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Hearing on “Medicare Physician Payment Reform After Two Years:
Examining MACRA Implementation and the Road Ahead”

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Chairman Grassley, Ranking Member Wyden, members of the Finance Committee, thank you for the opportunity to testify today. My name is Matthew Fiedler, and I am a Fellow with the USC-Brookings Schaeffer Initiative for Health Policy, where my research focuses on a range of topics in health care economics and health care policy, including provider payment policy. Previously, I served as Chief Economist on the staff of the Council of Economic Advisers, where I provided economic advice on a range of health care policy issues. This testimony reflects my personal views and should not be attributed to the staff, officers, or trustees of the Brookings Institution.

I am honored to have the opportunity to speak with you about implementation of the Medicare physician payment provisions of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).¹ My testimony makes four main points:

1. Research examining the structure of the Merit-Based Incentive Payment System (MIPS) and experience with similar programs suggest that MIPS is unlikely to improve the quality or efficiency of patient care. But MIPS is creating substantial administrative costs.
2. MACRA’s bonus payments for clinicians participating in advanced alternative payment models (APMs) have great potential to increase participation in these models, which recent research has shown can reduce health care spending while maintaining or improving quality. Consistent with this potential, implementation of the bonus has coincided with—and likely helped cause—greater participation in advanced APMs, while also encouraging the Centers for Medicare and Medicaid Services (CMS) to deploy more effective APMs.

¹ Many of the ideas discussed here were developed in joint work with several colleagues. See Fiedler, Matthew, Tim Gronniger, Paul B. Ginsburg, Kavita Patel, Loren Adler, and Margaret Darling. 2018. “Congress Should Replace Medicare’s Merit-Based Incentive Payment System.” Health Affairs Blog. <https://www.healthaffairs.org/doi/10.1377/hblog20180222.35120/full/>. Any errors are my own.

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3. Policymakers should build on what is working in MACRA and discard what is not by increasing the size of MACRA’s incentives for participation in advanced APMs, creating similar incentives for other categories of providers, and eliminating MIPS.
4. In the absence of broader changes to MACRA, several narrower reforms are worth considering. These include making the advanced APM bonus permanent, eliminating the “cliff” in the advanced APM bonus eligibility rules, standardizing the measures used in the MIPS quality category, and replacing the MIPS practice improvement and promoting interoperability categories with more targeted incentives.

Background on MACRA

In addition to reauthorizing the Children’s Health Insurance Program and repealing the sustainable growth rate formula that determined the overall level of Medicare’s physician payment rates, MACRA made important structural changes to how Medicare pays physicians. Under MACRA, clinicians choose between two tracks: (1) participating in MIPS; and (2) participating in an advanced APM.

Most clinicians are currently participating in MIPS, which adjusts clinicians’ payment rates upward or downward based on their performance in four categories: (1) quality of care; (2) cost of care; (3) completion of specified “practice improvement” activities; and (4) use of certified electronic health records (EHRs), now called the “promoting interoperability” category by CMS. In the quality and practice improvement categories, clinicians have broad flexibility to select the measures or activities they are evaluated on. With the exception of the cost category, clinicians are generally responsible for collecting the information used to evaluate their performance and submitting that information to CMS. The first “performance year” under MIPS was 2017; payment adjustments for the 2017 performance year are occurring during 2019.

Clinicians are permitted to opt out of MIPS if they participate to a sufficient degree in an advanced APM, as measured by the share of a clinician’s payments or patient volume connected with an advanced APM.² Importantly, clinicians with sufficient participation in advanced APMs are also eligible for a bonus payment equal to 5 percent of their physician fee schedule revenue. Paralleling MIPS, the first performance year for the advanced APM bonus was 2017, and the first bonus payments are occurring in 2019. The bonus for advanced APM participation will expire after the 2022 performance year.³

² For the current performance year, a clinician must serve at least 35 percent of its patients or receive at least 50 percent of its payments in connection with an advanced APM. For 2021 and later performance years, those thresholds rise to 50 percent and 75 percent, respectively. Clinicians with somewhat lesser engagement with advanced APMs are eligible to opt out of MIPS but are not eligible for bonus payments.

³ MACRA provides that payment rates for clinicians participating in advanced APMs will grow 0.5 percentage points per year more quickly than those for non-participants starting with the 2024 performance year, which will gradually re-create an incentive for participation in advanced APMs. However, it will take more than a decade after 2022 before incentives for participation in advanced APMs return to the level of the current bonus.

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To be considered an “advanced” APM, a payment model must make participants financially liable if spending exceeds an expected level. Advanced APMs must also base payment in part on participants’ quality performance and require participants to use an EHR that meets the certification criteria promulgated by the Department of Health and Human Services (HHS). The most prominent examples of advanced APMs are Accountable Care Organization (ACO) models that include “two-sided” risk (that is, ACO models that require participants to bear a portion of the costs if spending by their beneficiaries exceeds the “benchmark” spending level under the model). However, some episode (or “bundled”) payment models, as well as some medical home models, also qualify as advanced APMs.

MIPS Appears Unlikely to Meaningfully Improve Patient Care, but is Creating Burden

There is limited direct evidence on MIPS’s effects to date because data on the program’s first year were only recently released and because decisions CMS made to ease the transition to MIPS make this early experience a poor guide to how MIPS will perform in the long run. However, analyses of MIPS’s structure, as well as research examining prior similar programs, suggest that MIPS is unlikely to achieve its goals of reducing costs or improving quality. Nevertheless, MIPS is creating significant administrative costs for providers.

