HEALTH POLICY REPORT

Physician Payment Reform — Progress to Date

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The sustainable growth rate (SGR), a formula used by the Centers for Medicare and Medicaid Services (CMS), frequently specified large cuts in Medicare rates of payment for physician services, which led Congress to step in to defer the cuts. Now that the SGR has been repealed, the dominant policy issue regarding physician payment for the foreseeable future is the blending of fee-for-service payment with approaches based on broader units of service (e.g., an episode of care for a procedure or a clinical condition such as cancer, diabetes, or heart failure). Payment for these broader units of service incorporates spending by multiple providers who are involved in a patient's care. Such approaches result in payments to physicians that could be higher or lower than they were under the fee-for-service system. The hope is that these approaches will foster improved quality and more efficient care than fee for service.

Various names have been used to describe this change, including "paying on the basis of value," "population health," and "alternative payment." However, a key dimension that is often missed is that fee-for-service payment is not at all removed from the equation. These new payment approaches are all built on fee for service; physicians receive fee-for-service payments plus a share of savings or minus a share of loss based on calculations that compare total fee-for-service billings with benchmarks determined by historical spending. Thus, addressing the serious shortcomings of the Medicare Physician Fee Schedule is critical to the success of the new approaches.[1]

Medicare is playing a very important role in this shift to alternative payment. Most of the authority comes from the Affordable Care Act (ACA) and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Table 1). The policy direction is expected to continue during the new Republican administration, especially in light of the strong bipartisan support for MACRA. Medicaid programs are moving in the same direction, and private insurers have generally shared the vision of public policymakers and are contracting with providers in ways that are consistent with the Medicare approaches, in some cases in explicit coordination with Medicare. This report will focus on approaches authorized by the ACA and MACRA as well as efforts to effectively update the Medicare Physician Fee Schedule.

PHYSICIAN PAYMENT CHANGES AUTHORIZED BY THE ACA

Although most attention has been paid to parts of the ACA that expand insurance coverage, substantial portions of the legislation address Medicare, including two sections that specifically address approaches for paying providers. First, the legislation defined an accountable care organization (ACO) (Table 1) and outlined a mechanism through which CMS would contract with these organizations, called the Medicare Shared Savings Program (MSSP). Second, the ACA created the Center for Medicare and Medicaid Innovation (CMMI) and provided both broad authority and substantial funding to conduct a wide range of demonstrations, many of which focus on provider payment.

In contrast to most past demonstrations by CMS, the CMMI demonstrations can involve large numbers of providers, and the secretary of health and human services has the authority to expand and continue indefinitely approaches that reduce costs without decreasing quality or increase quality without increasing costs. Furthermore, the Obama administration set the goal of tying 50% of payment to improved quality of care or the value of care through alternative payment models by 2018.[2] Particularly relevant to physicians is the authority of the CMMI to contract with physicians and other providers in at least

Table 1. Key Definitions.

