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Testimony of Joe Albanese: One-Page Summary

- Congress enacted MACRA to address two key problems in Medicare: unsustainable spending growth on clinician services and poor incentives for quality improvement.
- MACRA's approach to controlling expenditures was to create a statutory schedule of annual payment updates, including a pay freeze from 2020 to 2025.
- These payment updates have helped slow clinician payment growth, but it is unclear whether they are sustainable in the long run since Congress has already overridden them several times.
- MACRA also created a Quality Payment Program (QPP) to incentivize quality improvement, an approach sometimes called "value-based care." By contrast, Medicare's default "fee-for-service" structure pays doctors for the number of services they provide regardless of their value.
- The QPP contains two separate tracks for clinicians. The Merit-Based Incentive Payment System (MIPS) provides financial rewards or penalties based on their performance on quality metrics. Alternatively, clinicians can receive bonuses for participating in advanced alternative payment models (APMs). APMs test new ways of paying clinicians for value outside of Medicare's normal structure, and advanced APMs contain even stronger incentives.
- The QPP, however, has not worked as intended. MIPS has enabled many clinicians to receive high scores without improving overall quality, including by cherry-picking what metrics they report. It has also increased administrative burden for its participants, particularly smaller clinician practices. APMs have also largely not been found to save money or improve quality.
- As lawmakers examine MACRA and its implementation, they should be mindful of Medicare's existing fiscal challenges and reevaluate the government-driven approach to promoting value in health care services in favor of one that is patient-driven.

Testimony of Joe Albanese before the House Committee on

Energy and Commerce Subcommittee on Oversight and Investigations

"MACRA Checkup: Assessing Implementation and Challenges That Remain for Patients and Doctors"

June 22, 2023

Thank you, Chairman Griffith and Ranking Member Castor, for the opportunity to testify before this subcommittee. My name is Joe Albanese, and I am a senior policy analyst at Paragon Health Institute. We are a new health policy think tank focused on empowering patients and reforming government programs. For Medicare, this includes increasing beneficiaries' control over their own decisions and finances while improving health outcomes and lowering costs.

Value-based care and physician payment policy have long been major focuses of reform efforts in traditional Medicare. Ensuring sustainable and high-quality care should be a top priority for lawmakers. That is why it is so important that this subcommittee is examining the framework created by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

I recently authored a Paragon report entitled "MACRA: Medicare's Fitful Quest for Value-Based Care."[1] This report analyzes the issues that the law set out to address, how it has been implemented in practice, and the shortcomings in its execution. In my testimony, I will summarize the major points from my report and offer thoughts on their implications. My testimony today represents my own views and not those of Paragon.

[1] Joe Albanese, *MACRA: Medicare's Fitful Quest for Value-Based Care*, Paragon Health Institute, May 2023, https://paragoninstitute.org/wp-content/uploads/2023/05/20230501_Albanese_MACRAMedicaresFitfulQuestforValue-BasedCare_FINAL_20230505_V2.pdf.

Origins of MACRA

Physician Payment and Medicare Spending

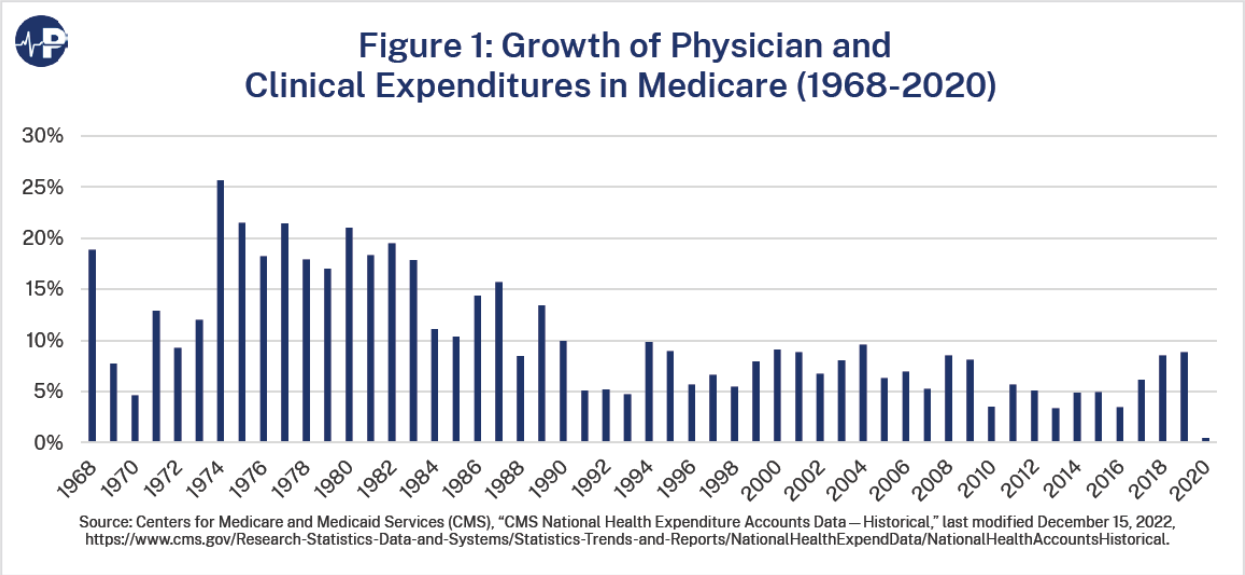
MACRA is just one example in a long line of legislation to overhaul physician reimbursement in Medicare Part B. During its first decades, Medicare paid doctors with few guardrails to control costs. Between 1968 and 1992, when Congress implemented a Medicare Physician Fee Schedule (PFS), the annual growth of Medicare's physician and clinician expenditures routinely exceeded 10 percent (in 18 out of 25 years).[2] Under the PFS, Medicare began to reimburse doctors based on the relative cost of services. Congress also placed aggregate targets on Medicare clinician spending, first with the Value Performance Standard in the Omnibus Reconciliation Act of 1989, then with the Sustainable Growth Rate (SGR) in the Balanced Budget Act of 1997.

