

Health Affairs

At the Intersection of Health, Health Care and Policy

Cite this article as:
Peter S. Hussey, Jodi L. Liu and Chapin White
The Medicare Access And CHIP Reauthorization Act: Effects On Medicare
Payment Policy And Spending
Health Affairs 36, no.4 (2017):697-705
doi: 10.1377/hlthaff.2016.0559

The online version of this article, along with updated information and services, is available at:

<http://content.healthaffairs.org/content/36/4/697>

For Reprints, Links & Permissions :

http://content.healthaffairs.org/1340_reprints.php

Email Alertings : <http://content.healthaffairs.org/subscriptions/etoc.dtl>

To Subscribe : <https://fulfillment.healthaffairs.org>

Health Affairs is published monthly by Project HOPE at 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133. Copyright © by Project HOPE - The People-to-People Health Foundation. As provided by United States copyright law (Title 17, U.S. Code), no part of may be reproduced, displayed, or transmitted in any form or by any means, electronic or mechanical, including photocopying or by information storage or retrieval systems, without prior written permission from the Publisher. All rights reserved.

Not for commercial use or unauthorized distribution

By Peter S. Hussey, Jodi L. Liu, and Chapin White

The Medicare Access And CHIP Reauthorization Act: Effects On Medicare Payment Policy And Spending

DOI: 10.1377/hlthaff.2016.0559
HEALTH AFFAIRS 36,
NO. 4 (2017): 697–705
©2017 Project HOPE—
The People-to-People Health
Foundation, Inc.

Peter S. Hussey (peter_hussey@rand.org) is a senior policy researcher at the RAND Corporation in Boston, Massachusetts.

Jodi L. Liu is an associate policy researcher at the RAND Corporation in Santa Monica, California.

Chapin White is a senior policy researcher at the RAND Corporation in Arlington, Virginia.

ABSTRACT In 2015, Congress repealed the Sustainable Growth Rate formula for Medicare physician payment, eliminating mandatory payment cuts when spending exceeded what was budgeted. In its place, Congress enacted the Medicare Access and CHIP Reauthorization Act (MACRA), which established a two-track performance-based payment system that encourages physicians to participate in alternative payment models. MACRA could have huge effects on health care delivery, but the nature of those effects is highly uncertain. Using the RAND Corporation's Health Care Payment and Delivery Simulation Model, we estimated the effects of MACRA on Medicare spending and utilization and examined how effects would differ under various scenarios. We estimate that MACRA will decrease Medicare spending on physician services by $-\$35$ to $-\$106$ billion (-2.3 percent to -7.1 percent) and change spending on hospital services by $\$32$ to $-\$250$ billion (0.7 percent to -5.1 percent) in 2015–30. The spending effects are critically dependent on the strength of incentives in the alternative payment models, particularly the incentives for physicians to reduce hospital spending and physician responses to MACRA payment rates.

The Medicare Access and CHIP Reauthorization Act (MACRA), enacted in 2015, fulfilled two long-standing desires among federal policy makers: to repeal the widely reviled Sustainable Growth Rate (SGR) formula and to expand the role of value-based payment in Medicare. For years, physicians operated under deep uncertainty as to how much they would be paid by Medicare, the largest health insurer in the United States. The SGR formula, which was designed to limit growth in Medicare spending with national caps on physician payments, would have led to annual cuts of 5–25 percentage points in the rate Medicare pays for services under the physician fee schedule. Instead, Congress overrode these cuts seventeen times between 2003 and 2015.

Recently, Medicare also increased the use of payment models that linked payments to health care quality and, in some cases, rewarded providers for slowing spending growth. For physicians, these models typically started as voluntary pay-for-reporting programs, shifting to mandatory participation over time. The trend toward value-based payment models was spurred on by the Affordable Care Act and solidified in 2015, when then secretary of health and human services (HHS) Sylvia Mathews Burwell set targets for the majority of Medicare payments to be tied to quality or value by 2018.¹ This trend coincided with the development of policy to replace the SGR formula, and thus the replacement legislation contained policy provisions designed to shift payments away from fee-for-service toward value-based payment.

MACRA introduced a new Medicare physician payment system, consolidating several existing performance reporting and incentive programs and creating incentives for increased participation by physicians in innovative payment models. Medicare will allow physicians to choose between two payment tracks starting in 2019. The first track, the Merit-Based Incentive Payment System (MIPS), more closely resembles previous Medicare payment methods. Physicians are reimbursed primarily via fee-for-service, with relative payment rates for each service determined by the resource-based relative value scale. Physicians will also receive bonuses or penalties related to their performance. Performance-based payments will be based on quality of care, resource use, meaningful use of electronic health records, and clinical practice improvement, replacing several previous Medicare physician incentive programs. The bonuses and penalty payment amounts will increase incrementally from a maximum 4 percent in 2019 to 9 percent in 2022; until 2024, bonuses for top performers may be increased by up to a factor of 3.