Name	Definition
Accountable care organization (ACO)	A group or network of doctors, hospitals, and other health care providers that provides coordinated care; also, a contract such an organization has with payers
Medicare Acute Care Episode (ACE) Demonstration project	A 3-yr program designed to test the use of a bundled payment for selected orthopedic and cardiovascular procedures as an alternative approach to fee for service
Advanced Alternative Payment Model (APM)	A contract between a provider organization and Medicare using an alternative to the fee-for-service model; under the Medicare Access and CHIP [Children's Health Insurance Program] Reauthorization Act of 2015, for designated models in which physicians are at some risk of being paid less than under the fee-for-service model, the physicians may be eligible for a 5% bonus in their payment rates under the Medicare Physician Fee Schedule
Affordable Care Act (ACA) (full name: Patient Protection and Affordable Care Act)	Passed in 2010, this act enacted expansion of access to health care through insurance subsidies, Medicaid expansion, and delivery system reforms
Medicare Bundled Payments for Care Improvement (BPCI) program	An initiative in which all the providers involved in an episode of care receive a set payment per patient episode, rather than payment for individual services rendered as part of that care
Center for Medicare and Medicaid Innovation (CMMI)	Part of the Centers for Medicare and Medicaid Services (CMS), this center was created as part of the ACA to test innovative payment and service-delivery models to reduce program expenditures while preserving or enhancing the quality of care; it has the authority and funding to pursue large-scale tests and continue those that are judged to be successful
Children's Health Insurance Program (CHIP)	A program that provides health care coverage to uninsured, low-income children in families with incomes that are too high for them to qualify for Medicaid but who cannot afford private coverage
Comprehensive Primary Care Plus (CPC+)	This advanced APM for primary care clinicians that began in January 2017 is designed to strengthen and support diverse needs of primary care practices through regionally based, multipayer reform
Fee for service (FFS)	A payment model for health services in which providers are paid separately for each service delivered (e.g., an office visit, test, or procedure)
Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)	A bipartisan piece of legislation that replaces the sustainable growth rate (SGR) formula to update physician payment rates with two approaches — APMs or the Merit-Based Incentive Payment System (MIPS) — which aim to encourage physicians to contract with Medicare using alternative payment models and reward improvements in quality and decreased costs
Merit-Based Incentive Payment System (MIPS)	One of two new payment tracks established by MACRA, MIPS combines aspects of the Physician Quality Reporting System (for quality), the Value-Based Payment Modifier (for resource use), and the Medicare Electronic Health Records (EHR) Incentive Program (for meaningful EHR use) and adds a new category called "clinical practice improvement activities," which is based on the medical-home model
Patient-centered medical home (PCMH)	A model of primary care in which physicians are part of a care team that often includes health coaches who engage patients as active participants in their own health; sometimes used to refer to contracts between these practices and payers
Medicare Physician Fee Schedule (PFS)	A schedule for setting Medicare payment rates on the basis of relative physician work and practice expense and a geographic adjuster that reflects local input prices; a conversion factor translates the relative values into dollars
Relative Value Update Committee (RUC)	A committee that develops recommendations for CMS regarding the relative value of physician services under the Medicare PFS; representatives from most specialty societies are included, and the American Medical Association is responsible for staffing and logistic support
Sustainable growth rate (SGR)	A formula for updating the conversion factor in the Medicare PFS in which the update is dependent on a comparison between Medicare spending on physician services and growth in the economy; with the enactment of MACRA, the SGR is no longer used in the Medicare program

three different ways. First, ACOs can assume financial risk that the cost of care will be less than benchmarks under fee for service, and they are either paid a proportion of the savings in the form of a bonus or charged a penalty if the spending exceeds thresholds. Second, the CMMI can pay providers bonuses or penalties on the basis of an episode of care (bundled payment), and third, the CMMI can pay primary care physicians who practice in certified patient-centered medical homes monthly amounts in addition to fee-for-service payments. A recent survey conducted by the Catalyst for Payment Reform noted that in 40% of all commercial in-network payments, payments are tied to improved value of care, and this survey showed the breadth of these changes in provider payment.[3]

PAYMENT UNDER ACOs

Primary care physicians are given a key role in ACOs, in particular by attributing beneficiaries largely on the basis of which physician provided the most services within a given time period. The role of specialists is much less clear, although better coordination between specialties and primary care is part of the concept behind how ACOs improve outcomes and reduce cost.[4] An analysis of the SK&A physician database for 2013 indicated that 39.2% of primary care physicians participated in a Medicare or commercial ACO, as compared with 26.5% of medical specialists and 19.7% of surgeons.[5] Leavitt Partners estimated that in 2016, spending on 28.3 million persons was covered by ACO contracts.[6]

Although many observers expected that most ACOs would be led by hospitals, among the MSSP ACOs, 51% have been physician-led as compared with 33% that have been jointly led by hospitals and physicians and 3% that have been led by hospitals alone.[7] The physician-led ACOs tend to be smaller and appear to have been more successful in the early years.[8,9] They have the advantage of not having offsets to the financial benefits of reducing hospital admissions and emergency department use.

