The Politics and Policy of Health Reform

No Permanent Fix: MACRA, MIPS, and the Politics of Physician Payment Reform

Steven B. Spivack
University of North Carolina at Chapel Hill

Miriam J. Laugesen
Columbia University

Jonathan Oberlander
University of North Carolina at Chapel Hill

Abstract Organized medicine long yearned for the demise of Medicare's Sustainable Growth Rate (SGR) formula for updating physician fees. Congress finally obliged in 2015, repealing the SGR as part of the Medicare Access and CHIP Reauthorization Act (MACRA). MACRA established value-based metrics for physician payment and financial incentives for doctors to join alternative delivery models like patient-centered medical homes. Throughout the law's initial implementation, the politics of accommodation prevailed, with federal officials crafting final rules that made MACRA more favorable for physicians. However, the era of accommodation could be short-lived. The discretion that the Centers for Medicare and Medicaid Services had during the first two years of implementation is ending. Additionally, euphoria over the SGR's repeal has given way to concerns over the new program's value-based purchasing arrangements and uncertainty over their sustainability. MACRA eliminated the SGR, but not the politics of physician payment.

Keywords MACRA, merit-based incentive payment system, alternative payment model, sustainable growth rate, Medicare

Organized medicine long yearned for the demise of Medicare's Sustainable Growth Rate (SGR). Enacted in 1997, the SGR established physician spending targets that tied Medicare fee updates to changes in national economic growth. It was intentionally designed to be a faceless entity that would impartially, technically, and automatically adjust physician payments, thereby protecting the federal budget against excessive expenditures.

Initially, the formula generated fee increases and scant controversy. However, starting in 2002 the SGR produced annual payment reductions.

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Doctors abhorred the yearly threat of Medicare cuts as a "guillotine over the head of the profession" (ACEP 2015) and "sword of Damocles" (Laff 2015). They warned of dire consequences for physician participation in Medicare and beneficiaries' access to care if such decreases were imposed. Congress heeded the warnings, repeatedly ditching the automatic process with last-minute stays of execution. It regularly overrode scheduled cuts—seventeen times between 2003 and 2014—through temporary "patches" that ranged in length from one month to two years (Hahn 2014; Lowery 2014).

Yet there were limits to congressional clemency. Lawmakers did not eliminate the scourge, choosing instead, as Oregon Senator Ron Wyden noted, to "punt, patch it up and let that SGR limp along" (Lowery 2014). Lawmakers found it hard to surrender the projected savings that the formula's future steep (albeit imaginary) cuts generated for the federal budget (Oberlander and Laugesen 2015). Meanwhile, the short-term "doc fix" patches increased the magnitude of subsequent scheduled reductions in Medicare physician payments—reaching 27.4 percent in 2012—due to the cumulative nature of the SGR's spending targets (Fiegl 2012; Laugesen 2009, 2011). Over time, the specter of the SGR and stakes of averting escalating payment cuts grew, as did medical societies' frustration with Congress's inability to move beyond temporary patches and "solve a problem that everyone wants solved" (Rivlin 2015). There was no saving the SGR. The American Medical Association (AMA) and other physician groups viewed "permanent SGR repeal" as the only acceptable outcome and even made it a condition of their support for the Affordable Care Act (ACA) (Hoven 2014; Laugesen 2011). Despite the AMA's efforts, though, the ACA did not resolve the issue.

Finally, in 2015, after over a decade of lobbying, disappointment, and legislative failure, organized medicine got its wish. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), enacted with broad bipartisan majorities, abolished the SGR. A critical obstacle to its elimination, how to offset the budgetary costs of forsaking future (mythical) scheduled cuts, was overcome when Congress belatedly decided it did not, in fact, need to pay for those costs (a Medicare spending slowdown greatly lowered the price tag of SGR repeal).