The second payment track includes physicians with significant participation in certain alternative payment models (APMs). The detailed definitions of payment methods that will be considered eligible for this track of MACRA will have important implications for the effects of the payment models. Proposed definitions for the first year of the program were released by the Centers for Medicare and Medicaid Services (CMS) in a proposed rule in April 2016 and were finalized in the final rule in October 2016. The MACRA legislation stipulates that APMs include payment models developed under sections 1115A (payment and delivery models developed by the Center for Medicare and Medicaid Innovation), 1899 (accountable care organizations [ACOs] with shared savings), and 1866C (health care quality demonstrations) of the Social Security Act, as well as demonstration models required by federal law. MACRA also established the Physician-Focused Payment Model Technical Advisory Committee, which will provide comments and recommendations on the payment models, with technical support provided by the HHS Office of the Assistant Secretary for Planning and Evaluation. Physicians will have several financial incentives to join the APM track; these incentives include annual lump-sum payments in each year from 2019 to 2024 and higher annual payment rate updates starting in 2026 (0.75 percent versus 0.25 percent in the MIPS track).

MACRA created a complex set of options for both policy makers and providers, with potentially huge implications for the Medicare pro-

gram. There is a great deal of uncertainty in how specific aspects of the law will be implemented and even greater uncertainty in how providers will respond. Increasing participation in APMs is a central feature of MACRA, and the details in APMs' design and implementation will mediate the effect of the new law. The objective of this study was to estimate trends in Medicare physician and hospital spending under MACRA and to measure the sensitivity of the trends to alternative assumptions about how APMs will be designed.

Study Data And Methods

We projected Medicare payment policy from 2015 to 2030 under four scenarios: a "pre-MACRA baseline" scenario and three MACRA scenarios with varying assumptions about APM design. The pre-MACRA baseline represents a counterfactual in which Medicare payment policy for physicians would continue to be determined as it had in the years immediately preceding MACRA, including overrides of the SGR. The three MACRA scenarios used different assumptions about the strength of financial incentives under APMs (low, medium, and high). We estimated spending on physician and hospital care provided to Medicare beneficiaries using the RAND Corporation's Health Care Payment and Delivery Simulation Model (PADSIM), a simulation model of provider responses to payment policy.

METHODS FOR ANALYZING PAYMENT POLICY

We characterized Medicare physician payment policy using two concepts: the payment rate and what we call "prospectiveness of payments," which refers to the quantification of differences in the degree of financial risk for providers under MIPS and APMs and which we define more fully later in the article.

PAYMENT RATE The *payment rate* is the average unit price for Medicare services. This payment rate was calculated in nominal terms relative to a base year, 2015, using historical Medicare data and information from the MACRA statute.²

In the pre-MACRA baseline scenario, we assumed that Medicare physician payment rates would grow at a nominal annual rate of 0.5 percent from 2015 to 2025 as a result of legislated overrides to the SGR. We also assumed that CMS would continue to roll out the various value-based payment models that were in process before the enactment of MACRA. These assumptions are similar to those made by the Congressional Budget Office and the Medicare Trustees in projections published before MACRA was passed and similar to the average annual update in the period 2003–14.^{3,4} We assumed that in

MACRA created incentives for increased participation by physicians in innovative payment models.

2026, physician payment rates would increase an additional 2 percent as a result of the expiration of the “sequester”—across-the-board cuts in Medicare payment rates instituted in 2013. We tested the sensitivity of the pre-MACRA baseline scenario to assumptions about payment rate updates, estimating the impact of annual updates between 0 percent and 1 percent (see the online Appendix).⁵

In the pre-MACRA baseline scenario, we assumed that hospital payment rates would increase according to the Medicare Trustees’ projections of the input price index, unit input intensity allowance, and other legislative rate adjustments.⁶

In the three MACRA scenarios, we assumed that nominal physician payment rates would increase by 0.5 percent per year between 2015 and 2019, as prescribed by law. Between 2020 and 2025, the rates will remain the same (0 percent annual update). From 2019 to 2024, qualifying APM participants will receive an annual lump-sum payment equal to 5 percent of their Medicare payments in the prior year. Starting in 2026, physician payment rate updates will depend on their participation in the MIPS or APM track (0.25 percent and 0.75 percent annual update, respectively).

PROSPECTIVENESS We used the concept of “prospectiveness” to quantify differences in the degree of financial risk for providers under MIPS and APMs. Conceptually, prospectiveness reflects the potential financial losses (or gains) that providers face if they increase (or decrease) the quantity and intensity of services provided.⁷ More formally, prospectiveness equals 1 minus the elasticity of provider payments with respect to the cost of services provided. Prospectiveness is measured on a scale from 0 to 1, with 0 representing pure cost reimbursement and 1 representing global capitation. Under pure cost reimbursement, providers are paid for all costs they incur in providing care and therefore face no

financial risk. Under global capitation, providers are paid a fixed amount per patient without regard to the cost of care actually delivered and therefore face full financial risk of any increased provision of services. APMs in MACRA will fall in between these extremes.

