

Health Policy Brief

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Medicare's New Physician Payment System. A 2015 law has the potential to transform how Medicare pays physicians.

WHAT'S THE ISSUE?

For more than two decades Congress and the federal government have wrestled with how to pay physicians in the Medicare program, which covers forty-seven million Americans. In 2014 Medicare paid physicians and other clinicians around \$138 billion—22 percent of total Medicare spending—up from \$59 billion in 2000.

The primary challenge of physician payment is determining fair fees for physicians and other clinicians. But, just as important, the challenge extends to 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 care that constitutes the lion's share of total Medicare spending.

An overwhelming body of research in recent years found that medical care in the United States was neither 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.

Against this backdrop, government and private-sector leaders have resolved to transform how physicians are paid in a way that holds them more accountable for the care they deliver. The latest salvo in this effort was the Medicare Access and CHIP Reauthorization

Act (MACRA) of 2015, signed into law April 16, 2015. This policy brief does not discuss MACRA's two-year extension of the Children's Health Insurance Program (CHIP) or provisions pertaining to issues other than physician payment.

WHAT'S THE BACKGROUND?

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 heavily 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 the interest groups and codified that 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 known as the Centers for Medicare and

\$138

billion

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Medicaid Services [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 Health Care Financing Administration rarely challenged fees as unnecessary, and the Professional Standards Review Organizations—now known as Quality Improvement Organizations—were unevenly effective.

In the mid-1980s a series of studies documented the widely varying fees that Medicare was paying physicians around the country. Research also found that physicians were billing for procedures and surgery at rapidly escalating rates that lacked any grounding in the “resources” used. In 1989 this led Congress to establish a fee formula called the resource-based relative value scale. This scale was based on a complex formula that gauges the amount of physician work required to perform each coded service, factoring in the cost of overhead and malpractice insurance. With fees for thousands of codes in the Medicare physician fee schedule, the scale is now continuously reviewed and revised.

CMS administers the fee schedule but is assisted in that task by the physician community through the Relative Value Scale Update Committee (RUC). The RUC is run by the AMA.

Payment reform advocates complain that CMS has essentially deputized the RUC to calculate what physicians get paid—an arrangement they assert is tantamount to the fox guarding the chicken coop. Separately, the Government Accountability Office and the Medicare Payment Advisory Commission have raised concerns that the RUC’s reliance on specialty societies to value their own services represents a conflict of interest. Indeed, these watchdogs and other critics of the present payment system have long maintained that given how the scale is structured, it inherently rewards procedure-based specialty care, while undervaluing primary and preventive care.

In fact, the resource-based relative value scale 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. As noted above, there are concerns about a conflict of interest in regard to the group overseeing the scale fee formula. And in the case of the physician fee schedule, for ex-

ample, it remains grounded in a fee-for-service payment model, which intrinsically gives physicians an incentive to increase the volume of their services. In turn, as policy makers have increasingly acknowledged, fee-for-service payment risks promoting unnecessary and inappropriate care.

In 1997 Congress tried to rein in physician-driven costs by creating the Medicare Sustainable Growth Rate (SGR). The formula used to calculate the SGR set an annual budget target for physician payment based on a number of factors—most importantly, that it not exceed the growth in gross domestic product. If spending exceeded the target, fees would be cut in the following year such that overall physician spending was limited to the target amount. If spending was below the target, fees would be increased in the following year to meet the target amount.

The SGR 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, Congress enacted seventeen so-called doc fixes over twelve years, freezing fees or granting small increases.

However, the SGR provision remained on the books, and the congressional overrides led to a large (more than \$100 billion) cumulative build-up in fee adjustments. By 2015 that build-up, if allowed to take place, would have led to a whopping (and untenable) 21.2 percent reduction in physician fees. For a confluence of reasons, Congress finally agreed to repeal the SGR provision. MACRA was the vehicle for that repeal. And the new law replaced the SGR formula with a new Medicare physician payment system.