The Medicare ACO model and particularly the model that most of the ACOs are participating in (the track 1 MSSP) has some serious shortcomings, at least from a physician's perspective. Current regulations make it difficult to proactively engage beneficiaries, and in many cases beneficiaries are not attributed to ACOs until after a contract year. Beneficiaries are generally unaware of ACOs and cannot be offered incentives to align with an ACO or to choose physicians and other providers affiliated with the ACO. A primary care physician can refer patients to other providers in the ACO, but such patients do not have to receive care within certain designated provider networks, which are common in commercial health maintenance organizations and preferred provider organizations (PPOs). Some policy analysts have suggested an alternative to create this engagement that resembles a commercial PPO. They suggest that an ACO should create a network of specialists, and beneficiaries should have incentives to stay within the ACO's network.[10]

Another problem involves setting the financial benchmark that each ACO will be judged against. Before 2017, the financial benchmark of an ACO was based on its own historical spending experience for the beneficiaries attributed to it. Since the beginning of 2017, financial benchmarks have been based partially on regional spending data, but only for ACOs that are entering a second contract period with CMS; new ACOs are still subject to the former benchmark. Previous studies have indicated that ACOs with higher benchmarks were more likely to earn shared savings than ACOs with lower benchmarks. In addition, there has been a direct correlation between years of experience and the rate of shared savings.[9]

As of this writing, almost all Medicare ACOs have generally been in one-sided risk arrangements in which providers could receive a portion of savings but were not subject to penalties for spending above benchmarks. This has resulted in underwhelming financial performance, with Medicare paying $646 million in savings to ACOs in 2015, but its share of these savings was smaller than its extra spending for ACOs that did not reduce spending.[11]

The ACA also included language supportive of Medicaid ACOs as well as ACOs focused on pediatric populations. Medicaid ACOs have proliferated in states such as Oregon, which has had overall success in coordinating care and improving clinical quality but with some challenges in cost containment.[12]

Commercial insurers have also pursued ACOs, although often with models that are distinct from those of Medicare. Some commercial ACOs in California have encouraged enrollees to choose

ACO-affiliated providers by offering lower patient cost sharing for ACO providers than for other network providers, whereas others offer direct payments to providers in addition to fee-for-service reimbursement. Data from 2015 and 2016 suggest that 8.3 million persons who receive Medicare, 2.9 million persons who receive Medicaid, and 17.2 million persons who have commercial insurance were attributed to ACOs. However, more than 177 million people have employer-sponsored or nongroup insurance, as compared with the 43 million Medicare beneficiaries, so Medicare penetration is actually higher.[6,13]

BUNDLED PAYMENT

Through the CMMI, numerous bundled payment demonstrations have been launched. The CMMI built on a pre-ACA demonstration of bundled payment for joint replacement and coronary-artery bypass grafting called the Medicare Acute Care Episode Demonstration, and it created the Medicare Bundled Payments for Care Improvement (BPCI) program, which offered a choice of four payment models and an extensive list of inpatient admissions that could be included. These bundled payment initiatives are distinguished from long-standing approaches, such as global fees for surgery, in that they involve multiple providers. The two most popular among providers are retrospective models (models 2 and 3) in which providers continue to receive fee-for-service payments and savings or losses are calculated by comparing actual fee-for-service spending with a benchmark based on historical experience. Medicare splits any savings or losses generated by providers. Model 2 applies to both the inpatient and postacute care period, whereas model 3 applies to the postacute care period only. Postacute care is seen as the major opportunity for savings in episodes involving inpatient care. Evaluations of the program have shown mixed results. Some clinical areas (e.g., orthopedic procedures) have had savings, whereas others (e.g., cardiovascular surgery) have exceeded cost targets.[14,15] Under a separate program, bundled payment for patients receiving chemotherapy has also been developed.