APMs are intended to affect not only the care directly provided by physicians but also the care that they recommend or order for their patients. For example, physicians participating in physician-led ACOs can increase the shared savings they receive by reducing the quantity or intensity of hospital services, Part B prescription drugs, and so forth. Thus, we differentiated between *own-provider prospectiveness*, which relates to how payments to one type of provider vary depending on the quantity of services they themselves provide, and *cross-provider prospectiveness*, which relates to how payments to one type of provider vary depending on the quantity of services provided by a different type of provider. For example, introducing physician bonuses for lower total cost of care would increase physicians’ own-provider prospectiveness (because physician revenues would no longer increase one-for-one with increases in physician volume) and would also increase cross-provider prospectiveness between physicians and hospitals, because reducing hospitalizations would increase physician revenues.

Our MACRA scenarios assume that Medicare payments will shift over time with the increasing prevalence of APMs.⁸ We used existing payment models—the Medicare Shared Savings Program (MSSP) Track 2 model, the Next Generation ACO model, and a generic patient-centered medical home model derived from several existing models—to develop estimates of the prospectiveness of APMs under MACRA. In the MACRA final rule published in 2016, CMS stated that it intends MSSP Track 2 ACOs, Next Generation ACOs, and the Comprehensive Primary Care Plus patient-centered medical home model as among the “advanced APMs” that could qualify physicians for the APM track. MSSP Track 2 model participants are eligible for shared savings or losses based on spending and quality of care.⁹ The Next Generation ACO model has higher levels of shared savings and losses.¹⁰ Patient-centered medical homes are a model focused on the patient, primary care, and care coordination. Patient-centered medical home payment arrangements have varied widely in past implementations. In our scenarios, we considered a case management fee to patient-centered medical homes for a defined panel of patients.

We calculated the prospectiveness of these three APMs by estimating providers’ expected marginal revenues if they increased the volume

of services provided, taking into account bonuses or penalty payments and any population-based payments. In the ACO models, we considered the minimum savings (or loss) rate to qualify for payment, the amount of savings (or loss) shared with providers by Medicare, and the quality threshold required to qualify for payment. In the patient-centered medical home model, prospectiveness was determined by the amount of the per capita case management fee. This fee increases prospectiveness because it reduces the extent to which marginal revenues vary with volume, even though providers do not assume downside financial risk. In MIPS, prospectiveness was determined by providers' expectations that their performance on cost and quality measures would result in a bonus (or penalty) payment. We calculated providers' probability of exceeding spending and quality benchmarks, using historical data on ACO performance.

In the MACRA medium-prospectiveness scenario, we assumed that APMs would resemble a mix of MSSP Track 2, Next Generation ACO, and patient-centered medical home models. In the low-prospectiveness scenario, we assumed that all APMs resembled patient-centered medical homes. In the high-prospectiveness scenario, we assumed that all APMs resembled Next Generation ACOs.

Because MACRA represents such significant changes, physicians' participation in APMs is highly uncertain. We made assumptions about the percentage of physicians qualifying for the APM track by extrapolating historical participation rates in ACOs. We performed sensitivity analyses testing the effect of different assumptions about participation rates (see the Appendix).⁵

METHODS FOR PROJECTING SPENDING We projected spending on Medicare-covered physician and hospital services using PADSIM, which is described in greater detail elsewhere.² The general approach was to project the quantities of services provided and then project spending, which, by definition, was equal to projected quantities multiplied by the projected payment rate. To project quantities of health care services, we used a blended equilibrium concept, in which provider output reflects a compromise between projected patient demand and the projected quantity that providers prefer to supply. Providers' preferred supply is, in turn, affected by the number of providers and by provider payment policy.

Because Medicare prices are generally set through statute, they don't adjust automatically in response to demand, as economic theory would predict in a competitive market. Therefore, we reconciled supply and demand using the concept of "congestion," which includes

MACRA ended a cycle of deep uncertainty about Medicare payment rates for physician services.

nonprice factors that reduce patient demand but increase (or leave unchanged) provider supply. For example, physicians facing high demand for their services might increase the time patients wait for their next appointment; this difference would be included in the estimate of congestion. We projected patient and provider populations for years 2015–30 by applying population weight adjustments, probabilistic transitions of health insurance coverage, and projected growth factors to historical data from 1996 to 2014. Patient demand was identical in the MACRA policy scenario and in the pre-MACRA baseline scenario.