Lawmakers hailed MACRA as "a monumental achievement" and "milestone" (Frieden 2015). President Obama (2015) praised the "gorgeous" bipartisanship that led to passage of the "permanent doc fix" and "crossed one of Washington's perennial 'cliffs' off the list for good." Medical societies celebrated vanquishing the SGR, with AMA president James Madera

declaring "an end to an era of uncertainty for Medicare beneficiaries and their physicians" (Frieden 2015). Many health policy analysts also welcomed the demise of the ineffective, unfair, and deeply flawed SGR formula that had been "an ongoing impediment to real payment reform" (Guterman 2015). They rejoiced that Congress had moved beyond short-term measures and adopted reforms that could "catalyze increased efficiency and greater cost control" (Aaron 2015: 1977).

Now that the SGR is gone, Congress, the Centers for Medicare and Medicaid Services (CMS), and the medical profession are grappling with the administrative, technical, and political realities of its replacement. Euphoria at the SGR's demise has given way to the formidable challenges inherent in implementing MACRA and the growing realization that it is not a permanent fix.

The MACRA Vision

In repealing the SGR, Congress sought to end the annual drama surrounding cuts in Medicare physician payments. MACRA set annual fee updates of 0.5 percent from 2016 to 2019 (Hahn and Blom 2015; Spitalnic 2015). Yet policy makers also wanted to move the program from paying for volume to paying for value, reflecting the view that "payers should do more than pay for services" (Tanenbaum 2016: 1033). The Obama administration believed that such a shift could enhance quality while reducing costs (Burwell 2015). The 2010 ACA contained a number of policies to increase value-based purchasing in Medicare, among them Accountable Care Organizations (ACOs), bundled payment, the Hospital Readmissions Reduction Program, and Hospital Value-Based Purchasing Program. Then, in 2015, health and human services secretary Sylvia Burwell (2015) announced the goal of tying 90 percent of all Medicare fee-for-service payments to "quality or value" by 2018. MACRA moved Medicare closer to that goal.

MACRA created two different pathways for physician compensation, collectively known as the Quality Payment Program. The Merit-Based Incentive Payment System (MIPS), which most physicians are initially expected to choose, allows providers to remain in the traditional fee-for-service model. Despite the volume-to-value rhetoric, clinicians are still paid based on how many and which services they provide: "Fee-for-service payment is not at all removed from the equation" (Ginsburg and Patel 2017: 285). However, MIPS adjusts fees through bonuses or penalties depending on physicians' performance on myriad quality measures. It "is an outgrowth of a decade of smaller pay-for-reporting and pay-for-performance

programs" (Berenson 2016). In the name of streamlining reporting requirements, MACRA combines three preexisting separate programs, the Physician Quality Reporting System, the Value-Based Payment Modifier, and Meaningful Use (for electronic health records), into MIPS, which also includes a new domain of clinical practice improvement. Crucially, MACRA provides "clinicians the flexibility to choose . . . the measures that are most meaningful to their practice" (CMS, n.d.-a). In other words, physicians' performance in MIPS will be assessed based on metrics they select (from a list of CMS-provided options).

These measures will comprise a composite performance score for individual clinicians (including physicians and other health care providers like nurse practitioners) that determines annual changes in payments. In 2019, Medicare payments under MIPS will be adjusted up or down by 4 percent, with the maximum bonuses or penalties rising to 9 percent in 2022 (Hahn and Blom 2015). Unlike the SGR, which entailed across-the-board fee changes, the new "merit-based" arrangements reward high-performing providers with larger payments while punishing poor performers with lower compensation (Guterman 2015). MIPS is a "true zero sum game . . . for every doctor that makes more from the MIPS, there will be one who makes less" (Wynne 2015). During 2019–24 "MACRA would provide $500 million each year . . . as an additional adjustment for providers in this program [MIPS] who achieved exceptional performance" (Spitalnic 2015: 3).

The second pathway, Advanced Alternative Payment Models (AAPMs), offers physicians financial incentives if they participate in innovative entities such as ACOs and medical homes that bear more than nominal amount of financial risk, make quality-based payments to providers, and use electronic health records. Physicians who join AAPMs are exempt from MIPS's reporting requirements and will receive a 5 percent annual payment bonus during 2019–24. In 2026 and beyond, physicians who participate in AAPMs will receive an annual fee update of 0.75 percent, while those in MIPS will receive increases of 0.25 percent (Hahn and Blom 2015; Spitalnic 2015). The strong incentives for AAPMs reflect policy makers' faith in the potential of payment and delivery reform models like ACOs and patient-centered medical homes to control spending and improve quality (Slavitt 2016).