In contrast to the voluntary programs discussed above, the CMMI has initiated a mandatory program for joint replacement and, more recently, a mandatory program for cardiac procedures. In randomly selected geographic areas, all joint replacements and cardiac bypass procedures as well as treatment for myocardial infarction and hip fracture will be covered under bundled payment. The mandatory nature of the program allows for a better approach to setting benchmarks, and a blended transition from a provider-specific spending experience to a community spending experience engages many more providers and permits more definitive evaluations. However, the initiative has received criticism for its mandatory nature as well as the fact that the hospital is designated as the organization to contract with CMS, in contrast to the Medicare BPCI program, which allows physician practices to contract directly with CMS. The Trump administration has delayed the implementation of the new mandatory bundled program but has not cancelled the existing programs.

PATIENT-CENTERED MEDICAL HOMES

Like an ACO, the term "patient-centered medical home" refers to a delivery organization — a primary care practice that meets certain certification requirements. Initial results from the medical-home model were mixed, with improvements in quality of care and some decreased utilization metrics but insufficient evidence to establish cost savings.[16] The payment approaches for the model range widely. Some medical-home initiatives by private insurers simply pay higher fee-for-service rates to those practices that are certified. In its Comprehensive Primary Care Initiative, Medicare pays the practice a monthly amount per beneficiary attributed to it in addition to regular fee-for-service payments. The initiative has been limited to selected regions in which private insurers and state Medicaid programs agreed to use the same approach, facilitating investment by the medical practices. A recent study of the Comprehensive Primary Care Initiative suggests that although substantial savings have not been achieved, transformation of care delivery is occurring across participating practices.[17]

In contrast, some newer approaches to medical-home payment are more promising because they do more to change physician incentives and therefore have more potential to affect savings. Medicare's recent Comprehensive Primary Care Plus Initiative pays much larger monthly amounts than under the earlier initiative but lower rates

for services paid under the Physician Fee Schedule. Effectively the initiative is blending fee-for-service payments with capitated payment, seeking a "sweet spot" by covering fixed costs through capitation and variable costs through the fee-for-service system. Even more promising are initiatives by some private insurers and the Medicaid program in Arkansas that offer bonuses to primary care physicians who succeed in lowering their patients' total spending (e.g., through fewer emergency department visits, referrals to more efficient specialists, and lower rates of hospital admission and postacute care).[18]

An issue that applies in differing degrees to all the alternative payment approaches and that has not received sufficient attention is risk adjustment. Different patients have different care needs, and these approaches all attempt to make adjustments. However, when adjustments are not adequate, there are positive and negative effects on various physician practices as well as incentives to avoid patients with complex problems. It is not clear whether limitations in methods of risk adjustment will constrain advances with these approaches.

PAYMENT UNDER MACRA

Before its implementation this year, MACRA was perceived by physicians to be the legislation that ended the SGR process. Under the SGR formula, all the physicians in the nation who treated Medicare patients were under a collective incentive to limit spending growth by a substantial amount. Although this might initially have been attractive from the perspective of Congress to make the federal budget more predictable, it was not realistic to think that such a large number of independent practices could respond constructively. After a few years of payment rate increases that were above or below a default update, in 2003, Congress was faced with the SGR formula calling for a large cut in rates. Congress deferred the cut. However, deferring the cut rather than cancelling it, presumably to hide the implications for future budget deficits, led to a saga that continued for well over a decade. This saga involved last-minute deferrals of large cuts in payment rates. In addition to the periodic uncertainty, the SGR formula affected physicians through increases in rates that were substantially smaller than increases in the index of practice expenses that had long been the basis for annual rate increases.

The MACRA legislation ended the SGR but without sufficient offsets to prevent a substantial increase in the projected federal budget deficit. This may help explain why MACRA also included many provisions aimed at reforming health care delivery to achieve lower costs and higher quality. The legislation received an unusual level of enthusiastic support from members of both parties and gained consensus votes at the committee level.