Providers' responses to changes in payment are highly uncertain, given the novelty introduced by MACRA. We used estimates from previous studies of previous payment changes to characterize how providers would respond to changes in payment rates and prospectiveness. Based on our interpretation of these studies, in our main analysis we assumed that, overall, physicians would respond to higher real payment rates by increasing the volume/intensity of services provided and would respond to payment methods with higher prospectiveness by decreasing the volume/intensity of services provided. In sensitivity analyses, we tested alternative assumptions, such as that the volume and intensity of services would increase to partially offset payment rate decreases (see the Appendix).⁵

LIMITATIONS Our estimates are subject to a high degree of uncertainty. Final regulations for MACRA could change, so the MACRA scenarios are subject to policy uncertainty. For example, MACRA implementation dates could be delayed. Elements of MACRA such as the definition of APMs will also change over time.

As discussed above, for some important parameters of the model, such as the rate of participation of physicians in APMs, the dynamic under MACRA is so new that historical experience provides limited guidance about parameter values. We relied on historical data for some aspects

of the model, such as provider performance in ACO models, but the design of these models and future provider performance could change significantly. For example, our APM scenarios currently include only ACO and patient-centered medical home-type models, not specialty-focused models that might be condition-specific (for example, Medicare's Oncology Care Model) and might have different types of effects. Design elements of APMs such as how performance targets are rebased will likely also affect responses to the models in the long term.

Our simulation used a simplified model of health care payment and delivery, which introduced structural uncertainty into estimates and omitted some potentially important effects. The model included physician and hospital services only, excluding potentially important impacts on other types of services, such as postacute care. The model did not differentiate between effects on different types of services so could not predict a result such as increased volume of primary care. Our projections also do not predict trends that might occur in commercial insurance plans, which are also introducing APMs that might reinforce or otherwise affect Medicare APMs.

For these reasons, our estimates should be interpreted with caution. Despite these limitations, given the limited alternative methods

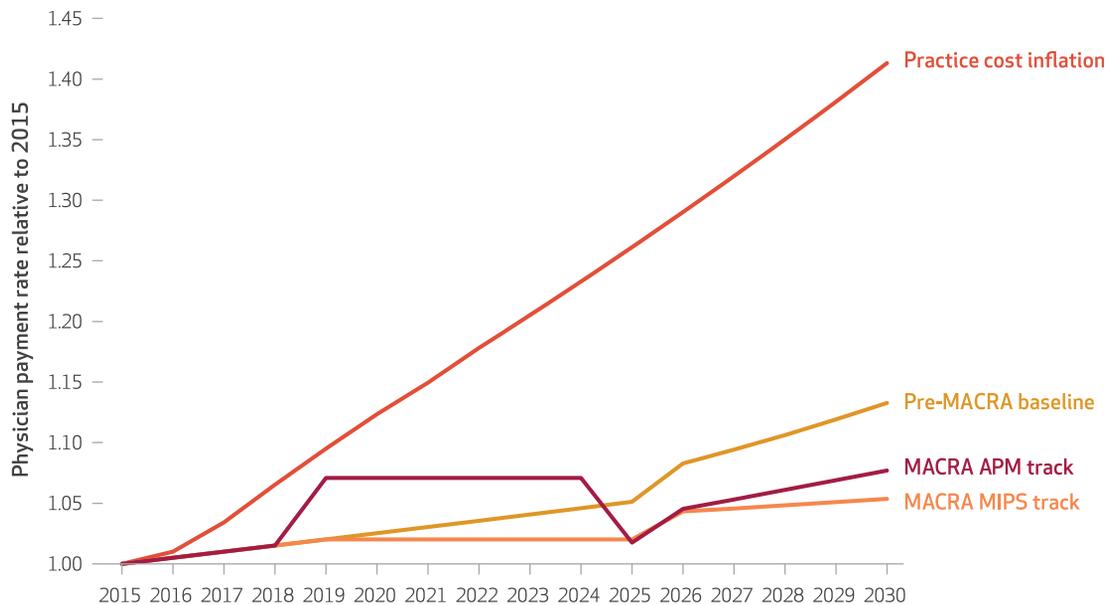
for estimating MACRA effects, we believe that the results provide useful information for policy makers and providers.

Study Results

PROJECTED PAYMENT RATES Physician payment rates are projected to increase gradually in nominal terms under both the MACRA and pre-MACRA scenarios (Exhibit 1). By 2030, physician payment rates will be 13 percent higher than in 2015 in the pre-MACRA baseline scenario, 8 percent higher than 2015 levels for physicians in the MACRA APM track, and 5 percent higher for physicians in the MACRA MIPS track. All of these increases are projected to be well below the rate of inflation in practice costs as measured by the Medicare Economic Index, which is projected to be 41 percent higher in 2030 than in 2015. For physicians qualifying for the MACRA APM track, payment rates will be higher than they would have been in the pre-MACRA baseline in 2019–24, when bonuses are in effect for APM participants. Starting in 2025, physician payment rates in both the APM and MIPS tracks of MACRA fall below the pre-MACRA baseline, although they are higher for APM participants than for MIPS participants. This is the result of 0 percent payment rate updates in 2019–24 and

EXHIBIT 1

Projected Medicare physician payment rates under MACRA versus a pre-MACRA baseline scenario, 2015–30



SOURCES Authors' analysis of pre-MACRA (Medicare Access and CHIP Reauthorization Act) trends and MACRA legislative requirements. Medicare Economic Index practice cost inflation projections are from the 2015 Boards of Trustees report (see Note 6 in text).