Notably, the MIPS/AAPM combination bet heavily both on organizational innovations and on pay for performance despite little evidence at the time of MACRA's enactment that such policies save much money (Oberlander and Laugesen 2015).

The Politics of Accommodation

It fell to CMS, which MACRA gave substantial discretion, to turn the new law's ambitious vision of value-based purchasing into reality through the rule-making process. CMS has grappled with numerous issues, including how to define the performance threshold to determine which providers receive payment penalties or bonuses and the nominal risk amount needed to qualify as an AAPM. Not surprisingly, medical societies have sought to soften the impact of MACRA's perceived harms and burdens. Throughout the law's initial implementation, the politics of accommodation have prevailed, with CMS crafting policies that make MACRA more favorable for physicians after receiving comments on proposed rules. Accordingly, federal officials have significantly reduced the initial performance threshold, cut the number of required MIPS quality measures, and simplified the nominal risk amount for AAPMs. A more comprehensive list of CMS's modifications during rule making is detailed in table 1. In this section, we highlight key areas that exemplify CMS's conciliatory stance, including how policy makers responded to provider groups' concerns over physician readiness and the treatment of small and rural practices.

Medical societies raised concerns about physicians' ability to understand the law's requirements in time for the initial reporting period. Barbara McAneny, past chair of the AMA's board of trustees, remarked that "the average physician . . . know[s] that it's there but they don't quite know how it's going to apply to them yet" (US House of Representatives 2016a: 63). A 2016 survey of over five hundred physicians (Deloitte. 2016) found that 82 percent of respondents either had never heard of MACRA or were unfamiliar with the law's requirements. One year later, a survey of a thousand physicians (AMA and KPMG 2017) discovered that 40 percent of respondents were still unaware of the law.

In response to such worries, CMS used its statutory authority to slow MACRA implementation. Acting administrator of CMS under the Obama administration, Andy Slavitt, explained that "there are very few changes when the program first begins. . . . The first couple of years are aimed at getting physicians gradually more experienced with the program" (2016: 3). The result was what CMS called a "transition year" (2016a: 77010) where providers could initially "pick [their] pace for participation" (n.d.-b: 20) in MIPS.

Throughout the rule-making process, CMS made multiple changes to alleviate MACRA's burdens on physicians. In 2017, the first year of implementation, CMS drastically reduced the number of reporting requirements and significantly lowered the performance threshold used

Table 1 Key Changes to 2017 and 2018 Proposed Rules for MACRA

	2017		2018	
Topic	**Proposed rule (May 2016)**	**Final rule (November 2016)**	**Proposed rule (June 2017)**	**Final rule (November 2017)**
Implementation schedule				
Performance threshold	Mean or median	Reduced to 3 out of 100	Increased to 15 out of 100	No change
Exceptional performance threshold for bonus payment	70 points or higher	No change	Maintained	No change
Performance period	One year	Reduced to 90 days	Increased to one year for quality and cost domains; maintained 90 days for electronic health record and improvement domains	No change
Payment penalties	Providers below the mean or median	Only providers who submit no performance data	Increased to providers who score less than 15 points	No change
MIPS				
Resource use weight	10%	Reduced to 0%	Maintained (0%)	Increased to earlier 2017 level: 10%
Low-volume exemption from reporting	Less than $10,000 in Medicare charges *and* fewer than 100 Part B patients	Increased to $30,000 in Medicare charges *or* fewer than 100 Part B patients	Increased to $90,000 in Medicare charges or fewer than 200 Part B patients	No change
Electronic health record measures	Required 11 measures	Reduced to 5 measures	Maintained (5)	No change

Table 1 (*continued*)