Structural Problems Limit MIPS’s Ability to Improve the Quality or Efficiency of Patient Care

MIPS has several structural problems that limit the program’s ability to improve the quality or efficiency of the care Medicare beneficiaries receive. I focus on three that are particularly significant. Other experts and the Medicare Payment Advisory Commission (MedPAC) have expressed similar concerns about MIPS’s architecture.⁴

Problem #1: Orienting Payment Incentives Around Clinicians, Rather than Patients

MIPS aims to improve the quality and efficiency of patient care by adjusting payments for individual clinicians or practices. But a given patient’s care often involves multiple different clinicians, each playing a different role. Ensuring that the payment incentives MIPS creates for individual clinicians or practices add up to a coherent set of incentives for the management of each patient’s care is at best difficult and, as a practical matter, probably impossible.

For example, under the MIPS cost category as currently implemented, the need to measure cost performance at the clinician or practice level has led CMS to create multiple different cost measures, score each clinician or practice on all measures for which minimum sample size requirements are met, and then compute a final category score as an equally weighted average of the scored measures. This approach creates an unpredictable and haphazard overall set of

⁴ See, for example, Schneider, Eric C. and Cornelia J. Hall. 2017. “Improve Quality, Control Spending, Maintain Access — Can the Merit-Based Incentive Payment System Deliver?” *New England Journal of Medicine* 376(8): 708-710; Medicare Payment Advisory Commission. 2018. “Moving beyond the Merit-based Incentive Payment System.” http://www.medpac.gov/docs/default-source/reports/mar18_medpac_ch15_sec.pdf?sfvrsn=0; Rathi, Vinay K. and J. Michael McWilliams. 2019 “First-Year Report Cards From the Merit-Based Incentive Payment System (MIPS): What Will Be Learned and What Next?” *Journal of the American Medical Association*.

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incentives to reduce spending since a given dollar of spending may factor into zero, one, or more than one of the cost measures that end up being scored for any given provider.

Problem #2: Limited Panel Sizes at the Practice Level

It is difficult to reliably measure cost or quality performance at the level of an individual clinician or practice because of the relatively small number of Medicare beneficiaries involved. This problem is particularly acute when measuring cost performance since health care spending varies so widely across individuals. As a result, at least once MIPS is fully implemented, chance will play a large role in determining where a clinician falls on the spectrum of possible payment adjustments under MIPS, which weakens the incentives those payment adjustments create for clinicians to improve performance. Incentives could, of course, be strengthened by making the MIPS payment adjustments larger, but clinicians would have legitimate concerns about basing large payment adjustments on performance measures influenced so strongly by random chance.

Problem #3: Clinician Choice of Quality Measures

Clinicians' ability to choose the quality measures they are evaluated on undermines the effectiveness of the MIPS quality category. Allowing clinicians to choose quality measures was a well-intended effort to allow clinicians to tailor the measures they report to the nature of the care they provide. However, the lack of common measures makes comparing the performance of different clinicians—even clinicians providing similar services—difficult or impossible. That, in turn, makes it hard to determine which clinicians are, in fact, high or low performers for the purposes of MIPS payment adjustments. The lack of common measures will also make it difficult or impossible for patients to use the data generated by MIPS to compare providers.

Allowing choice also creates strong incentives for clinicians to selectively report quality measures on which they perform well while declining to report measures on which they perform poorly. Indeed, due to the financial stakes under MIPS, it is hard for clinicians to avoid doing this, even if that would be their preference. This type of selective reporting causes the data collected under MIPS to provide a skewed picture of each clinician's performance, making it even more difficult for patients or CMS to use the data to evaluate clinicians. These incentives for selective reporting likely also increase administrative costs by requiring providers to invest time and effort (or hire consultants) to identify the measures they are likely to perform best on, or, alternatively, to collect data on many more measures than they are required to report and submit only the best ones.

The MIPS practice improvement activities category suffers from similar problems. Practices are permitted to select from a list of more than 100 practice improvement activities and can achieve a maximum score by completing at most four (and sometimes fewer) activities.⁵ The list is sufficiently broad that, at least in many instances, clinicians can achieve the maximum score for the practice improvement category by reporting on activities that they had already planned to complete. In those instances, the practice improvement category creates reporting costs for providers, but no benefit to patients. Even when the category does induce providers to take action they would not otherwise have taken, the benefit to patients is uncertain. While many of the

⁵ Practice improvement activities include items like reporting to clinical registries, conducting a survey on patient satisfaction, participating in specific trainings, or integrating recommended clinician screenings into routine practice.

included activities are at least superficially appealing, the evidence base supporting them is not always clear, nor is it clear that the level of engagement with these activities required to gain credit under MIPS is sufficient to generate meaningful changes in care.

Research on Programs Similar to MIPS has Found Discouraging Results

MIPS is not the first instance in which Medicare has sought to improve the quality or reduce the cost of patient care by adjusting providers' fee-for-service payment rates upward or downward based on performance on a broad set of cost and quality measures. Research on these similar programs has found little evidence that such programs have achieved their objectives, and there is little reason to believe that a different result should be expected under MIPS.