NOTES Bonus payments for qualifying alternative payment model (APM) providers are shown in the year in which they are accrued (not the next year when the lump sum bonus is paid out). MIPS is Merit-Based Incentive Payment System. APM track and MIPS track are explained in the text.

the expiration of the 5 percent APM bonus in 2025. The year 2025 therefore looms as a pivotal year—one in which a confluence of policy factors are expected to significantly reduce physician payments, a situation reminiscent of the SGR.

PROJECTED PROSPECTIVENESS APMs have higher prospectiveness than other Medicare physician payments. We estimated that patient-centered medical homes would increase overall prospectiveness by 0.03, two-sided MSSP-like ACOs would increase prospectiveness by 0.22, and Next Generation-like ACOs would increase prospectiveness by 0.79, while MIPS would increase prospectiveness by 0.01–0.10.

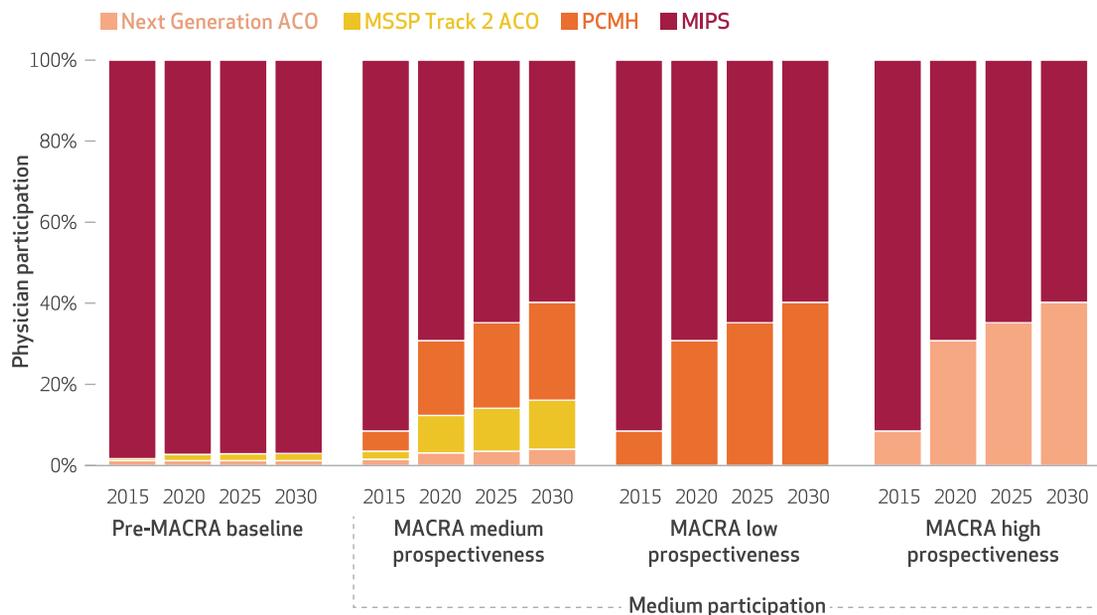
As shown in Exhibit 2, in the pre-MACRA baseline scenario, the prospectiveness of provider payments will gradually increase over time as physicians increasingly participate in APMs. Based on the number of beneficiaries assigned to Medicare ACOs in 2014,^{11–13} we estimated that the share of Medicare physicians in ACOs similar to the MSSP Track 2 model was 0.1 percent and the share in ACOs similar to the Next Generation ACO model was 1.2 percent in 2014. In the MACRA scenarios overall, we assumed that APM participation would grow from 8.5 percent of physicians in 2015 to 31 percent in 2020 and to 40 percent in 2030. In the medium-prospective-

ness scenario in 2015, we assumed that 1.5 percent of physicians will be in Next Generation-like models, 2.0 percent in MSSP Track 2-like ACOs, and 5.0 percent in patient-centered medical home-like models. In 2030 we assumed that 4 percent of physicians will be in Next Generation-like models, 12 percent in models like MSSP Track 2 ACOs, and 24 percent in patient-centered medical home-like models. In the MACRA low- and high-prospectiveness scenarios, we assumed that overall trends in APM participation would be similar to the medium scenario but that the APMs would have mean prospectiveness similar to patient-centered medical home (low scenario) or Next Generation ACOs (high scenario).