While these policies reduced Medicare's clinician spending growth, it still averaged about 7 percent per year for the next two decades.[3] In part, this was because Congress waived payment adjustments required by the SGR every year from 2002 until 2015, although it usually offset the budgetary effects of these "doc fixes" with other health spending reductions.[4] The escalating size of cuts required by the SGR, which accumulated over time and would apply to doctors across the board, prompted Congress to enact a fixed schedule of payment updates in MACRA.

[2] Centers for Medicare and Medicaid Services (CMS), National Health Expenditure data, accessed June 14, 2023, https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical.

[3] Ibid.

[4] Committee for a Responsible Federal Budget, "SGR Continues to Slow Health Care Cost Growth," March 31, 2014, https://www.crfb.org/blogs/sgr-continues-slow-health-care-cost-growth.



"Value-Based" Care

Under the PFS, Medicare's clinician reimbursement is calculated based on the input costs of each service, such as the amount of physician work required and practice expenses. However, Medicare's fee-for-service (FFS) model pays providers for the number of services they provide regardless of value. Over the past two decades, policymakers have increasingly attempted to create payment arrangements that instead hold providers accountable for the quality of their services, often called "value-based care." To this end, Congress began to enact programs to incentivize clinicians to report data and improve their performance on certain metrics. Specifically:

- The Tax Relief and Health Care Act of 2006 initiated the Physician Quality Reporting System (PQRS), which originally provided additional PFS payments to eligible professionals (EPs) who reported on quality metrics. Congress later changed this to payment reductions for EPs who did not meet reporting requirements.[5]
- The Health Information Technology for Economic and Clinical Health Act of 2009 created the Medicare EHR Incentive Program (now called Promoting Interoperability) to accelerate hospitals'

[5] N. Anumula and P. C. Sanelli, "Physician Quality Reporting System," *American Journal of Neuroradiology* 32, no. 11 (December 2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7964408/.

and EPs' adoption of electronic health record (EHR) technology and, later, to improve health information exchange with incentive payments and penalties.[6]

- The Patient Protection and Affordable Care Act (ACA, 2010) created the Value-Based Payment Modifier (VM), which reduced PFS payments for clinicians that did not meet reporting requirements and applied performance-based payment adjustments (both positive and negative) unless they participated in certain alternative payment models (APMs).[7]
- The ACA also created the Center for Medicare and Medicaid Innovation (CMMI),[8] which is part of the Centers for Medicare and Medicaid Services (CMS), the agency responsible for managing Medicare. CMMI has the authority to waive parts of the Medicare statute to develop APMs, which are models that test out new rules for paying participating health care providers for their services in order to reduce costs or improve quality.

Having multiple quality programs for clinicians added complexity and burden. Medical groups alleged that these programs sometimes overlapped or conflicted and that the pass/fail approaches of the PQRS and EHR Incentive Program were excessively stringent.[9]

With MACRA, Congress sought to move clinician reimbursement from volume-based toward value-based care by creating the Quality Payment Program (QPP), which contained two pathways: the Merit-Based Incentive Payment System (MIPS) and the advanced APM pathway. In each pathway, clinicians would receive additional payment adjustments on top of their PFS payments, which MACRA froze between 2020 and 2025.

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[6] Micky Tripathi, "Delivering on the Promise of Health Information Technology in 2022," *Health Affairs*, February 22, 2022, https://www.healthaffairs.org/content/forefront/delivering-promise-health-information-technology-2022; CMS, *An Introduction to: Medicare EHR Incentive Program for Eligible Professionals*, last updated April 2014, https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/downloads/ehr_medicare_stg1_begguide.pdf.

[7] Eric T. Roberts, Alan M. Zaslavsky, and J. Michael McWilliams, "The Value-Based Payment Modifier: Program Outcomes and Implications for Disparities," *Annals of Internal Medicine* 168, no. 4 (February 20, 2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5820192.

[8] Also called the CMS Innovation Center.

[9] Troy Parks, "How Medicare Payment Changes Will Affect Physicians," American Medical Association, August 12, 2016, https://www.ama-assn.org/practice-management/payment-delivery-models/how-medicare-payment-changes-will-affect-physicians.

