

# BACKGROUND

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## Overcoming Challenges to Physician Payment Reform in a Post-SGR World

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### Abstract

*On April 16, 2015, President Barack Obama signed the Medicare Access and CHIP Reauthorization Act (MACRA), which, among other things, finally repealed the Sustainable Growth Rate (SGR) mechanism of paying for physician services in Medicare. The SGR had been blamed for causing instability and uncertainty among physicians for over a decade and led to 17 overrides of scheduled cuts to the physician fee schedule, at a cost well in excess of \$150 billion. Although the passage of MACRA was a significant legislative event, it is the implementation of MACRA, along with other health care payment and delivery reforms, that will profoundly shape the future health care system in the U.S.*

On April 16, 2015, President Barack Obama signed the Medicare Access and CHIP Reauthorization Act (MACRA),<sup>1</sup> which among other things, finally repealed the Sustainable Growth Rate (SGR) mechanism of paying for physician services in Medicare. The SGR had been blamed for causing instability and uncertainty among physicians for over a decade and led to 17 overrides of scheduled cuts to the physician fee schedule, at a cost well in excess of \$150 billion. Although the final version of the MACRA legislation may not be perfect,<sup>2</sup> its basic framework is sound and, if implemented according to the original intent, could lead to a payment system that is based on providing better value, higher quality, and more efficient care.

Over the past several decades there have been calls to move from the current volume-based fee-for-service payment system to a value-based system that pays for patient outcomes rather than individual services. On January 26, 2015, even before the fate of MACRA

### KEY POINTS

- Although the repeal of SGR was a major legislative event, it is the implementation of MACRA, along with other health care payment and delivery reforms that will profoundly shape the future health care system in the U.S.
- Policymakers should ensure that payment reform has an adequate infrastructure of meaningful performance measures and a sufficient number of PF-APMs.
- Policymakers should avoid the unintended consequences of additional administrative burden and greater health care consolidation.
- MACRA, if not implemented correctly, could force physicians to choose between an overly burdensome pay-for-performance program and impractical alternative payment models that are likely to be both professionally and financially unrewarding.
- If implemented correctly, MACRA could give physicians the choice of how they practice and how to meaningfully measure the value of their care.

This paper, in its entirety, can be found at <http://report.heritage.org/bg3101>

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was known, Department of Health and Human Services (HHS) Secretary Sylvia Burwell announced a major initiative calling for 30 percent of Medicare payments to be *value-based* by 2016. In addition, the Administration wants to tie 50 percent of payments to *quality or value* by 2018.<sup>3</sup>

The common goal of payment reform should be to deliver high-quality care in the most efficient and cost-conscious way. However, there are currently major challenges to achieving that goal. Secretary Burwell's aggressive timeline, as well as the implementation of MACRA, should be tempered by a mounting accumulation of warning signs that concern key areas of payment and delivery reform, such as the validity of quality and performance measures and the ability of alternative payment models (APMs) to achieve their stated objectives. Policymakers and others involved in payment reform should also remain acutely aware that the current multitude of health reform initiatives and incentive programs have already created a heavy administrative burden on physician practices.

### Payment Reforms Under MACRA

MACRA repeals the SGR and stabilizes payments for a period of time to allow providers to prepare for the next phase of payment reforms.<sup>4</sup> As provided for in MACRA, following the repeal of SGR, provider payments for the years 2015–2019 are stabilized at a modest 0.5 percent annual update. From 2019 until 2025, reimbursement rates are held constant at 2019 levels with no automatic increases or decreases, leaving physicians with two choices:

1. Remain in fee-for-service and be subject to payment adjustments through the Merit-based Incentive Payment System (MIPS), essentially a complex pay-for-performance (P4P) system; or

2. Participate in qualifying APMs and be exempt from MIPS. Beginning in 2026 and beyond, physicians who receive a significant share of their revenues through an APM are eligible for 0.75 percent annual increases as opposed to 0.25 percent updates for those not participating in APMs.

### Merit-based Incentive Payment System (MIPS)

Section 101(c) of MACRA requires establishment of the Merit-based Incentive Payment System (MIPS). Although it is essentially a complex and elaborate P4P system that carries with it considerable reporting requirements, it should also be seen in light of current legislation that requires physicians to report on measures in three separate incentive programs: the Physician Quality Reporting System (PQRS); the Value-based Modifier (VBM); and the Electronic Health Record-Meaningful Use (EHR-MU) program. MACRA consolidates these three programs into the MIPS program, streamlining the reporting process. In addition, scheduled penalties in the three incentive programs are replaced by an opportunity to receive positive payment updates.

MIPS requires the Secretary of HHS to develop and provide clinicians with a Composite Performance Score (CPS) that evaluates provider performance on each of four categories: Quality, Resource Use, Clinical Practice Improvement Activities, and Meaningful Use of Certified EHR Technology. Based on their CPS, providers may receive an upward, downward, or no adjustment to their fees.