Laws passed between 2006 and 2010, including the Affordable Care Act (ACA), were forerunners to Congress’ approach in MACRA. For example, Congress created the Physician Quality Reporting System in 2006 and the Physician Value-Based Payment Modifier in 2010. And in 2009 Congress created the Electronic Health Record (EHR) Incentive Program. The ACA contains numerous provisions that promote transparency, accountability, payment reform, and quality improvement—including the creation of Physician Compare, a website mandated to, over time, contain compara-

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tive performance and quality measures on physicians. MACRA’s new physician payment system builds on and is synced up with these efforts.

It’s worth noting that in the context of the ongoing political divisiveness surrounding the ACA that MACRA passed with overwhelming bipartisan support: 392–37 in the House and 92–8 in the Senate.

WHAT’S IN THE LAW?

Between 2016 and 2019, MACRA will give physicians a fee increase of 0.5 percent per year. From 2020 to 2025, no across-the-board fee increase will be granted because physicians treating Medicare beneficiaries will have been asked to choose between two newly designed payment paths. Both base payment on performance and quality metrics and participation in efforts to improve care and restrain cost growth.

Initially, physicians can choose a program called the Merit-Based Incentive Payment System (MIPS) or join an alternative payment model such as an accountable care organization or patient-centered medical home. If they make no choice or are deemed to be ineligible for an alternative payment model incentive payment, they will be assigned to MIPS.

At the same time, three existing payment incentive and quality improvement initiatives will be dissolved as separate programs and melded into MIPS. They are the Physician Quality Reporting System, Meaningful Use, and the Physician Value-Based Payment Modifier. The majority of physicians today participate in one or more of these programs.

Physicians in MIPS must report performance measures to CMS. They’ll then be graded on four factors: quality of care (30 percent); resource use (30 percent); meaningful use of EHRs (25 percent); and clinical practice improvement activities (15 percent).

High-scoring physicians will get a bonus, and low-scoring physicians will see their fees reduced. Physicians will be allowed to choose on which quality measures they want to be evaluated. For the calculation of payment bonuses and penalties (and for ease of eventual consumer use through public reporting on Physician Compare), the Department of Health and Human Services (HHS) will be tasked with developing a composite score for each physician based on these factors.

Maximum bonuses and penalties will be 4 percent in 2019, 5 percent in 2020, 7 percent in 2021, and 9 percent in 2022 and beyond. Additional funding of up to \$500 million a year will be provided for separate bonuses for “exceptional performance,” from 2019 through 2024.

Physicians choosing the alternative payment model path will have to join an accountable care organization or an approved patient-centered medical home, or otherwise be in an alternative payment model entity (see discussion below) where payment is at least partly based on quality performance and on total spending. Payment tied to performance must be 25 percent of a doctor’s or group practice’s Medicare revenue in 2019, increasing to 75 percent in 2022.

Physicians who join a CMS-approved alternative payment model will get an annual 5 percent bonus in their fees from 2019 to 2024. And, starting in 2026, physicians in alternative payment models will receive an annual across-the-board fee increase of 0.75 percent. Physicians participating in MIPS will get a 0.25 percent annual increase.

MACRA authorizes \$100 million for technical assistance to small practices (up to fifteen professionals), \$20 million per year from 2016 through 2020. And under MIPS, small practices (for example, those in rural areas) can elect to report together as “virtual groups” and receive a MIPS composite score for their combined performance. The law also authorizes \$75 million for physician groups to improve quality measure development.

