

Health Policy Brief

MARCH 27, 2017

Implementing MACRA. Physicians who treat Medicare beneficiaries are subject to a new law and regulations governing their payment.

WHAT'S THE ISSUE?

President Barack Obama signed the Medicare Access and CHIP Reauthorization Act (MACRA) into law on April 16, 2015. The law, passed by a strong bipartisan majority in both chambers of Congress, replaced a controversial existing Medicare physician payment system in effect since 1999. The new law makes fundamental changes in the government's approach to physician payment.

The new approach is consistent with, and draws on, a shift in the private sector and government over the past decade toward value-based payment: paying providers based on the quality, value, and results of the care they deliver and not piecemeal for individual services regardless of the clinical need for or appropriateness of those services.

This shift is potentially transformational but presents serious implementation and logistical challenges. Not all doctors embrace the change, and the philosophical and economic underpinnings of value-based payment—and the mechanisms to achieve it—continue to be vigorously debated.

Congress gave the Centers for Medicare and Medicaid Services (CMS) the task of developing regulations to implement MACRA. That process has been under way since May 2015, encompassing three comment periods that yielded some 4,000 comments. The agency issued final regulations October 14, 2016. They

contained significant changes from the proposed rules promulgated in April 2016.

The initial phase of the law commenced January 1, 2017. CMS now refers to the program as the “Quality Payment Program.”

The administration of President Donald Trump, as of the date of publication of this brief, had not indicated whether it plans changes to the MACRA rules now in effect. Such changes would require formal rulemaking. However, the final MACRA regulation stipulates that the program will likely require modifications as time goes on and urges an open and public approach to that process. Additionally, the new administration could seek changes in the law in Congress this year or in the future.

This policy brief focuses primarily on the context in which these changes are taking place, implementation challenges, and the debate over the law and the concepts that underlie it. This brief represents a significant update to [a brief](#) about MACRA's core provisions published by *Health Affairs* in April 2016.

WHAT'S THE BACKGROUND?

For more than two decades, Congress and the federal government have wrestled with how to pay physicians in the Medicare program, which covers fifty-five million Americans. In 2015 Medicare paid physicians and other clinicians around \$130 billion, one-fifth of total Medicare spending.

\$3 billion

CMS estimates that it will provide \$3 billion in positive payment adjustments from 2019 to 2025.

A primary challenge of physician payment is determining fair fees for physicians and other clinicians that assure Medicare beneficiaries have access to care by maintaining physician participation in the Medicare system. But just as important is paying physicians in a way that promotes efficient, effective, and safe care; does not incentivize excessive and unnecessary care; and fosters the judicious use of medical resources since physicians order and direct the lion's share of total Medicare spending.

An overwhelming body of research in recent years has led to the conclusion that medical care in the United States is neither as efficient nor as effective as it could be. Inappropriate and excessive care is common, even as rising health care costs burden government, business, and families.

Hence, the growing momentum for change that encompasses more accountability and incentives to improve care and restrain cost growth.

History

But physician payment under Medicare has been contentious and fraught with problems from the beginning.

In the run-up to creation of the program in 1965, physician interest groups—led by the American Medical Association (AMA)—lobbied strenuously to assure that physicians would be paid the “usual, customary, and reasonable” fees they were getting from private insurers and not fixed fees set by government.

Congress went along with this and codified it in legislative language. Fraud and excessive billing was alleged almost immediately. The US Senate held hearings in July 1969 in which senators and policy experts accused some providers of billing the government two to four times what they billed private insurers.

The then-new program also bent to the will of the physician interest groups by giving oversight of care quality to physicians themselves. But concern about cost and quality accountability led Congress in 1972 to authorize the Health Care Financing Administration (now CMS) to disallow “any costs unnecessary to the efficient provision of care.” At the same time, lawmakers created Professional Standards Review Organizations—entities that would oversee care quality in Medicare.

In practice, the agency has rarely challenged fees or care as unnecessary or inefficient, and the Professional Standards Review Organizations—now known as Quality Improvement Organizations—have been, by general consensus, unevenly effective.

