CHAPTER 2

Medicare's new framework for paying clinicians

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Chapter summary

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repealed the sustainable growth rate (SGR) system and established a new approach to updating payments to clinicians. This approach incentivizes clinicians to participate in alternative payment models (APMs). Examples of APMs could be accountable care organizations, bundled payment models, and medical homes. MACRA establishes specific criteria for "eligible alternative payment entities," which operate under one of these APMs. Essentially, MACRA establishes two paths for payment updates—a path for clinicians who participate in eligible alternative payment entities and a path for all other clinicians.

Beginning in 2019 and continuing through 2024, clinicians will receive a 5 percent incentive payment if the level of revenue they receive through eligible alternative payment entities meets a certain threshold. In 2025, there will be no update and no incentive payments, and from 2026 on, clinicians meeting the revenue threshold will receive a higher update than clinicians who do not meet that threshold. Thus, how CMS defines eligible alternative payment entities and how clinicians qualify for the incentive payment are of great interest to clinicians.

For clinicians who do not qualify for the APM incentive payment, a separate program exists for assessing clinicians on their performance—the Merit-based Incentive Payment System (MIPS). Performance on MIPS will determine

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whether clinicians receive a bonus or a penalty on their fee-for-service (FFS) payments. Although budget neutral in aggregate, these bonuses and penalties could have a large effect on payments for individual clinicians and hence on the attractiveness of the APM and MIPS paths.

In this chapter, we present the Commission's principles concerning the APM provisions and discuss some key considerations for the design of MIPS. The principles for the APM provisions are meant to inform the debate on how APMs should be defined in regulation and, more broadly, how APMs should function in the quest both to improve quality and to contain costs for beneficiaries and the taxpayers who support Medicare. These principles help further shape a program aimed at controlling costs and improving quality in Medicare. For MIPS, we outline some lessons that can be learned from CMS's experience with the existing performance incentive programs that may be incorporated into the eventual MIPS program, and we seek to reinforce the Commission's position that quality measures should emphasize population-based outcomes. Finally, we conclude with observations on the importance of coordinating MIPS and APM implementation to reduce the chance of unintended consequences for the Medicare program, its beneficiaries, and taxpayers.

The following are the Commission's basic principles for APMs:

- Clinicians should receive an incentive payment only if the eligible alternative payment entity in which they participate is successful in controlling cost, improving quality, or both.
- The eligible alternative payment entity should be at financial risk for total Part A and Part B spending.
- The eligible alternative payment entity should be responsible for a beneficiary population sufficiently large to detect changes in spending and quality.
- The eligible alternative payment entity should have the ability to share savings with beneficiaries.
- CMS should give eligible alternative payment entities certain regulatory relief.
- Each eligible alternative payment entity should assume financial risk and enroll clinicians.

Given the principles above, certain implementation issues are expected to arise because APMs will continue to function for the foreseeable future in a largely FFS environment with beneficiaries free to move among providers. These implementation issues include the definition of the statutory term *risk beyond a nominal amount* and attribution of beneficiaries to eligible alternative payment entities. This discussion of MIPS addresses how to consider factors such as quality

and resource use at the individual clinician level. Finally, there will be an issue of how to balance MIPS and APM incentives. In developing and implementing these programs, the broader challenge will be to further the sustainability of the Medicare program and ensure access to services for Medicare beneficiaries. The Commission intends its discussion of the principles and issues in this chapter to help provide a road map for thinking through the complex issues raised by MACRA and to help move the Medicare program from one oriented toward FFS payment to one that encourages delivery system reform oriented toward payment for value. ■

Introduction

Medicare pays physicians and other health professionals providing care to Medicare beneficiaries using a fee schedule under Part B of the program. In 2013, Medicare paid over $68.6 billion to 876,000 professionals, including 573,000 physicians and 303,000 nurse practitioners, physician assistants, therapists, chiropractors, and other practitioners.

On the one hand, Medicare's fee schedule is incredibly complex, comprising over 7,000 services and their respective payment rates that can further vary based on where the service is provided and the circumstances under which it is provided. On the other hand, the fee schedule is simple in that each of the 7,000 payment codes corresponds to a set fee, and the clinician is paid for each code. Increasing the volume of services, therefore, increases payment. Under this structure, payments increased, with growth in real (that is, adjusted for inflation) spending per beneficiary for physician services averaging 2.4 percent from 1991 to 1998 (Medicare Payment Advisory Commission 2001).

To control the increase in spending for services covered under Medicare's fee schedule for clinicians, the Congress created the sustainable growth rate (SGR) system in 1997. The SGR was meant to control the growth of fee schedule spending by making the conversion factor update (that is, the percentage amount by which the rates in the fee schedule are increased or decreased each year) subject to a limit determined by a formula tied to the gross domestic product and other factors. After positive updates in its first two years, the SGR system resulted in a negative update in 2002 and continued to do so for the rest of its existence. The Congress overrode the negative update in 2003 and every year thereafter, but this created ever-larger negative updates because of the way the SGR system operated and the mechanism of the overrides, thus making the system difficult and costly to repeal.

From a Medicare spending control aspect, the SGR had two major limitations. First, it addressed only clinician spending, not Medicare spending in total. Second, it acted as a blunt instrument, reducing fee updates across the board, regardless of which clinicians were responsible for high spending levels. Thus, there was no connection between an individual clinician's behavior and the resulting reward or penalty. In fact, some service categories grew far more rapidly than others over the SGR's 15-year existence, yet the annual updates were uniform across all specialties (Medicare Payment Advisory Commission 2016).

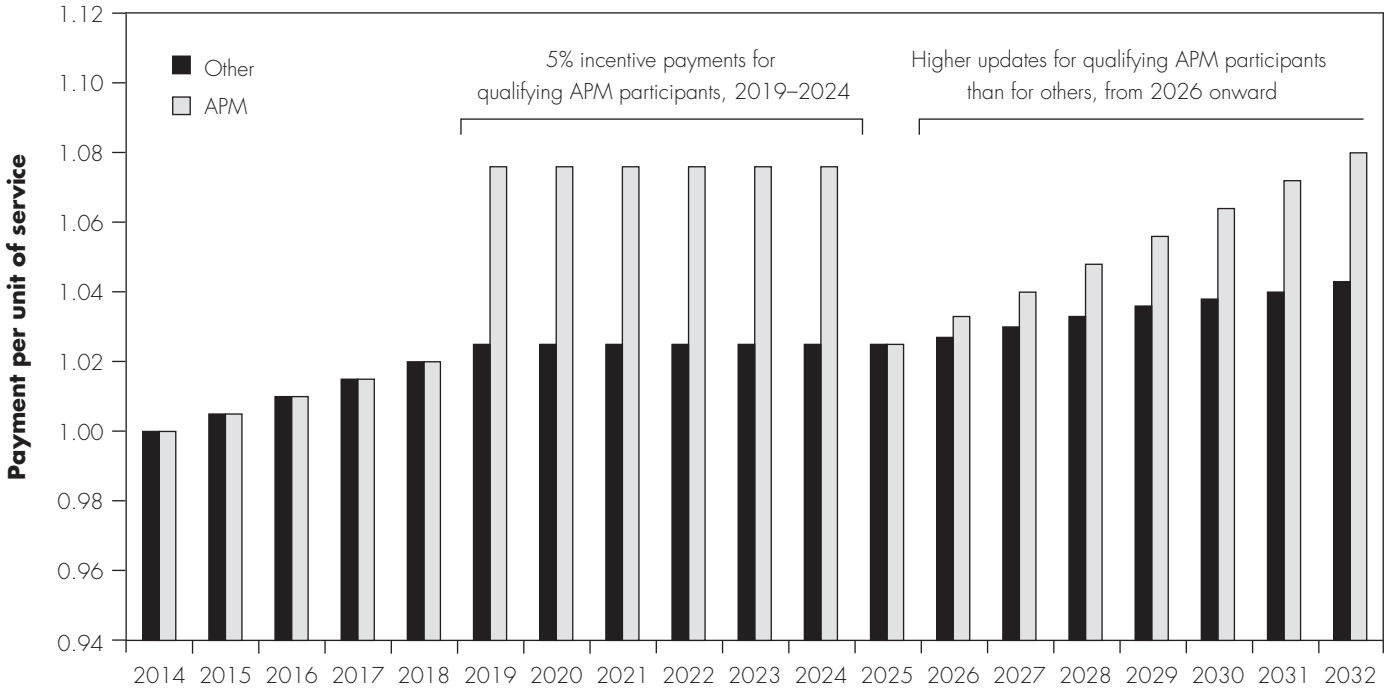
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repealed the SGR system and established a new approach to updating payments to clinicians. Rather than use a formula, MACRA specified the clinician fee schedule update each year. Specifically, the updates are 0.5 percent each year for 2016, 2017, and 2018; zero for 2019 through 2025; and either 0.75 percent or 0.25 percent from 2026 on. However, Medicare's payments to clinicians will follow two separate paths—a path for clinicians who participate in eligible alternative payment entities (EAPEs) (the alternative payment model (APM) path) and a path for all other clinicians.

In 2019 through 2024, clinicians participating in an APM will receive a 5 percent incentive payment if they have a sufficient share of revenue coming through one or more EAPEs. From 2026 on, clinicians meeting the threshold criterion for participation in EAPEs will receive a higher update than clinicians who do not meet that criterion. (There is no update and no incentive payment in 2025 for anyone.) Thus, how eligible alternative payment entities are defined and how clinicians qualify for the incentive payment are very important policy decisions.