MIPS				
Quality weight	50%	Increased to 60%	Maintained (60%)	Reduced to 50%
Improvement measures	Required 6 medium- or 3 high-weighted activity scores	Reduced to 4 medium and 2 high; reduced to 2 medium and 1 high for small and rural providers	Maintained	No change
Non-patient-facing clinician	Clinician who bills 25 or fewer patient-facing encounters	Increased to 100 or fewer encounters	Maintained	No change
Virtual groups	Implement in 2018	No change	Maintained	No change
Complex patients bonus	Not created until 2018	Not created until 2018	3 point bonus	No change
Small practice bonus	Not created until 2018	Not created until 2018	5 point bonus	No change
Advanced Alternative Payment Models (AAPMs)				
AAPM nominal financial risk	30% marginal risk, 4% total risk, and <4% minimum loss rate	Single measure: 8% of provider revenue	Maintained until 2019	No change
AAPM certified electronic health record technology **requirement**	75% for 2017	Reduced to 50%	Maintained for 2018	No change

Source: Authors' analysis of proposed and final rules in the *Federal Register (CMS 2016a; CMS 2016b; CMS 2017a; CMS 2017b)*

to determine a provider's payment adjustment. For example, providers needed to score only 3 out of 100 to avoid penalties (table 1). CMS continued this trend in 2018, only slightly increasing the reporting requirements and raising the performance threshold from 3 to 15 points. This effectively transformed the first two years of MACRA from a pay-for-performance program into a pay-for-reporting program. CMS (2016a, 2017a) estimated that over 95 percent of providers will receive a neutral or positive payment adjustment in 2019, rising to 97 percent in 2020.

CMS's decision to implement a transition period may have reflected the signals it received from legislators on these issues, which were likely influenced by major medical societies. Yet a slow transition to full implementation means that only a fraction of providers will obtain a substantial payment bonus (more than $1,000) in the first two years. The statutory language requires MACRA to be budget neutral. Because the payment bonuses are funded by penalties imposed on other providers, the fewer the number of penalized providers the smaller the pool of money available to redistribute to high performers scoring above the performance threshold.

Another key issue, one closely monitored by Congress, has been MACRA's impacts on small and rural practices. In a July 2016 hearing, Senator Orrin Hatch (R-UT) stressed that lawmakers "recognized the inherent challenges of these types of practices [small and rural] when we crafted the MACRA statute, and I know CMS is aware of these issues, but we need to make sure that the law is implemented in a way that works for these physicians" (US House of Representatives 2016b: 3). In particular, CMS had to decide where to set the low-volume threshold that exempts from MACRA's requirements those physicians who do not see a certain number of Medicare patients or bill Medicare less than a set amount. Once CMS proposed the initial threshold amount, Representative Tom Price (R-GA) and the GOP Doctors Caucus sent a letter to CMS requesting that the amount be increased (Price and Roe 2016). A majority of public comments from medical groups and other stakeholders during the first two years of rule making also sought a generous low-volume threshold.

In response, CMS adopted an expansive low-volume threshold that became even more generous over time. CMS defined the threshold in 2017 as a provider who received less than $30,000 in Part B annual payments or cared for fewer than one hundred Medicare patients. After Tom Price became the Trump administration's health and human services secretary, CMS raised the threshold in 2018 to $90,000 or two hundred patients. Consequently, nearly two-thirds of providers will be exempted from MACRA in 2018 and beyond (CMS 2017a). Consumer groups are

frustrated by that outcome, arguing that "CMS is sending the message that these excluded clinicians are not expected to deliver quality, high-value care" (Consumer-Purchaser Alliance 2017: 2). Other critics contend that exempting most providers will shrink the size of the performance curve, causing nonsignificant differences in MIPS scores to result in large differences in payment adjustments (Introcaso 2017). CMS (2017a) has countered that small providers were more likely to perform poorly under the Physician Quality Reporting System and therefore would be unfairly targeted by MACRA.

Accommodation Lost?

The era of accommodation in MACRA implementation could be short-lived. The discretion that CMS had during the first two years of implementation (2017–18) disappears thereafter. Beginning in 2019, MACRA no longer grants CMS the authority to modify several of the law's crucial policies, including the definition of the MIPS performance threshold. Unlike the first two years, when CMS set an easily attainable score, MACRA requires CMS to use either the mean or median provider score as the performance threshold beginning in 2019 (with the accompanying payment adjustments implemented in 2021). MIPS will thus soon generate penalties for half of participating providers.