From the mid-1980s to the mid-1990s, a series of studies documented the widely varying fees that Medicare was paying physicians around the country. At the same time, research found that physicians were billing for procedures and surgeries at rapidly escalating rates that lacked any grounding in the “resources” used.

This led Congress in 1989 to establish a fee system called the resource-based relative value scale (RBRVS), which began operating in 1992. The scale was based on a complex formula that gauges the amount of work required of physicians to perform each coded service, valuing and accounting for a wide range of costs including malpractice insurance.

With fees for thousands of codes in what is known as the “Medicare physician fee schedule,” the relative value scale is now continuously reviewed and revised. CMS administers the fee schedule but is assisted by the physician community through the Relative Value Scale Update Committee (RUC). The RUC is run by the AMA.

Critics allege that with this arrangement, CMS has essentially deputized the RUC (and the AMA) to calculate what physicians get paid—tantamount, the critics argue, to the fox guarding the chicken coop even though rule-making allows other stakeholders to weigh in. The Government Accountability Office and the Medicare Payment Advisory Commission have also raised concerns, asserting in particular that the RUC's reliance on specialty societies to value their own services represents a conflict of interest and has led to a system that persistently rewards procedure-based specialty care while undervaluing primary and preventive care.

In fact, the RBRVS and the physician fee schedule do not currently attempt to base physicians' fees on the value of care to the patient or the outcomes of care. And both remain grounded in a fee-for-service payment model, which intrinsically gives physicians an incentive to increase the volume of their services.

To address the “volume problem,” Congress in 1997 replaced an existing weak program

“The new law makes fundamental changes in the government’s approach to physician payment.”

that had failed to limit the growth in the volume of services with the Medicare Sustainable Growth Rate (SGR) formula. It required CMS to set an annual budget target for physician payment pegged to the growth in the gross domestic product. If spending exceeded the target, fees would be cut in the following year to meet the target. If spending was below the target, fees would be increased in the following year.

The SGR formula quickly turned controversial when in 2002 it yielded an almost 5 percent *decline* in fees. Physician interest groups mobilized to block future decreases, warning that physicians would see fewer Medicare beneficiaries or stop seeing them altogether. The AMA and other physician interest groups lobbied Congress to repeal the SGR. Instead, from 2003 to 2015 Congress enacted seventeen so-called doc fixes, freezing fees or granting small increases each year—each time having to find budget savings elsewhere.

As the SGR provision remained on the books, the congressional overrides led to a cumulative \$100 billion, 21.2 percent, downward fee adjustment by 2015. Because that adjustment was clearly never going to happen and to shift the system in the direction of value-based payment, Congress finally repealed the SGR. MACRA was the vehicle for that repeal.

Also noteworthy, the Institute of Medicine in 2006 released “Rewarding Provider Performance: Aligning Incentives in Medicare,” a report that embraced the shift to value-based payment for doctors and hospitals but warned of the difficulty and advocated new quality metrics to support it.

Also aligned with the push to value-based payment, between 2006 and 2010 Congress created a series of programs to advance payment reform: the Physician Quality Reporting System in 2006, the Electronic Health Record Incentive Program in 2009, and the Physician Value-Based Payment Modifier in 2010. These programs were forerunners to Congress’s approach in MACRA, and all three are absorbed into the new MACRA system.

And in 2010 Congress passed the ACA. It’s worth noting that while Republicans opposed the law’s insurance expansion and Medicaid and Medicare components, they never objected to significant provisions in the law that promoted value-based payment, quality and safety improvement, and quality and price transparency. Neither did they oppose the

law’s creation of Physician Compare, a website mandated to make public comparative performance and quality measures of physicians.

CMS claims that under ACA-promoted payment reform initiatives, 30 percent of Medicare fee-for-service payments are now tied to assessments of the value of care, encompassing about ten million Medicare beneficiaries. The Obama administration’s goal was for 50 percent of Medicare payments to be made through value-linked payment by 2018. Whether the new administration will retain that goal is unknown.

WHAT’S IN THE RULES?