For clinicians who do not qualify for the APM incentive payment, a separate program—the Merit-based Incentive Payment System (MIPS)—exists for assessing clinicians on their performance in four areas: quality, resource use, meaningful use of certified electronic health records, and clinical practice improvement activities. Clinician performance relative to others in MIPS will determine whether clinicians receive a bonus or a penalty on their fee-for-service (FFS) payments. Although budget neutral in aggregate, these bonuses and penalties could have a large effect on payments for individual clinicians and hence on the relative attractiveness of the APM versus MIPS paths.[1]

The SGR was designed to control Medicare spending under the fee schedule by adjusting conversion factor updates. MACRA has some elements that could potentially serve to control spending. Specifically, the updates in MACRA are slightly lower than recent updates, and MACRA includes elements in APMs and MIPS designed to help address two of the SGR's limitations. First, eligible alternative payment entities must bear some financial risk for spending, which might help limit spending growth. Second, MIPS has a resource use component, and individual clinicians get bonuses and

FIGURE 2–1 **Illustrative update path for qualifying APM participants and all other clinicians**



Note: APM (alternative payment model). The figure shows a stylized example in which the provider received 1.0 payment per unit of service in 2014.

penalties in direct relation to their performance. The principles we propose for APMs and MIPS are designed to make these indirect spending controls as effective as possible.

Statutory provisions for clinician payment in MACRA

MACRA repealed the SGR and in its place set statutory updates for the fee schedule, set broad parameters for how participation in APMs affects a clinician's payment, and established MIPS for clinicians not eligible for the APM incentive payment.

Updates set in law

The statutory update in MACRA for all clinicians billing Medicare through the fee schedule was 0.5 percent in July 2015 and January 2016.[2] The update in January 2017, 2018, and 2019 will also be 0.5 percent. Beginning in 2019, clinicians who meet the criteria set out in the law as qualifying APM participants will receive an incentive payment of 5 percent of their fee schedule payments for each year that they qualify through 2024. The incentive payment will be distributed as a lump sum each year. Qualifying APM participants will also receive a higher yearly update (0.75 percent) than others (0.25 percent) in 2026 and later years. Figure 2-1 illustrates that Medicare payments to qualifying APM participants per unit of service will decline between 2024 and 2025.

Provisions for alternative payment models and eligible alternative payment entities

MACRA establishes criteria for how eligible alternative payment entities are defined and how a clinician becomes a qualifying participant (see text box for a definition of terms). For each year that an incentive payment or higher update is possible, clinicians must qualify anew as participating in an eligible alternative payment entity. For example, a physician could qualify in 2019 and receive a 5

Definitions of key terms

Alternative payment model (APM): APMs are defined by statute as all models in the Center for Medicare & Medicaid Innovation (CMMI) (except Innovation Awards), Medicare demonstration authority through Section 1866C of the Social Security Act, the Medicare Shared Savings Program, or a demonstration required by law.

Eligible alternative payment entity (EAPE): An entity that operates under an APM that meets three criteria: (1) the model requires use of certified electronic health record technology; (2) the model makes payment based on a set of quality measures comparable with the Merit-based Incentive Payment System; and (3) the model requires the entity to bear financial risk for monetary losses under such alternative payment model in excess of a nominal amount or be a medical home expanded under Section 1115A(c).

Qualifying APM participant: A clinician who has a minimum share of his or her professional services revenue (or patients) coming through an EAPE.[3] The numerical share is set in statute and rises each year. Qualifying APM participants receive the APM incentive payment.

APM incentive payment: A 5 percent incentive payment (applied to the clinician's Medicare fee-for-service professional payments from the previous year) from 2019 to 2024 paid directly from the Medicare program to clinicians who are qualifying APM participants. ■

percent incentive payment but not qualify in the next four years and receive no incentive payment and a zero update.

From 2026 onward, the incentive for clinicians to participate in an APM is a higher update, not the 5 percent incentive payment. A clinician must meet the qualifying APM participant criteria yearly to receive the higher update. The differential payment updates from 2026 into the future also compound, so CMS will have to develop an individual-level update based on whether the clinician received the higher update in prior years. In other words, if a clinician qualifies for the higher update in 2026 but not thereafter, he or she would have a different payment rate than the clinician who qualifies in multiple years. Each clinician's update history from 2026 onward has to be known to determine his or her payment rate in the succeeding years. This process could be difficult for CMS to implement and for clinicians to understand.

Eligible alternative payment entities will be a subset of all entities participating in APMs

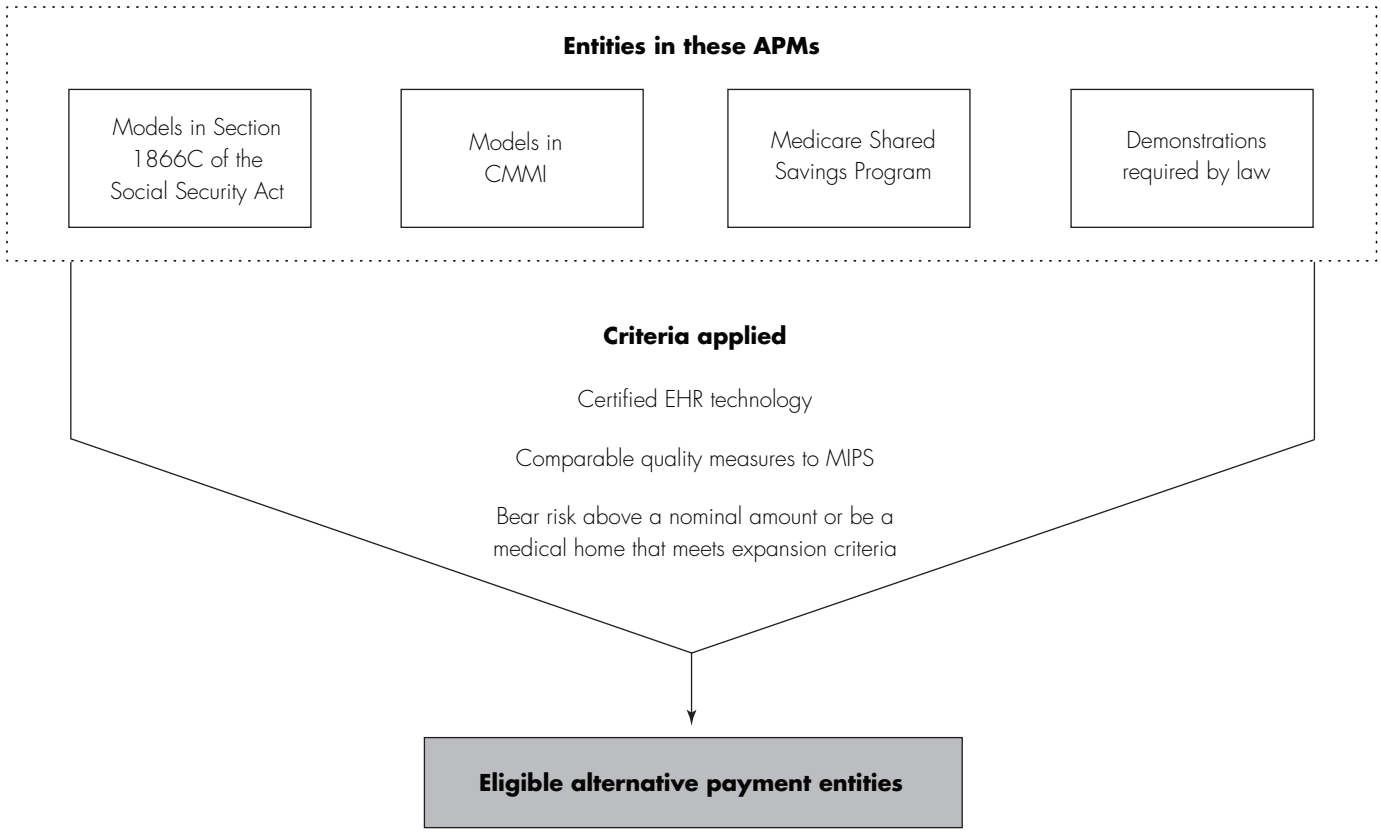
The pool of APMs under MACRA includes all models in the Center for Medicare & Medicaid Innovation (CMMI) (except for Innovation Awards), models in Section 1866C of the Social Security Act (the Health Care Quality Demonstration), the Medicare Shared Savings Program (MSSP), and demonstrations required by law.

Currently, CMMI runs approximately 60 separate models in 7 categories: accountable care, episode-based payment initiatives, primary care transformation, initiatives focused on Medicaid and the Children's Health Insurance Program, initiatives focused on dual-eligible beneficiaries, initiatives focused on accelerating new payment and delivery models, and initiatives to speed the adoption of best practices. In addition, the Medicare Shared Savings Program, which is part of permanent Medicare law, is also considered an APM.

MACRA sets certain criteria for this group of *all* APMs and then defines a subgroup of them as *eligible*. The law makes a further distinction to define the *entities* that operate under these eligible alternative payment models—referred to as EAPEs. EAPEs must participate in an APM that:

- requires use of certified electronic health record (EHR) technology,
- provides for payment based on quality measures comparable to MIPS, and
- requires the entity to bear financial risk above a nominal amount or be a medical home meeting the expansion criteria (see text box, pp. 38–39).

FIGURE 2–2 **Eligible alternative payment entities will be a subset of entities participating in APMs**



Note: APM (alternative payment model), CMMI (Center for Medicare & Medicaid Innovation), EHR (electronic health record), MIPS (Merit-based Incentive Payment System). Models in Section 1866C of the Social Security Act refer to the Health Care Quality Demonstration Program. All CMMI models are APMs except for models under the Innovation Awards. The Medicare Shared Savings Program is a part of permanent Medicare law.