Those physicians with a composite score in the bottom quartile, as compared with a predetermined performance threshold (based on an average of the previous year's MIPS scores), will receive reimbursement cuts up to the cap set for each year (4 percent in 2019, 5 percent in 2020, 7 percent in 2021, and 9 per-

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1. Medicare Access and CHIP Reauthorization Act of 2015, Public Law 114-10.

2. James C. Capretta, "An Unappealing Doc Fix," *National Review*, March 25, 2015, <http://www.nationalreview.com/article/415931/unappealing-doc-fix-james-c-capretta> (accessed March 1, 2016).

3. News release, "Better, Smarter, Healthier: In Historic Announcement, HHS Sets Clear Goals and Timeline for Shifting Medicare Reimbursements from Volume to Value," U.S. Department of Health and Human Services, <http://www.hhs.gov/about/news/2015/01/26/better-smarter-healthier-in-historic-announcement-hhs-sets-clear-goals-and-timeline-for-shifting-medicare-reimbursements-from-volume-to-value.html> (accessed March 1, 2016).

4. On October 1, 2015, the Centers for Medicare and Medicaid Services (CMS) published a "Request for Information Regarding Implementation of the Merit-Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models," *Federal Register*, Vol. 80, No. 90 (October 1, 2015), p. 59102. The comment period for the Request for Information ended on November 17, 2015.

cent in 2022). Negative and positive payment adjustments will be ratcheted up or down in a proportional manner for those scores closer to the threshold. Additionally, physicians scoring in the top 75 percent of all scores above the threshold will receive an additional positive payment adjustment, allocated using a linear distribution formula. In essence, this allows for a greater number of physicians to be eligible for incentive payments, even if the vast majority of them are above the threshold score.

### Alternative Payment Models (APMs)

Section 101(e) of MACRA promotes the development of, and participation in, Alternative Payment Models (APMs) with payment incentives from 2019 through 2024. Specifically, this section:

1. Creates a payment incentive program that applies to providers who are qualifying APM participants for years from 2019 through 2024;
2. Requires the establishment of a process for stakeholders to propose Physician-Focused Payment Models (PF-APMs) to an independent Physician-Focused Payment Model Technical Advisory Committee (PTAC) that will review, comment on, and provide recommendations to the Secretary on the proposed PF-APMs; and
3. Requires the establishment of criteria for PF-APMs for use by the PTAC for making comments and recommendations to the Secretary.<sup>5</sup>

However, there is nothing in the legislation to specify that the Secretary is obligated to implement PF-APMs, even if the models meet the accepted criteria and are favorably reviewed by the PTAC.

Physicians who receive a significant share of their revenues through an APM that involves risk of financial losses (two-sided risk) and a quality measurement component will receive a 5 percent bonus each year from 2019–2024. Beginning in 2025 and beyond, the bonus payments phase out and providers receive a 0.75 percent increase if they participate

in a qualifying APM or a 0.25 percent increase if they do not.

### Current Performance Measurements: Burdensome and Largely Meaningless

In addition to the various pay-for-performance initiatives currently underway, the MIPS program will evaluate provider performance on each of four categories: Quality, Resource Use, Clinical Practice Improvement Activities, and Meaningful Use of Certified EHR Technology. In addition, APMs will also need to include performance metrics comparable to those in MIPS that must be achieved if providers are to share in any savings realized through cost reduction. By and large, physicians not only want to provide the best quality health care to their patients, but also want to know they are doing so. Physicians currently labor, however, under an increasingly burdensome and often meaningless number of reporting requirements that take time away from patients and fail to help them improve the quality of their care.

A recent national survey of physician practices published in *Health Affairs* found that physicians and their staff spend, on average, 785.2 physician and staff hours per physician annually—equaling \$15.4 billion—to track and report quality measures for Medicare, Medicaid, and private health insurers. Three-quarters of surveyed practices did not feel that the measures helped them improve their care, even though the average cost to a practice for spending this time is \$40,069 per physician per year.<sup>6</sup> According to a commentary in *The New England Journal of Medicine* in 2014, “the quality-measurement enterprise in U.S. health care is troubled. Physicians, hospitals, and health plans view measurement as burdensome, expensive, inaccurate, and indifferent to the complexity of care delivery. Patients and their caregivers believe that performance reporting misses what matters most to them and fails to deliver the information they need to make good decisions.”<sup>7</sup> The recent report by the Centers for Medicare and Medicaid Services (CMS) that 40 percent of Medicare providers face 1.5 percent cuts for failing to submit data to the Physician

5. Medicare Access and CHIP Reauthorization Act of 2015, Public Law 114–10.

6. Lawrence P. Casalino, et al., “US Physician Practices Spend More Than \$15.4 Billion Annually to Report Quality Measures, *Health Affairs*, vol. 35, no. 3 (March 2016), pp. 401–406, <http://content.healthaffairs.org/content/35/3/401.full.pdf+html> (accessed March 11, 2016).