Responding to criticism that the initial proposed rules were too burdensome on doctors, especially those in small practices, CMS adopted an approach in the final regulations that sets 2017 and 2018 as “transition” years and that permits clinicians to “pick the pace” at which they participate.

As mentioned, the detailed rules of the new road for doctors can be found at CMS’s [Quality Payment Program website](#). Other organizations have also created useful guides, which can be found on the web via a search engine. Below are the basics to inform a broader health policy audience about the structure of the program.

The two tracks: MIPS and APM

The final rules create two tracks that physicians and other clinicians (physician assistants, nurse practitioners, clinical nurse specialists, and certified and registered nurse anesthetists) can choose between.

The first is a program called the Merit-Based Incentive Payment System, or MIPS. The second track is called the Alternative Payment Model, or APM, program.

Clinicians who bill Medicare more than \$30,000 a year and/or provide care for more than 100 Medicare patients a year are required to be in either program, as described below. This means that clinicians with less than \$30,000 in Medicare charges or fewer than 100 Medicare patients per year are excluded from MIPS for now, and quite possibly for many years. An analysis by the AMA found that these thresholds would exclude about 30 percent of the nation’s physicians, the vast majority of them in small and solo practices.

\$100
million

MACRA authorizes \$100 million for technical assistance to small practices (up to fifteen professionals).

CMS notes that even with this exclusion, 90–95 percent of Medicare Part B billings nationwide will still be subject to the new payment system. And CMS estimates that some 500,000 clinicians will meet MIPS participation criteria in 2017.

Physicians participating in MIPS will be scored on an overall 1–100 scale consisting of four performance categories: quality of care (60 percent in 2017); practice improvement (15 percent in 2017); advancing care information, which refers to using electronic medical records to enhance care (25 percent in 2017); and cost or resource use (not required in 2017, so 0 percent that year, but will be added in 2018 and the other segments adjusted accordingly).

Quality and performance measures apply to all of these categories. In the future, the list of quality measures will be selected annually through a public process, with a final list published in the *Federal Register* by November 1 each year.

In 2017 and 2018, clinicians in MIPS have a further choice among four levels of participation, the details of which are well explained on the CMS website. Most notably, they can choose not to actively participate. Attached to each level of participation are financial penalties or rewards.

For example, clinicians in MIPS who choose not to participate will have their Medicare reimbursements adjusted downward by 4 percent in 2019, the first year that actual payment adjustments start, based on 2017 reporting.

At the fourth and highest level of participation, clinicians would be required to submit a full year of data and could earn a positive payment adjustment up to 4 percent. More likely, however, that adjustment would be in the 1–3 percent range.

The maximum fee adjustment grows to plus or minus 5 percent in 2020, 7 percent in 2021, and 9 percent in 2022 and beyond.

An additional \$500 million pool of funds is available each year from 2019 to 2024 for bonuses to clinicians who achieve a final score of 70 or higher (out of 100).

As a last bit of complexity, in 2017, 2018, and 2019, clinicians choosing the MIPS path get an automatic 0.5 percent across-the-board-fee increase, irrespective of the bonuses or penalties based on their quality reporting.

Notably, CMS estimates that it will provide \$3 billion in positive payment adjustments from 2019 to 2025.

The Alternative Payment Model program

CMS defines an APM as a payment approach, developed in partnership with the clinician community, that provides added incentives to clinicians to provide high-quality and cost-efficient care.

APMs can apply to a specific clinical condition, a care episode, or a whole population. Both the law and the final rules seek to have APMs, over time, encompass entire populations.

CMS's challenge was to adapt its existing value-based payment programs to the new MACRA system. The agency sought especially to preserve the framework it created for accountable care organizations (ACOs) over the past five years. Some 450 ACOs now exist around the country and serve about ten to twelve million Medicare beneficiaries.

In doing so, the agency has created—at least initially—several levels of alternative payment organizations. At the top are “advanced APMs.” The critical criteria to be designated an advanced APM is that it requires physician practices to take on a level of financial risk for patients' outcomes. Such risk-bearing dates to the early days of managed care. Capitated payment is one form.