Within MIPS, Congress consolidated the existing quality programs for clinicians. It scores participants on performance in four measurement components: Quality, Promoting Interoperability,[10] Clinical Practice Improvement Activities, and Cost. CMS sets an annual score threshold, with those above it receiving a pay increase and those below receiving a penalty.

Practitioners can opt out of MIPS only by obtaining exemptions (i.e., by having a low volume of Medicare patients or revenue) or by receiving sufficient Medicare patients or revenues from advanced APMs.[11] Advanced APMs are models where participants receive rewards for good performance but also face penalties for poor performance. These APMs also require quality measures and adoption of EHR technology. MACRA provides qualifying participants in advanced APMs with 5 percent payment bonuses each year from 2019 through 2024. Given these consistent bonuses and higher annual payment updates from 2026 onward (0.75 percent versus 0.25 percent for MIPS), the long-term incentives for participation in advanced APMs are stronger than for MIPS.

[10] In the context of MIPS scoring components, Promoting Interoperability was previously called Advancing Care Information. In multiple contexts, it has also been referred to as Meaningful Use.

[11] Specifically, clinicians must receive at least 50 percent of Medicare Part B payments or 35 percent of Medicare patients through an advanced APM to be qualifying participants.

Table 1: QPP Implementation by Payment Year (Percentages)

	2016-18	2019	2020	2021	2022	2023	2024	2025	2026+
FFS payment update (statutory)	0.50	0.50	0.00	0.00	0.00	0.00	0.00	0.00	0.25
FFS payment update (actual)	0.50	0.25*	0.00	3.75**	3.00**	2.50**	1.25**	0.00	0.25
MIPS adjustment (maximum)	N/A	+/-4.00	+/-5.00	+/-7.00	+/-9.00	+/-9.00	+/-9.00	+/-9.00	+/-9.00
MIPS adjustment (actual)	N/A	-4.00 to +1.88	-5.00 to +1.68	-7.00 to +1.79	-9.00 to +1.87	-9.00 to +2.33	TBD	TBD	TBD
APM bonus (statutory)	N/A	5.00	5.00	5.00	5.00	5.00	5.00	0.00	0.50
APM bonus (actual)	N/A	5.00	5.00	5.00	5.00	5.00	5.00	3.50**	0.50

Sources: American Medical Association, "Understanding Medicare's Merit-Based Incentive Payment System (MIPS)," accessed April 8, 2023, https://www.ama-assn.org/practice-management/payment-delivery-models/understanding-medicare-s-merit-based-incentive-payment; CMS, "Quality Performance Program Participation in 2019: Results at-a-Glance," accessed April 8, 2023, https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1190/QPP%202019%20Participation%20Results%20Infographic.pdf; CMS, "Quality Payment Program Participation in 2020: Results at-a-Glance;" CMS, "FAQs about the MIPS Feedback Reports and Payment Adjustments," *MD Interactive*, accessed April 8, 2023, https://mdinteractive.com/mips-feedback-reports.

Notes: *Decreased from 0.50 percent to 0.25 percent by the Bipartisan Budget Act of 2018. **Increased from 0 percent by the Division N, Section 101, of the Consolidated Appropriations Act, 2021; Section 3 of the Protecting Medicare and American Farmers from Sequester Cuts Act; and Sections 4111 and 4112 of the Consolidated Appropriations Act, 2023.

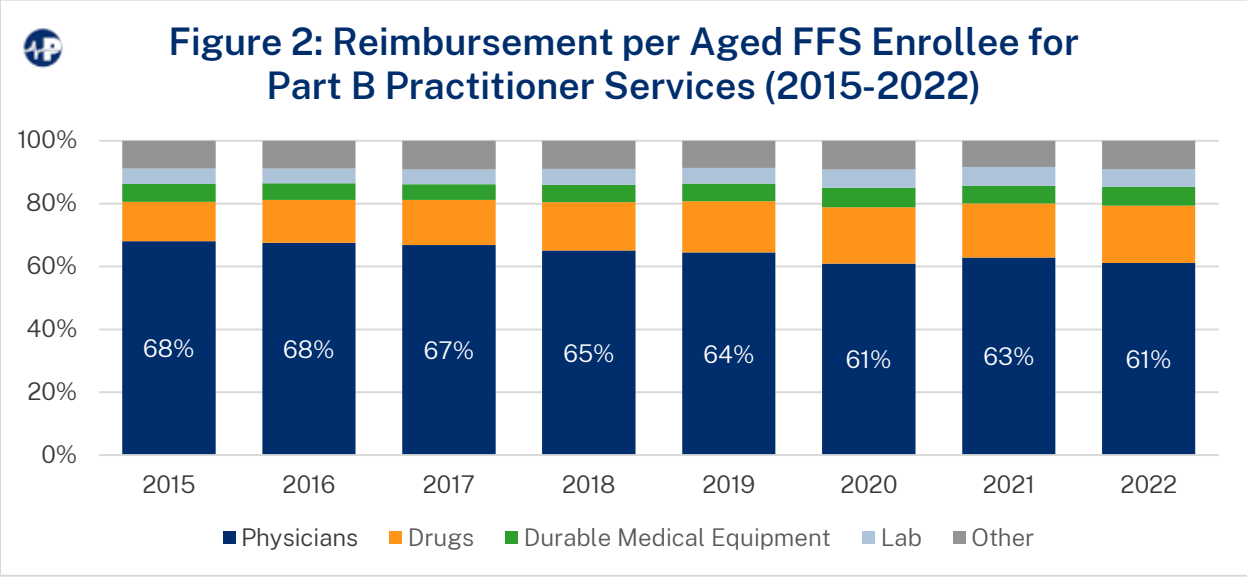
MACRA'S Implementation and Results

MACRA was intended to solve multiple problems. Medicare's clinician expenditures were fiscally unsustainable, in part because the SGR was politically unsustainable. The program's volume-based payments were also widely understood to be a central obstacle to promoting value, but existing quality programs for clinicians were not working. Eight years later, there is a clearer picture of how MACRA has addressed these concerns.