7. Elizabeth A. McGlynn, Eric C. Schneider, and Eve A. Kerr, “Reimagining Quality Measurement,” *The New England Journal of Medicine*, Vol. 371, No. 23 (December 4, 2014), pp. 2150–2153, <http://www.nejm.org/doi/full/10.1056/NEJMp1407883> (accessed March 1, 2016).

Quality Reporting System underscores the fact that many providers, especially those who see few Medicare patients, view the cuts as a cost of doing business to avoid the administrative hassle.<sup>8</sup>

Developing more meaningless measures and designing more incentive payment arrangements based on these measures will not fix the problem. In December 2015, Don Berwick, former CMS Administrator under the Obama Administration from July 2010 to January 2011, asserted that the current measurement enterprise is causing doctors, nurses, hospitals, and clinics to spend far too much time and billions of dollars generating reports that “help no one, except maybe the measurement industry.” He called for a reduction of at least 75 percent of all metrics currently being used in health care. In addition, he also appealed for a moratorium on complex incentive programs for individual providers.<sup>9</sup> These recommendations are particularly telling, since Dr. Berwick has been a leader in the health reform movement throughout his career and is even more widely known for his support of a single-payer system and his espousal of Great Britain’s centralized National Health Services (NHS) and its National Institute for Clinical Excellence (NICE) that evaluates the costs and effectiveness of medical therapy as guidance for local authorities to decide what services to cover.<sup>10</sup>

### **Alternative Payment Models (APMs): Early Results Are Mixed**

Both public and private payers are increasingly using alternative payment models (APMs) in an effort to improve quality and to slow the growth in health care spending. APMs have the potential, at least conceptually, to address some of the deficiencies in the current payment system. For example, in cancer care, where there is considerable variability in spending and where care is often fragmented,

these models show some early promise in terms of better coordinated, less costly care, and can provide payment to doctors for needed services that are not always reimbursed under traditional fee-for-service (FFS).<sup>11</sup>

However, the results are as yet limited and much more work is needed before extrapolating early and often anecdotal experience to the larger health care system. The future course of payment and delivery reform currently centers on efforts to move providers out of FFS payment and into Alternative Payment Models (APMs). A reasonable path to achieve this goal is to make FFS increasingly less attractive than participation in an APM. However, moving providers out of FFS assumes that they will have a viable place to go. At this point, it is far from clear that they do.

Value-based purchasing (VBP), the concept behind APMs, refers to a broad set of performance-based payment strategies that attempt to use financial incentives to influence provider performance on a set of defined measures. As early as the mid-1990s, private payers and some Medicaid programs experimented with APMs (mostly P4P models). In 2010, the ACA provided for the substantial expansion of APMs by requiring the Medicare program, through the Centers for Medicare and Medicaid Innovation (CMMI), to design, implement, and test APMs across a broad set of providers and settings. Secretary Burwell’s timeline highlights the Administration’s increased efforts to implement VBP and APMs. In addition, MACRA strongly encourages the development and implementation of APMs and offers incentives for providers to move into these models.<sup>12</sup>

Currently, the APM strategies that have received the most effort and attention in terms of design and implementation are: pay for performance (P4P); Accountable Care Organizations (ACOs); Bundled or Episodic Payments (BP); and Patient-Centered

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8. Centers for Medicare and Medicaid Services, “Fact Sheet on 2013 PQRS and E-prescribing Program,” April 23, 2015, <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-04-23-1.html> (accessed March 2, 2016).
  9. Donald Berwick, “The Moral Era,” Institute for Healthcare Improvement, 27th Annual National Forum, [https://www.youtube.com/watch?v=DKK-yFn7e\\_0](https://www.youtube.com/watch?v=DKK-yFn7e_0) (accessible March 1, 2016).
  10. Donald M. Berwick, “A Transatlantic Review of the NHS at 60,” speech delivered at Wembley, London, England, July 1, 2008, <http://www.pnhp.org/news/2010/may/a-transatlantic-review-of-the-nhs-at-60> (accessed March 1, 2016).
  11. Kavita Patel et al., “Transforming Oncology Care: Payment and Delivery Reform for Person-Centered Care,” *The American Journal of Managed Care*, Vol. 21, No. 5 (May 2015), pp. 388–393, <http://www.ajmc.com/journals/issue/2015-vol21-n5/Transforming-Oncology-Care-Payment-and-Delivery-Reform-for-Person-Centered-Care> (accessed March 1, 2016).
  12. Medicare Access and CHIP Reauthorization Act of 2015, Public Law 114-10.

Medical Homes (PCMHs). All of these models share the worthy goal of improving quality and reducing spending, i.e., providing high-value health care. While the efforts to develop better systems of payment and delivery are commendable and should continue, early results from these models, as well as inherent conceptual shortcomings, should restrain the impulse to move too quickly toward their widespread implementation.