This time around, MACRA is sweetening the pot to encourage physician participation. From 2019 to 2024, clinicians who join a designated advanced alternative payment entity could get a 5 percent bonus based on their Medicare billings. And they will be exempt from MIPS as long as a certain threshold of their care each year is provided through value-based payment.

In addition, starting in 2026, after the 5 percent bonus period ends, physicians in advanced APMs revert to an annual across-the-board fee increase of 0.75 percent instead of the 0.25 percent increase other clinicians will receive.

Advanced APMs must also require participants to use certified electronic health record (EHR) technology; base payments for services on quality measures comparable to those in MIPS; and bear more than nominal financial

“The Trump administration, as of the date of publication of this brief, had not indicated whether it plans changes to the MACRA rules now in effect.”

risk for losses or meet the specifications of a “medical home.”

The MACRA final rule lowered the bar to form an advanced APM after overwhelming dissent from physician interest organizations on the stringency of the initially proposed rules.

A committee, created by the law and dubbed the Physician-Focused Payment Model Technical Advisory Committee, is to advise CMS on APM policy going forward.

Notably, in 2017 and 2018, participation in an APM—set up to conform to the final rules—is based only on Medicare payments and patients. Starting in 2019, though, clinicians can include non-Medicare payments and patients in their reporting of performance and result.

That’s important because it aligns physicians’ incentives and practice patterns across all their patients. Bear in mind that it’s a minority of doctors—and especially primary care doctors—whose practices are made up of more than 30–40 percent Medicare patients.

CMS estimates that 70,000–120,000 clinicians in 2017, and 125,000–250,000 in 2018, will join advanced APMs and qualify for the 5 percent incentive payment.

Confusingly for now, CMS has specified two other APMs. One is designed to serve people enrolled in both Medicare and Medicaid—the so-called dual eligibles, who number around nine million nationwide and are high medical care utilizers. CMS has dubbed the other one the “MIPS APM.” These entities might not meet the criteria to become advanced APMs in 2017 or 2018 (or possibly beyond). Put simply, clinicians joining such organizations are subject to special reporting and scoring requirements for MIPS (if they aren’t exempt), until the APM qualifies to be an advanced APM.

Congress did foresee the need for technical assistance as doctors and other clinicians figure all of this out. MACRA authorizes \$100 million for technical assistance to small practices (up to fifteen professionals), \$20 million a year from 2016 through 2020. The law also authorizes \$75 million for physician groups to improve quality measure development.

In documents accompanying the final MACRA rule, CMS states: “We envision that it will take a few years to reach a steady state in

the program...[and] we recognize, that many eligible clinicians face challenges in understanding the requirements.” Exhibit 1 details the implementation process to 2022.

WHAT’S THE DEBATE?

Many issues are raised by this substantial change in the way Medicare pays clinicians. A dialogue has commenced on this that will continue for years as the regulations are implemented and, inevitably, altered over time. For now, these issues predominate.

Is the overall design coherent and workable?

Major special-interest groups, including those representing physicians, industry, and consumers and patients, supported MACRA’s intent and the general framework of the regulations through the three comment periods.

However, almost all groups sought changes and raised questions. CMS’s final revisions were most responsive to physician groups, which were insistent on an easier path and more flexibility for doctors in the initial years of the program.

Dissenting voices raised questions that are not easy to dismiss, however. These could gain credence and traction if implementation proves difficult or falters. For example, does the assessment of individual physicians’ performance with existing quality measures yield meaningful results?

Some critics say there’s no clear evidence that current measures, or the scoring framework proposed by CMS, will provide anything close to a full and accurate picture of how well an individual doctor does in treating his or her Medicare patients. Thus, basing payment to individual doctors on the MIPS scoring system—or any scoring system—is flawed and irresponsible.

These critics would scrap MIPS and, over time, prod doctors to join APMs.

But other critics take aim at the whole notion of changing or incentivizing physician behavior through performance measurement and financial incentives. They assert that this has not conclusively yielded improvements in care or in the health status of the US population.