PROJECTED SPENDING Under the pre-MACRA baseline, projected physician revenue from Medicare grows from \$81 billion in 2014 to \$109 billion in 2030 (Exhibit 3), and projected hospital revenue grows from \$223 to \$413 billion (Exhibit 4). MACRA reduces physician revenue from Medicare in 2015–30 by \$47 billion (3.2 percent decrease) in the medium-prospectiveness scenario compared to the pre-MACRA baseline scenario, with the reduction occurring mainly in 2022–2030 (data not shown). In the period 2019–21, physician revenue is higher than the

EXHIBIT 2

Participation in alternative payment models under MACRA versus a pre-MACRA baseline scenario, 2015–30



SOURCE Authors' estimates based on Centers for Medicare and Medicaid Services historical data on accountable care organization (ACO) participation rates and on MACRA (Medicare Access and CHIP Reauthorization Act) provisions. **NOTES** We estimated own- and cross-prospectiveness (explained in the text) to be 0.79 for Next Generation ACOs and 0.22 for two-sided Medicare Shared Savings Program (MSSP) ACOs. For patient-centered medical home (PCMH) models, own- and cross-prospectiveness was 0.10 and 0.00, respectively. For non-ACO providers participating in the Merit-Based Incentive Payment System (MIPS), own- and cross-prospectiveness was 0.01 and 0.08, respectively, and 0.10 for one-sided MSSP ACOs participating in MIPS.

Downloaded from <http://content.healthaffairs.org/> by Health Affairs on April 6, 2017 by HW Team

pre-MACRA baseline scenario, but lower thereafter.

Exhibit 3 demonstrates that MACRA's effects on physician payments are highly dependent on the design of APMs. In the high-prospectiveness scenario—in which all APMs pay physicians using methods that are as prospective as Next Generation ACOs—physician revenue is \$106 billion lower (7.1 percent decrease) than the pre-MACRA baseline scenario over the 2015–30 time period. Physician payments decrease between 2019 and 2025, as bonus payments for APM participants would be offset by reduced use of services in response to APMs. In the low-prospectiveness scenario, physician revenue is \$35 billion lower (2.3 percent decrease) than the pre-MACRA baseline scenario over the 2015–30 time period.

The largest effects of MACRA may actually be on hospital revenue (Exhibit 4). Hospital revenue from Medicare will decrease by a larger magnitude than physician revenue under the MACRA high-prospectiveness scenario (\$250 billion [5.1 percent decrease] over the period 2015–30). This is the result of physicians' responding to payment models in ways that reduce the use of hospital care, such as avoiding admissions and readmissions, reducing use of care in the hospital, and so forth. In addition, Medicare is experimenting with new hospital payment methods, which if implemented broadly could change these projections downward substantially.

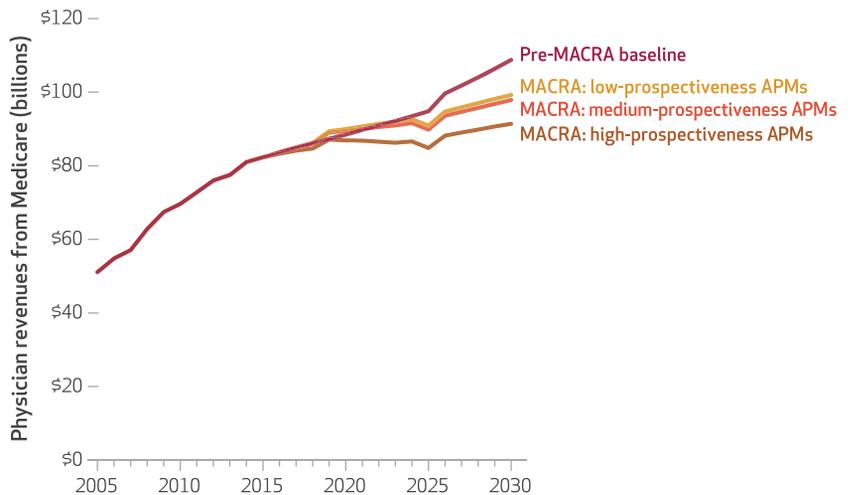
In contrast, hospital revenue could increase under some APM designs. For example, in the low-prospectiveness MACRA scenario, in which APMs are all similar to patient-centered medical home models that do not hold physicians at financial risk for hospital spending, hospital revenue will increase by \$32 billion, offsetting the decrease in physician revenue (\$35 billion). This is the result of a lower number of physicians in the MIPS track, in which part of the value-based payment adjustment will be based on total cost of care—creating incentives to decrease hospital use.

These results are sensitive to assumptions about payment rate increases. In an alternative non-MACRA baseline in which Congress updated rates at 0.2 percent annually (versus 0.5 percent in the main analysis), physician revenue from Medicare are \$47 billion lower than the pre-MACRA baseline scenario (see the Appendix).⁵ Thus, annual payment reductions of 0.2 percent have effects similar to those of APMs in the medium-prospectiveness scenario.