An illustrative example may be useful. Consider an APM that is a risk-bearing accountable care organization (ACO) model. Posit that this particular model requires ACOs under the model to do the three things that correspond to MACRA's statutory language: have certified EHR technology, make payment based on quality measures comparable to MIPS, and bear financial risk above a nominal amount. Then, any ACO in this specific model would be an EAPE, and the clinicians who participate in the ACOs in this model could, if their revenue met the criteria (discussed next), qualify for the APM incentive payment.[4] The clinicians in the EAPE would receive the APM incentive payment as a lump sum, sent directly to them from the Medicare program.

A key point is that the statute strictly limits EAPEs to only those that meet the three criteria (Figure 2-2). Although many entities operate under APMs, very few will be EAPEs under the statutory definition because the models under which they operate often do not meet the three criteria set out in law (see online Appendix 2-A, available at http://www.medpac.gov, for a discussion of the number of beneficiaries currently in APMs).

Another mechanism for the development of APMs is through the Physician-Focused Payment Model Technical Advisory Committee (PTAC) established by MACRA. This panel could develop or approve models and submit them to the Secretary of Health and Human Services for consideration. The PTAC was chartered in January 2016, and the Secretary has a statutory deadline of November 1, 2016, to establish criteria for physician-focused payment models that could be used by the PTAC in their review of

models. Any models reviewed by PTAC would be tested by CMMI to be considered an APM.

Clinicians become qualifying APM participants based on meeting a specified threshold

MACRA specifies how a clinician becomes a qualifying APM participant. Qualification can be based on the clinician's Medicare FFS payment or the share of Medicare patients in a Medicare EAPE, and in later years, the share of payment or patients in EAPEs from all payers combined (Medicare and other payers). To start with, a qualifying APM participant must have at least a minimum share of his or her Medicare FFS professional services payments coming through an EAPE. This criterion allows the clinician to receive the 5 percent APM incentive payment. CMS may also make this determination based on the share of beneficiaries coming through the EAPE instead of the share of payments. This criterion could allow more (or different) clinicians to qualify.

The minimum share is set in statute and increases over time. In 2019 and 2020, clinicians must have at least 25 percent of their FFS payment coming through an EAPE, 50 percent in 2021 and 2022, and 75 percent in 2023 and later. If a clinician meets the threshold, he or she receives a 5 percent incentive payment for that year, regardless of whether the EAPE is successful at lowering spending or improving quality. In addition, the incentive payment is applied to all the clinician's professional services paid by FFS Medicare, irrespective of the amount of Medicare payment associated with the EAPE.

Clinicians with revenue from Medicare Advantage (MA) cannot count their MA revenue in the Medicare FFS EAPE determination. CMS is required by the statute to submit a study to the Congress that "examines the feasibility of integrating alternative payment models in the Medicare Advantage payment system…[and] shall include the feasibility of including a value-based modifier and whether such modifier should be budget neutral." This study is due June 2016.

MACRA establishes an alternative calculation for clinicians who do not meet the criteria for qualifying participants in EAPEs based solely on their Medicare FFS payment. This all-payer calculation starts in 2021. Consider the following example: A clinician participates in an EAPE, does not meet the Medicare revenue threshold for being a qualifying participant based on his or her Medicare FFS revenue alone, but has a significant share of revenue from a private insurer. CMS could certify that the relationship between the private insurer and the clinician meets the requirements for an EAPE under the statutory definition. With this certification, the clinician could add the revenue from the private insurer to his or her Medicare revenue to see whether the individual meets the threshold when all revenues from EAPEs are taken into account. Under this all-payer variant, the clinician would need to provide CMS with information on the nature of his or her contract with the payer so that CMS could determine whether it met the EAPE criteria.[5] There are also rules for partial-year qualifying APM participants.[6]

The APM incentive payment applies to all of a clinician's FFS revenue

The 5 percent incentive payment is applied to all of the clinician's prior-year professional services billed under the Medicare fee schedule (not just the share of revenue coming through any EAPE). The APM incentive payment is paid separately from regular fee schedule services as a lump sum directly from the Medicare program to the clinician. The APM incentive payment is not counted as spending for the purposes of computing savings (or losses) for ACOs or other shared savings models. It also is not counted as spending for the next year's incentive payment calculation. If clinicians are in an EAPE that does not use FFS payment (e.g., if an ACO receives a partially capitated payment from Medicare and the clinician is not paid FFS), CMS is directed to establish processes for making APM incentive payments to those clinicians.[7]

The Merit-based Incentive Payment System

Under MACRA, clinicians who are not qualifying APM participants are subject to payment adjustments under the Merit-based Incentive Payment System (MIPS). MIPS consolidates three existing payment adjustment programs for clinicians: the Physician Quality Reporting System (PQRS), the value-based payment modifier (also called the value modifier (VM)), and the payment adjustment for the meaningful use of EHRs (see text box, pp. 42–43). MACRA continues these separate payment adjustments through 2018 and then repeals the individual payment adjustments and establishes the MIPS to take effect in 2019.

The medical home provision

Under the statutory definition of eligible alternative payment entities, medical homes do not need to meet the financial risk criterion if the model is certified for national expansion by CMS's Office of the Actuary. Whether this policy is executed will depend on the performance of the medical home models currently under way.

The expansion criterion referenced in the Medicare Access and CHIP Reauthorization Act of 2015 is the statutory authority given to CMS in the Center for Medicare & Medicaid Innovation (CMMI) authorizing statute. Under this authority, the Secretary of Health and Human Services may, based on the results from the independent evaluations mandated for each CMMI project, expand the "duration or scope" of a model (including nationally) if it would reduce spending without harming the quality of care or would improve quality (without increasing spending). CMS's Office of the Actuary must certify that the expansion of the model would not increase spending. The set of CMMI models that could be considered medical homes falls in the category description of "primary care transformation," under which nine models are currently listed. Three models are no longer active (the Federally Qualified Health Center Advanced Primary Care Practice Demonstration, the Frontier Extended Stay Clinic Demonstration, and the Medicare Coordinated Care Demonstration); one model is in development (Advanced Primary Care Initiatives); and the Transforming Clinical Practices Initiative is a quality improvement initiative, not a payment model. Another model listed (the Graduate Nurse Education Demonstration) entails providing resources for hospitals to train clinical nursing staff and is not therefore a medical home model. The four remaining models are as follows:

- ***Comprehensive Primary Care Initiative (CPCI)***—CPCI operates in seven regions and consists of financial support to eligible primary care practices to help them advance in five areas: risk stratification, access and continuity, care planning, patient engagement, and coordination. The payment model includes a monthly care management fee plus shared savings and includes participation by other payers. In evaluations of the first two years, spending for attributed beneficiaries was lower than expected in the first year, and no significant difference in the second. In neither year were reductions sufficient to recoup the cost of the care management fees, so in total the program increased Medicare spending. There were few changes in quality (Taylor et al. 2015). CPCI is scheduled to end in December 2016.

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MIPS will assign a composite score to each clinician that will determine how much the clinician's payment rate is increased or decreased from the base amount. The basic MIPS adjustments are budget neutral. The maximum *negative* MIPS adjustment factors are set in statute: 4 percent in 2019; 5 percent in 2020; 7 percent in 2021; and 9 percent in 2022 and subsequent years. The maximum *positive* adjustment may be larger than these figures for two reasons. First, the adjustment factors can be scaled up or down to achieve budget neutrality for the basic MIPS adjustment. Second, MACRA appropriated an additional $500 million a year for exceptional performance, defined as the quartile of performance above the performance threshold.

MIPS, effective 2019, applies to clinicians who do not qualify as APM participants. Under MIPS, upward and downward payment adjustments would apply based on the clinician's performance in four areas: quality, resource use, clinical practice improvement activities, and meaningful use of EHR. The legislation allows CMS to retain the measurement process for PQRS, EHR, and VM for use in MIPS, but merges the individual adjustments into the one MIPS adjustment. The clinician's composite score will reflect the weighted performance in the four areas; once phased in, quality and resource use will make up 30 percent each, clinical practice improvement activities will account for 15 percent, and EHR meaningful use will be 25 percent.[8]

The medical home provision (cont.)

- ***Comprehensive Primary Care Plus (CPC+)***—This newly announced model will replace the existing CPCI model and is scheduled to run from January 2017 through 2021. It uses largely the same framework as CPCI for primary care practices to achieve milestones in five areas. The payment model will continue to include a monthly care management fee for attributed beneficiaries and will include an at-risk performance fee and an option for practices to receive partial capitation.
- ***Independence at Home (IAH)***—Under the IAH Demonstration (mandated by law in the Patient Protection and Affordable Care Act of 2010 and subsequently extended by the Congress), participating practices that focus on home-based primary care can receive shared savings for their attributed beneficiaries. Under current law, Medicare covers home visits by Medicare clinicians. The IAH Demonstration extends a shared savings opportunity to practices. Under the statute, the number of IAH participants is capped. CMS has not released an evaluation of IAH to date, although it did issue a press release citing first-year shared savings results: 9 of 17 practices received shared savings payments, and all 17 practices improved quality for at least 3 of 6 quality measures (Centers for Medicare & Medicaid Services 2015c).
- ***Multi-payer advanced primary care practice (MAPCP)***—Under the MAPCP, CMS joined seven states in making enhanced primary care payments to practices that have characteristics of the patient-centered medical home. States established requirements for participation and add-on payment amounts. After the first year, there was no significant difference from expected program spending for beneficiaries treated in MAPCP practices, although one part of Vermont's initiative did have statistically significant savings. Performance across states varied, with the evaluators concluding that two states (of eight) reduced the rate of spending growth below trend. Evidence regarding quality improvements or utilization reduction was also mixed or not evident (McCall et al. 2015).