Still other critics say there’s only weak evidence indicating that ACOs and APMs

(including bundled care payment) improve care and lower cost growth enough to justify the administrative costs they incur—which would extend to the administrative costs that physician groups, APMs, and the federal government will now incur as MACRA gets implemented.

CMS officials and other health policy experts don't reject these critiques completely. But they do argue that some early evidence suggests that financial incentives, performance measurement, and ratings can and do propel individual clinicians and groups of physicians to improve care.

Moreover, they assert, the government has a moral duty to prevent unnecessary and wasteful care, and a powerful fiduciary duty to spend tax dollars wisely, in part by restraining excessive growth in health care spending, which makes up a substantial part of the federal budget as well as business and consumer spending.

Is the program good or bad for solo doctors and small or rural practices?

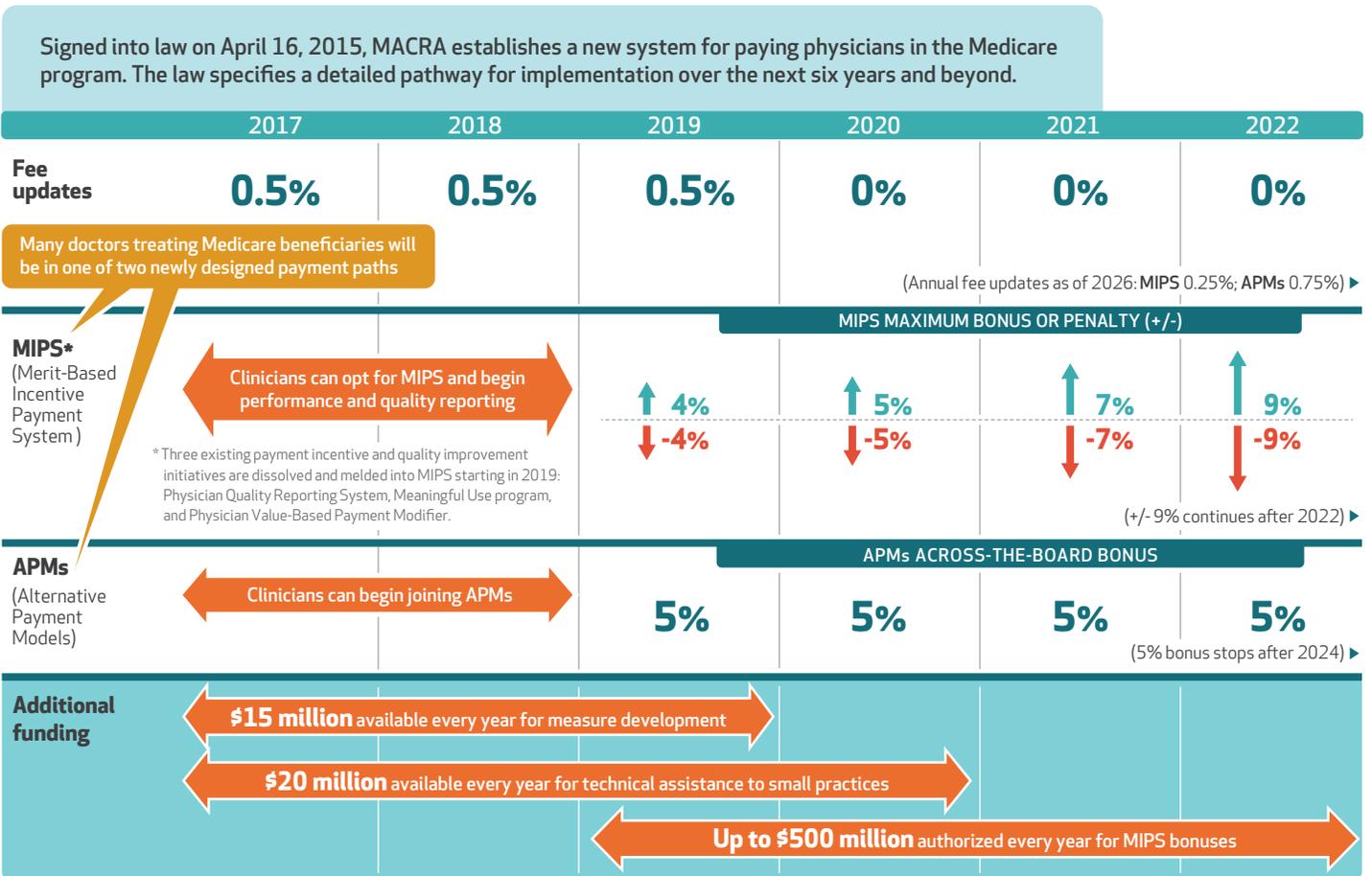
MACRA is designed to push doctors who practice on their own or in small groups into larger groups and into APMs. A vocal group of such doctors don't want to do this. They prefer their current arrangement.