Fiscal Impact

MACRA's schedule of payment updates (0.5 percent per year from 2016 to 2019 and 0.0 percent per year from 2020 to 2025) was intended to control clinician expenditures after the SGR had not been implemented for over a decade and Congress instead found savings elsewhere. It has had some success on this front: Although Part B benefits are the fastest growing expenses in Medicare,

physician payments have grown more slowly than for other Part B practitioner services in traditional FFS Medicare. From 2015 to 2022, per capita PFS reimbursement grew about 14 percent, compared to 32 percent for durable medical equipment, 46 percent for laboratories, and 86 percent for physician-administered drugs.[12] As a share of practitioner expenses in FFS Part B, per capita PFS reimbursement shrank from 68 to 61 percent.[13] It has also grown more slowly than overall inflation: The consumer price index for urban customers (CPI-U) increased 23 percent during that period.[14]



However, recent policy decisions suggest that these trends may not hold. Concerns about the financial stability of the health care sector during the COVID-19 pandemic led Congress to deviate from the original text of MACRA and boost doctors' pay by 3.75 percent in 2021, 3.00 percent in 2022, 2.50 percent in 2023, and 1.25 percent for 2024. Starting in 2026, the annual payment update for MIPS participants will be 0.25 percent rather than 0, far lower than the updates rates prescribed by Congress in 2021 through 2024. This raises the question of whether MACRA's lower annual payment updates will endure in the long run or result in the same pattern of yearly exemptions as the

[12] See Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds (Medicare Trustees), *2023 Annual Report*, Table IV.B2, https://www.cms.gov/oact/tr/2023.

[13] Ibid.

[14] Federal Reserve Bank of St. Louis, "Consumer Price Index for All Urban Consumers: All Items in U.S. City Average," May 2023, https://fred.stlouisfed.org/series/CPIAUCSL#0.

SGR's doc fixes did. Doctors will likely argue that statutory payment levels are inadequate and will compromise access to care for Medicare beneficiaries.

Clinician Burden

MACRA's QPP component has also had a significant impact on doctors' finances due to its compliance costs, described below, and its performance incentives, discussed in the next section.

MIPS was particularly significant for clinicians. It consolidated existing programs into a new, comprehensive reporting structure subject to annual regulatory updates from CMS. But complexity remained in the new system. CMS estimated a total burden of roughly $2 billion in the first two years of the program, and one study found that physician practices spent an average of $12,811 and 200 hours per physician to comply with MIPS.[15] Many participating doctors have said that MIPS has refocused their attention on box-checking exercises and adhering to government metrics rather than developing relationships with patients to guide the quality of their care experience.[16]

These burdens have been even greater for small providers, which tend to score significantly lower on average and face inherent resource constraints that make compliance costs more difficult to bear. CMS has taken various steps to reduce burden. For example, in 2017 it finalized rulemaking to increase the low-volume exemption, causing the estimated number of exempt clinicians to almost double from 380,000 to 690,000 in 2018.[17] By comparison, in 2018 there were roughly 916,000

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[15] Medicare Payment Advisory Commission (MedPAC), "Moving Beyond the Merit-Based Incentive Payment System," in *Report to the Congress: Medicare Payment Policy*, March 2018, https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar18_medpac_ch15_sec.pdf; Dhruv Khullar, Amelia M. Bond, and Eloise May O'Donnell, "Time and Financial Costs for Physician Practices to Participate in the Medicare Merit-Based Incentive Payment System: A Qualitative Study," *JAMA Health Forum* 2, no. 5 (2021), https://jamanetwork.com/journals/jama-health-forum/fullarticle/2779947.

[16] Albanese, *MACRA: Medicare's Fitful Quest for Value-Based Care*.

[17] The low-volume threshold for clinicians was increased from receiving $30,000 in Part B revenue per year or seeing 100 Part B patients to receiving $90,000 or seeing 200 patients from Part B. See: Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, 81 Fed. Reg. 77014 (Nov. 4, 2016), https://www.federalregister.gov/documents/2016/11/04/2016-25240/medicare-program-merit-based-incentive-payment-system-mips-and-alternative-payment-model-apm; Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year, 82 Fed. Reg. 53930 (Nov. 16, 2017), https://www.govinfo.gov/content/pkg/FR-2017-11-16/pdf/2017-24067.pdf.

clinicians receiving MIPS payment adjustments.[18] This, in addition to numerous flexibilities provided due to the COVID-19 pandemic, raises the question of how much good MIPS can do if it is considered to be too burdensome to apply as written to more than 40 percent of potentially eligible clinicians. Importantly, relieving clinicians from the costs of MIPS participation means they are subject to the reduced PFS payment updates without the option to receive a performance-based adjustment.