The Department of Health and Human Services has not promulgated rules to date to expand any of the medical home models under the CMMI authority. Two of the models (CPCI and MAPCP) would not meet the criteria for expansion in current law based on their results to date, and CMS has not released an independent evaluation of the third (the IAH Demonstration). Therefore, in developing our thinking regarding alternative payment model policy, we have focused on an accountable care–type model instead of a medical home model. ■

The category of clinical practice improvement activities must include the following: expanded practice access, population management, care coordination, beneficiary engagement, patient safety and practice assessment, and participation in an APM. It can also include other activities to be defined in regulation. The Secretary may vary the weights based on relevance to the clinician's specialty.

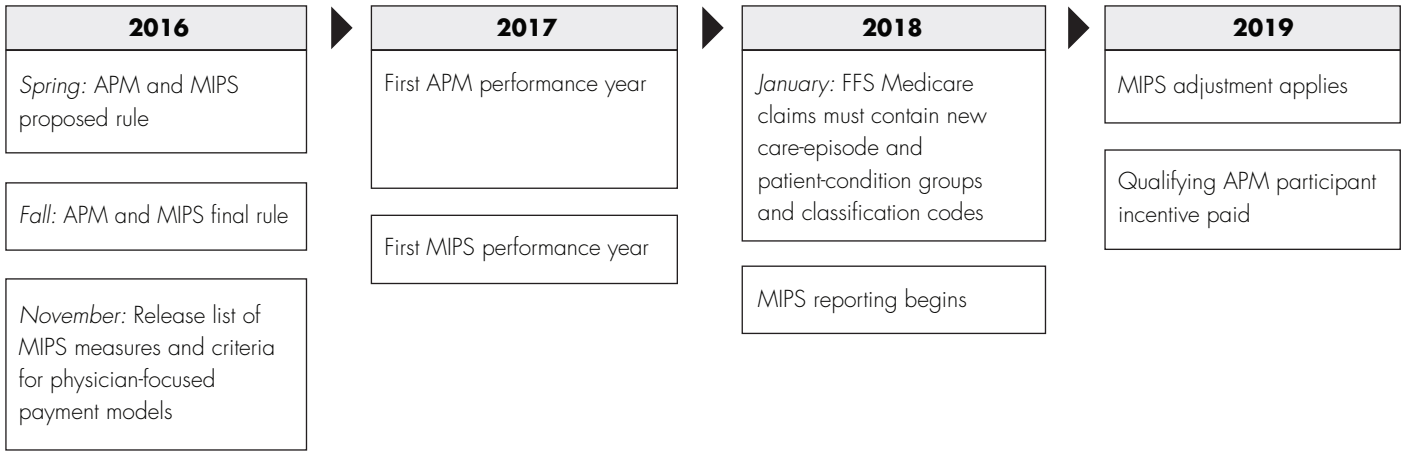
The performance standards in each area will be established by the Secretary and will be based on historical performance, improvement, and opportunity for continued improvement. Each clinician receives a MIPS adjustment factor based on his or her composite performance in all four areas.

The Secretary retains discretion to modify some of the policies regarding the MIPS program—developing options for virtual group assessment, using EHR or clinical registries to collect performance measures, and developing a feedback program to assist clinicians. The Secretary can establish a process for informal review of clinicians' MIPS scores, but the scores are not subject to appeal.

Time frame and linkage between APM and MIPS

CMS faces an expedited time frame for issuing guidance and setting rules for MACRA implementation (Figure 2-3, p. 40). To date, the agency has discussed MACRA in a Request for Information in October 2015, the physician

FIGURE 2–3 **Projected APM and MIPS development time frame for 2019 payment year**



Note: APM (alternative payment model), MIPS (Merit-based Incentive Payment System), FFS (fee-for-service). Dates are illustrative, based on current CMS process and statutory deadlines. The new codes required on claims are to identify the particular relationship that the clinician has to the patient.

fee schedule rule for 2016 (issued in November 2015), and a proposed rule published May 9 (Centers for Medicare & Medicaid Services 2016, Centers for Medicare & Medicaid Services 2015d).

The time line also highlights the choice that clinicians face. Importantly, MIPS is the default option not only at the beginning of the process but also throughout the years leading up to the payment year.

As shown in Figure 2-4, clinicians could participate in an APM, such as an ACO or a medical home. The entity in which the clinician participates could be an EAPE. However, even if the clinician is in an EAPE, he or she may not have sufficient revenue or beneficiaries coming through the entity to be a qualifying APM participant. The determination of whether a clinician is a "qualifying participant" is made anew each year as the clinician's circumstances and the thresholds change. If the clinician is in an APM that is not determined to be an EAPE or the clinician does not have a sufficient share of services coming through the EAPE, then he or she becomes subject to MIPS as the default.

The existence of multiple points on the APM path for a given payment year at which clinicians could qualify or not qualify for the APM incentive payment underscores the importance of MIPS as the default. Clinicians will be on either the APM or the MIPS payment path, but they may not know at a given point in time which path will ultimately prevail.

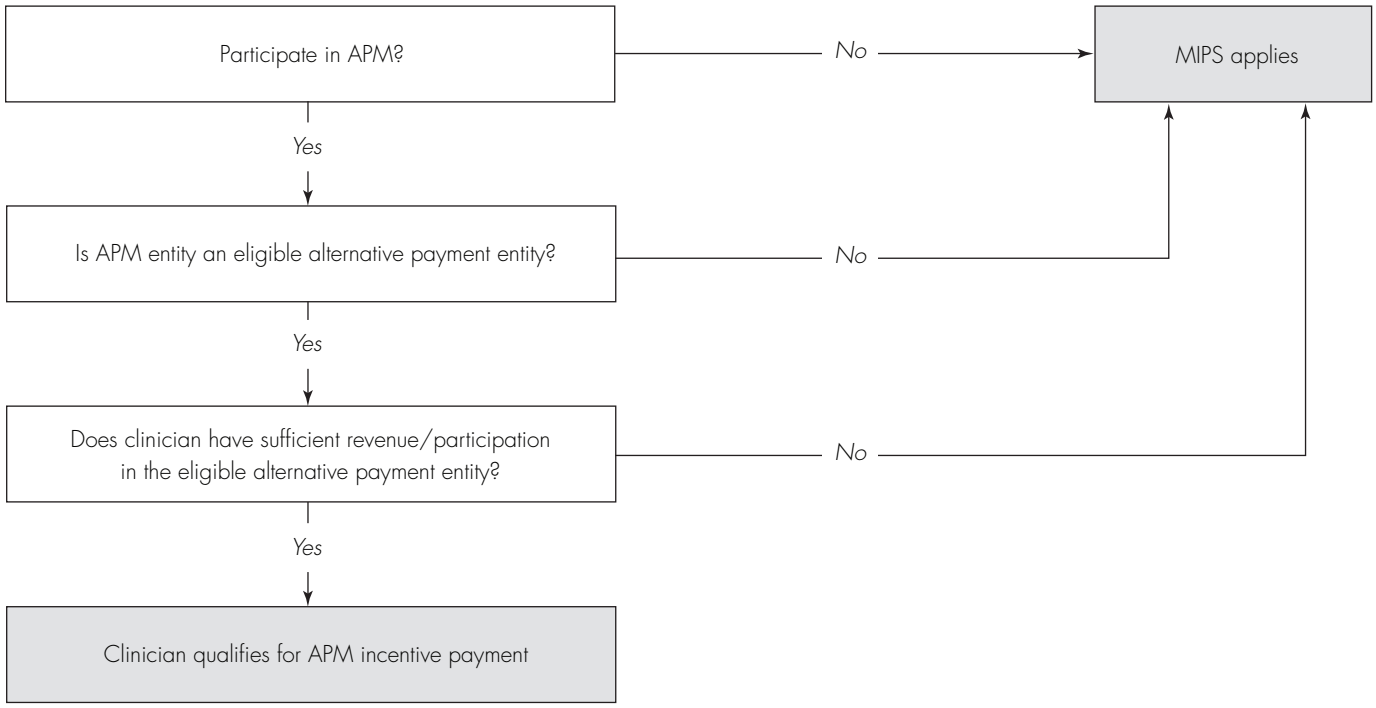
For example, clinicians can elect to be in an APM in 2017, but CMS may not make the determination of whether they are qualifying APM participants until 2019. If CMS determines that they are not qualifying APM participants, then the MIPS applies, so clinicians may need to report on measures required by MIPS in the years before 2019. (Currently, some payment models allow entities to report quality as a substitute for PQRS. CMS could choose to take a similar approach with respect to MIPS.)

Principles for eligible alternative payment entities

MACRA lays out the basic requirements for EAPEs and the thresholds clinicians must reach to be qualifying APM participants. CMS will write the regulations for the implementation of MACRA with more detail on how EAPEs will qualify. The Commission recommends certain principles to inform the development and implementation of EAPEs. These principles represent a

FIGURE 2–4

MIPS is the default option for clinicians at multiple points



Note: MIPS (Merit-based Incentive Payment System), APM (alternative payment model).

departure from MACRA in some cases to help further shape a program oriented toward controlling costs and improving quality in Medicare.

The basic principles are as follows:

- Clinicians should receive an incentive payment only if the eligible alternative payment entity in which they participate is successful in controlling cost, improving quality, or both.
- The eligible alternative payment entity should be at financial risk for total Part A and Part B spending.
- The eligible alternative payment entity should be responsible for a beneficiary population sufficiently large to detect changes in spending and quality.
- The eligible alternative payment entity should have an ability to share savings with beneficiaries.
- CMS should give the eligible alternative payment entity regulatory relief.
- Each eligible alternative payment entity should assume financial risk and enroll clinicians.