### Pay for Performance

Based on the belief that data is essential to the provision of better quality health care, concerted efforts to develop valid metrics to assess the performance of physicians and other providers have been underway for at least two decades.<sup>13</sup> In principle, many physicians support performance measurement. In fact, according to a 2015 study, some physicians even reported wanting to have their incomes more closely linked to the quality and efficiency of their care. These physicians expressed an underlying desire to have better alignment between what they thought they should do for patients and what they were paid to do, provided the metrics are valid and the measurement process is reasonable.<sup>14</sup>

However, a number of health care researchers have identified serious gaps in the current quality measurement system. A 2014 RAND report looked at 49 studies that examined the effect of P4P on process and intermediate outcome measures and found the overall results of the studies to be mixed. In fact, the studies with stronger methodological designs were less likely to identify significant improvements associated with the P4P programs and any identified effects were relatively small. In short, “The evidence from the past decade is that pay for performance had modest effects on closing the quality gap,” according to Cheryl Damberg, the study’s lead author.<sup>15</sup>

A basic flaw in the design of existing P4P models is the fact that the vast majority of current quality measures are either structural or process measures.

Structural measures assess whether a health care provider or organization has the infrastructure to provide high-quality health care. One example is the capacity for physicians to use Computerized Physician Order Entry (CPOE) to reduce medication errors. Process measures assess health care–related patient care activities. An example of a process measure is whether the patient got the appropriate antibiotic at the right time. Structural and process measures are valid only if there is direct connection between the measures and what is really important to the patient (their health outcome after treatment).

So far, however, outcome measures have been exceedingly difficult to develop. It is relatively easy to ascertain whether and at what time a patient received antibiotics and then assign accountability. Correction of any deficiencies is therefore under the provider’s control. However, there are a number of barriers when attempting to measure patient outcomes, including agreeing on the desired outcome, which may differ from patient to patient, as well as the large number of variables, including patient compliance, that may be out of the provider’s control. Most physicians do not want to be held accountable if patients fail to take their medication or do not keep their follow-up appointment.

### Accountable Care Organizations

Accountable Care Organizations (ACOs) are health care organizations that tie provider reimbursements to quality and cost metrics related to the total care of an assigned population of patients. Although there is considerable variability in the structure of ACOs, the incentives in this model are based on the shared-savings concept. If the providers in the ACO are able to deliver care for the assigned beneficiaries at a cost below an agreed-upon benchmark and realize certain quality goals, they get to keep a portion of the savings. ACOs are among the most well-known APMs and are considered by many as central components of payment and delivery reform.

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13. Robert H. Brook, Elizabeth A. McGlynn, and Paul D. Cleary, “Measuring Quality of Care,” *The New England Journal of Medicine*, Vol. 335, No. 13 (September 26, 1996), pp. 966–970, <http://www.nejm.org/toc/nejm/335/13/> (accessed March 1, 2016).
  14. Mark W. Friedberg et al., “Effects of Health Care Payment Models on Physician Practice in the United States,” RAND Corporation, 2015, [http://www.rand.org/pubs/research\\_reports/RR869.html](http://www.rand.org/pubs/research_reports/RR869.html) (accessed March 1, 2016).
  15. News release, “Promise of Value-Based Purchasing in Health Care Remains to Be Demonstrated,” RAND Corporation, March 4, 2015, <http://www.rand.org/news/press/2014/03/04.html> (accessed March 1, 2016).

Nonetheless, as shown by the early results, the ability of ACOs to generate savings to share with participants is so far not encouraging. According to data released by CMS, of the 333 ACOs participating in the Medicare Shared Savings Program (MSSP) in 2014, 72 percent failed to generate enough savings to earn a bonus payment. In fact, almost half of the MSSP ACOs ended up costing Medicare more than expected.<sup>16</sup> Furthermore, of the 23 ACOs that participated in the Pioneer ACO<sup>17</sup> program in 2013, only 11 earned any shared savings. The savings totaled about \$41 million, while 6 ACOs lost a total of \$25 million. The Pioneer ACO program began in 2012 with 32 participants. At least 13 have dropped out, citing weak incentives and overly stringent requirements. In 2014, 20 ACOs participated in the Pioneer program with only 11 generating enough savings to share, while three generated a total of \$9 million in shared losses.<sup>18</sup>

A recent study that looked at the performance of ACOs from a different vantage point reported that Pioneer ACOs were able to reduce the increase in per-beneficiary-per-month (PBPM) spending, compared to traditional Medicare, by \$35.62 in 2012 (first year) and \$11.18 in 2013 (second year) with similar scores on patient experience surveys.<sup>19</sup> This report is reason for some degree of cautious optimism, especially given how difficult it has been for prior demonstrations to produce savings. However, the results of the study also underscore major challenges that need to be addressed if ACOs are to be successful in the long term.

Of particular interest is the finding that the reduction in spending growth in the second year shrunk to roughly one-third of what it was in the first year. This may be the result of a turnover in providers and patients, or of spillover effects of

treating non-ACO patients, as the authors suggest. They also suggest a third possibility, however, claiming that the savings in the first year may not have been sustainable over time. This suggestion highlights a basic conceptual flaw present not only in ACOs, but also in shared-savings models in general. Even the most inefficient system has a finite amount of waste. Although it may be relatively easy to address “low hanging fruit” early on, achieving sustained savings over time will prove increasingly difficult, eventually reaching a point of diminishing returns.