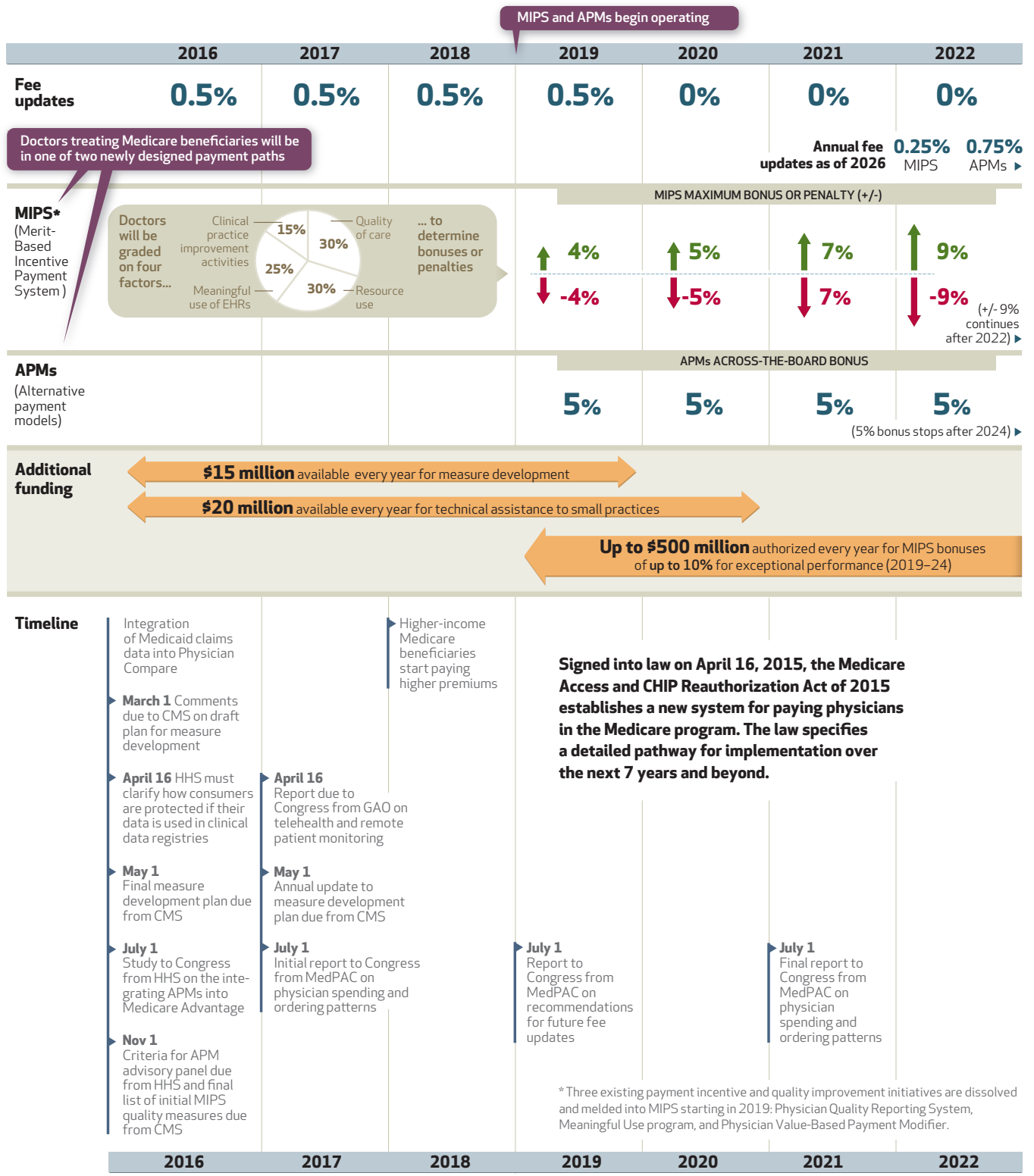
MACRA specifies a detailed pathway to implementation (see Exhibit 1), which began in 2015 with CMS seeking public comment. An initial set of rules is expected by the end of 2016, although in February 2016 some physician groups signaled they might seek a delay in MACRA rulemaking.

WHAT’S THE DEBATE?

On October 1, 2015, HHS published a request for information on MACRA’s implementation. The request posed some seventy-five questions on how the law should unfold. The questions addressed overall design and in-the-weeds technical details. Comments were due November 17, 2015, and are posted and publicly available at [Regulations.gov](https://www.regulations.gov). Almost every major physician interest group and stakeholder offered input.