The subsequent principles build from the first principle that incentive payments should be made only if the EAPE is successful in controlling cost, improving quality, or both. In other words, incentive payments would be available only for clinicians in entities that improved value for their beneficiaries. Notably, this principle departs from the MACRA legislation; incentive payments under MACRA are made to qualifying APM participants irrespective of the entity's performance. This first principle derives from the Commission's long-held view that Medicare payments should not be dictated by the status of the provider but rather by the value of the service provided to the beneficiary. For example, our work on paying the same amount for the same service across settings has resulted in recommendations for equalizing payments for certain services whether provided in hospital outpatient or clinician office settings (Medicare Payment Advisory Commission 2014b, Medicare Payment Advisory Commission 2012). This principle, as it applies to APMs, is discussed in the following sections.

The Physician Quality Reporting System, value-based payment modifier, and meaningful use of electronic health records

Under current law, CMS oversees three key programs that adjust payments for physicians and other health professionals based on performance: the Physician Quality Reporting System (PQRS), the value-based payment modifier (also called the value modifier (VM)), and payment adjustments for the meaningful use of electronic health records (EHRs).

Physician Quality Reporting System

Under current law (from 2015 through 2018), eligible professionals who do not satisfactorily report under the PQRS receive a payment adjustment of –2 percent. To avoid a downward adjustment in 2018, eligible professionals must submit data on nine PQRS measures in 2016, covering at least three of the National Quality Strategy domains. Eligible professionals for whom fewer than nine measures apply must report on the measures that apply to them for more than 50 percent of all of their patients.

Currently there are at least 10 ways that clinicians can report PQRS measures or report through an alternative mechanism, depending on whether they report as a group or as an individual and whether they participate in the Comprehensive Primary Care Initiative or an accountable care organization model (Centers for Medicare & Medicaid Services 2015a).

Value-based payment modifier

Current law requires that CMS develop and apply a VM to individuals billing under the fee schedule. This VM must adjust fee schedule payments for each clinician based on the quality of care provided to Medicare beneficiaries as compared with the cost of that care. By law, the VM first applied to payments in 2015, and using a phased approach starting with the largest clinician practices, will apply to all individual clinicians and clinician groups by 2017.

TABLE 2–1

Measures included in the value-based payment modifier

Type of measure	Measure
Quality measures	The PQRS measures reported by the clinician
	Patient experience (CAHPS® measures)
	Claims-calculated measure: All-cause readmissions
	Claims-calculated measure: Potentially preventable admissions (acute conditions)
	Claims-calculated measure: Potentially preventable admissions (chronic conditions)
Cost measures	Claims-calculated per capita costs: All beneficiaries
	Claims-calculated per capita costs: Beneficiaries with diabetes
	Claims-calculated per capita costs: Beneficiaries with coronary artery disease
	Claims-calculated per capita costs: Beneficiaries with chronic obstructive pulmonary disease
	Claims-calculated per capita costs: Beneficiaries with heart failure
	Claims-calculated Medicare spending per beneficiary

Note: PQRS (Physician Quality Reporting System), CAHPS® (Consumer Assessment of Healthcare Providers and Systems®). CMS may elect to not use some measures for certain clinicians if there are insufficient numbers. Only large groups must report the CAHPS measures.

Source: CMS. Revisions to payment policies under the physician fee schedule and other revisions to Part B for calendar year 2016. CMS–1631–P.

(continued next page)

The Physician Quality Reporting System, value-based payment modifier, and meaningful use of electronic health records (cont.)

TABLE 2–2 **Maximum value-based payment modifier payment adjustments in 2018**

		Low quality	Average quality	High quality
Physicians, NPs, PAs, CNSs, and CRNAs in groups with 10 or more eligible professionals	Low cost	0.0%	+2.0x	+4.0x
	Average cost	–2.0%	0.0%	+2.0x
	High cost	–4.0%	–2.0%	0.0%
	Did not report PQRS	–4.0%	–4.0%	–4.0%
Physicians, NPs, PAs, CNSs, and CRNAs in groups with 1 to 9 eligible professionals	Low cost	0.0%	+1.0x	+2.0x
	Average cost	–1.0%	0.0%	+1.0x
	High cost	–2.0%	–1.0%	0.0%
	Did not report PQRS	–2.0%	–2.0%	–2.0%

Note: NP (nurse practitioner), PA (physician assistant), CNS (clinical nurse specialist), CRNA (certified registered nurse anesthetist), PQRS (Physician Quality Reporting System). The amount of the total value-based payment modifier increase (x) will be calculated after the end of the performance period based on the penalties and downward adjustments. There will be an increase in the positive payment adjustment for clinicians or groups with average or high quality who have a relatively high average beneficiary risk score. The maximum adjustments are bigger for large groups because CMS applies smaller adjustments to groups/individuals who are newly measured.

Source: CMS. Revisions to payment policies under the physician fee schedule and other revisions to Part B for calendar year 2016. CMS–1631–P.

The VM is calculated in two steps for each clinician or group at the level of the tax identification number. First, an eligible professional must successfully report on a minimum number of quality measures through PQRS. Those who do not successfully report through PQRS are subject to an automatic negative payment adjustment under the VM (in addition to the PQRS penalty).

Clinicians who successfully report PQRS measures then move on to the cost and quality tiering process (based on the measures in Table 2-1). The quality and cost measures are risk adjusted, and an attribution process exists for the claims-based measures. The cost measures are adjusted by specialty. CMS is phasing in the VM by clinician group size. In 2015, groups of 100 clinicians or more were subject to the VM.

In the first year, each clinician or group is measured, and they have the option of electing a zero adjustment. (For example, in 2017, all individuals and groups are subject to the VM, but solo practitioners, who will be in their first year, could elect no adjustment.) By 2018, all groups and individual clinicians will be subject to the VM under the terms shown in Table 2-2. In 2019, the VM will be repealed and replaced with MIPS.

Meaningful use of electronic health records

Under the American Recovery and Reinvestment Act of 2009, eligible professionals and hospitals were able to receive incentive payments for the meaningful use of certified electronic health record technology from 2011 through 2014 through either Medicare or Medicaid. Under the Medicare EHR incentive payment program, up to $44,000 was available to clinicians who demonstrated meaningful use.

Beginning in 2015, eligible professionals who do not successfully demonstrate EHR meaningful use are subject to a payment penalty, starting at 1 percent and increasing each year that an eligible professional does not demonstrate meaningful use, to a maximum of 5 percent. To avoid a payment penalty in 2015, clinicians had to attest that they met the 10 measures and objectives outlined in regulation as "Modified Stage Two" of EHR meaningful use. ■

In addition, the principles work together. For example, EAPEs could receive regulatory relief from statutory requirements designed to protect against overuse only if they are at risk for total Part A and Part B spending for their attributed beneficiaries. Similarly, having a beneficiary population of sufficient size to detect changes in spending or quality is of particular importance when measuring total spending and the kinds of population-based outcome measures (such as avoidable hospitalizations) of greatest importance to beneficiaries and the program.

Clinicians should receive incentive payments only if the eligible alternative payment entity in which they participate is successful at controlling cost, improving quality, or both

In the Commission's view, incentive payments should not be awarded for simply participating in an EAPE but should also be contingent on quality and spending performance. Performance already has some importance, in that the EAPE must—with an exception for certain medical homes—bear financial risk for monetary losses in excess of a nominal amount. However, if that risk for the entity were very low, it might be outweighed by the guaranteed 5 percent incentive payment for the clinicians, and so they might not have sufficiently strong incentive to control their spending.

An argument for awarding incentive payments simply for participating in an EAPE could be that investment is needed in new models and that they cannot be expected to work right away. Change is difficult in itself, and moving to something different requires an impetus. By this logic, it might be reasonable to have Medicare provide the initial investment to get models started and allow providers to invest in the tools needed to change how they provide care.[9]

However, a concern about rewarding providers for simply being in an EAPE as a transitional policy rather than rewarding the entity's performance is that, once a program is in place, historically Medicare has found it difficult to reduce rewards for being in a particular program or achieving a certain designation. Thus, one could argue that EAPEs should be required to meet a performance goal from the start. If the defining criteria for EAPEs are broad and do not require improved performance, it might be very difficult to roll them back if they are unsuccessful—with consequences for the sustainability of the Medicare trust funds.

The eligible alternative payment entity should be at financial risk for total Part A and Part B spending

MACRA requires that EAPEs be at financial risk (except for certain medical homes), have the capability to measure quality, and use EHRs. But entities do not have to improve value for the clinicians in them to receive the incentive payment. Making EAPEs responsible for total spending and patient outcomes might help move the FFS payment system from volume to value, encourage care coordination, and more broadly reform the delivery system. EAPEs could be at risk for total spending for a year or for an episode of care, depending on how the EAPE is defined. Risk in this context means that an entity would get a reward if performance exceeded expected performance and a penalty if actual performance were less than expected performance.

EAPEs should be at risk for total Part A and Part B spending, initially.[10] Under an ACO-like design, if spending is lower than a target, the APM would share in the savings, and if spending is higher than the target, the APM would share in the loss (the design could include limits on the loss or gain, such as risk corridors). The sharing percentage could be adjusted by performance on quality measures. Other designs, such as a per beneficiary payment that is contingent on performance calibrated to total Part A and Part B spending, could also be contemplated. Such approaches would limit risk yet still hold with the principle of performance being assessed on total Part A and Part B spending.

The basic argument for making the EAPE accountable for all Medicare spending per year for an attributed or enrolled patient is twofold: Such accountability is necessary (1) to achieve the clinical and financial integration promised by a reformed payment system and (2) to reduce the risk of excess spending without value.