A recent study examining the Value-Based Payment Modifier (Value Modifier), a predecessor to MIPS that adjusted Medicare payment rates for physician groups based on cost and quality performance, provides particularly relevant and compelling evidence.⁶ This research draws on the fact that practices with 100 or more clinicians could receive either bonuses or penalties under the Value Modifier, while practices with between 10 and 99 clinicians could receive only bonuses and smaller practices were excluded entirely. The researchers were thus able to isolate the effect of the Value Modifier by looking for sharp changes in cost or quality performance at these practice size thresholds. The authors found no evidence that the Value Modifier had any effect on potentially avoidable hospitalizations, hospital readmissions, Medicare spending, or mortality.

Research examining the Hospital Value-Based Purchasing Program (HVBP), which adjusts Medicare hospital payments upward and downward based on a similarly broad set of measures, has reached similar discouraging conclusions.⁷ The same is true of research on the Premier Hospital Demonstration, a demonstration project that was a predecessor of the HVBP.⁸ It is notable that these hospital-focused programs avoid at least some of MIPS's shortcomings since most hospitals have much higher patient volumes than individual clinicians or practices and these programs do not allow hospitals to choose which measures they are evaluated on.

Before proceeding, I note two caveats on this evidence. First, the estimates from these studies are subject to some uncertainty. Thus, while this evidence largely rules out the possibility that these programs caused large improvements in patient care, these programs could have caused smaller improvements in patient care that these studies were unable to detect.

Second, this evidence should not be interpreted as showing that adjusting payments based on particular outcomes within a fee-for-service structure can never be successful. Notably, research

⁶ Roberts, Eric T., Alan M. Zaslavsky, and J. Michael McWilliams. 2018. "The Value-Based Payment Modifier: Program Outcomes and Implications for Disparities." *Annals of Internal Medicine* 168(4): 255-265.

⁷ Ryan, Andrew M., Sam Krinsky, Kristin A. Maurer, and Justin B. Dimick. 2017. "Changes in Hospital Quality Associated with Hospital Value-Based Purchasing." *New England Journal of Medicine* 376(24): 2358-2366;

Figuroa, Jose F., Yusuke Tsugawa, Jie Zheng, E. John Orav, and Ashish K. Jha. 2016. "Association between the Value-Based Purchasing pay for performance program and patient mortality in US hospitals: observational study." *British Medical Journal* 353: i2214.

⁸ Jha, Ashish K., Karen E. Joynt, E. John Orav, and Arnold M. Epstein. 2012. "The Long-Term Effect of Premier Pay for Performance on Patient Outcomes." *New England Journal of Medicine* 366(17): 1605-1615.

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on the Hospital Readmission Reduction Program (HRRP), which penalizes hospitals at which a large share of patients are readmitted soon after discharge finds that it substantially reduced hospital readmission rates.⁹ Moreover, while there has been some recent controversy on this point, there is, in my view, some evidence that the HRRP reduced post-discharge mortality rates and no compelling evidence that the HRRP increased mortality.¹⁰ One plausible explanation for why the HRRP has been more successful than the Value Modifier or HVBP is that the HRRP is a much more targeted program that attaches relatively strong incentives to a narrow set of outcomes.

Providers Incur Significant Costs to Comply with MIPS

While MIPS, at least in its current form, appears unlikely to substantially improve patient care, it is creating substantial compliance costs. For the 2019 performance year, CMS estimates that providers will incur \$482 million in reporting costs related to MIPS, with the MIPS quality category accounting for the majority of those costs.¹¹ Notably, this figure does not include the costs providers incur to develop a strategy for complying with MIPS, including deciding which quality measures it is most advantageous to collect and report. These activities are likely to require providers to invest substantial staff time, hire outside consultants, or both.

Of course, the fact that complying with MIPS creates administrative costs is not, in itself, evidence of a problem. If MIPS was improving the quality or efficiency of patient care, then these costs could be worth incurring. Indeed, the \$482 million in estimated reporting costs cited above constitute only around 0.5 percent of projected spending on services under the physician fee schedule during 2019, so even modest improvements in care could suffice. But it is hard to justify requiring clinicians to incur these costs in service of an ineffective program.

Research Finds APMs Can be Effective, and Participation in Advanced APMs is Rising

While I am pessimistic about MIPS, I am optimistic about MACRA's bonus payments for participation in advanced APMs. Recent research has shown that well-designed APMs can reduce health care spending while maintaining or improving quality. Furthermore, implementation of MACRA's bonus payments has coincided with—and likely helped cause—an increase in participation in these models, while also facilitating the deployment of more effective APMs.

⁹ Zuckerman, Rachael B., Steven H. Sheingold, E. John Orav, Joel Ruhter, and Arnold M. Epstein. 2016. "Readmissions, Observation, and the Hospital Readmission Reduction Program." *New England Journal of Medicine* 374: 1543-1551; Medicare Payment Advisory Commission. 2018. "Mandated report: The effects of the Hospital Readmissions Reduction Program." http://www.medpac.gov/docs/default-source/reports/jun18_ch1_medpacreport_sec.pdf; Atul Gupta. 2017. "Impact of performance pay for hospitals: The Readmissions Reduction Program." Working Paper. https://www.dropbox.com/s/rfwok9en2c5812j/Gupta_HRRP.pdf.