Incentivizing Value-Based Care

Placing more requirements on doctors may be worth the additional costs if it encourages them to adopt necessary improvements that will benefit patients in the long run. But QPP's financial incentives may not have had their intended effect.

Compared to its predecessors, MIPS offered theoretically higher benefit and lower downside risk.[19] In practice, the upside potential for participants is watered down significantly by the high number of clinicians exceeding the performance threshold: over 90 percent in the first four years of the program. On the one hand, this means fewer clinicians are subject to penalties, which could be an encouraging sign that the vast majority of practitioners meet a minimum level of value. On the other hand, this makes it difficult to discern differences in quality among clinicians, particularly because 71 to 84 percent of participants earned additional "exceptional performance" bonuses every year during that period. As a result, penalties have been heavily concentrated among the relatively few doctors with low scores, but pay increases have been spread thinly, ranging between 1.68 and 2.33 percent from 2019 to 2023.[20]

Nor do these high pass rates necessarily indicate widespread high-quality care. One major factor is that participants can pick their own measures to report to CMS. For example, in 2023, clinicians

[18] CMS, "Quality Payment Program (QPP) Participation in 2018: Results at-a-Glance," https://qpp.cms.gov/resources/resource-library.

[19] In terms of benefits, the maximum payment adjustment under VM was +4 percent in 2015 compared to +9 percent starting in 2022 under MIPS. In terms of risk, combined penalties from MIPS predecessors were estimated at -11 percent in 2019 versus -9 percent under MIPS starting in 2022. See Roberts, Zaslavsky, and McWilliams, "The Value-Based Payment Modifier;" Parks, "How Medicare Payment Changes Will Affect Physicians."

[20] Albanese, *MACRA: Medicare's Fitful Quest for Value-Based Care*.

choose six measures to report out of roughly 200 to obtain a score from the Quality performance category (accounting for 30 percent of the total MIPS score).[21] Although this provides more flexibility for clinicians to choose measures that are relevant to them and ignore those that are not, it results in a biased measure of their actual performance. In fact, doctors are incentivized to avoid reporting areas of potential problems in order to avoid large penalties. The methods of calculating MIPS scores even lead clinicians who report the same performance level on the same measure to receive different MIPS scores based on their reporting methods. These factors suggest that MIPS rewards practices that are most able to navigate its complexities, which is perhaps a reason why smaller practices with fewer resources tend to fare worse.[22]

Compared to the more complex scoring and payment structure of MIPS, the relatively straightforward 5 percent bonuses for advanced APM participation seems like a stronger incentive to participate. However, advanced APMs by definition require participants to take on more financial risk and often have special rules that increase compliance costs, which can theoretically force participants to be more innovative (see the "APM Experimentation" section below) but also discourage participation. The potential costs of joining an advanced APM — plus the relative ease with which clinicians can avoid penalties in MIPS — means that there is no substantial evidence that MACRA's APM bonuses caused doctors to join them who otherwise would not have done so. Rather, it is possible that the bonuses were paid to those who would have participated regardless.[23]

Quality Measure Performance

If MACRA imposes burden without strongly inducing fundamental changes in care delivery, the next question is whether the incentive structure can simply be fixed to encourage more rigorous adherence to quality measurement. But this underlying goal may be flawed as well.

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[21] See QPP, *Merit-Based Incentive Payment System (MIPS): Participating in the Quality Performance Category in the 2023 Performance Year: Traditional MIPS*, https://qpp.cms.gov/resources/resource-library.

[22] Zack Cooper et al., "Review of the Expert and Academic Literature Assessing Impact of Medicare Access and CHIP Reauthorization Act of 2015," Yale Tobin Center for Economic Policy, April 13, 2023, https://tobin.yale.edu/sites/default/files/2023-06/20230413_MACRA Literature Review_0.pdf.

[23] Cooper et al., "Review of the Expert and Academic Literature."

A core premise of many value-based care programs is that offering providers incentives to report or perform well on specific quality measures will translate directly into better care. However, it does not work like this in practice. Studies of MIPS predecessor programs found no evidence that they led to improvements in program measures (for the VM), patient outcome improvements, or cost reductions (for the Medicare EHR Incentive Program).[24] A recent literature review by economists at Yale concluded that MIPS has not led to improvements in quality or increases in value.[25]

A 2019 report from the Government Accountability Office (GAO) found that CMS does not have procedures in place to systematically assess whether the measures for its various quality programs even achieve the strategic objectives of those programs. Furthermore, it found that CMS's budget database does not capture all agency funding for quality measurement activities or how that funding supports its quality measurement strategic objectives. It is unclear whether CMS is currently able to account for both the funding and effectiveness of its quality measurement programs.[26]

CMS has attempted to incrementally improve the quality measures in MIPS. In 2018, Medicare Payment Advisory Commission (MedPAC) criticized MIPS for, among other things, having excessively complex quality measures, having differing rules and scoring methods between clinicians, and being overly reliant on process measures as opposed to measures of health outcomes or patient experience.[27] To address some of these concerns, CMS is attempting to transition away from "traditional MIPS" to "MIPS Value Pathways," a new reporting structure meant to align measures and activities to be relevant to clinicians' scopes of practice.[28] However, progress has been slow: The start of MIPS Value Pathways was delayed from 2021 to 2023, and the Biden administration has said

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[24] MedPAC, "Moving Beyond the Merit-Based Incentive Payment System."