As more physicians are subject to performance penalties, the politics of MACRA could shift and demands for MIPS reform could intensify (MedPAC 2017c). However, CMS's sympathetic treatment of small and rural practices via exemptions could reduce the ability of physician organizations to rally the troops. Most providers are exempted from MACRA in 2018 and beyond, and even fewer will receive large negative payment adjustments, attenuating the scope of redistribution. In that respect, MACRA is an important departure from previous policies, like the SGR, in which all physicians faced mounting payment cuts. Nonetheless, questions persist about whether MACRA's fee updates will keep pace with physician cost increases in the long run, especially after 2025, when the law's supplemental funding for exceptional performing providers in MIPS expires (Spitalnic 2015).

MIPS's Shaky Future

Beyond the looming issues with MIPS's accelerating implementation, there is the question of its survival. MIPS has come under criticism for its

complexity and administrative burden (AAFP 2017; Shea 2017). A survey of nearly four hundred physician practices across four specialties reported that total spending on pre-MACRA reporting requirements for physician practices in these specialties surpassed $15 billion (Casalino et al. 2016). Although CMS (2017a) argues that MACRA will reduce this burden by consolidating existing reporting programs, provider groups are not convinced, especially since MIPS measurement requirements expand over time.

Critics, including the Medicare Payment Advisory Commission (MedPAC), additionally contend that MIPS has serious design flaws. Some analysts argue that we do not have adequate measures to evaluate the value or quality of care provided by individual physicians (Berenson 2016; Ginsburg and Patel 2017). Too many MIPS measures are neither reliable nor valid (MedPAC 2017c; Wynne 2016). Several of the measures lack adequate sample size, resulting in noisy estimates. Additionally, numerous measures are close to being topped out, meaning that miniscule differences in clinical quality could produce large differences in payment adjustments (McWilliams 2017). Further, clinicians can select which measures to report on, enabling them to cherry pick measures in areas where they are already performing more favorably.

MedPAC has grown increasingly disenchanted with MIPS. One commissioner, Kathy Buto, noted that "there is very little to redeem MIPS. Maybe nothing" (MedPAC 2017a: 78). Another commissioner, David Grabowski, proclaimed that "we have a lot of experience with pay for performance in this country. We have a lot of experience with doing it badly. I would put MIPS in the bad pay for performance Hall of Fame, like this is not going to end well" (MedPAC 2017b: 64). This culminated in MedPAC's formal recommendation that Congress eliminate MIPS in its March 2018 report to Congress (2018). Rather than providing a permanent solution to physician payment, the successor to the SGR has itself become a problem that some reformers want to repeal and replace.

In lieu of MIPS, MedPAC has recommended Congress implement a voluntary value program (MedPAC 2018). Physicians would either be measured as part of a voluntary group, join an AAPM, or do nothing. This program would thus move away from a core tenet of MIPS: mandatory assessment of individual physician performance. The voluntary value program would be funded by withholding a percentage of fee schedule payments from all providers. High-performing clinicians who join the voluntary program would receive a payment bonus, while providers who join AAPMs

would not be subject to withholding. Nonparticipants would lose the withheld fee (MedPAC 2017b).

Beyond MIPS: Can AAPMs Advance?

While MIPS has received most of the attention to date, MACRA's other major component, AAPMs, soon could draw more scrutiny. MACRA incentivizes physicians to join AAPMs by exempting them from MIPS, granting them 5 percent payment bonuses during 2019–24 and providing higher annual fee updates starting in 2026. This has led critics to argue that MIPS masked Congress's true intent. Paul Ginsburg alleged that "MIPS was a fig leaf that Congress wanted. . . . MACRA is about advanced alternative payment mechanisms" (MedPAC 2017b). Accordingly, some analysts predict that AAPM participation will rise substantially over time, reaching 40 percent by 2030 (Hussey, Liu, and White 2017). Indeed, CMS initially predicted that the loaded financial incentives meant that by 2038 all Medicare physician payments would go to providers in such alternative models (Spitalnic 2015). MACRA would thereby catalyze a movement away from fee-for-service payment for physicians.

