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.

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Physician Payment after the SGR — The New Meritocracy

Meredith B. Rosenthal, Ph.D.

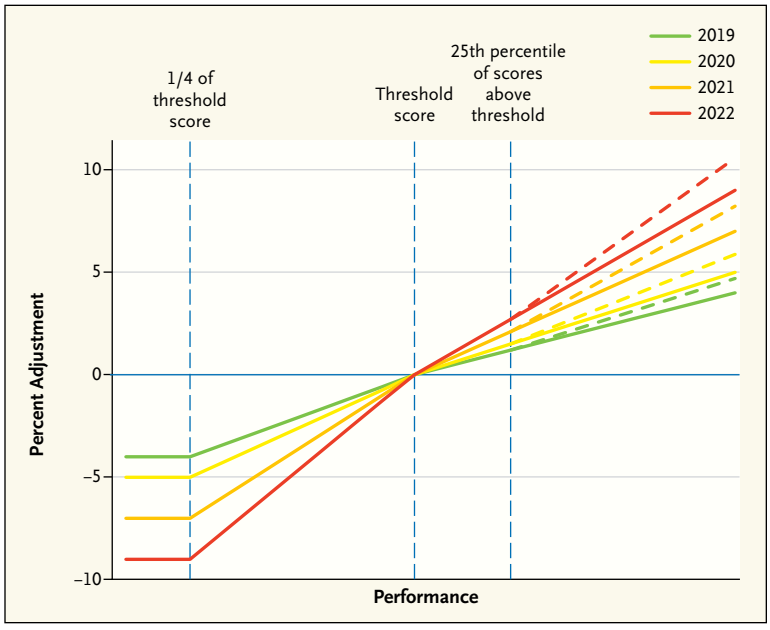
The "doc fix" — a permanent replacement for the unworkable sustainable growth rate formula (SGR) enacted in 1997 for calculating Medicare's physician fees — had been a long time coming when it emerged from Congress this past spring. The law that did away with the SGR was an elegant compromise from a 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-



Adjustments to Medicare Payments to Physicians under the Merit-Based Incentive Payment System (MIPS).

The solid lines indicate the percentages by which physician payments will be adjusted. A threshold will be calculated as the mean or median of all composite MIPS scores in a prior period. All eligible physicians who score below the threshold will have their reimbursements adjusted downward; those who score below one quarter of the threshold score will automatically receive the greatest negative adjustment possible for that year. Physicians with scores at the threshold will receive no adjustment. Physicians with scores above the threshold will receive positive adjustments proportional to their score and set at a level that is fully offset by negative adjustments (i.e., is budget neutral) for Medicare as a whole. Positive adjustments will be capped at a maximum of three times the maximum negative adjustment in that year. Additional positive adjustments will be made to the payments for all physicians with scores above the 25th percentile of all physicians whose scores exceed the threshold (dashed lines). These additional payments will be proportional to the physician's score and are capped at $500 million per year.

provement activities. Improvement in performance year over year will also be considered in physician assessments.

The selection of the quality and resource-use measures that will be used for the MIPS is perhaps the most important element of its design from an economic perspective. Measures that are not connected to outcomes that matter to beneficiaries and CMS may lead to wasted effort (or worse, reductions in value). In addition, if the measures are subject to substantial random error — that is, if there are factors outside physicians' control that cause variability in performance in unpredictable ways — then the program will amount to allocating a share of physician pay by lottery, which will not provide incentives for improvement and will cause substantial dissatisfaction among physicians. A key challenge on this front will be measuring quality at the level of individual professionals. It is likely, though not assured, that CMS will also recognize self-identified groups for the purpose of performance assessment and payment under the MIPS, as it has done under the Physician Value-Based Payment Modifier. Finally, if the measures are systematically influenced by patient factors and these factors are not accounted for (e.g., through risk adjustment) in benchmarking physicians' performance, then the MIPS will be unfair and will create incentives for physicians to avoid patients who would negatively affect their performance scores.