The government recognized this dilemma and increased the number of physicians who would be exempt. It also gave clinicians more flexibility, primarily to accommodate those in small practices who had not to date been participating in any pay-for-reporting or pay-for-performance programs.

CMS officials and other experts acknowledge that the evidence is not strong that solo or small practices deliver poorer-quality care than larger practices. Even so, debate continues about the pros and cons of larger versus small physician groups or solo doctors.

EXHIBIT 1

Implementing the Medicare Access and CHIP Reauthorization Act's (MACRA's) physician payment reforms, 2017–22



SOURCE Author's analysis.

That debate will continue and is likely to trigger changes to MACRA rules in the years ahead as evidence mounts one way or the other.

In comments accompanying its final rules, CMS said: “Although small and solo practices have historically been less likely to engage in [the existing physician quality reporting system] and quality reporting, we believe that small and solo practices will respond to MIPS by participating at a rate close to that of other practice sizes.” The agency also estimates that “at least 80 percent of clinicians in practices with 1–9 clinicians will receive a positive or neutral MIPS payment adjustment [in 2017 and 2018].”

Does MACRA constitute government intrusion in the practice of medicine?

Federal law dating back to the 1930s discourages, and in some cases prohibits, the government from dictating how doctors practice medicine, collectively or individually. Some, mostly conservative, commentators and physician organizations say that recent history has eroded that principle.

In keeping with that emerging debate, doctors and groups allied with conservative and libertarian interests believe that MACRA is intrusive and that, by definition, pushes doctors to practice in certain ways that could be inimical to good patient care. The same argument was brought to bear against managed care, as wielded by both government and private insurers, in the 1990s and early 2000s.

Mainstream medical groups disagree that MACRA dictates to doctors how to treat individual patients. However, recent surveys indicate that a majority of physicians have low morale and are concerned about excessive paperwork, the time they have with patients, and the future of medicine. In one large-scale 2016 survey that garnered responses from 17,236 physicians, 14 percent said they had the time they needed to provide the highest standards of care.

“Volume to value”—slogan or sound policy?

Critics allege that the volume-to-value movement is, for now, based more on faith than on strong or conclusive evidence. For example, they cite the experience of countries in Europe that control spending primarily through regulating prices and fees in fee-for-service systems, instead of relying on performance measurement and payment incentives.

Critics also argue that “value” in medicine is an elusive concept and not one likely to be pinned down through a single composite score—especially for an individual physician. As yet, these critics further allege, value has not been clearly pegged or produced by ACOs, patient-centered medical homes, or integrated health care systems.

Such criticisms are countered by researchers who point to published studies as well as hundreds of initiatives and innovations in care delivery over the past twenty years that claim to have improved care delivery through enhanced accountability, quality measurement, and incentive payments.

The magnitude, depth, and significance of the improvements certainly can be disputed, and MACRA’s impact will almost certainly trigger continued debate on this issue.

MIPS versus alternative payment entities

It’s clear that in designing MACRA, Congress wanted the majority of physicians, over time, to join APMs. Larger potential bonuses (compared to MIPS) and fee increases are inducements to physicians to take the alternative model path. MIPS is designed as a bridge to that end, although it is unclear when and if MIPS would be terminated.