We illustrate the importance of this principle by looking at the extreme alternative—holding the EAPE responsible only for the direct spending delivered by clinicians in the entity (that is, only fee schedule services).[11] This alternative would be unlikely to lead to improved value. First, there would be no incentive to coordinate care or reduce unnecessary services provided outside the entity. For example, there would be no reward for reducing readmissions because that would be a service delivered by a hospital, not by the EAPE's clinicians. A model in which the entity was at risk for only its direct revenue

would thus produce a disincentive for true savings or care coordination. In addition, such a design would encourage the entity's primary care clinicians to reduce their direct services and refer to specialists outside the entity—conceivably the direct opposite of what would be desirable to improve quality and control total spending.

Second, the structure of the APM incentive payment could reinforce FFS incentives to increase volume, particularly if the entity is responsible only for the spending of its own clinicians. The level of the APM incentive payment is based on the clinician's FFS revenue. A clinician who bills more services to Medicare receives a higher APM incentive payment than a clinician who bills fewer services to Medicare. Indeed, if the amount of revenue "at risk" is capped at 2 percent of the entity's own billing and the incentive payment is 5 percent, providing additional services would net 100 percent of billing plus at least 3 percent. The incentive to provide more (or more intensive) services would be even greater than it is now. This scenario also underscores the importance of defining what spending the EAPE is responsible for and the meaning of "risk above a nominal amount."

The eligible alternative payment entity should be responsible for a beneficiary population sufficiently large for CMS to detect changes in spending or quality

The third principle is to require EAPEs to be responsible for a sufficient number of beneficiaries for CMS to reliably detect changes in spending or quality.

Detecting changes in spending

The statute requires that an EAPE bear financial risk for monetary losses in excess of a nominal amount. To determine whether a loss occurred, CMS has to determine what spending the entity is responsible for, what that spending would have been for these beneficiaries in the absence of the entity (a spending benchmark), and what spending actually occurred.

To measure spending reliably, a sufficient number of cases are needed so that the signal is not overcome by the noise of random variation. This requirement is of particular importance when the EAPE is responsible for all Part A and Part B spending for an attributed patient. As an example, the MSSP requires that a minimum of 5,000 beneficiaries be attributed to an ACO. Even with 5,000 beneficiaries, there is sufficient random variation that the difference between actual and benchmark spending must exceed 3.9 percent to be counted as meaningful (in the case of one-sided-risk MSSP ACOs). Requiring EAPEs to be responsible for a minimum number of beneficiaries or cases could further restrict the number of entities that qualify, but otherwise it would be difficult to determine whether a meaningful change in spending occurred. One way to reach a minimum number would be to allow EAPEs to aggregate geographically dispersed clinicians to increase the number of attributed beneficiaries. This strategy is currently being used by certain rural MSSP ACOs.

Detecting changes in quality

The Commission supports assessing quality performance for ACOs and MA plans in comparison with local FFS performance on the basis of a small number of measures primarily focused on outcomes, such as potentially avoidable hospital admissions and emergency department visits, readmissions, mortality, and patient experience (Medicare Payment Advisory Commission 2014a). To do so, a minimum number of attributable beneficiaries for EAPEs is necessary for CMS to detect changes in performance on these key outcome measures.

MACRA requires that EAPEs have quality measures "comparable" to MIPS. This requirement links the two paths explicitly. However, MIPS, in contrast to EAPEs, is designed by law to assess performance at the individual clinician level, which poses a number of technical challenges. In any case, the methodologies used for quality measures in MIPS should not constrain EAPEs from innovating with respect to quality measurement. One way to ensure that constraint does not occur is to break the statutory link between EAPE quality and MIPS quality, or to interpret "comparable" quality measures in the broadest way possible. Another way is to ensure that the MIPS quality measurement process is less burdensome to clinicians and focuses on the most effective measures.

Eligible alternative payment entities should have the ability to share savings with their beneficiaries

One of the challenges for EAPEs will be to encourage involvement of the beneficiaries in their care decisions and incentivize use of providers that increase value. Beneficiary involvement would help entities' efforts to control spending and improve quality. Strategies to affect beneficiary behavior could include lower cost sharing for using providers in the entity or a reward after the fact if most visits were with entity providers (this is the route

proposed in the Next Generation ACO program). The Commission has noted that the lack of any mechanism for beneficiaries to share in savings accruing to ACOs was a shortcoming of that program and suggested that reduced cost sharing for primary care services in the ACO be allowed. If CMS could incorporate opportunities for beneficiaries to share in potential savings of EAPEs, the entities might be able strengthen beneficiary engagement.

CMS should give eligible alternative payment entities certain regulatory relief

Certain existing Medicare regulations were designed to prevent excessive service use. To the extent that an EAPE is at two-sided risk for total Part A and Part B spending, the entity could be given relief from some of those regulations. For example, Medicare statute requires a three-day inpatient hospital stay before use of a skilled nursing facility (SNF). In the case of an entity with two-sided risk, this regulation could be waived because the entity has a strong incentive not to overuse SNF stays that are not clinically appropriate (particularly if the SNF is not in the ACO). The Commission's work on ACOs has established the principle that ACOs bearing two-sided risk should be given regulatory relief. Similarly, EAPEs, to the extent that they are at risk, could be given relief from certain regulations. However, the extent to which the entity is at risk would dictate the regulatory relief provided.

Each eligible alternative payment entity should assume financial risk and enroll clinicians

Each EAPE should have a single body (such as a governing board) responsible for assuming risk, enrolling or certifying clinicians, and allocating bonuses or losses. From the entity's perspective, the power of the incentive is increased by allowing the EAPE to make its own rules for sharing savings and losses among its clinicians in a way that would reinforce incentives for care coordination and higher quality. Otherwise, it would need to be subject to CMS's administration of risk, enrollment, and rewards, which would not likely be optimal for payment entities in different geographic areas.

From CMS's perspective, the EAPE is at risk for financial loss. If that entity is not defined clearly, CMS would have to allocate losses and rewards to clinicians individually. That approach may be feasible, but difficult to carry out.

Delegating the responsibility of allocating rewards and penalties from the Medicare program to a single responsible entity would give maximum flexibility for delivery system reform. Each EAPE will differ in terms of the patients it serves, the delivery system in which it operates, and the resources available to improve patient care. Thus, a single body could allocate bonuses and penalties in ways that maximize value.

Implementation issues

Certain implementation issues will arise regarding EAPEs. They include defining what is "risk in excess of a nominal amount," specifying how beneficiaries and providers are attached to entities, and limiting beneficiaries and providers to a certain number of entities. Some of these issues could be addressed in regulations while others may require legislation.

Defining risk in excess of a nominal amount

MACRA requires that EAPEs be at "risk in excess of a nominal amount." This requirement could be construed as a very small amount of risk—for example, the "risk" of the entity's investment in setting up the entity. We have defined *risk* in this report to mean that an entity would get a reward if performance exceeded expected performance and a penalty if performance were less than expected.[12]

It follows from our principles that the EAPE should be at sufficient financial risk to motivate clinician improvement and counter FFS volume incentives. First, there must be sufficient incentive to motivate clinicians to improve the quality of the care they deliver. Forming entities, figuring out what processes to improve, changing processes, and making improvement continual all require effort and investment. The possible reward would need to be perceived as being sufficient to make that investment pay off. Part of the reward for clinicians would be the 5 percent incentive payment on clinician revenue and part would be the prospect of a reward if actual spending were below expected spending. Second, without sufficient risk, the FFS incentive to increase the volume of services that clinicians can bill for is undiminished and in fact reinforced because the 5 percent bonus is computed on the clinician's total FFS revenue (not just the revenue coming through the EAPE). Thus, the incentive to reduce spending must be sufficient to counter this increased volume incentive as well.[13]

Although being at financial risk in excess of a nominal amount does not seem to be a significant threshold,

currently only a small number of models could truly qualify if "risk in excess of a nominal amount" is defined as the difference between actual and expected benefit spending. A few existing models presently have shared risk for total population costs (Pioneer ACOs, Track 2 and Track 3 MSSP ACOs, Next Generation ACOs, and some End-Stage Renal Disease Seamless Care Organizations). Another select few have shared risk for a certain episode or time frame (Bundled Payments for Care Improvement).

Attributing or enrolling beneficiaries

The Medicare program currently uses several methods to attribute beneficiaries to entities (see online Appendix 2-B, available at http://www.medpac.gov). In addition to attribution methods (which are passive), there are also enrollment methods (which are active). Attribution is used in the MSSP ACO program, and enrollment is used for Medicare Advantage. The Pioneer ACO model uses attribution as the principal method, but there was a limited test of enrollment in addition to attribution. That model of attribution plus limited enrollment is being extended to the Next Generation ACOs also. Under MACRA, a key implementation decision will be to decide whether alternative payment models should be required to use passive attribution of beneficiaries, active enrollment of beneficiaries, or a combination of both.

Under passive attribution, beneficiaries are associated with an entity without the beneficiary making any active choice. For example, beneficiaries are attributed to MSSP ACOs based on their Medicare claims history. Passive attribution has three advantages relative to enrollment for an EAPE: (1) the entity does not have the expense of marketing itself to beneficiaries; (2) it gives the entity a better chance to have a sufficient number of beneficiaries to reliably measure performance; (3) it helps ameliorate concerns about selection—that is, the possibility for the providers to steer patients with certain characteristics into or out of the entity. Beneficiaries could be attributed to the entity and subsequently given a chance to opt out, but they would not be required to opt in (enroll). Behavioral economics has shown that an opt-out scenario such as passive attribution is much more likely to engender participation than an opt-in scenario (Choi et al. 2002). However, beneficiary engagement—involving beneficiaries in helping make their health care decisions—can be much lower in an opt-out scenario because beneficiaries do not take an active role in signing up or enrolling. For example, in the Medicare ACO models (in which beneficiaries are free to go to any provider participating in Medicare), some ACOs have had trouble motivating beneficiaries to use providers in the ACO instead of outside the ACO. This situation can make it more difficult to coordinate care and control spending.