### **Bundled (Episodic) Payments**

In the Bundled Payment (BP) model, a single payment is made for services delivered during an episode of care related to a medical condition or procedure and may include services delivered by multiple providers across various settings. Since this model covers only those services related to a single condition or procedure it can be thought of as lying somewhere between FFS, which pays for each individual service, and ACOs, which cover the totality of care delivered to a beneficiary during a defined period of time. Similar to shared savings models, if providers are able to deliver the covered services at lower than agreed upon costs with the same or better quality, they can benefit from the savings.

Whereas ACOs are primary care-based models and often have a difficult time engaging with specialists such as surgeons,<sup>20</sup> BP models can often be a better fit for the services provided by specialists. Although there are few data about the impact of BP models on quality, early results suggest that they may show some promise in terms of cost reduction. For example, results from the Medicare Acute Care Episode (ACE) demonstration, that bundled Part A

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16. Centers for Medicare and Medicaid Services, “Medicare Shared Savings Program Accountable Care Organizations Performance Year 2014 Results,” <https://data.cms.gov/ACO/Medicare-Shared-Savings-Program-Accountable-Care-O/ucce-hhpu> (accessed March 1, 2016).
  17. Pioneer ACOs are early adopters of coordinated care and tend to be more experienced, have an established care coordination infrastructure, and assume greater performance-based downside financial risk.
  18. News release, “Medicare ACOs Provide Improved Care While Slowing Cost Growth in 2014,” Centers for Medicare and Medicaid Services, August 25, 2015, <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-08-25.html> (accessed March 1, 2016).
  19. Daniel J. Nyweide et al., “Association of Pioneer Accountable Care Organizations vs Traditional Medicare Fee for Service with Spending, Utilization, and Patient Experience,” *The Journal of the American Medical Association*, Vol. 313, No. 21 (June 2, 2015), <http://jama.jamanetwork.com/article.aspx?articleid=2290608> (accessed March 1, 2016).
  20. James M. Dupree et al., “Attention to Surgeons and Surgical Care Is Largely Missing from Early Medicare Accountable Care Organizations,” *Health Affairs*, Vol. 33, No. 6 (June 2014), pp. 972-979, <http://content.healthaffairs.org/content/33/6/972.abstract> (accessed March 1, 2016).

(hospital) and Part B (physician) payments for certain cardiac surgery and orthopedic procedures found a reduction in costs per case of roughly \$2,000 over a two-year period.<sup>21</sup>

CMS is currently in the process of implementing the Bundled Payments for Care Improvement (BPCI) initiative, comprised of four broadly defined models of care that link payments for multiple services that beneficiaries receive during an episode of care. Under the initiative, organizations enter into payment arrangements that include financial and performance accountability for episodes of care. Participants can select up to 48 different clinical condition episodes based on an acute care hospital stay.<sup>22</sup> In addition to the BPCI, efforts are underway in several specialty areas, including oncology, cardiology, cardiothoracic surgery, and gastroenterology, to design BP models tailored to the services provided by those specialists.

Conceptually, BP models offer the promise of better care coordination, better quality, and lower costs, but the devil is in the details. Like other APMs, the lack of accurate cost data, a dearth of meaningful outcome measures, and the difficulty of deciding what services to include in the bundle present a challenge to model design. In spite of a high level of enthusiasm and effort, a recent initiative in California did not succeed in its goal of implementing a BP model for orthopedic procedures across multiple payers and hospital-physician partners. An evaluation of the pilot documented a number of barriers, such as administrative burden, state regulatory uncertainty, and disagreements about bundle definition and assumption of financial risk.<sup>23</sup>

There are also potential unintended consequences that need to be addressed if BP models are to be suc-

cessful. For one thing, if a bundle is financially attractive, there is nothing to prevent providers from simply delivering too many of them, perpetuating the problem inherent in FFS. Although the cost of each bundle may be reduced, without any volume control, overall spending may not go down. Without meaningful quality measures, BP models could run the risk of underuse of appropriate care services that may lead to poorer outcomes for patients. BP models also need accurate risk adjustment to avoid the exclusion of high-risk patients that may be more costly.

### Patient-Centered Medical Home

A 2010 definition of the Patient-Centered Medical Home (PCMH) by physician and consumer groups includes the following core principles: wide-ranging, team-based care; patient-centered orientation toward the whole person; care that is coordinated across all elements of the health care system and the patient's community; enhanced access to care that uses alternative methods of communication; and a systems-based approach to quality and safety.<sup>24</sup> Conceptually, this model is expected to result in better care coordination, better quality care, and cost reduction through, for example, reduction in emergency department visits and hospitalizations.