This approach is consistent with the Obama administration’s approach under the ACA and with other recent bipartisan laws, as well as marketplace dynamics, over the past fifteen years. All promote larger group practices, integrated systems, a shift away from fee-for-service, and enhancement of the Medicare Advantage program as an alternative to traditional Medicare.

A multistakeholder group—the Health Care Payment Learning and Action Network—published a framework for developing criteria for APMs in January 2016 that is being used as a template for APM designs.

As yet unclear is what path some Medicare Advantage plans—those that serve as both insurer and provider—would take to be deemed advanced APMs.

How much financial risk should physicians take on in alternative payment models?

An APM will qualify as an advanced APM in performance years 2017 and 2018 if it is at risk of either losing 8 percent of its revenues when

Medicare expenditures are higher than expected or repaying CMS up to 3 percent of total Medicare expenditures, whichever is lower.

However, it's not yet clear how much financial risk will flow down to individual physicians in APMs. CMS uses the phrase "more than nominal risk" to define its approach, but physician interest groups want limited physician exposure to losses from taking on insurance or financial risk.

"Physicians will be much more willing to take on accountability for costs that they can affect through their own performance, such as the costs of preventable complications, than they are to take on risk for the total cost of care for a large patient population," the AMA said in its initial comments on the MACRA proposed rules.

Meaningful measures?

A majority of the comments on the proposed regulations urged CMS to adopt a common core set of measures focused on population health, clinical outcomes, and assessments of patient experience for both MIPS and the alternative payment entities.

Most also urged CMS to eliminate overlapping, duplicative measures and "topped out" process measures that no longer provide meaningful barometers of quality of care or performance. CMS in its final rule concurred on these points and said it was undertaking efforts to focus on "measures that matter."

Notably, in February 2016 CMS and the insurance industry jointly released an initial set of core physician performance measures intended to replace existing overly complex measure sets.

In its initial MACRA comments, the AMA expressed concern about a too-rapid shift to claims-based cost and outcome measures. "We would view proposals to dictate the percentage of measures that must be based on outcomes rather than process as highly premature," the group said.

For their part, employer and consumer groups want CMS to put more emphasis on the results of patient experience surveys such as those developed by the Agency for Healthcare Research and Quality's Consumer Assessment of Healthcare Providers and Systems (CAHPS) program.

Employer and consumer groups also have urged CMS to aggressively explore the use of patient-reported outcomes—information and data that patients themselves document about their care. Physician interest groups such as the AMA are divided on the utility of CAHPS and patient-reported outcomes. The American College of Physicians, for example, requests that CAHPS surveys not be used at all under MIPS.

Other comments reflect near-universal agreement that CMS should make more use of the data contained in patient registries, as CMS proposes. But how such registries can be standardized is an open question.

Attribution

Physician groups urged CMS to concentrate on assessing performance and quality at the group-practice level and avoid grading individual physicians in MIPS and APMs.

Employer and consumer groups, in contrast, want CMS to push toward performance measures at the level of the individual physician, where appropriate, since, they argue, that is what consumers want.

Under the ACA and now MACRA, CMS is mandated to assess performance and quality at the individual physician level. But this intense debate is unlikely to go away anytime soon. It reflects a fundamental disagreement—as mentioned above—about whether current methods and tools allow accurate assessments of individual physician quality of care or outcomes.

Public reporting

MACRA mandates that performance results be made available to Medicare beneficiaries and consumers broadly, to aid their choice of individual physicians and physician groups.

CMS says it is finalizing how it will fulfill this public reporting requirement, of MIPS information, through the [Physician Compare website](#). The agency says it remains committed to reporting performance results for both individual physicians and groups, in "an easily understandable format" for consumers.

Debate over the reliability of performance results for individual physicians, versus groups, could undermine this intent, however. Some observers say they expect the new administration to take a fresh and close look

at what will be posted on Physician Compare, and when.

Electronic health records

CMS concurred with commenters that the previous EHR “meaningful-use” program was in need of reengineering under MACRA. To that end, there will be far less emphasis on data entry and “check the box” use of EHRs and more emphasis on the secure exchange of patient information; promoting patient engagement; and reporting to state and federal public health agencies and clinical data registries.