The basic argument for enrollment is that beneficiaries should have the choice to join or not join an entity that could have an effect on their health care. If a beneficiary had to enroll to be in an EAPE, the beneficiary would be more engaged and be more aware of the entity's goals. However, for this to happen, there would need to be a marketing and education effort before the beneficiary made that choice. Either CMS or the EAPE would have to develop and fund that effort. In addition, enrollment could theoretically lead to selection problems, which could argue for limiting it. For example, enrollment in Pioneer ACOs was limited to beneficiaries who had been attributed in previous years to forestall selection issues.

One form of enrollment is attestation. Attestation is a declaration by a beneficiary that a certain clinician is the beneficiary's chosen primary care provider. The advantage of attestation in an APM context is that beneficiaries do not have to be aware of the existence of an EAPE, but just need to know who they commonly go to for care.[14] There are some precedents that suggest beneficiaries are willing to designate which clinician is their primary care provider. For example, in the Chronic Care Management (CCM) payment code, beneficiaries consent to receive CCM services from a provider and even pay for that privilege; there is cost sharing for the CCM payment (although thus far there has been relatively low use of the CCM code). More beneficiaries might be willing to select a primary care provider if that choice were associated with additional benefits or lower cost sharing (for the use of providers in the EAPE vs. providers outside, for example). A beneficiary's selection of a primary care provider could be considered selecting the EAPE that the primary care provider participates in. Such a design could be combined with passive attribution to increase the number of beneficiaries in an EAPE and yet preserve beneficiary choice and increase beneficiary engagement.

Restricting the number of EAPEs a beneficiary or a provider can be in per year

MACRA appears to permit clinicians to participate in, and beneficiaries to be attributed to, multiple EAPEs in a year. There are pros and cons to restricting the number

of entities in which either a clinician or a beneficiary can participate in during the year. Limiting the number of entities per beneficiary (e.g., by specifying that the EAPE must be at risk for all spending for the beneficiary for the full year, or stating that beneficiaries cannot be in more than one EAPE at a time) would simplify assessing performance and calculating incentive payments. This method could also improve coordination if beneficiaries know that one provider or entity is responsible for the full continuum of their care.

On the other hand, limiting the number of entities per beneficiary or provider would decrease the number of such entities and could restrict options for certain specialties. For example, if the number of EAPEs were limited to only one per patient per year, entities in bundled payment models could be less likely to have many patients attributed to them because some patients may already have been attributed to a different EAPE.

Also, if beneficiaries are attributed to EAPEs based on their relationship with a clinician, that clinician would need to be unequivocally associated with one entity so that the beneficiary could be attributed unequivocally to that same entity. Clinicians who are not used for attribution could still participate in multiple entities.

Considerations for MIPS

MIPS sets out the framework for Medicare to measure and report clinicians' performance and to adjust their payments. To start with, MIPS consolidates the three existing performance programs: the PQRS, meaningful use of certified EHR technology, and the VM. MIPS will assess clinician performance in four areas—quality, resource use, meaningful use of certified EHR technology, and clinical practice improvement activities. MIPS is the default option for clinicians who make no affirmative choice to join an EAPE and will apply to clinicians who do participate in an EAPE but do not have sufficient revenue coming through the EAPE to meet the statutory minimum participation level.

Policy making with respect to MIPS will build on Medicare program experience with the performance systems currently in use—PQRS, VM, and meaningful use of certified EHR technology. Medicare's experiences with these programs give some insight into the challenges facing individual clinician performance measurement.

Attempts to measure clinician performance have limitations

Since 2007, CMS has had a clinician-level quality reporting system (i.e., PQRS), to which additional requirements and capacities have been added to build to a value-based purchasing program for clinicians. The VM began applying to clinicians and clinician groups in 2015.

Along the way, policymakers have learned several lessons. The first is the questionable utility of the PQRS measures. PQRS consists largely of clinician-reported process measures such as whether the clinician ordered the appropriate tests or conducted appropriate follow-up. The benefit of such measures is that they are completely within the clinician's control. The drawback is that the measures are often poor signals of ultimate outcomes of importance to the patient (such as improvement in functioning or avoiding unnecessary hospital stays). For example, the most commonly reported measure in PQRS (with 110,000 clinicians reporting in 2014) is measure 130: *Documentation of Current Medications in the Medical Record* (Centers for Medicare & Medicaid Services 2015a). While documentation of medications is important, reporting that this happened (often requiring chart review or EHR extraction) to Medicare adds a burden that may not be commensurate with the value of the measure. Reporting and analyzing such ineffective measures absorbs resources for clinicians and CMS that could be used in a more productive way.

In addition, performance on these clinician-reported process measures is often tightly clustered, limiting the ability to differentiate clinicians based on their performance. Some measures are "topped out," which means that virtually all providers report doing them. One example of a measure that is topped out is measure 242: *Coronary Artery Disease (CAD) Symptom Management*, which had a mean performance rate of 99.9 percent in 2014 (Centers for Medicare & Medicaid Services 2015a). In general, if one goal of quality measurement is to spur improvement, it is unlikely to do so if all clinicians can perform well on the measures without actually improving.

A different approach to quality measurement, which the Commission finds of greater value for assessing the performance of groups such as ACOs and Medicare Advantage plans, is to focus on outcome measures (such as readmissions, mortality and patient experience) (Medicare Payment Advisory Commission 2014a). However, these measures are not as statistically reliable as

process measures at the individual clinician level and must be risk adjusted. In addition, claims-based and patient-experience measures require attribution to clinicians, who may not feel that they should accept full responsibility for (or could influence) the outcome at hand.[15]

CMS has attempted to straddle these two approaches in the current VM. The VM uses nine clinician-reported PQRS measures, three claims-based avoidable-hospitalization measures, and six claims-based resource use measures. The use of both clinician-reported quality measures (clinicians choose their 9 from nearly 300 PQRS measures) and claims-derived measures (requiring minimum thresholds, risk adjustment, and attribution rules) has contributed significantly to both the program's complexity and its indeterminate findings. In the VM's first year, CMS applied it to groups with 100 clinicians or more. Of this group of large practices (for whom quality and resource use measures should be more reliable than average, given their large panel sizes), CMS determined that 80 percent of those measured could not be differentiated from average (i.e., were within one standard deviation of the mean) (Centers for Medicare & Medicaid Services 2015b).[16]

Possible paths forward

MIPS will shine a bright light on these performance measurement limitations as clinicians face increasing penalties for nonreporting and low performance and possibly large rewards for high scores. It is therefore important to improve and possibly simplify the current set of measures rather than just incorporate all the current programs into MIPS. Improving the value of the quality measure set and using claims-based quality and resource measures are two ways to move toward strengthening performance measurement. Additional issues will be risk adjustment, attribution or other methods of attaching beneficiaries to clinicians, definition of episodes, and comparison groups.

Improve the value of the quality measure set

Some of the quality measures in PQRS are inefficient, meaning that their benefit is outweighed by the burden imposed by reporting, collecting, and analyzing them. CMS should move expeditiously to eliminate such measures from the measure set, particularly those that impose a reporting burden, are poorly linked to outcomes of importance for beneficiaries and the program, and reinforce FFS incentives to overprovide clinically marginal care.

One reason for the multiplicity of measures and reporting methods in PQRS is CMS's attempt to ensure that all clinicians have multiple measures on which they can report.[17] Another way to ensure this coverage is to add clinician-level measures that can be calculated solely from claims. Of particular importance are measures of overuse or inappropriate care, especially in the FFS environment, where clinicians have a financial incentive to overprovide low-value care. CMS could consider adding more measures of low-value care to the MIPS measure set, such as claims-calculated measures of low-value care (Medicare Payment Advisory Commission 2016). CMS has retired some measures and added overuse measures in the past few years. MACRA also appropriated additional funding for CMS to develop quality measures, which represents an opportunity to improve the quality measure set.

Consider approaches using claims-based quality and resource use measures

The Commission has supported claims-based outcome measures for use in assessing ACO and MA performance (relative to FFS performance in a local area) and making payment adjustments based on quality for ACOs and MA plans that perform better than FFS in their local area (Medicare Payment Advisory Commission 2015, Medicare Payment Advisory Commission 2014a). We outline three possible considerations for using a similar approach for clinician-level performance.

Exploit and improve the measures currently in use For use in the VM, Medicare is currently calculating six resource use measures and three quality measures using claims (Centers for Medicare & Medicaid Services 2015b).[18] Some of these measures could be used more directly in the Medicare program. They could be used in MIPS, for example, or to identify persistent outliers. More claims-based measures could also be developed. In addition, some of the claims-derived measures may be more reliable than widely believed. For example, the Commission has done work showing that, for half of physicians, a relative resource use measure could be calculated with moderate reliability (Miller et al. 2010). It might be possible to improve the reliability of these individual- and group-level measures using multiple years of data, or potentially data from other payers. In addition, there may be opportunities to augment claims-based measures with information from electronic medical records that could be reported on claims.

Assess performance at an aggregate level One way to handle the problem of reliability at the individual

clinician level is instead to aggregate across providers. This aggregation is part of what makes it possible to assess ACO and MA performance using broader outcome measures. The Medicare program could assess performance across all FFS clinicians in a local area and consider whether modest payment adjustments would be appropriate at the extreme ends of performance for those clinicians considered as a group. (Although this approach would seem to create an issue similar to the SGR problem of being a collective assessment, the assessment would be at a local level, not nationwide. It might be possible to define *local* in a way that would make this assessment more acceptable to clinicians.) Such an approach could also motivate discussions of quality improvement and redirecting resources to localities needing improvement (Medicare Payment Advisory Commission 2011).