Although early limited evaluations and anecdotal experience with the PCMH model have suggested the promise of cost savings and higher patient and provider satisfaction,<sup>25</sup> a recent multi-payer medical home pilot, in which participating practices adopted new structural capabilities and received National Committee for Quality Assurance (NCQA) certification, was associated with limited improvements in quality and was not associated with reductions

21. "Episode Payment: Private Innovation and Opportunities for Medicare," conference report, Brandeis University, May 17, 2011, <http://healthforum.brandeis.edu/meetings/materials/2011-17-may/Final%20cr5-17-11.pdf> (accessed March 2, 2016).
22. News release, "Bundled Payments for Care Improvement (BPCI) Initiative: General Information," Center for Medicare and Medicaid Services, August 13, 2015, <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-08-13-2.html> (accessed March 1, 2016).
23. M. Susan Ridgely et al., "Bundled Payment Fails to Gain a Foothold in California: The Experience of the IHA Bundled Payment Demonstration," *Health Affairs*, Vol. 33, No. 8 (August 2014), pp. 1345-1352, <http://content.healthaffairs.org/content/33/8/1345.abstract?etoc&cited-by=yes&legid=healthaff;33/8/1345> (accessed March 1, 2016).
24. Sarah Hudson Scholle et al., "Engaging Patients and Families in the Medical Home," Mathematica Policy Research, Publication No. 10-0083-EF, June 2010, <https://pcmh.ahrq.gov/sites/default/files/attachments/Engaging%20Patients%20and%20Families%20in%20the%20Medical%20Home.pdf> (accessed March 1, 2016).
25. Robert J. Reid et al., "The Group Health Medical Home at Year Two: Cost Savings, Higher Patient Satisfaction, and Less Burnout for Providers," *Health Affairs*, Vol. 29, No. 5 (May 2010), pp. 835-843, <http://content.healthaffairs.org/content/29/5/835.full> (accessed March 1, 2016).

in utilization of hospital, emergency department, ambulatory care services, or total costs over three years.<sup>26</sup> Furthermore, an analysis of the transformation costs incurred by primary care practices participating in the pilot (median ongoing yearly costs associated with transformation were \$147,573 per practice) suggest that these expenditures create potentially prohibitive financial challenges for primary care practices, especially those that are small and independent.<sup>27</sup>

### Impact on the Practice of Medicine

Given the plethora of payment and delivery reform initiatives currently underway or in development, there is relatively little discussion about the long-term goal of payment reform or the impact of these initiatives on the practice of medicine. There at least two areas of particular concern: the administrative burden on physicians and the push toward greater consolidation.

**Burden on Practicing Physicians.** According to a 2014 Medscape Physician Lifestyle Report, nearly half (46 percent) of doctors report they felt burnout, up from 40 percent in the 2013 report. Other studies back up Medscape's findings that physician burnout is on the rise, and the reasons are familiar: administrative burdens, Electronic Medical Records (EMRs), as well as other technology-related office tasks, and too many hours spent at work. A large part of the administrative burden on physician practices comes from the multitude of reporting requirements they face.<sup>28</sup> Another burden on physicians is the amount of largely unhelpful data with which they contend. According to AMA President Steven J. Stack, although physicians are receptive to alternative care models, they face the paradox of having too

much data, yet there is a "dearth of accurate, actionable and timely information."<sup>29</sup>

A 2015 AMA/RAND study that looked at the effect of APMs on physician practices found that the overall quantity and intensity of physician work had increased because of growing patient volume expectations and that additional nonclinical work, particularly documentation requirements, created significant discontent.<sup>30</sup> Mark W. Friedberg, M.D., an internist and lead author of the study recently stated, "Physician practices need support and guidance to optimize the quantity and content of physician work under alternative payment models. Many [physicians] were very concerned about burnout to the extent that participating in an alternative payment model and requiring different work also added to the total amount of work that physicians were doing."<sup>31</sup> There were also concerns that APM participation would increase "busy work" at the expense of patient care.

**Consolidation and the Loss of Private Practice.** Another possible outcome of the added administrative burden and financial risk of participation in APMs is an increase in the already considerable trend toward practice consolidation. Small, independent practices are more likely to lack the resources to comply with the myriad of regulations and reporting requirements involved in APM participation. They are also less likely to be able to absorb the potential losses in a payment model that involves down-side financial risk.

Health care market consolidation has accelerated sharply in the past few years with the number of self-described independent practitioners drastically declining from 62 percent in 2008 to 35 percent in 2013, according to a survey of over 20,000 physi-