EXHIBIT 1

Implementing the Medicare Access and CHIP Reauthorization Act's (MACRA's) physician payment reforms, 2016–22



SOURCE Author's analysis. **NOTES** EHR is electronic health record. CMS is Centers for Medicare and Medicaid Services. HHS is Department of Health and Human Services. GAO is Government Accountability Office. MedPAC is Medicare Payment Advisory Commission.

0.5%

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Mandated by MACRA, on December 18, 2015, CMS published a proposed plan for developing clinical quality measures for the new payment system, including both MIPS and alternative payment models. Public comments on this plan were due March 1, 2016. CMS has pledged to post a final plan for measure development on May 1, 2016.

Comments on the MACRA request for information represent the initial salvos in what promises to be a roller-coaster ride toward implementation. Space restrictions here prevent a comprehensive analysis of the many complex issues. But among the major ones are these:

MIPS versus alternative payment entities

It's clear that Congress wants the majority of physicians, over time, to join alternative payment entities. That's consistent with the Obama administration's approach under the ACA and with bipartisan laws and marketplace dynamics over the past fifteen years promoting larger groups practices, integrated systems, a shift away from fee-for-service, and promotion of Medicare Advantage as an alternative to traditional Medicare.

The ACA, for example, prods physicians to become part of organizations (such as accountable care organizations) that embrace payment methods that nurture quality improvement and can manage financial risk for the health of covered populations. Under MACRA, CMS is tasked with developing a process to certify organizations as alternative payment models. The criteria surrounding that alone are likely to be contentious. A multistakeholder group—the Health Care Payment Learning and Action Network—published a [framework](#) for developing such criteria in January 2016 that is likely to be used as a template for alternative payment model rules.

As yet unclear is what path Medicare Advantage plans—which now cover one in five Medicare beneficiaries—will need to take to be deemed as alternative payment entities.

Larger potential bonuses (compared to MIPS) and fee increases are inducement to physicians to take the alternative payment model path. Several physician groups noted in their comments that many physicians are still novices when it comes to quality reporting. That cuts several ways. It could drive such physicians into larger alternative payment models, or it could lead some physicians to think that they can do it as part of a smaller group.

Accountable care organizations are likely to be the major alternative payment platform. With some 400 accountable care organizations now serving eight million Medicare beneficiaries, they could attract more and more physicians. As a side note, with their almost-certain ramp-up under MACRA, accountable care organizations will come under even more intense pressure and scrutiny; studies are mixed on the results they have achieved to date.

MIPS design

Physician groups want CMS to create a MIPS system that is, in the words of the American College of Physicians, “flexible, not prescriptive or rigid.”

More pointedly, the AMA said: “The current ‘one-size-fits-all’ approach with its ever-expanding requirements, flawed methodologies, and insufficient measures has created a situation where many—perhaps most—physicians are judged at least in part on cost and/or quality measures that are largely irrelevant to their practice.... The goal in MIPS should be to create a new program with a limited set of requirements but with more options for meeting those requirements.”

In contrast, employer and consumer groups want CMS to impose clear requirements that don't allow physicians to report and be judged on a weak set of [performance metrics](#). For example, they advocate physician accountability in MIPS equal to that of alternative payment entities. Indeed, the law specifies that MIPS and alternative payment model quality metrics be “comparable”—a possibly difficult task for CMS to achieve.

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

Minimal, said most physician groups. Substantial (more than “nominal” in the parlance of the CMS proposal), said employer, insurer, and consumer groups.

All stakeholders urge CMS to dramatically improve “risk adjustment”—the technical process by which quality measurement is adjusted for mix of patients and their health status. In contrast, physician interest groups want limited physician exposure to losses from taking on insurance or financial risk. “Physicians will be much more willing to take 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 new law replaced the Sustainable Growth Rate with a new Medicare physician payment system.”

the total cost of care for a large patient population,” the AMA said in its comments.