SENSITIVITY ANALYSES These results are sensitive to several assumptions, as shown in the Appendix.⁵ In particular, projected Medicare spending is highly sensitive to assumptions

EXHIBIT 3

Physician revenues under MACRA versus a pre-MACRA baseline scenario, 2005–30

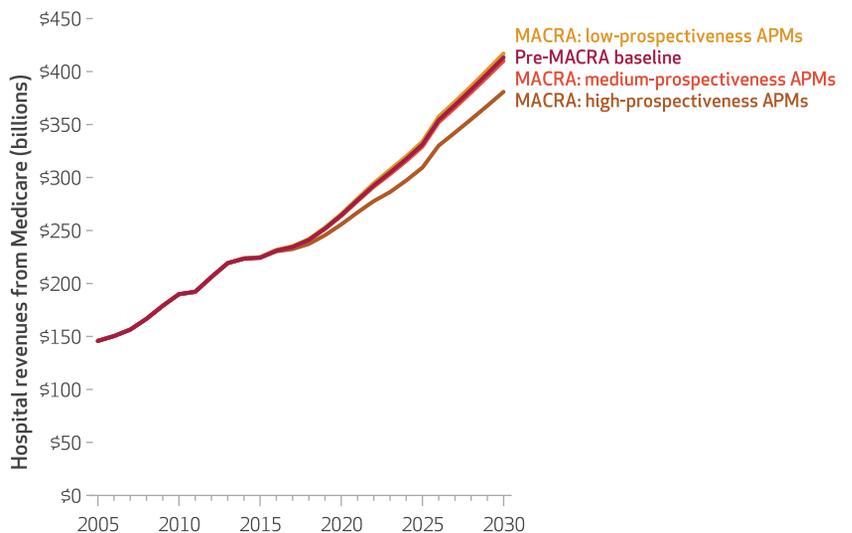


SOURCE Authors' analysis based on the RAND Corporation's Health Care Payment and Delivery Simulation Model (PADSIM). **NOTES** Relative to the pre-MACRA (Medicare Access and CHIP Reauthorization Act) baseline from 2015 to 2030, physician revenues would be reduced by \$47 billion under MACRA. The MACRA scenarios with low and high prospectiveness (explained in the text) would reduce revenues by \$35 billion and \$106 billion, respectively. APM is alternative payment model.

about the price-elasticity of supply—the extent to which the supply of health care services responds to changes in price, or payment rates. The projections are less sensitive to assumptions about APM participation rates and the degree to

EXHIBIT 4

Hospital revenues under MACRA versus a pre-MACRA baseline scenario, 2005–30



SOURCE Authors' analysis based on the RAND Corporation's Health Care Payment and Delivery Simulation Model (PADSIM). **NOTES** Relative to the pre-MACRA (Medicare Access and CHIP Reauthorization Act) baseline from 2015 to 2030, hospital revenues would be reduced by \$22 billion under MACRA. The MACRA scenario with low prospectiveness (explained in the text) would increase revenues by \$32 billion, while the MACRA scenario with high prospectiveness would decrease revenues by \$250 billion. APM is alternative payment model.

which health care volume and intensity respond to changes in prospectiveness.

Discussion

MACRA ended a cycle of deep uncertainty about Medicare payment rates for physician services under the Sustainable Growth Rate formula. The annual rate of increase in payment rates for years in the future is now clearly laid out in statute. Physician payment rate updates will no longer be subject to a formula that is determined by a national spending target. Instead, MACRA will encourage migration to alternative payment models, which are intended to transform Medicare physician payment from fee-for-service to a new system based on value. What should physicians and policy makers expect?

We found that under the three MACRA scenarios with varying degrees of prospectiveness, physicians' Medicare payments will be lower under MACRA than they would have if MACRA had never been passed and the cycle of SGR overrides had continued. This is the result of both low rates of annual increases in physician payment rates under MACRA—payments per unit of service will not keep pace with practice cost inflation—and changes that physicians are expected to make in the provision of care under APMs.

Evidence on the changes in care resulting from APMs is emerging, and at this time it is difficult to determine the specific impacts of APMs on health care delivery. In addition, it is uncertain whether payment rate changes will be offset by increases in the volume or intensity of services. For these reasons as well as others discussed above, it is difficult to predict exactly how care will change. However, our estimates suggest that the biggest budgetary impact of physician payment changes under MACRA might be not from physician payments at all but rather from reduced volume of hospital services that are sensitive to physicians' decisions.