¹⁰ Ibid.

¹¹ See Table 91 in Centers for Medicare and Medicaid Services. 2018. "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019..." *Federal Register* 83(226): 59452. <https://www.govinfo.gov/content/pkg/FR-2018-11-23/pdf/2018-24170.pdf>.

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Evidence on APMs' Effectiveness

Recent research indicates that APMs can be effective tools for reducing health care spending. I focus on the evidence on ACO models since they account for the large majority of participation in APMs and advanced APMs in Medicare. The best such research has focused on the Medicare Shared Savings Program (MSSP), which is by far the largest Medicare ACO program.¹² This research has found that MSSP ACOs reduce average spending per beneficiary by between 0 and 5 percent, with the size of the spending reduction depending on an ACO's composition and how long it has participated in the MSSP. On average, physician-group ACOs that have a few years of experience in the MSSP have performed at the high end of this range, while ACOs containing a hospital have performed at the low end of this range. Research examining the Center for Medicare and Medicaid Innovation's Pioneer ACO model has also found evidence that the model reduced spending, as has research examining a commercial ACO-like contract operated by Blue Cross Blue Shield of Massachusetts.¹³

For a few reasons, I suspect these findings may understate the overall savings that should be expected from ACO models, at least over the long run. First, the research cited above provides some evidence that providers perform better in these models as they gain experience. Second, the research on MSSP examines years in which essentially all ACOs were participating in one-sided models under the program's original benchmarking methodology; as discussed below, CMS has made changes in both these areas that will likely cause MSSP ACOs to have stronger incentives to reduce spending in the future than they have in the past. Third, these models may reduce spending through a variety of channels that were not examined in these studies. Most directly, reductions in traditional Medicare spending reduce payments to plans under the Medicare Advantage program.¹⁴ Medicare's deployment of these models also appears to have coincided with—and plausibly helped cause—increased use of these models by private insurers.¹⁵ Providers participating in ACOs may also change the way they treat patients covered by other payers or play a role in reshaping the practice norms adhered to by other providers.¹⁶

¹² McWilliams, J. Michael, Laura A. Hatfield, Bruce E. Landon, Pasha Hamed, and Michael E. Chernew. 2018. "Medicare Spending after 3 Years of the Medicare Shared Savings Program." *New England Journal of Medicine* 379(12): 1139-1149.

¹³ McWilliams, J. Michael, Michael E. Chernew, Bruce E. Landon, and Aaron L. Schwartz. 2015. "Performance Differences in Year 1 of Pioneer Accountable Care Organizations." *New England Journal of Medicine* 372(20): 1927-1936; Nyweide, David J., Woolton Lee, Timothy T. Cuerdon, Hoangmai H. Pham, Megan Cox, Rahul Rajkumar, Patrick H. Conway. 2015. "Association of Pioneer Accountable Care Organizations vs Traditional Medicare Fee for Service With Spending, Utilization, and Patient Experience." *Journal of the American Medical Association* 313(21): 2152-2161; Song, Zirui, Sherri Rose, Dana G. Safran, Bruce E. Landon, Matthew P. Day, and Michael E. Chernew. 2014. "Changes in Health Care Spending and Quality 4 Years into Global Payment." *New England Journal of Medicine* 371(18): 1704-14.

¹⁴ Centers for Medicare and Medicaid Services. 2018. "Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations-Pathways to Success and Extreme and Uncontrollable Circumstances Policies for Performance Year 2017." *Federal Register* 83(249): 67816; McWilliams, J. Michael. 2016. "Savings from ACOs—Building on Early Success." *Annals of Internal Medicine* 165(12): 873-875.

¹⁵ Muhlestein, David, Robert S. Saunders, Robert Richards, and Mark B. McClellan. 2018. "Recent Progress In The Value Journey: Growth Of ACOs And Value-Based Payment Models In 2018." *Health Affairs Blog*, <https://www.healthaffairs.org/doi/10.1377/hblog20180810.481968/full/>.

¹⁶ Baicker, Katherine, Michael E. Chernew, and Jacob A. Robbins. 2013. "The spillover effects of Medicare managed care: Medicare Advantage and hospital utilization." *Journal of Health Economics* 32(6): 1289-1300; Glied,

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It is less clear how ACOs have affected quality of care, in part because measuring changes in quality of care is more difficult. There is reasonably persuasive evidence that the savings achieved under Medicare’s ACO models have not come at the cost of worse health outcomes.¹⁷ What is less clear is whether ACO models have actually improved quality of care and, if so, by how much. There is some evidence that ACOs have improved patients’ experience of care.¹⁸ Some research has also suggested that ACOs have increased receipt of certain recommended screenings services, but this finding has been inconsistent.¹⁹ More research on this question would be valuable.

An important question is why ACOs have performed better than pay-for-performance programs like MIPS, at least with respect to the cost of care. I suspect two factors are important. First, an ACO serves many more patients than an individual clinician or practice. That larger size makes it much easier to produce statistically reliable measures of providers’ performance, which in turn allows ACOs to use payment designs that create much stronger incentives to reduce spending than programs like MIPS. Second, ACOs make one provider (or group of providers) accountable for the overall cost and quality of a patient’s care. That allows ACOs to create much more coherent—and comprehensible—incentives to improve patient care than programs like MIPS that make disconnected payment adjustments for each individual provider.