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26. Mark W. Friedberg et al., "Association Between Participation in a Multipayer Medical Home Intervention and Changes in Quality, Utilization, and Costs of Care," *The Journal of the American Medical Association*, Vol. 311, No. 8 (February 26, 2014), pp. 815-825, <http://jama.jamanetwork.com/article.aspx?articleid=1832540> (accessed March 1, 2016).
  27. Grant R. Martsolf et al., "Cost of Transformation among Primary Care Practices Participating in a Medical Home Pilot," *Journal of General Internal Medicine*, December 29, 2015, pp. 1-9, <http://link.springer.com/article/10.1007%2Fs11606-015-3553-6> (accessed March 1, 2016).
  28. Carol Peckham, "Medscape Physician Lifestyle Report 2015," *Medscape*, January 26, 2015, <http://www.medscape.com/features/slideshow/lifestyle/2015/public/overview#1> (accessed March 1, 2016).
  29. John Commins, "Data Swamps Docs, Slows Movement to Alternative Payments," *HealthLeaders Media*, March 20, 2015, <http://healthleadersmedia.com/content/PHY-314540/Data-Swamps-Docs-Slows-Movement-to-Alternative-Payments> (accessed March 1, 2016).
  30. Mark W. Friedberg et al., "Effects of Health Care Payment Models on Physician Practice in the United States," RAND Corporation, 2015, [http://www.rand.org/pubs/research\\_reports/RR869.html](http://www.rand.org/pubs/research_reports/RR869.html) (accessed March 1, 2016).
  31. Commins, "Data Swamps Docs."

cians.<sup>32</sup> Increased market consolidation is of particular concern, since market consolidation has been linked to increased health care costs and a decline in productivity among both hospitals and physicians. Specifically, a study from the National Bureau of Economic Research observed that an increase in hospital market concentration leads to an increase in the cost of hospital care.<sup>33</sup> Furthermore, according to a recent Medical Group Management Association study, when doctors abandon private practice to become a hospital employee, their productivity falls by more than 25 percent on average.<sup>34</sup>

### Physician Payment Reform: A Way Forward

Given the considerable individual efforts to design, develop, and implement alternative payment models, there is surprisingly little discussion about the overarching goal of payment reform. Ideally, payment reform should support the transformation to a health care system where patients receive high-quality, efficient care that meets their personal health care needs and providers should have the option of providing that care in whatever practice arrangement they choose, as long as they can demonstrate that they are providing high-quality health care with the most efficient use of limited resources.

It is obvious that, given the diversity of the current U.S. health care system, a one-size-fits-all approach to payment reform is not appropriate. In addition, proceeding with payment reform without the necessary infrastructure, such as meaningful performance measures and sufficient access to appropriate payment models, will not achieve the goal and will likely be counterproductive in the long run.

The pursuit of better value in health care is a laudable goal and should continue. However, as payment reform moves beyond SGR, special attention will need to be given to how the reforms are implemented. The Administration's timeline

regarding value-based payments and the expanded use of APMs comes with very little detail on the process of how those goals will be realized, making it difficult to comment, other than to say that, given the current state of payment and delivery reform, it is likely to be overly aggressive. How CMS will interpret and implement the MACRA legislation remains unknown. The ongoing pursuit of payment and delivery reform, including the implementation of MACRA, should be guided by the following principles:

**Performance Measurement Needs to be Meaningful.** Given the current gaps in performance measurement, the poor track record with P4P programs and the considerable administrative burden that physicians already face, CMS should start with a small, easily reportable, specialty-specific core set of performance measures to meet the MIPS requirements and build from there. Furthermore, the measures should be developed and vetted by the appropriate specialty organizations. In order to ensure that the measures will lead to better care for the patients they treat, providers should have maximum flexibility in choosing the metrics by which they will be assessed.

MACRA stipulates that the quality measures in an APM be "comparable" to the quality measures in the MIPS program. However, for CMS to interpret the term "comparable" to mean "the same" would be overly prescriptive and inappropriate. One of the more powerful incentives for providers to participate in APMs is the exemption from the complex performance measurement process of MIPS. Requiring providers in APMs to make substantial changes to the way they practice, assume financial risk, and be subject to the same rigorous and burdensome measurement process in MIPS would discourage APM development and participation and would be contrary to the intent of the legislation.

**Alternative Payment Models Should Be Sufficient in Number and Variety.** According to the

32. The Physicians Foundation, *2014 Survey of America's Physicians: Practice Patterns and Perspectives*, September 2014, [http://www.physiciansfoundation.org/uploads/default/2014\\_Physicians\\_Foundation\\_Biennial\\_Physician\\_Survey\\_Report.pdf](http://www.physiciansfoundation.org/uploads/default/2014_Physicians_Foundation_Biennial_Physician_Survey_Report.pdf) (accessed March 1, 2016).

33. Jean M. Abraham, et al., "Entry and Competition in Local Hospital Markets," National Bureau of Economic Research *Working Paper* No. 11649, September 2005, <http://www.nber.org/papers/w11649.pdf> (accessed March 11, 2016).

