives created (e.g., Medicare statute requiring a three-day inpatient hospital stay before use of a SNF). Finally, MedPAC wants designated Advanced APMs to directly assume financial risk and enroll physicians. MedPAC holds that such an approach will maximize flexibility for delivery system reform and keep CMS off the hook for individually allocating losses and rewards.

Continuing to look at the definition and designation for Advanced APMs under MACRA, MedPAC supports using the share of beneficiaries coming through the Advanced APM for threshold determination for deciding whether a clinician participating in an Advanced APM is a QP. MedPAC believes that a beneficiary-focused threshold (as opposed to revenue-focused) for QP determination would be to help more (or different) clinicians become QPs.

The considerations surrounding MIPS that MedPAC presents center on supporting quality measures that emphasize population-based outcomes. They urge CMS to move toward removing measures that that impose reporting burden, are poorly linked to outcomes of importance, and reinforce FFS incentives. Moreover, as part of an overall goal of minimizing the burden of quality reporting, MedPAC believes that a beneficiary-focused threshold (as opposed to revenue-focused) for QP determination would be to help more (or different) clinicians become QPs.

Looking at implementation issues that MedPAC outlines, the general fear that Advanced APMs could take on only a very small amount of risk (e.g., the “risk” of the entity’s investment in setting up the entity) and still meet the nominal risk requirement remains. And thus, there would be insufficient risk to motivate improvement and counter FFS volume incentives. At the same time, MedPAC admits that few models currently qualify as Advanced APMs and that the modifications proposed for the APM requirements will probably be sufficient safeguards. MedPAC also wants to see a decision on whether to use passive or active attribution of beneficiaries, or a combination, while understanding that the attribution approach will have direct effects on beneficiary engagement.

Another potential problem that MedPAC highlights is that MACRA currently appears to permit clinicians to participate in (and have beneficiaries be attributed to) multiple Advanced APMs in a single year. Deciding to limit the number of Advanced APMs that a clinician can participate in could simplify assessing performance and calculating incentive payments; however, limiting participation could decrease the number of APMs, particularly in certain specialties using bundled payment models.

An added problem persists in the set-up that forces physicians to re-qualify each year to determine what incentives payment(s) they will be eligible for, and thus makes it so physicians do not know at a given point in time whether they will be on the MIPS or Advanced APM payment path. For instance, clinicians can elect to be in an APM in 2017, but CMS may not determine if they are qualifying APM participants until 2019 -- posing difficulties in ensuring that they are reporting on the correct measures in the years before 2019. MedPAC proposes allowing entities to report quality as a substitute for MIPS quality measures (i.e. use of a less standardized report, similar to how some payment models currently allow entities to report quality as a substitute for PQRS) in order to avoid the risk of collecting non-relevant measure information.

Ultimately, MedPAC’s feedback and recommendations in response to MACRA are aimed at supporting the transition from FFS to a payment-for-value delivery system. MedPAC hopes to ensure that incentives in place continue to further the stability of the Medicare program and ensure access and service for beneficiaries, while aiding in this payment evolution.