Advanced APM Participation Has Risen Markedly in Recent Years

Participation in APMs that meet the advanced APM criteria has increased markedly since MACRA’s enactment. Figure 1 presents data on participation in ACOs, which, as noted above, account for the large majority of APM and advanced APM participation in Medicare.²⁰ The share

Sherry and Joshua Graff Zivin. 2002. “How do doctors behave when some (but not all) of their patients are in managed care?” *Journal of Health Economics* 21(2): 337-353; McWilliams, J. Michael, Bruce E. Landon, Michael E. Chernew. 2013. “Changes in Health Care Spending and Quality for Medicare Beneficiaries Associated With a Commercial ACO Contract.” *Journal of the American Medical Association* 310(8): 829-836.

¹⁷ Herrel, Lindsey A., Edward C. Norton, Scott R. Hawken, Zaojun Ye, Brent K. Hollenbeck, and David C. Miller. 2016. “Early Impact of Medicare Accountable Care Organization Cancer Surgery Outcomes.” *Cancer* 122(17): 2739-2746; McWilliams, J. Michael, Lauren G. Gilstrap, David G. Stevenson, Michael E. Chernew, Haiden A. Huskamp, and David C. Grabowski. 2017. “Changes in Post-acute Care in the Medicare Shared Savings Program.” *JAMA Internal Medicine* 177(4): 518-526.

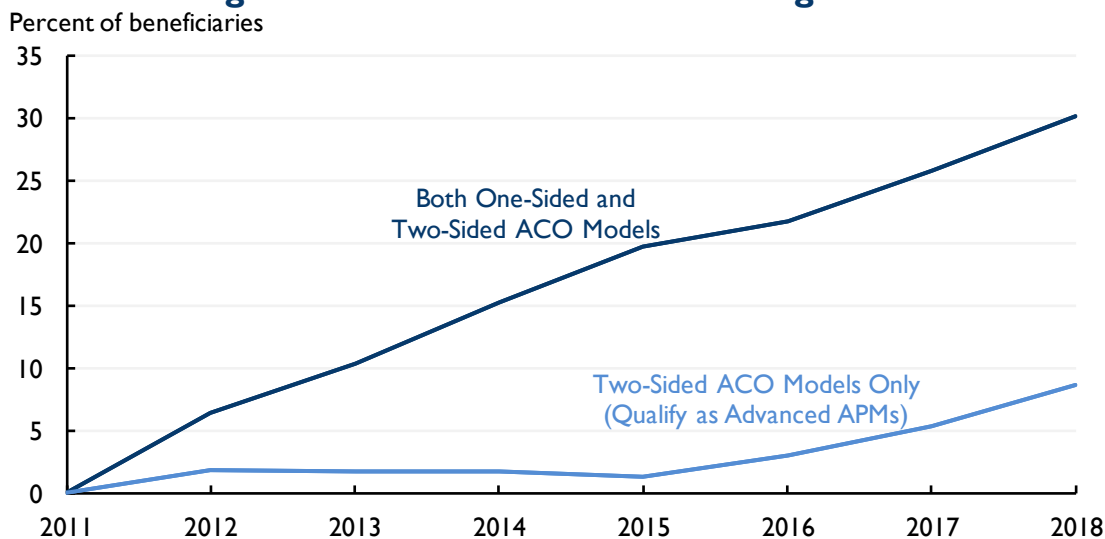
¹⁸ McWilliams, J. Michael., Bruce E. Landon, Michael E. Chernew, and Alan M. Zaslavsky. 2014. “Changes in Patients’ Experiences in Medicare Accountable Care Organizations.” *New England Journal of Medicine* 371(18): 1715-1724.

¹⁹ McWilliams et al. (2015); McWilliams, J. Michael, Laura A. Hatfield, Michael E. Chernew, Bruce E. Landon, and Aaron L. Schwartz. 2016. “Early Performance of Accountable Care Organizations in Medicare.” *New England Journal of Medicine* 374(24): 2357-2366.

²⁰ These estimates include beneficiaries assigned to ACOs participating in the Medicare Shared Savings Program or the Center for Medicare and Medicaid Innovation’s Pioneer and Next Generation ACO models. Estimates use the MSSP public use files produced by CMS, as well as the published financial results for the Pioneer and Next Generation models. Enrollment data are not yet available for 2018, but the number of ACOs participating in each program is available, so I have assumed that the number of beneficiaries assigned to each type of ACO grew in proportion to the number of ACOs of that type. Track 1+ did not exist as an MSSP participation option until 2018, so I assume that the average number of beneficiaries assigned to each Track 1+ ACO in 2018 was the same as the average number of beneficiaries assigned to each Track 1 ACO in 2017.

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Figure 1: Share of Traditional Medicare Beneficiaries Assigned to an Accountable Care Organization



Source: Author's calculations based on CMS data.

Note: Estimates are for the end of the calendar year. Estimates for 2018 are based on preliminary data.

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of Medicare beneficiaries served by providers that participate in an ACO that involves “two-sided” risk—the types of ACO models that qualify as advanced APMs—stood at 9 percent in 2018, up from 3 percent in 2016, the last year before the advanced APM bonus became available. Advanced APM participation also increased from 2015 to 2016, from 1 percent to 3 percent, and it is possible that a portion of this increase occurred because providers were anticipating the fact that bonuses for advanced APM participation would become available in 2017.