However, AAPM expansion could be more limited than many originally envisioned. AAPM participation has been low to date, with the rhetorical promise of such models outpacing the more sober reality. Currently only 5 percent of physicians participate in AAPMs (CMS 2017a) and only 18 percent report that they are planning to join an AAPM in the near future (AMA and KPMG 2017). As a result, "whether MACRA will ultimately lead Medicare (and other payers) to a true alternative to the fee-for-service model through physicians' involvement in alternative payment models is not at all clear" (Ginsburg and Patel 2017: 290).

AAPMs face substantial barriers to future growth. CMS has not allowed ACOs with "one-sided risk" (under such arrangements, providers can receive bonuses for meeting targets but are not subject to penalties for missing targets), a model that had attracted growing physician participation in Medicare, to count as an AAPM (Ginsburg and Patel 2017). Moreover, in 2022 and beyond, to qualify for incentive payments providers must either have at least 50 percent (compared to 20 percent in 2017) of their attributed patients receiving care from an alternative payment model like a medical home or receive 75 percent of payments from an eligible AAPM (up from 25 percent in 2017) (CMS, n.d.-a). Groups like the Association of American Medical Colleges (2017) view those requirements as overly stringent. While providers can combine Medicare and non-Medicare payments to

reach the 75 percent threshold, the process of determining patient eligibility across all payers could add to an already significant administrative burden.

Additionally, the amount of downside risk (exposure to penalties) physicians need to assume to qualify as an AAPM provider will likely increase over time. Currently, CMS requires 8 percent of provider payments to be at risk. This is a considerably simpler and more generous standard than CMS's original proposal, which included a combination of a 30 percent marginal risk rate, 4 percent minimum loss rate, and 4 percent total cost of care. The AMA (2016: 4) hailed the change to 8 percent as a "significant reduction." However, CMS plans to increase this figure to 10–15 percent in coming years, which would tie a larger percentage of AAPM payments to their performance (CMS 2017a).

Finally, the 5 percent bonus that providers can receive for participating in an AAPM expires in 2024. While physicians in AAPMs will subsequently receive higher fee updates than those who are in MIPS, the extent to which that fee differential will help overcome the barriers to AAPM participation remains uncertain.

Conclusion

The early years of MACRA demonstrated the predictable challenges in implementing value-based purchasing. The powerful rhetorical appeal of value obscures the formidable obstacles to operationalizing and realizing the often exaggerated promise of such payment schemes. Measuring and paying for value in medical care are not merely a technical exercise (Tanenbaum 2016). Value can be contested, resisted, recounted, and redefined. CMS's efforts to balance provider interests, congressional pressures, and policy goals in crafting MACRA rules illuminated the politics of value. They also produced payment reforms that differ in key respects from what was originally envisioned when Congress enacted MACRA.

The politics of accommodation that have governed MACRA implementation are a familiar way to launch a controversial program. When Medicare began operations in 1966, its administrators adopted policies to conciliate medical providers (Feder 1977). However, MACRA's politics of accommodation may not endure for long. As CMS's discretion declines, frontloaded incentives recede, budgetary pressures intensify, and the law's more onerous provisions begin, MACRA could take another, less conciliatory turn. Potential provider backlash against MACRA's accelerating implementation and rising penalties, as well as growing disillusionment

with the law's value-based purchasing arrangements, makes its future highly uncertain. MACRA eliminated the SGR but not the politics of physician payment.

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Steven B. Spivack is a PhD student in the Department of Health Policy and Management in the Gillings School of Global Public Health at the University of North Carolina at Chapel Hill. He is supported by a fellowship from the National Center for Advancing Translational Sciences, National Institutes of Health, through grant TL1TR001110.
sspivack@live.unc.edu

Miriam J. Laugesen is an associate professor in the Department of Health Policy and Management at Columbia University's Mailman School of Public Health. Miriam Laugesen received support from the National Institute for Health Care Management (NIHCM) Foundation.

Jonathan Oberlander is professor and chair of social medicine in the School of Medicine and professor of health policy and management in the Gillings School of Global Public Health at the University of North Carolina at Chapel Hill.

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