34. Medical Group Management Association, "Trends in Physician-Hospital Alignment since the Passage of Health Care Reform of 2010," ACMPE Fellow Paper, 2013, <http://www.mgma.com/practice-resources/articles/fellow-papers/2013/trends-in-physician-hospital-alignment-since-the-p> (accessed March 1, 2016).

language in MACRA, CMS is under no obligation to implement any PF-APMs, even if they are favorably reported by the PTAC, and so far, CMS has made no clarifying statement in this regard. Whether or not CMS is willing to implement well-designed PF-APMs will largely determine the success or failure of MACRA in terms of fulfilling the promise of meaningful payment and delivery reform. It should be recognized that CMS, as a federal organization with finite resources may find it more manageable to administrate and oversee a few models that they have had a substantial role in designing. However, if CMS is unwilling to implement truly innovative payment models, providers will be left with the option of *fitting* into one of the existing models, none of which, as discussed above, has shown considerable promise so far.

CMS should be willing to implement any well designed PF-APM that meets the minimum requirements and is favorably reported by the PTAC. Furthermore, there needs to be a well-defined, streamlined process from proposal to implementation. Using the complex and burdensome process now used by CMMI will stifle reform and will result in a majority of providers not having access to an appropriate APM by 2019.

**The Degree of Financial Risk in APMs Should Be Reasonable.** Assumption of financial risk by physicians and other providers is relevant only if it serves to incentivize the delivery of high-quality, efficient health care. In its requirements for an eligible PF-APM, MACRA states that financial risk is “in excess of a nominal amount.” As payment models develop, CMS should require only the minimum financial risk and the definition should be broadly interpreted. Harold Miller has suggested that “more than nominal financial risk” should mean no more than 4 percent in 2019, increasing to 5 percent in 2020, 7 percent in 2021, and 9 percent in the year 2022, since these are the maximum percentage adjustments in payment under MIPS in those years.<sup>35</sup> This is a reasonable approach.

However, the definition of financial risk should not be limited to a shared savings model. Whether a physician is rewarded or penalized should not be

based solely on the costs to the Medicare program for the services they provide through the model. Any costs incurred by a physician practice in setting up the model (e.g., hiring of additional personnel, extended hours of access, costs of quality reporting or other infrastructure) should be included in the financial-risk calculation.

**Administrative Burden Should Be Minimal with Special Attention to Small Independent Practices.** Given the already heavy load of non-clinical work that takes up as much as one-sixth of working hours and contributes to career dissatisfaction among U.S. doctors,<sup>36</sup> the processes involved in drafting, submitting, revising, and implementing proposals for PF-APMs should be as streamlined as possible and involve the minimum administrative burden on physicians. Otherwise, many physicians, especially those in small, independent practices, will be limited in their access to an appropriate APM.

To its credit, MACRA provides for technical assistance, with \$20 million in annual funding for years 2016–2020 to help small practices (15 or fewer professionals) and practices in rural and health-professional-shortage areas deal with the demands of the MIPS program and help remove barriers to participation in APMs.

In addition to its role in evaluating and recommending PF-APM proposals to CMS, the PTAC should function as a true advisory committee. Applicants should not have to wait for a “yes” or “no” decision on their proposal; rather, the PTAC should assist applicants throughout the proposal process, making suggestions on how the proposal could be improved to increase the chance of success. CMS should also provide support especially with access and management of data to small independent practices which would otherwise have no option but to join a large organization, adding to the already considerable consolidation in health care.

## Conclusion

Although the passage of MACRA was a significant legislative event, it is the implementation of MACRA,

35. Harold D. Miller, “Implementing Alternative Payment Models Under MACRA: How the Federal Government Can Accelerate Successful Health Care Payment Reform,” Center for Healthcare Quality and Payment Reform, <http://www.CHQPR.org/downloads/ImplementingAPMsUnderMACRA.pdf> (accessed March 1, 2016).

36. Steffie Woolhandler and David U. Himmelstein, “Administrative Work Consumes One-Sixth of U.S. Physicians’ Working Hours and Lowers Their Career Satisfaction,” *International Journal of Health Services*, Vol. 44, No. 4 (2014), pp. 635–642.

along with other health care payment and delivery reforms, that will profoundly shape the future health care system in the U.S.

In addition, without more detail, the Secretary's timeline seems inappropriate and is likely to limit physician choice and be potentially harmful to efforts at lasting payment reform. It seems likely that the coming era in health reform will include an increasing reliance on performance measurement as well as a concerted effort to find new and even novel payment and delivery models to replace some or all of the traditional FFS system. While some physicians have elected to participate in new delivery models such as Accountable Care Organizations, many are dubious about the benefits of these models and do not believe they will achieve cost or quality gains.<sup>37</sup>

The basic premise of payment reform should be that doctors are able to choose the payment system and practice arrangement that best suits their practice, as long as they provide high-quality, patient-centered health care with the most efficient use of limited resources. MACRA, if not implemented correctly, could result in forcing physicians to choose between being reimbursed through an overly burdensome pay-for-performance program or participation in impractical alternative payment models that are likely to be both professionally and financially unrewarding. However, if implemented carefully and correctly, MACRA has the potential to move gradually toward a payment and delivery system that will allow physicians the choice of how they practice while providing the opportunity to choose how to meaningfully measure the value of their care.

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37. Physicians Foundation, 2014 Survey of America's Physicians: Practice Patterns and Perspectives.