Additional research on why participation in two-sided ACO models has risen in recent years would be valuable, but I suspect that the advanced APM bonus has played an important role. That said, the bonus payment is likely not the only factor. Notably, CMS has recently been expanding its portfolio of two-sided ACO models: in 2016, CMS introduced the Track 3 participation option under the MSSP and introduced the Next Generation ACO model under the auspices of the Center for Medicare and Medicaid Innovation; and, in 2018, CMS introduced the Track 1+ participation option under the MSSP, an option that includes “two-sided” risk, but in a more limited form than prior models. Providers have also gained experience with ACO models over time, which may make them more willing to take on two-sided risk.

MACRA’s Advanced APM Bonus Has Supported Deployment of More Effective APMs

The existence of the advanced APM bonus has also encouraged CMS to be more aggressive in deploying ACO models that create stronger incentives for providers to reduce health care spending. This is the case in at least two areas.

First, in 2016, CMS finalized changes to the rules for calculating the spending “benchmarks” used to evaluate MSSP ACOs’ spending performance. Prior to this change, benchmarks for MSSP

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ACOs were set based on each ACO's own spending over the three years preceding each agreement period. This methodology greatly weakened ACOs' incentives to reduce spending since success in reducing spending during an ACO's current agreement period was penalized by a dollar-for-dollar reduction in the ACO's benchmark for the subsequent agreement period.

To ameliorate this problem, CMS changed the benchmark calculation so that each ACO's benchmark equaled a blend of the ACO's own past spending and average spending in the ACO's region.²¹ The revised methodology has the downside, however, of making MSSP participation less attractive for ACOs with high spending relative to their regions. The upward pressure on ACO participation from implementation of the advanced APM bonus helped counteract the downward pressure on participation among high-cost ACOs from the benchmarking change and likely made CMS more willing to implement these improvements to the benchmarking methodology.

Second, in late 2018, CMS finalized rules that will require all ACOs to shift into models that include two-sided risk more quickly than had been required under prior rules.²² Like the benchmarking change, this policy change involves a tradeoff. Models that include two-sided risk create stronger incentives for providers to reduce spending and, even holding underlying health care spending constant, directly generate larger savings for the Medicare program. Models with two-sided risk are also, however, less attractive to providers (all else being equal), so requiring two-sided risk is likely to put downward pressure on ACO participation. The existence of the advanced APM bonus appears to have shaped how CMS weighed these tradeoffs and made it more willing to move ahead, which was, in my view, the right decision, although it was a close call.²³

The Best Path Forward: Eliminate MIPS and Strengthen Advanced APM Incentives

Policymakers should seek to build on the parts of MACRA that are working well, while discarding the parts that are not. To that end, I believe that the best path forward is to eliminate MIPS, but expand incentives for participation in advanced APMs. I will discuss each recommendation in turn.

²¹ Centers for Medicare and Medicaid Services. 2016. "Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations-Revised Benchmark Rebased Methodology, Facilitating Transition to Performance-Based Risk, and Administrative Finality of Financial Calculations." *Federal Register* 81(112): 37950.

²² Centers for Medicare and Medicaid Services. 2018. "Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations-Pathways to Success and Extreme and Uncontrollable Circumstances Policies for Performance Year 2017." *Federal Register* 83(249): 67816.

²³ For additional discussion of my views on these changes, see Fiedler, Matthew. 2018. "Comments on CMS's Proposed Rule, 'Medicare Shared Savings Program; Accountable Care Organizations-Pathways to Success'" <https://www.brookings.edu/opinions/comments-on-cmss-medicare-shared-savings-program-accountable-care-organizations-pathways-to-success/>. For a thoughtful opposing view, see McWilliams, J. Michael, Michael Chernew, and Bruce Landon. 2018. "Comment Letter on MSSP Proposed Rule." <https://hmlab.hcp.med.harvard.edu/mcwilliams-chernew-and-landon-comment-mssp-proposed-rule>.

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Recommendation #1: Eliminate MIPS

In light of the problems with MIPS discussed earlier, I agree with MedPAC and other experts that eliminating MIPS is the best path forward.²⁴ Some of MIPS's problems—particularly those stemming from clinicians' ability to choose the quality measures they are evaluated on—could be addressed while retaining MIPS's basic structure. However, many of MIPS's issues are more fundamental. In particular, generating statistically reliable measures of cost and quality performance at the practice level is likely effectively impossible, as is creating coherent overall incentives to improve patient care by adjusting payments to individual physician practices.

These challenges, together with the evidence that prior programs similar to MIPS have not been effective, lead me to believe that a reformed MIPS would still fail to generate improvements in the quality or efficiency of patient care sufficient to justify its administrative costs. I thus view eliminating MIPS as the best path forward. If MIPS were eliminated, policymakers should consider creating targeted incentives for use of certified EHRs and reporting to clinical registries; I discuss such incentives later in this testimony in the section on potential incremental changes to MIPS.

Recommendation #2: Strengthen Incentives for Advanced APM Participation

In contrast to MIPS, MACRA's incentive for participation in advanced APMs appears to be achieving its main goal of increasing participation in effective alternative payment models. Policymakers should seek to build on the success of this component of MACRA by strengthening incentives for participation in advanced APMs.

