The Congressional Role in Advancing National Payment and Delivery Reform

There has been bipartisan support over the past decade to change the way that the United States pays for health care, with an emphasis on enabling health care providers to adopt accountable care models, which provide more flexibility to shift resources towards innovative services and care focused on patient-centered, coordinated care that lowers costs and improves outcomes. This momentum drives the Centers for Medicare and Medicaid Services’ (CMS’) current goal to give most Medicare and Medicaid beneficiaries access to accountable care models by 2030.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which governs Medicare’s physician payment updates and quality adjustments, is an important component of this approach. It was designed with two goals:

1) Providing predictable payment updates to replace the Sustainable Growth Rate (SGR) Formula, which consistently required Congress to override statutory cuts that were viewed as too large to be sustainable.
2) Creating physician payment incentives designed to improve care and accelerate the transition away from fee-for-service payments to accountable care models.

MACRA has aimed to achieve these goals in part through two payment pathways:

1) The Merit-Based Incentive Payment System (MIPS), which assessed clinicians on quality, use of electronic health records, practice improvement, and resource use; and
2) Advanced Alternative Payment Models (A-APMs), accountable care models that require providers to take on downside risk—that is, responsibility for any additional spending over a prescribed benchmark. Participants in these models receive a 5% bonus payment and are not required to report measures to MIPS.

Growth in accountable care models has resumed since the public health emergency, across Medicare, Medicaid, and commercial insurance, and is expected to continue. CMS’ experience in building and maintaining accountable care models over the past decade has played a major role in driving this growth. The Medicare Shared Savings Program (MSP) is the foundation for Traditional Medicare’s shift to accountable care, with CMMI pilots testing out ways to extend this program to more comprehensive payment shifts and to increase participation by smaller primary care practices and safety-net organizations. CMS’ Accountable Care Organization (ACO) program now covers 10.4 million beneficiaries—about one-third of all enrollees in Traditional Medicare. The most recent MSSP analysis estimates at least 84% participating ACOs achieved a combined $1.8 billion in savings in 2022, the sixth consecutive year the program achieved net savings relative to the benchmarks. The unmeasured impact of spillover effects may mean the actual amount of saving is even higher. Organizations taking on more downside risk—currently representing one-quarter of all health care payments and rising—tend to save more money than organizations that do not while still maintaining quality. ACOs also serve higher percentages of populations historically characterized as higher cost and higher need (such as dual eligible patients and minoritized racial and ethnic groups), reporting comparable savings and quality scores.

Despite MACRA’s intent to provide predictable physician payments and support these shifts towards accountable care models, including A-APMs, the MIPS program has not had its intended effects:
MIPS has not led to improvements in quality, cost savings, or value, with concerns the program does not accurately reflect the quality of care provided;

About half of all providers have been exempt from MIPS, largely because they do not reach a specific financial threshold, limiting the program’s overall reach;

The wide variety of possible measures in MIPS—with providers able to choose their own to report—means there is little if any consistency in measurement, making it impossible to compare performance in meaningful ways;

Implementing MIPS has increased administrative burden for physicians. One analysis found the mean per-physician cost to practices of MIPS participation was $12,811 in 2019;

The ease with which physicians can qualify for MIPS bonuses without undertaking steps to shift out of FFS may lower physician interest in participating in an APM; and

Congressional support for the Advanced Alternative Payment Model Bonus has declined despite overwhelming stakeholder support, with Congress reducing the bonus to 3.5% in 2023. A new Senate Finance draft proposes to reduce the bonus to 1.75% in 2026.

These shortcomings do not mean MACRA overall is a failure. However, after eight years and with evidence that MACRA is not providing predictability and effective incentives for helping clinicians shift to alternative payment models, it is time to assess the progress MACRA has made and where it can be improved, especially given its role as the primary Congressional vehicle for supporting the bipartisan accountable care vision. Reform efforts should reinforce movement across the health care system towards accountable care, create long-term predictability, and build on the lessons learned from the program so far. To support these reforms, we outline key principles below, drawing on our own research and insights from a range of health care thought leaders and stakeholders.