[25] Cooper et al., "Review of the Expert and Academic Literature."

[26] GAO, *Health Care Quality: CMS Could More Effectively Ensure Its Quality Measurement Activities Promote Its Objectives*, September 19, 2019, https://www.gao.gov/products/gao-19-628.

[27] MedPAC, "Moving Beyond the Merit-Based Incentive Payment System."

[28] CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations, 84 Fed. Reg. 40732-40745 (Aug. 14, 2019), https://www.govinfo.gov/content/pkg/FR-2019-08-14/pdf/2019-16041.pdf.

that more funding is needed to fully implement them.[29] And while CMS has streamlined MIPS measures by 26 percent, more than half of them are still process-based, and only 30 percent are outcome- or patient-experience-based (compared to 31 percent being outcome-based in 2018).[30]

APM Experimentation

APMs have been an even more far-reaching development than MIPS. Although there are fewer qualifying advanced APM participants in the QPP than in MIPS (there were 237,000 APM qualifying participants in 2022 compared to 934,000 MIPS participants), APMs have appeared across the Medicare program and in other parts of the health care system. CMMI and statutory models such as the Medicare Shared Savings Program predate MACRA as well. The ACA granted CMMI broad authority to develop, manage, and evaluate models with little congressional or judicial oversight in order to find new payment arrangements that would either save money or improve quality in Medicare.[31] The Congressional Budget Office (CBO) projected that CMMI would be a boon for Medicare's finances, assuming that its models would yield savings over time.[32]

It is no surprise then that APMs proliferated. In its first decade, CMMI tested over 50 models (most of which were advanced APMs eligible for QPP bonuses). The portion of payments in FFS Medicare tied to APMs grew to 43 percent by 2020, compared to 41 percent of overall health care dollars.[33]

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[29] CMS, "Transition from Traditional MIPS to MVPs," accessed April 8, 2023, https://qpp.cms.gov/resources/resource-library; U.S. Department of Health and Human Services (HHS), "Fiscal Year 2024: Budget in Brief," accessed April 8, 2023, https://www.hhs.gov/sites/default/files/fy-2024-budget-in-brief.pdf.

[30] CMS, "Quality Payment Program Measure Development," https://www.cms.gov/medicare/quality-payment-program/measure-development/measure-development; MedPAC, "Moving Beyond the Merit-Based Incentive Payment System."

[31] Tyler Van Patten, "Congress Should Place Guardrails on the Center for Medicare and Medicaid Innovation," National Taxpayers Union, July 26, 2021, https://www.ntu.org/publications/detail/congress-should-place-guardrails-on-the-center-for-medicare-and-medicaid-innovation.

[32] Doug Badger, "Resetting the Scoreboard," National Taxpayers Union, February 8, 2018, https://www.ntu.org/foundation/detail/resetting-the-scoreboard.

[33] Health Care Payment Learning and Action Network, "APM Measurement: Progress of Alternative Payment Models," 2016, http://hcp-lan.org/workproducts/apm_measurement_report_2017.pdf; Health Care Payment Learning and Action Network, "APM Measurement: Progress of Alternative Payment Models," 2021, http://hcp-lan.org/workproducts/APM-Methodology-2020-2021.pdf.

Table 2: Medicare Models Qualifying as Advanced APMs

Model Name/Track(s)	Start Date	End Date	Active
Comprehensive Care for Joint Replacement: Track 1	Jan 2017	Dec 2024	Yes
Bundled Payments for Care Improvement Advanced	Oct 2018	Dec 2025	Yes
Vermont Medicare ACO Initiative	Jan 2019	Dec 2024	Yes
Maryland Care Redesign Program	Jan 2019	Dec 2026	Yes
MSSP: Basic Track E; Enhanced Track	Jan 2019	N/A	Yes
Primary Care First	Jan 2021	Dec 2026	Yes
ACO Realizing Equity, Access, and Community Health*	Apr 2021	Dec 2026	Yes
Kidney Care Choices: Comprehensive Kidney Care Contracting (Graduated (Level 2), Professional, and Global Options); Kidney Care First	Jan 2022	Dec 2026	Yes
Maryland Primary Care Program Track 3	Jan 2023	Dec 2026	Yes
Enhancing Oncology Model	Jul 2023	Jun 2028	No
Comprehensive ESRD Care: LDO, non-LDO 2-sided risk	Jan 2017	Mar 2021	No
Comprehensive Primary Care Plus	Jan 2017	Dec 2021	No
MSSP: Medicare ACOs Tracks 1+, 2, and 3	Jan 2017	Dec 2021	No
Next Generation ACO	Jan 2017	Dec 2021	No
Oncology Care Model: two-sided risk arrangement	Jan 2017	Jun 2022	No

Source: CMS, "Alternative Payment Models in the Quality Payment Program as of December 2022," December 2022, https://qpp-cm-prod-content.s3.amazonaws.com/uploads/2180/2022%20and%202023%20Comprehensive%20List%20of%20APMs.pdf.