Creating stronger incentives for participation in advanced APMs would have two benefits. First, stronger incentives for advanced APM participation would directly increase participation in these models, which the research reviewed earlier indicates would increase the efficiency of Medicare spending while maintaining or improving the quality of the care Medicare beneficiaries receive. Second, stronger incentives for participation in advanced APMs would allow CMS to make further progress in deploying versions of APMs that create stronger incentives to reduce spending. In particular, it will likely ultimately be desirable for CMS to go further in requiring ACOs to take on two-sided risk and in basing ACOs' "benchmarks" on regional average spending rather than ACOs' own historical costs. However, as noted earlier, changes like these make ACO participation less attractive for some categories of providers. Sufficiently strong incentives for advanced APM participation could mitigate or eliminate this tradeoff.

A good first step to strengthen incentives for participation in advanced APMs would be to make MACRA's bonus for participation in advanced APMs permanent, a point I return to in the next section of my testimony. However, more significant enhancements are warranted:

- *Increase the size of the incentive for advanced APM participation:* One worthwhile step would be to increase the size of MACRA's incentives for participation in advanced APMs.

²⁴ See, for example, Medicare Payment Advisory Commission. 2018. "Moving beyond the Merit-based Incentive Payment System." http://www.medpac.gov/docs/default-source/reports/mar18_medpac_ch15_sec.pdf?sfvrsn=0; Rathi, Vinay K. and J. Michael McWilliams. 2019 "First-Year Report Cards From the Merit-Based Incentive Payment System (MIPS): What Will Be Learned and What Next?" *Journal of the American Medical Association*.

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Determining the appropriate magnitude of the increase would require additional modeling and analysis, but creating an incentive for advanced APM participation that is at least twice as large as the current incentive could easily be appropriate.

Since a major objective of promoting greater participation in advanced APMs is to reduce Medicare spending, additional incentives for advanced APM participation should be structured in a way that does not increase federal costs. To that end, Congress could implement a budget-neutral combination of larger bonuses for advanced APM participation and penalties for providers that decline to participate in an advanced APM. This approach of using penalties from poor performers to fund bonus payments to high performers is similar to the approach Congress has taken under MIPS and many other programs.

- *Create incentives for other categories of providers to participate in advanced APMs or collaborate with participants in advanced APMs:* An additional worthwhile step would be to create incentives for other categories of providers, particularly hospitals, to participate in advanced APMs or collaborate with providers who participate in advanced APMs. Providers could qualify for incentive payments in essentially the same way that clinicians can qualify under MACRA, with the exception that providers could count services or patients associated with an advanced APM in which the provider was not itself participating if the provider had a written collaboration agreement with participants in that advanced APM. This approach would, for example, allow a hospital to earn the incentive payment by collaborating with one or more physician-only ACOs in its community rather than setting up its own ACO. Allowing hospitals to take this approach is particularly important in light of the evidence noted above that physician-only ACOs have been more successful in reducing spending than those containing a hospital as a participant.

There are two reasons to extend advanced APM incentives to non-physician providers. First, it would give these providers a greater stake in the deployment and success of advanced APMs, which may be necessary to fully realize these models' potential to improve the quality and efficiency of patient care. Second, there are likely limits on how low payment rates for clinicians not participating in advanced APMs can be set, which limits the overall size of the incentives that can be created for advanced APM participation if the physician fee schedule is the sole vehicle for creating those incentives. Extending incentives for advanced APM participation for other providers relaxes this constraint.

As above, it would be important that additional incentives for advanced APM participation be structured in a way that would not increase federal costs. To this end, any incentive for hospitals or other categories of providers could be structured as a budget-neutral combination of bonuses for participants and penalties for non-participants.

Incremental Steps: Extend the Advanced APM Bonus and Make Targeted MIPS Changes

While eliminating MIPS and expanding MACRA's advanced APM incentives is the best path forward in my view, there are also opportunities to make incremental improvements in both areas.

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Permanently Extend the Advanced APM Bonus and Eliminate the Eligibility “Cliff”

There are at least two incremental changes that could be made to the advanced APM bonus:

- *Permanently extend the advanced APM bonus:* One important step Congress can take is to permanently extend the advanced APM bonus, which is currently scheduled to expire after the 2022 performance year. It would be best to enact an extension well before the bonus expires. Many of the investments providers need to make to be successful under advanced APMs are only likely to be attractive to providers that expect to continue participating in advanced APMs in the future, and the likelihood that the advanced APM bonus will continue is one major factor shaping providers’ plans about future APM participation. Waiting until the last minute to extend the bonus would thus likely reduce advanced APM participation in the near term and forfeit a portion of the bonus’ potential benefits.

The advanced APM bonus can and should be extended in a way that does not increase overall Medicare spending. One approach to achieving this objective, discussed above, would be to replace the current bonus payment with a budget-neutral combination of bonuses for advanced APM participation and penalties for non-participation. Another approach would be to pair the extension with offsetting changes to Medicare payments.

- *Smooth out the “cliff” in the advanced APM bonus eligibility criteria:* A clinician’s eligibility for the advanced APM bonus depends on whether a sufficient share of its payments or patient volume is connected with an advanced APM. Clinicians that exceed the threshold are eligible for the full bonus, while clinicians that fall short, even by a very small amount, are eligible for no bonus payments at all.