MACRA requires physicians to choose one of two pathways: the Merit-Based Incentive Payment System or an advanced alternative payment model. When the legislation was enacted, most observers focused on its strong endorsement of alternative payment models. In these models, which were described as payment approaches that were distinct from the fee-for-service model, physicians face "nominal financial risk," meaning that the payment could be more or less than it would have been under the fee-for-service model, with payment determined by the ability to reduce cost from a historical financial benchmark. For physicians with a substantial level of advanced use of alternative payment models, such as those who participate in models that include the risk of a penalty as well as the opportunity for a bonus ("two-sided" risk) and that meet a threshold for a sufficient number of patients, an initial bonus of 5% is applied to all services.

For the foreseeable future, most providers will be in the Merit-Based Incentive Payment System pathway, which is a series of budget-neutral bonuses and penalties related to quality of care (replacing the prior Physician Quality Reporting System), resource use (replacing the previous Value-Based Payment Modifier program), clinical practice improvement activities, and advancing care information (replacing "meaningful use" requirements for electronic health records). Thus, although MACRA strongly endorsed advanced alternative payment models, it created a parallel set of incentives for physicians to perform better under the fee-for-service system by adjusting fee-for-service payments according to performance in the Merit-Based Incentive Payment System. It is not clear whether members of Congress thought the incentive system would be effective or whether they felt compelled to do something that af-

fected all physicians in the face of increases in the federal deficit associated with the cancellation of the SGR.

A lot of the enthusiasm for MACRA on the part of physicians ended when the proposed rule to implement the program was published in April 2016. The reporting requirements for the new categories of measures under the Merit-Based Incentive Payment System were perceived to be administratively burdensome and beyond the capabilities of many small practices. In particular, physicians criticized the proposed requirements for additional codes to document the type of clinician who is delivering care, an overwhelming number of quality measures to choose from, and a rapid reporting timeline. In addition, the requirements for an advanced alternative payment model turned out to be more restrictive than some physician organizations had expected. For example, the alternative payment approach that involved the most physicians, an ACO with only the opportunity for a bonus and no risk of a penalty ("one-sided risk"), was not an option that satisfied the requirements of the law because MACRA requires that in order to qualify as an advanced alternative payment model, physicians must face the risk of being paid less than under the fee-for-service system. Few advanced alternative payment models that might be suitable for physicians in a number of specialties were available. Simulations of how various physicians would perform under the Merit-Based Incentive Payment System if their practice patterns and reporting did not change from a recent year indicated that small practices as a group might fare very poorly; this concern led CMS to dedicate $100 million to help small practices understand MACRA.

The eagerly awaited final rule, released in late October 2016, addressed some of the issues of concern for providers. Although CMS stood firm on not allowing ACOs with one-sided risk to qualify as an advanced alternative payment model, it promised a new ACO model (called track 1+), which was described as an "on-ramp" to two-sided risk because it has limited downside financial risk as compared with more advanced ACO models in Medicare. In addition, many aspects of the Merit-Based Incentive Payment System were delayed or reduced for 2017. Far fewer quality measures had to be reported, and the resource-use measure was excluded for now from the calculations for bonuses and penalties. A substantial proportion of small practices were excluded from the incentive system entirely because of insufficient numbers of Medicare patients. An opportunity for physicians to join "virtual practices" for the purposes of the Merit-Based Incentive Payment System was promised for the future along with dedicated financial resources to support small practices through quality improvement.

Whether MACRA will ultimately lead Medicare (and other payers) to a true alternative to the fee-for-service model through physicians' involvement in alternative payment models is not at all clear. Currently, only six payment models, some of which are closed to new providers, qualify as advanced alternative payment models. The legislation created the Physician-Focused Payment Model Technical Advisory Committee to advise the secretary of health and human services on new payment models for possible implementation.