While physicians now have more certainty about payment rates, there are many important and currently unresolved questions related to MACRA implementation, especially the design of APMs. We found that if these models use fairly strong financial incentives, Medicare payments to physicians will be far lower than they would have been without MACRA. Physician participation rates in these models—and the changes they make in provision of care—will be highly dependent on specific elements of model design. The American Medical Association has released a position paper describing three necessary characteristics of physician-focused APMs: flexibility in

MACRA is a big, complicated undertaking that aims to substantially change the incentives providers face.

care delivery, adequacy and predictability of payment, and accountability for costs and quality that physicians can control.¹⁴ The position paper notes that Medicare Shared Savings Program accountable care organizations do not meet these criteria and proposes seven types of APMs that would be preferable. It's easy to imagine many future political skirmishes being fought over the design of APMs, replacing the annual scrambles to undo SGR payment rate updates.

Conclusion

Despite the importance of APMs for MACRA's impact, these projections also underscore the impact of legislated payment rate updates. A difference in Medicare's annual update to physician payment rates of approximately 0.2 percentage points would have the same estimated impact on physician payments as MACRA APMs in our middle scenario.

MACRA is a big, complicated undertaking that aims to substantially change the incentives providers face. These scenarios assume that MACRA is implemented as planned. Will MACRA fare better than the SGR in this regard? The new Medicare physician payment system can work if it meets two conditions. First, organized medicine, and individual physicians, must accept that one of their roles is to be responsible stewards of society's resources and redesign their business model around value. Second, APMs must be well designed and implemented, which is no small feat. If successful APMs are not available to physicians, there could be unintended consequences for patients, and one of the key goals of MACRA will be missed. If these conditions are not met, then in coming years (2025 is a key year to watch), changes to Medicare payment policy will again be at the top of the federal health policy legislative agenda. ■

NOTES

- 1 Burwell SM. Setting value-based payment goals—HHS efforts to improve U.S. health care. *N Engl J Med*. 2015;372(10):897–9.
- 2 White C, Liu J, Zaydman M, Nowak S, Hussey P. The RAND Health Care Payment and Delivery Simulation Model (PADSIM): concepts, methods, and examples. Santa Monica (CA): RAND Corporation; 2016.
- 3 Congressional Budget Office. Medicare's payment to physicians: the budgetary effects of alternative policies relative to CBO's January 2015 baseline [Internet]. Washington (DC): CBO; 2015 Feb 2 [cited 2017 Feb 1]. Available from: <https://www.cbo.gov/publication/49923>
- 4 Boards of Trustees, Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds. 2014 annual report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services; 2014 Jul 28 [cited 2017 Feb 1]. Available from: <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/reportstrustfunds/downloads/tr2014.pdf>
- 5 To access the Appendix, click on the Appendix link in the box to the right of the article online.
- 6 Boards of Trustees, Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds. 2015 annual report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services; 2015 Jul 22 [cited 2017 Feb 1]. Available from: <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/reportstrustfunds/downloads/tr2015.pdf>
- 7 McClellan M. Hospital reimbursement incentives: an empirical analysis. *J Econ Manage Strategy*. 1997; 6(1):91–128.
- 8 Alternative Payment Model Framework and Progress Tracking (APM FPT) Work Group. Alternative Payment Model (APM) framework [Internet]. Washington (DC): Health Care Payment Learning and Action Network; 2016 Jan 12 [cited 2017 Feb 1]. Available from: <https://hcp-lan.org/workproducts/apm-whitepaper.pdf>
- 9 Centers for Medicare and Medicaid Services. Shared Savings Program 2015 [Internet]. Baltimore (MD): CMS; 2015 [cited 2017 Feb 1]. Available from: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html>
- 10 Centers for Medicare and Medicaid Services. Pioneer ACO model 2015 [Internet]. Baltimore (MD): CMS; 2015 [cited 2017 Feb 1]. Available from: <https://innovation.cms.gov/initiatives/Pioneer-aco-model/>
- 11 Centers for Medicare and Medicaid Services. Fast facts: all Medicare Shared Savings Program (Shared Savings Program) accountable care organizations (ACOs) [Internet]. Baltimore (MD): CMS; 2017 [cited 2017 Feb 1]. Available from: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/All-Starts-MSSP-ACO.pdf>
- 12 Centers for Medicare and Medicaid Services. Fast facts: all Medicare Shared Savings Program (Shared Savings Program) ACOs and Pioneer ACOs [Internet]. Baltimore (MD): CMS; 2015 Apr [cited 2017 Feb 1]. Available from: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/PioneersMSSPCombinedFastFacts.pdf>
- 13 Henry J. Kaiser Family Foundation. Total number of Medicare beneficiaries [Internet]. Menlo Park (CA): KFF; 2015 [cited 2017 Feb 1]. Available from: <http://kff.org/medicare/state-indicator/total-medicare-beneficiaries/>
- 14 Miller HD, Marks SS. A guide to physician-focused alternative payment models [Internet]. Pittsburgh (PA): Center for Healthcare Quality and Payment Reform; 2016 [cited 2017 Feb 1]. Available from: <http://chqpr.org/downloads/Physician-FocusedAlternativePaymentModels.pdf>