Note: *Starting January 2023, the Global Professional Direct Contracting model transitioned to the ACO REACH model.

Analyses of these models — from both CMMI and outside studies — have cast doubt on their effectiveness. CMMI reviewed its first decade of models and found that only six produced statistically meaningful net savings. Some produced savings that were erased by additional model costs such as operational and incentive payments.[34] Of these six, only two showed significant quality improvement. Only four CMMI models overall have met the criteria for expansion (but were also not

[34] One of these models, the Maryland All-Payer Model, was later replaced with the Maryland Total Cost of Care Model, which had components that qualified as an advanced APM. The All-Payer Model was not among those seeing significant quality improvement or meeting the criteria for expansion.

advanced APMs).[35] Other studies have found that few advanced APMs yielded net savings or quality improvements.[36] Importantly, the biggest savings by model participants might have been driven by early adopters who joined because they were most likely to succeed in them. And contrary to CBO's projections that CMMI would save the federal government $34 billion during the 2017-2026 period, one study found that it was on track to instead lose $9.4 billion.[37]

Policy Implications

Efforts to reform clinician payment and incentivize better quality were necessary, and the approach taken under MACRA was understandable given the clearly identified shortcomings with Medicare's previous status quo. With the benefit of hindsight, policymakers can identify areas of improvement but should be mindful of MACRA's lessons and of potential risks going forward.

PFS Payment Updates

One key question is whether MACRA's statutory updates are sustainable and, if not, whether they or the PFS itself should be fundamentally changed. MACRA pay freezes can effectively mean cuts on net when CMS incorporates other factors such as statutorily required budget neutrality adjustments, not to mention inflation. MedPAC has found that Medicare beneficiaries' access to clinician services is equal to or better than the privately insured population (despite higher private payment rates), yet it has recommended setting annual payment updates to 50 percent of the Medicare Economic Index. (This would mean a 1.45 percent pay bump in 2024 compared to the 1.25 percent that Congress enacted in 2022 for that year.)[38]

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[35] Brad Smith, "CMS Innovation Center at 10 Years—Progress and Lessons Learned," *New England Journal of Medicine*, February 25, 2021, https://www.nejm.org/doi/full/10.1056/NEJMsb2031138; CMMI, "2022 Report to Congress," 2022, https://innovation.cms.gov/data-and-reports/2022/rtc-2022.

[36] Specifically, they found that the Medicare Shared Savings Program physician group accountable care organizations saw net savings, and the Comprehensive End-Stage Renal Disease Care saw modest quality improvements. See Cooper et al., "Review of the Expert and Academic Literature."

[37] Avalere, "Analysis of CMMI Models Projects Costs Rather Than Savings," August 25, 2022, https://avalere.com/insights/analysis-of-cmmi-models-projects-costs-rather-than-savings.

[38] MedPAC, "Physician and Other Health Professional Services," in *Report to the Congress: Medicare Payment Policy*, March 2023, https://www.medpac.gov/wp-content/uploads/2023/03/Ch4_Mar23_MedPAC_Report_To_Congress_SEC.pdf.

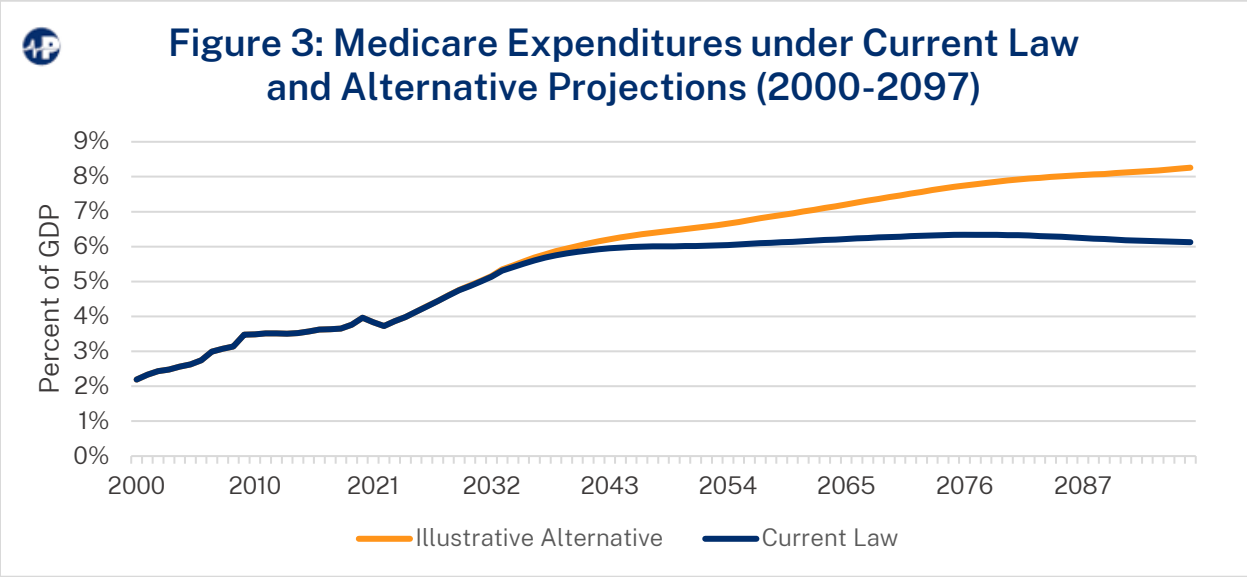
Policymakers may also opt for more technical changes to the PFS. For example, in 2015 GAO recommended that CMS improve its process of reviewing and approving changes to payment rates for individual services based on their relative costs of delivery. These figures are updated annually through rulemaking, with stakeholder input, but CMS has disagreed with GAO's recommendation to direct stakeholders to identify potentially misvalued services.[39]

