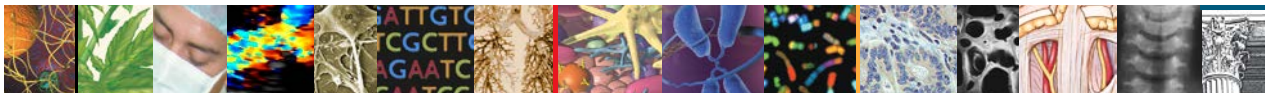

The NEW ENGLAND JOURNAL of MEDICINE

Perspective

SEPTEMBER 24, 2015

Leap of Faith — Medicare's New Physician Payment System

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Repealing Medicare's sustainable growth rate formula (SGR) for calculating annual updates to physician payments has long been a priority for organized medicine. The annual "mandatory" fee cuts it dictated (that were then averted by last-minute congressional action) earned the SGR few fans in the medical profession. Many health policy analysts also saw the formula as deeply flawed, unfair, and ineffective. Yet it survived, largely because official budget projections continued to assume that steep cuts would actually be made to Medicare's physician payments over the ensuing decade. Democrats and Republicans alike found it difficult to surrender these imaginary savings. Though most health policymakers wanted to eliminate the SGR, it seemed impossible to find a way out of the budgetary trap.

Until now. In a rare show of bipartisanship, Congress repealed the SGR in the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. Its repeal was made possible by Congress's newfound willingness to scrap it without offsetting most of the projected costs with other savings. MACRA establishes a new schedule of Medicare fee updates for doctors and other health professionals.[1] Between 2016 and 2019, Medicare's payment rates will increase by 0.5% a year, and there will be no rate changes between 2020 and 2025. Beginning in 2019, Medicare payments will vary according to whether a physician elects to be paid under the new Merit-Based Incentive Payment System (MIPS) or to join the Alternative Payment Model (APM) program.[1]

Physicians who receive a substantial portion of their payments from an accountable care organization (ACO), medical home, or another APM will receive 5% annual increases in Medicare payments through 2024. Payments to medical professionals who instead participate in the MIPS will be adjusted upward or downward (by 4% in 2019, increasing to 9% by 2022) according to measures of their performance quality, resource use, clinical practice improvement activities, and use of electronic health records (the MIPS thereby combines existing incentive programs). Physicians who are rated as exceptional on these measures will be eligible for additional payments through 2024. From 2026 on, Medicare will have two separate fee-update systems: physicians participating in the APM program will receive annual increases of 0.75%, while nonparticipants will receive increases of 0.25%.

These changes mark a new era, in which Medicare offers powerful incentives for physicians

to participate in ACOs and other innovative payment and delivery models. Indeed, the chief actuary of the Centers for Medicare and Medicaid Services (CMS) predicts that eventually all physicians participating in Medicare will be paid through such APMs.[1] In the meantime, the secretary of health and human services is charged with developing a "composite performance score" for individual physicians on which Medicare's merit-based payments will be based.

This revamping reflects a broader movement in U.S. health care toward paying for medical services on the basis of value rather than volume — a movement built on the prevailing view in the health policy community that cost-containment efforts can succeed only if we move away from fee-for-service payment. But there are several important problems with this belief and the reforms it inspires.

The first is that, though "logically powerful," such a view is "inconsistent with the facts," according to Bruce Vladeck, former head of CMS's predecessor, the Health Care Financing Administration.[2] Other countries that spend far less than the United States does on medical care pay physicians through fee for service, demonstrating that value-based purchasing is not necessary for controlling spending. Instead, international experience suggests that the key to cost control is regulating absolute prices.[3]

Second, even if the efficacy of a volume-to-value shift were established, the claim that Medicare's new payment system decisively effects such a shift is premature. In the post-SGR era, physicians' incomes will still largely depend on the number and mix of services they deliver. Even for salaried physicians, bonuses are often tied to targets based on volume and service intensity. At this juncture, "volume to value" is as much (or more) a marketing slogan as it is actual policy.

Improving the quality of care is an important goal, and it's understandable that policymakers would aspire to harness payment incentives toward advancing that aim. However, Medicare's new payment system illustrates the difficulties inherent in operationalizing value-based payments. Value in medicine is an elusive concept. Medicare's MIPS will rely on development of a composite performance score, 30% of which will initially be derived from measures of individual physicians' quality. But it's unclear that we have the appropriate measures to accurately, meaningfully, and comprehensively evaluate the quality of physicians' care, let alone to render such a judgment in a single score.[4]

What is clear is that the new payment system bets heavily on ACOs, medical homes, and other new payment and delivery models as the keys to cost control and quality improvement. The enthusiasm for such innovations reflects the yearning for a "magic bullet" that can fix the problems of U.S. medicine. It doesn't reflect the evidence, which is thin, mixed, and preliminary. It is far too early to conclude that such APMs will save substantial amounts of money or improve care quality and patient outcomes. Medicare, in other words, is set to pay physicians more to embrace innovations whose effectiveness is highly uncertain — a remarkable leap of faith.