WHAT'S NEXT?

MACRA and the rules implementing it create a payment system for physicians that will

accelerate Medicare’s transition from fee-for-service payment untethered to any accountability to payment based on performance metrics, patient experience, patient outcomes, and public health improvement.

But years of complex implementation lie ahead amid continued political debate and rancor over the fate of the ACA, structural reforms to the Medicare and Medicaid programs, and the best ways to improve care quality, reduce unnecessary and wasteful care, and control rising costs.

In the context of the history of the Medicare program, MACRA is but the latest experiment. It is a large one and will be closely monitored. Changes are inevitable, and the final rules create a formal pathway for continued stakeholder and public comment in coming years. ■

RESOURCES

American Medical Association, [Understanding Medicare Payment Reform \(MACRA\)](#) (Chicago, IL: AMA, 2017).

Robert A. Berenson, [“If You Can’t Measure Performance, Can You Improve It?”](#) *Journal of the American Medical Association* 315, no. 7 (2016):645–6.

Robert A. Berenson and John D. Goodson, [“Finding Value in Unexpected Places—Fixing the Medicare Physician Fee Schedule,”](#) *New England Journal of Medicine* 374, no. 14 (2016):1306–9.

Centers for Medicare and Medicaid Services, [Modernizing Medicare to Provide Better Care and Smarter Spending for a Healthier America](#) (Baltimore, MD: CMS, 2016).

Jim Hahn and Kirstin B. Blom, [The Medicare Access and CHIP Reauthorization Act of 2015 \(MACRA; P.L. 114-10\)](#) (Washington, DC: Congressional Research Service, November 10, 2015).

Merritt Hawkins, [2016 Survey of American’s Physicians; Practice Patterns and Perspectives](#) (Boston, MA: Physicians Foundation, September 2016).

Erin Heilman, [A Beginner’s Guide to MACRA](#) (Columbia, MD: Medisolv, November 18, 2016).

Dhruv Khullar, Dave A. Chokshi, Robert Kocher, Ashok Reddy, Karna Basu, Patrick H. Conway, and

Rahul Rajkumar, [“Behavioral Economics and Physician Compensation—Promise and Challenges,”](#) *New England Journal of Medicine* 372, no. 24 (2015):2281–3.

[Medicare Access and CHIP Reauthorization Act of 2015](#), Pub. L. No. 114–10 (April 16, 2015).

John O’Shea, [Overcoming Challenges to Physician Payment Reform in a Post-SGR World](#) (Washington, DC: Heritage Foundation, March 16, 2016).

Bryan Oshiro, Bobbi Brown, and Dorian DiNardo, [Preparing for MACRA: A Comprehensive FAQ for Physicians](#) (Salt Lake City, UT: Health Catalyst, January 2017)

Kavita Patel, Margaret Darling, and Paul B. Ginsburg, [Key Takeaways from the Final MACRA Rule, Plus Remaining Challenges](#) (Washington, DC: Brookings Institution, December 15, 2016).

Meredith B. Rosenthal, [“Physician Payment after the SGR—the New Meritocracy,”](#) *New England Journal of Medicine* 373, no. 13 (2015):1187–9.

Stephen B. Soumerai and Ross Koppel, [Paying Doctors Bonuses for Better Health Outcomes Makes Sense in Theory. But It Doesn’t Work](#) (Washington, DC: Vox News, January 25, 2017).

About Health Policy Briefs

Written by
Steve Findlay
Health Journalist

Editorial review by
Robert Berenson
Institute Fellow
Urban Institute

Rob Lott
Deputy Editor
Health Affairs

Matthew Richardson
Associate Editor
Health Affairs

Health Policy Briefs are produced under a partnership of *Health Affairs* and the Robert Wood Johnson Foundation.

Cite as: “Health Policy Brief: Implementing MACRA” *Health Affairs*, March 27, 2017.

Sign up for free policy briefs at:
www.healthaffairs.org/healthpolicybriefs