In designing the MIPS, Congress anticipated the need to develop meaningful quality measures, which have been missing from many areas of medicine. Important components of the law include a process for vetting new measures and $15 million per year of funding for measure development. In some areas where performance measurement is not well established, there may not be enough time and resources available to develop, test, and refine meaningful quality measures. The law also directs CMS to refine methods of attribution and risk adjustment to ensure accurate capture of resource use and minimize the adverse consequences noted above.

In contrast to the Physician Value-Based Payment Modifier, which is scheduled to sunset when the MIPS takes effect in 2019, the MIPS has the potential to create a relatively large fee differential between high- and low-performing physicians (see graph). The MIPS includes both negative and positive adjustments to physician pay based on a composite measure that reflects performance in each of the four areas of "merit" relative to a prospectively set threshold. The poorest performers will face fee cuts of 4% in 2019, 5% in 2020, 7% in 2021, and 9% in 2022. Positive adjustments for physicians performing above the threshold will be based on the level of performance and will be scaled to offset the negative adjustments.

In addition, the law allocates $500 million in each year from 2019 through 2024 for bonuses

that will be awarded to the top 75% of professionals who perform above the threshold, with higher bonuses awarded for better performance. Therefore, even if all professionals score above the performance threshold — and as a result no negative or positive adjustments are made — the top performers will still receive bonuses.

Because what qualifies as a sufficient incentive depends on the effort required to attain a specific performance goal — which itself varies by measure and person — there is no magic number for the optimal share of physician payment that is determined by pay for performance. Nonetheless, the dollar amounts at stake under the MIPS on their face appear to be a meaningful incentive, assuming that the performance criteria are reasonably achievable for most physicians and are not set so low that they inspire little or no effort.

The new law should encourage participation in alternative payment models, including those associated with accountable care organizations and patient-centered medical homes. Professionals who receive a substantial share of their Medicare or all-payer clinical revenues through qualifying alternative payment models will receive a 5% bonus in each year from 2019 through 2024 and will be exempt from payment adjustment under the MIPS. This component of the law may well result in reaching an important tipping point in the take-up of voluntary alternative payment models in Medicare — and could potentially have a larger effect on value-based purchasing than the MIPS itself.

When it is implemented, the MIPS will become the largest physician pay-for-performance scheme in the world and the first to create a single value-based purchasing framework covering the full spectrum of physician specialties. This new meritocracy will need to be flexible enough to account for the heterogeneous practice styles of the professionals who care for Medicare beneficiaries and the settings in which they work, while ensuring that all specialties are subject to fair and robust assessment. Effective engagement of physicians and professional associations will be critical as the contours of the MIPS are hammered out through federal rulemaking and the acceleration of quality-measure development begins in earnest.

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Politics and Universal Health Coverage — The Post-2015 Global Health Agenda

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When the United Nations summit for the adoption of the post-2015 development agenda begins on September 25, the attainment of universal health coverage (UHC) is expected to garner substantial attention. Bolstered by increasing evidence that UHC improves health outcomes,[1] countries are seeking to build health-related goals around the concept of health care for all. Yet many lower- and middle-income countries (LMICs) have not created UHC systems (see map). How can the global community translate vision into policy, especially in the face of complicated politics?

To elucidate some of the political dynamics involved, we developed a conceptual model describing sociopolitical factors that have helped catalyze reform in selected countries. We focused on trends over time in these variables during the lead-up to major health care legislation. Based on interviews with high-level former policymakers, civil-society members, and academics who oversaw the successful implementation of UHC initiatives in LMICs, our framework draws on information from Chile, Mexico, China, Thailand, Turkey, and Indonesia — countries with emerging economies that have recently instituted UHC schemes.

We sought to understand how each country's political landscape evolved to support UHC, examining how key factors had changed in the years preceding health care reform. We aimed to highlight the dominant sociopolitical forces that influenced debates on welfare expansion, rather than including all potential variables. Moreover, since several of these variables are challenging to define quantitatively, we tried to characterize patterns of change — whether the condition or characteristic was increasing or