1) **Prioritizes helping clinicians succeed in care models with accountability for Total Cost of Care**

ACOs and other accountable care models focusing on total cost of care and accountability for coordinated, longitudinal care are continuing to grow. Combining evidence-based updates of these models with aligned incentives in Medicare’s physician payment programs would create the strongest opportunity to improve health care delivery and the patient experience while lowering costs.

Reform efforts should continue incentivizing clinicians to move into these models and supporting those already participating by retaining a financial wedge between traditional fee-for-service and participation in total cost of care models – that is to say, a predictable payment differential that favors participation, and supports long-term planning and investments to succeed in accountable care models. There are alternative ways to achieve that predictability. Extending the 5% bonus payment for participants in Advanced APMs or a similar program (ie: those with downside risk) is one approach. Policymakers could also increase the difference between A-APMs and FFS through the conversion factor and create model benchmarks that eliminate the ratchet effect. Bonus payments could also be based on a flat, per beneficiary payment rather than a percentage of billed services, so as not to disadvantage smaller practices from participating in these models.

2) **Ensures meaningful opportunities and incentives for specialist engagement with APMs**

Over half of providers are specialists, but most do not have meaningful opportunities to participate in total cost of care models today or to engage with primary care and other providers in accountable care. Targeted reforms
can help make specialist engagement in accountable care models easier. Reforming MIPS payments to provide better support and incentives, increasingly linked to relevant performance measures for specialists’ contributions to reducing total costs and improving outcomes for the patients they serve, could accelerate specialty participation and collaboration in total cost of care models. Such actions could be supported by new CMS care management fees for specialists to facilitate primary care collaboration. Engagement efforts should prioritize specialists focusing on longitudinal patient management within accountable care relationships, such as musculoskeletal care, cardiovascular care, and GI.

3) Reduce Burdensome Requirements Through Alignment With Broader CMS Strategy

To increase the impact of Medicare support for improving outcomes and lowering costs, the mechanisms should align as closely as possible across Medicare, Medicaid, and commercial insurance programs. That is, Congress should help CMS advance universal, meaningful measures relevant to major areas of care. For example, policymakers could require that measures in MIPS submitted align with measures currently used in accountable care models like MSSP or CMS’ Universal Foundation, which aims to unite adult and pediatric measures across all of CMS’ programs. Performance-based measurement can still be meaningful for improving care, as long as providers are not overburdened with measure reporting, can be meaningfully compared to their peers. Efforts like these can complement broader data interoperability initiatives, transparency initiatives, and development of validated patient-reported outcome measures to ensure patients and providers alike are supported in tracking and improving quality and outcomes that matter.

4) Better Utilize CMMI to Advance Accountable Care Goals

The CMS Innovation Center has developed and implemented major payment models that have helped build a foundation for accountable care, both through the expansion of models that work and through lessons learned from other pilots that have increasingly been incorporated into models. MACRA reforms should also utilize this approach to better support the transition to accountable care. For instance, Congress could take steps through MIPS and MACRA reform to help CMS build out and accelerate its steps for increasing specialty participation in accountable care and strengthen specialty relationships with primary care. These steps could include aligning MIPS measures with those in present and future CMMI models, and helping providers get better and more timely data to improve care. MACRA should encourage the widespread implementation of validated measures that are more relevant to patients. Finally, MACRA reform could help CMS collaborate with states and private-sector innovators to develop additional technical assistance, best practice guidance, and more standardized and less costly data sharing to help ensure providers are appropriately equipped and empowered to succeed in CMS programs.

Conclusion/Next Steps

Discussions around MACRA reform offer policymakers a major opportunity to take the lessons learned from the past eight years and continue the bipartisan push to build a better health care system for all beneficiaries. Doing so requires not just further investments and technical changes to programs like MACRA and MIPS, but ensuring that we are appropriately catalyzing the push to accountable care across the health care system and can ultimately help foster patient-centered, affordable care for all beneficiaries.
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