This “all or nothing” structure is hard to justify. The Medicare program frequently benefits from clinician engagement with advanced APMs even when that engagement falls short of the eligibility thresholds; that will be particularly true under the relatively high eligibility thresholds that will apply over the long run. Additionally, the Medicare program would sometimes benefit if clinicians that meet the current thresholds had incentives to further increase their engagement with advanced APMs.

Thus, it would be desirable to replace the current “all or nothing” structure with a structure in which a clinician’s bonus phased up gradually once a clinician’s engagement with advanced APMs crossed a threshold level. Under such an approach, it would be important that the bonus payment phase in rapidly enough to ensure that clinicians currently receiving bonuses generally received bonuses comparable to those they receive today. This approach has similarities to a proposal included in the Administration’s fiscal year 2020 budget, but there are two important differences.²⁵ First, the Administration’s proposal appears to reduce bonuses for many current recipients, which would be a step in the wrong direction. Second, the Administration’s proposal would pay bonuses to some providers with very limited advanced APM engagement, which is likely a low-priority use of bonus funds.

²⁵ Department of Health and Human Services. 2019. “Fiscal year 2020 Budget-in-Brief.” <https://www.hhs.gov/sites/default/files/fy-2020-budget-in-brief.pdf>.

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Make Targeted Improvements to MIPS

As noted earlier, I believe there are limits to what a reformed MIPS program could realistically achieve. But there are three changes that I believe would improve MIPS's performance:

- *Standardize quality measures:* The problems that arise from clinicians' ability to choose quality measures under MIPS could be addressed by directing CMS to establish standardized measure sets for each specialty (or subspecialty) and requiring clinicians to report those standardized measure sets. The applicable measure set could be determined from claims data based on the mix of services a clinician delivered.²⁶

Particularly initially, it is likely that some clinicians would lack a standardized measure set appropriate to their practice. For these clinicians, the quality category could be excluded from scoring under MIPS. Excluding the quality category would be preferable to requiring clinicians to incur the costs necessary to continue reporting under the current system since such reporting appears unlikely to meaningfully benefit Medicare beneficiaries.

CMS could be directed to collaborate with other payers in constructing these specialty-specific standardized measure sets, to the extent feasible, in order to reduce administrative burden for providers. CMS is already engaged in such a process via the Core Quality Measures Collaborative operating under the auspices of the National Quality Forum.

An alternative approach to reforming the MIPS quality category would be to eliminate the requirement that clinicians report quality measures and instead rely on measures derived from claims records or beneficiary surveys. The Administration's fiscal year 2020 budget and MedPAC have both put forward proposals in this vein.²⁷ This approach would generate large reductions in clinicians' reporting burdens and is worth considering. However, even with this change, I expect that MIPS would remain an ineffective tool for improving the quality and efficiency patient care, so if Congress is willing to consider changes this large, I would encourage it to consider eliminating MIPS entirely.

- *Eliminate the practice improvement category and create a targeted incentive for reporting to clinical data registries:* The MIPS practice improvement category is essentially a "box checking" exercise that is doing little to improve patient care but is creating reporting costs for clinicians. I recommend eliminating this category.

That said, there may be some specific activities currently included on the list of practice improvement activities that are worth encouraging. Notably, clinician reporting to clinical data registries has features of a "public good." Reporting to registries generates benefits for the health care system as a whole by facilitating research on ways to improve patient care and allowing clinicians to compare themselves to their peers.

²⁶ Multi-specialty groups could be required to report on all measure sets that applied to more than a specified share of their clinicians.

²⁷ Ibid.; Medicare Payment Advisory Commission. 2018. "Moving beyond the Merit-based Incentive Payment System." http://www.medpac.gov/docs/default-source/reports/mar18_medpac_ch15_sec.pdf?sfvrsn=0.

To encourage registry reporting, Congress could create a small, targeted incentive for clinicians to report to registries that meet rigorous criteria. The appropriate size of such an incentive merits further research, but a reasonable starting point would be 0.5 percent of clinicians' payments. The incentive could be structured as a budget neutral combination of bonuses for compliance and penalties for non-compliance, similar to the existing payment adjustments under MIPS. Congress could consider applying this incentive to clinicians participating in advanced APMs in addition to those participating in MIPS, as reporting by advanced APM participants generates similar systemic benefits.

- *Eliminate the promoting interoperability category and create a targeted incentive for use of a certified EHR:* Encouraging clinicians to use EHRs that meet the certification standards promulgated by HHS generates substantial benefits for the health care system by facilitating interoperability. It is much less clear, however, that there is a rationale for requiring providers to use these tools in particular ways, rather than allowing providers to use these tools in whatever way generates the greatest value for their patients.

For that reason, I recommend eliminating the MIPS promoting interoperability category and replacing it with a small, targeted incentive for having an EHR that meets the HHS certification standards. Practices could earn the incentive merely by showing that they have a suitable EHR installed and in active use, similar to the requirements currently in place for advanced APMs. Clinicians would not be required to perform any specific activities with that EHR, unlike under MIPS. CMS has moved a significant distance in this direction in creating the requirements for the current promoting interoperability category, but it would be possible to at least modestly reduce burden by simplifying further. Like the incentive for registry reporting, the appropriate size of such an incentive merits further research, but a reasonable starting point would be 0.5 percent of clinicians' payments, structured as a budget-neutral combination of bonuses and penalties.