The potential for the Merit-Based Incentive Payment System to improve delivery is more tenuous. It probably will be slowed substantially so as not to get too far ahead of physicians' ability to efficiently report the information needed. This ability may evolve quickly as specialty societies develop registries that are capable of allowing physicians to meet reporting obligations at a low cost. A major potential shortcoming is the extent to which it is possible to make reliable assessments of quality and resource use for small practices on the basis of claims data and additional low-cost reporting by physicians. With advanced alternative payment models, these assessments are made for an organization rather than a practice, and the larger numbers of physicians involved avoid many small-sample issues. In an analysis of MACRA, the Medicare Payment Advisory Commission points out that many of the quality measures do little to differentiate among physician practices.[19]

PHYSICIAN FEE SCHEDULE

Although alternative payment has captured most of the attention in policy circles over the past few years, one cannot overestimate the continuing importance of the Medicare Physician Fee Schedule to physician payment. All the payment approaches that are now used or being discussed

for the future are built on a foundation of the fee schedule. Benchmarks are based on this schedule. The large gaps in income among primary care, other specialties that derive most of their revenue from patient visits, and specialties that derive most of their revenue from procedures are a problem in their own right with respect to the physician work force and incentives to provide too many procedures. Such gaps are also a barrier to many payment reforms that are based on an increased role for primary care to promote care coordination.

The Medicare Physician Fee Schedule was implemented in 1992, with much of the measurement of relative resources for various services based on a major study from the mid-1980s. The implementation led to a substantial redistribution from physicians performing many procedures to those who provide care primarily during patient visits. However, much of this redistribution has been reversed over time due to shortcomings in the process for updating relative values. The key failing is that most of the attention goes into identifying services that are undervalued rather than those that have become overvalued as advanced techniques increase physician productivity for many procedures.[1]

Congress has been expressing increasing concern about the accuracy of the relative values in the Medicare Physician Fee Schedule. Initially, Congress intervened on an ad hoc basis — for example, by reducing the relative value of advanced imaging services. In the ACA, Congress directed CMS to undertake a systematic review of relative values and establish priorities for services to review. Subsequent legislation required that reductions in relative value of at least 1% of physician spending per year be distributed to other services — but only for a few years. CMS fell short of this extremely limited objective in 2016 (we think that at least 20% is required), which casts doubt on how effective this approach can be. Although many observers have debated the degree to which the Relative Value Update Committee of the American Medical Association is responsible, we think that, in either case, CMS needs to play a much more active role by drawing on various sources of objective data on physician time and on practice expenses. The Medicare Payment Advisory Commission (the first author is a commissioner), which has endorsed this approach, has reported many examples in which the relative values for procedures have substantially exceeded what objective data would support.[20] Much is at stake in the success of alternative payment approaches; not pursuing the limited investments that are needed to shore up the foundation of the Medicare Physician Fee Schedule seriously compromises this potential.

CONCLUSIONS

Recent legislation and regulatory changes have created new energy for physician payment reform, which has fostered a lot of activity around new models of payment that blend the fee-for-service model with care management fees or shared savings arrangements. However, the jury is still out on whether achievements in quality and costs will materialize. Although the change in administrations has generated many questions about which aspects of the ACA might remain in place, it is clear that there is strong momentum to move away from fee for service and paying for volume. MACRA endorsed this direction, but its approach to advanced alternative payment models has been hindered by few opportunities for physicians to participate, and the likely path in MACRA with respect to the Merit-Based Incentive Payment System may do more harm than good. Ultimate success may lie in the development of additional models, some of which will be relevant only to a few specialties. Although the road is long, so far the enthusiasm of leadership among both providers and payers seems intact.

It is very early in the new administration to assess a potential change in direction on physician payment, but we note two things. First, efforts to repeal and replace the ACA have not included changes in physician payment. Second, although Congressional Republicans have become increasingly unhappy with some of the demonstrations proposed by the CMMI over the past year, we do not perceive any initiative to eliminate them. However, Secretary of Health and Human Services Tom Price has been highly critical of demonstrations that mandate participation by all physicians in a geographic area, such as the Comprehensive Care for Joint Replacement Model. So additional demonstrations that mandate participation might not be pursued, and existing demonstrations might not be extended.[21]

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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