In contrast, Mayo Clinic—an integrated delivery system—commented that “the metrics and rules used to establish payments in APMs [alternative payment models] must reflect the same type of risk assumed by integrated care delivery systems and be similar to the rate methodologies used for managed care models.”

Meaningful measures

The vast majority of commenters, across the stakeholder spectrum, recommended that CMS adopt a smaller, common 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.

Progress on this front is already under way. 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 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. They also urge CMS to aggressively explore the use of patient-reported outcomes—information and data that patients themselves document about their care. Physician groups, however, 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.

Clinical practice improvement activities

Physician groups want wide latitude to adapt to and implement the “practice improvement” component of the MIPS scoring system (15 percent of the score). The law specifies a host of areas it is designed to encourage physicians to focus on, such as care coordination and adopting patient decision support and shared-decision-making tools.

In the words of the American College of Surgeons: “It is critical that CMS conduct pilot testing to define improvement for the MIPS program. CMS must account for the different types of practices and the type of improvement needed by those practices before this program becomes punitive.” Other stakeholder groups see the practice improvement metric as an opportunity to improve both quality and the service component of physicians’ practices.

Electronic health records

Physician groups want CMS’s EHR meaningful-use program to be substantially re-engineered under MACRA—consistent with their mounting criticism of the program over the past several years. Specifically, they want far less emphasis on data entry and “check the box” use of EHRs; more emphasis on care coordination, transitions of care, and quality reporting; and greater inclusion of oral health and behavioral health providers.

The AMA stated its desire as follows: “The current [meaningful-use] program fails to provide an avenue for innovation or ensure that all care providers can participate. CMS should therefore collaborate with national specialty societies to develop alternatives or pilots that could be optionally used to satisfy the [meaningful-use] component of the composite score.”

Other stakeholders urge CMS to hold physicians accountable for extending the content of EHRs and other physician-held data to consumers/patients. The National Partnership for Women and Families, for example, noted that “patients with online access to the health information in their providers’ EHRs overwhelmingly use this capability...yielding better care and improved health outcomes.”

Attribution

Physician groups want CMS to concentrate on assessing the performance at the group practice level under MIPS and avoid grading individual physicians. Some academics

agree. Experts from Dartmouth College and the Brookings Institution, for example, commented: “CMS should emphasize the development of mechanisms to aggregate patient populations and attribute them to the groups of physicians involved in their care. This will improve the reliability and validity of the measurement effort, and secondly, further the goals of [alternative payment model] formation—encouraging physicians and systems to work together to improve performance, share information more effectively, and accept accountability for their populations.”

Employer and consumer groups, in contrast, advise CMS to push toward performance measures at the levels of the individual physician, where appropriate. Under the ACA, CMS is mandated to assess performance and quality at the individual physician level.

‘Volume to value’—slogan or sound policy?

Some [critics](#) argue that the volume-to-value movement is, for now, based more on faith than on strong 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 through 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. As yet, these critics further allege, value has not been clearly pegged or produced by accountable care organizations, patient-centered medical homes, or integrated health care systems. Such criticisms are countered by [researchers](#) who point to dozens of initiatives that have yielded better care at lower cost with approaches using measurement and incentive payments.

WHAT'S NEXT?

MACRA creates a payment system for physicians that will accelerate Medicare's transition from fee-for-service to payment based on performance metrics, patient experience, and patient outcomes. But three years of complex MACRA rulemaking lie ahead amid a still-entrenched fee-for-service system, continued political rancor over the ACA, and a change in administrations and a new Congress. The trajectory of health care spending over the next few years could also affect the urgency and design components of MACRA implementation. The hundreds of comments on CMS's request for information signal many areas of tension but also areas of agreement. The major question is whether MACRA will succeed at improving quality, reducing unnecessary care, and lowering cost growth where past efforts have lagged or failed outright. ■

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