Whatever approach lawmakers choose to pursue, they should keep in mind the overall fiscal impact to avoid unduly shifting financial risk from providers to taxpayers. As mentioned above, Part B is the fastest growing part of Medicare and, due to its reliance on general revenues (rather than payroll taxes, as in Part A), is increasingly straining the federal budget.[40] The Medicare trustees' 2023 report points out that Medicare participation by doctors may be an issue in the long run if Medicare payment updates do not keep pace with their costs or if they do not achieve productivity gains. However, the trustees also estimate "alternative projections" based on tying physician payment updates to the Medicare Economic Index, extending APM bonuses, renewing $500 million MIPS payments for "exceptional performance," and other factors. Under this scenario, Medicare spending would reach 6.4 percent of gross domestic product by 2047 and 8.3 percent in 2097, compared to 6.0 and 6.1 percent under current law, as Figure 3 shows.[41]

[39] GAO, "Medicare Physician Payment Rates: Better Data and Greater Transparency Could Improve Accuracy," May 21, 2015, https://www.gao.gov/products/gao-15-434.

[40] Paragon Health Institute, "Medicare Financing," https://paragoninstitute.org/wp-content/uploads/2023/03/Medicare-financing-two-pager-FINAL-2303271212.pdf.

[41] Medicare Trustees, *2023 Annual Report*



MIPS Quality Measures

Policymakers have rightfully pointed out that FFS payment does not incentivize innovation in the delivery of care. This is why MACRA attempted to hold providers accountable to objective metrics. Such value-based care programs have also become a mainstay across Medicare payment systems.

As mentioned above, however, these efforts have had mixed results in MIPS. At a high level, this may be because a government-centric approach to quality measurement suffers from inherent flaws. After all, patients are the ultimate recipients of care, and they therefore are better arbiters of what "value" means, in consultation with their doctors. In practice, quality measures reflect the priorities of federal agencies. However, quality measurement programs can still be made more effective, so Congress should scrutinize CMS's quality programs to better understand their shortcomings, whether CMS has been able to identify and address them, and why or why not. At the very least, CMS should have processes in place to track funding for these programs and whether they are achieving their strategic objectives. It should also evaluate CMS's efforts to improve quality measures such as its National Health Quality Roadmap and Meaningful Measures Initiative.[42]

[42] HHS, *National Health Quality Roadmap*, May 15, 2020, https://www.hhs.gov/sites/default/files/national-health-quality-roadmap.pdf; CMS, "Meaningful Measures Initiative," accessed June 18, 2023, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy.

APMs

APMs developed by federal agencies suffer from similar flaws in terms of their overall approach and practical implementation. On the latter point, a major question relates to CMMI's development, management, and evaluation of many of these models. From the start, CMMI had much more leeway than CMS did under existing Medicare demonstration authority. It can require participation by providers, impose nationwide models, and avoid budget neutrality requirements as well as administrative or judicial review.[43] Yet Congress does not currently conduct significant oversight over CMMI's processes or decisions. And despite its own underwhelming results, CMMI has not opted to embrace the perspectives of non-government stakeholders. For example, MACRA created the Physician-Focused Payment Model Technical Advisory Committee (PTAC), an independent federal advisory committee that recommends stakeholder-submitted, physician-focused APMs. Despite much public praise of it by senior health officials, CMS has not adopted any models recommended by PTAC. After CMS rejected 16 recommended models, two PTAC members resigned in 2019.[44]

Conclusion

The goals of MACRA — fostering a sustainable and high-quality Medicare program for beneficiaries — continue to be as relevant as ever. Its first years of operation have been instructive, and Congress is in a position to gain even more information about its impact on providers and agencies' approach to implementation. These insights can guide Congress's actions going forward. Future policy changes should seek to improve Medicare's fiscal impact and ensure that innovations in care are based on what patients, not federal bureaucrats, value.

[43] Badger, "Resetting the Scoreboard."

[44] Joyce Frieden, "Two PTAC Members Quit in Frustration," *MedPage Today*, November 25, 2019, https://www.medpagetoday.com/publichealthpolicy/medicare/83502; Joey Berlin, "Going Nowhere: APM Committee Resignations Cast Doubt on Payment Models' Future," Texas Medical Association, April 2020, https://www.texmed.org/Template.aspx?id=53087.