Finally, regardless of whether ACOs or other initiatives deliver on their promise, repealing the SGR will not end political struggles over Medicare fees. Physician payments are both a source of income and an instrument of cost containment. The result is an inevitable tension in health policy: medical professionals typically want higher payments, whereas governments prefer to pay less. Controlling the rate of spending growth necessarily entails controlling the incomes of medical providers, which provokes resistance.

The SGR is an instructive case. It was enacted to constrain Medicare's total expenditures on physician services by providing a countervailing force against increases in service volume and intensity. Congress was never supposed to play a starring role in this drama: reliance on a technical formula was meant to insulate it from any backlash when cuts occurred.[5] When the formula produced fee increases, which it did from 1998 to 2001, it drew little scrutiny. But as it began generating fee reductions, its technical veneer and political insulation quickly wore away. Physicians' groups vigorously lobbied Congress to overturn cuts that they argued would erode Medicare beneficiaries' access to care. Congress found those entreaties impossible to resist.[5]

Medicare's new payment system is front-loaded with bonuses and extra payments through 2024. After that, however, the bonuses expire and Medicare updates may not keep pace with increases in medical expenses.[1] Physicians may again pressure Congress to raise fees. There is no assurance that lawmakers will be more successful in resisting such pleas than they were under the SGR. In other words, if Medicare's new payment system works too well to contain spending, it could fail politically.

Moreover, the elasticity of concepts such as "alternative payment model" and payment "dem-

onstration projects" gives physician interest groups the opportunity to stretch the criteria for obtaining higher payments. The implementation of a physician performance score will be another battleground: MACRA allows medical professionals to pick which quality measures they will be evaluated on, and there will be pressure for CMS to offer more concessions. There may also be additional pressure to delay the introduction of this new system.

An audio interview with Dr. Oberlander is available at NEJM.org

No technical formula is immune from the politics of health care. The SGR is gone, but there is no permanent fix for physician payment.

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

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DOI: 10.1056/NEJMp1509154

Physician Payment after the SGR — The New Meritocracy

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The "doc fix" — a permanent replacement for the unworkable sustainable growth rate formula (SGR) enacted in 1997 for calculating Medicare's physician fees — had been a long time coming when it emerged from Congress this past spring. The law that did away with the SGR was an elegant compromise from a political point of view, crafted to end the tyranny of annual delays in physician-payment reductions but also to balance the need for public accountability against the profession's interest in implementing a reasonable and predictable payment system.[1]

At the heart of the legislation is the new Merit-Based Incentive Payment System (MIPS), which replaces the Physician Value-Based Payment Modifier to move physician payment under Medicare further into the territory of value-based purchasing. The MIPS will be phased in over 5 years beginning in 2019. Although many of the finer details will be wrought through the rulemaking process, it is now possible to discern the outlines of the economic issues that surround the MIPS.

The replacement of the SGR with the MIPS marks a fundamental shift from setting annual fee levels on the basis of macroeconomic indicators (overall growth in Medicare spending relative to the sustainable growth rate) to relying on individual-physician- or group-level indicators of cost and quality. This change overcomes the "commons" problem that was inherent in physician incentives under the SGR. All physicians together were supposed to be accountable for the volume of services that drove Medicare spending, and all, regardless of their specialty or practice pattern, risked facing fee cuts when spending growth exceeded the target rate. That arrangement ensured that the SGR was only an accounting mechanism designed to force spending control after the fact (i.e., if price times quantity exceeds a given value, decrease price) rather than an incentive program — no individual physician had an incentive to reduce spending.

The design of the SGR also favored specialties in which volume increases are more lucrative and more feasible — in particular, specialties in which procedures account for a substantial portion of reimbursement. Had the SGR been enforced in recent years as intended, it would have led to across-the-board fee cuts for all physicians as a consequence of volume increases driven disproportionately by some physicians, who in turn might have been better able to further increase volume to offset the lost revenues. In contrast, the MIPS will base payment levels on the performance of individual physicians or self-identified groups that have agreed to work together as an accountable unit for payment purposes. Thus, unlike the SGR, the MIPS creates an incentive for professionals to practice in a manner consistent with the performance goals set by the Centers for Medicare and Medicaid Services (CMS).

As its name suggests, the new payment system also takes into account more than just total costs to determine annual fee increases. "Merit" will be judged on the basis of four domains: quality of care, resource use, meaningful use of electronic health records, and participation in clinical practice im-