Focus on outliers The Medicare program could also use outcomes and resource use measures to focus on persistent clinician outliers—that is, clinicians whose performance diverges radically from their peers year after year. The benefit of such an approach is that it could focus Medicare's attention on clinicians with the most divergent patterns. It also could help identify clinicians with aberrant billing patterns that indicate fraud or inappropriate use. Measures of low-value care and relative resource use may be particularly relevant.

In setting MIPS policy, CMS should focus on improving the value of its quality programs

Minimizing the burden of quality reporting and maximizing the use of claims data, which the Medicare program already collects, as a source for quality measurement can improve the program in two ways. First, it will simplify the administration of MIPS. Second, it could provide a more seamless transition between the two programs (MIPS and APMs) as clinicians move from one to the other. In addition, ensuring that MIPS is consistent in principle with the kind of measurement that is most desirable for assessing ACO and MA plan performance (as well as APMs, potentially) would provide consistency across the Medicare program.

Considering MIPS and APM incentives

If one goal of MACRA is to "push" clinicians from FFS and "pull" them into EAPEs, then the incentives for clinicians must be sufficiently strong to achieve that goal. However, constructing such incentives will be a challenge (in part because clinicians in EAPEs will often continue to be paid under FFS). Giving clinicians a 5 percent incentive payment if they participate in EAPEs and meet the threshold is a strong draw. However, some clinicians may be convinced they could get rewards under MIPS that would be greater than the incentive payments for being in an EAPE—possibly with less disruption to their practice.[19]

The maximum penalties under MIPS rise from 4 percent to 9 percent over time; however, bonuses for good performance could be much higher because of the way the budget-neutrality calculation is made. For example, if there is a large share of clinicians losing 9 percent for poor performance and relatively few clinicians being rewarded for good performance, the rewards for those few could greatly exceed 9 percent.[20] Clinicians' confidence in making an a priori judgment about their relative performance under MIPS will depend on what measures are included in MIPS and how predictable performance under MIPS will be. Of particular importance will be CMS's ability to reliably differentiate among individual clinicians' performance using the MIPS framework, which in our view will be limited at best.

However, clinicians do not face a clear choice between the APM and the MIPS paths. A clinician's choice is to participate in one (or more) models and hope that the entities in which he or she participates are deemed EAPEs by CMS and that enough of his or her personal billings go through the EAPEs each year to meet the threshold for qualifying participation. Further, this calculation has to be made every year, and the threshold gets higher each year. Because a participating clinician's ability to meet the APM threshold is not a foregone conclusion, clinicians in EAPEs may also report under MIPS in the event that the APM threshold is not met. For this reason, MIPS and APMs should be aligned.

Taking similar approaches to similar issues

There are several considerations that argue for resolving issues that will arise in both MIPS and APMs in similar ways to avoid unintended consequences and to reduce the burden on clinicians when they inevitably move across programs—either by design or by circumstance. MACRA requires the quality measures for EAPEs to be comparable to those in MIPS. But MIPS could resemble the current VM and could use some inefficient quality measures because of the particular challenge of assessing quality at the individual clinician level. Clinicians will face the uncertainty of whether they will qualify to meet

the threshold for the APM incentive payment and the exemption from MIPS even if they participate in an EAPE.

The issue of how beneficiaries are attributed to an EAPE will be of consequence to determine how much of a clinician's billings go "through" the entity. At the same time, certain measures under MIPS (for example, those concerned with resource use) will also depend on how beneficiaries are attributed to clinicians. In addition, resource use will need to be defined in each program. Will it mean total Part A and Part B spending for attributed beneficiaries, as we suggest in the APM context, or something else such as episode spending? These and other issues will need to be addressed consistently across both programs to avoid opportunities for arbitrage that might otherwise arise. Such opportunities could be disadvantageous for the program and create confusion and burden for clinicians. Measurement in MIPS also should be designed to increase the value of the quality and resource use measures that clinicians report and that CMS uses for adjusting payments.

At the same time, limitations that may be present in the FFS environment (particularly those arising from the need to measure an individual clinician's performance) should not limit efforts to better measure EAPEs' performance. Certain entities may closely resemble ACOs, and the Commission has suggested that ACOs and MA plans, which have taken responsibility for Medicare spending and quality for a population of Medicare beneficiaries, could best be measured using population-based outcome measures.

Conclusion

We conclude that clinician quality reporting under MIPS should be designed to minimize the collection of inefficient quality measures and improve the overall value of the quality programs, as discussed earlier. Such a design will make it easier for all clinicians to report under MIPS if they unexpectedly do not meet the requirements to be qualifying participants in EAPEs. Resource use and other measures should track across the MIPS and APM paths to the extent possible to avoid unintended consequences. However, the end goal of using a small set of population-based outcome measures for APM entities, ACOs, and MA plans should not be compromised. In short, as regulations are written for both APMs and MIPS, these issues and definitions will have to be carefully coordinated to create the right incentives for clinicians. The right incentives will result in delivery system reforms that further the goal of controlling Medicare spending and improving quality while preserving or improving access for Medicare beneficiaries. ■

Endnotes

1 The basic MIPS adjustments are budget neutral, but there is an additional amount appropriated for high performers for a limited period.

2 The actual update in any year will be the result of all provisions in law; for example, in 2015, a misvalued code target reduced the update.

3 CMS can use either a revenue calculation or a patient calculation to determine whether a clinician meets the threshold to be a qualifying participant. Exactly what "revenue coming through" an EAPE means will be defined in regulation. It could depend on what spending the EAPE is responsible for. For example, if the EAPE a clinician is participating in is responsible for all of its attributed beneficiaries' Part A and Part B spending, then all of the clinician's billing for any of those beneficiaries could be defined as coming through the EAPE. If the EAPE's responsibility is limited to spending during an episode, then the revenue coming through the EAPE could be limited to spending billed during the episode.

4 The following is a more concrete example. The Pioneer ACO model is an alternative payment model (run through CMMI authority). The Montefiore ACO is an entity operating a Pioneer ACO. For the Montefiore ACO to be an eligible alternative payment entity, the Pioneer ACO model would have to require risk above a nominal amount, use of certified EHR technology, and payment based on quality measures comparable to MIPS.

5 The criteria for these all-payer EAPEs are largely the same as for Medicare EAPEs: The payment arrangement requires use of certified EHR technology, makes payment based on a set of quality measures comparable to MIPS, and requires them to assume risk for losses above a nominal amount, or the entity is a medical home. The financial losses language in the statute for the all-payer calculation is slightly different from the Medicare APM calculation. Specifically, the all-payer language refers to "nominal financial risk if actual aggregate expenditures exceed expected aggregate expenditures."

6 In general, partial-qualifying APM participants can elect to be excluded from MIPS payment adjustments.

7 For example, the Next Generation ACO demonstration has an option for ACOs to receive partial capitation payments.

8 Each of these terms will need to be defined in regulation. For example, *resource use* could mean the measures in use in the value-based payment modifier, which are five per capita spending measures and the Medicare spending per beneficiary measure. The category weights reflect the fully phased-in weights. In the first two years, resource use weights will be lower and quality weights will be higher.

9 Models to improve care coordination in FFS Medicare have had only modest success to date. See the Commission's June 2012 report to the Congress.

10 It is not clear how APMs could be responsible for Part D spending at this time. We are continuing to assess approaches to incorporating Part D spending into shared savings models.

11 This alternative is extreme in the sense that it is at the opposite end of the spectrum from total Part A and Part B spending. Some have proposed that the EAPE be responsible only for spending by its clinicians or the spending they directly control.

12 There could be limits on the risk involved, particularly if the APM covers small entities. These limits could involve risk corridors, caps on individual spending, or other features of the model.

13 Another option would be to limit the billing on which the 5 percent incentive payment is computed to the revenue coming "through" eligible entities. This option would eliminate the threshold requirement (e.g., 25 percent of billings in 2019) and the uncertainty of clinicians as to whether they would be eligible for the incentive payment. This approach would require a legislative change.

14 In the APM context, when beneficiaries are still free to go to any provider, attestation has very little downside for the beneficiary because the beneficiary does not give anything up in attesting.

15 Current claims-based attribution rules (like those used in the VM) can be more useful for assessing the performance of primary care clinicians than some specialty clinicians because those attributions are often based on a plurality of evaluation and management visits.

16 The Medicare program may be unable to differentiate clinicians because of both the measures in use and the small number of cases applicable for each measure.

17 Even with multiple options, in 2016, 40 percent of clinicians did not successfully report PQRS measures—and as a result accepted penalties totaling 4 percentage points.

18 The six resource use measures (called "cost measures" in the VM) are per capita spending measures for four chronic conditions, total per capita spending, and the Medicare spending per beneficiary measure.

19 These considerations might also change clinicians' judgments about the desirability of being in MA networks. Although there are many other considerations, such as being in an insurer's network for other products and the insurer's market share in the community, how a clinician thinks he or she will fare in MIPS may change the desire to accept MA plan payment rates and agree to MA plan contracting terms.

20 In the 2016 VM calculation, the upward adjustment for good performance was nearly 16 percent (or 32 percent for the highest performance) because about 40 percent of clinicians and groups subject to PQRS did not successfully report PQRS quality measures. The maximum upward adjustment by 2022 under MIPs will be 37 percent.

References

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2016. Medicare program; Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the physician fee schedule, and criteria for physician-focused payment models. Proposed rule. *Federal Register* 81, no. 89 (May 9): 28161–28586.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2015a. *2013 reporting experience including trends (2007–2014): Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Program.* Baltimore, MD: CMS.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2015b. *2015 Value-Based Payment Modifier Program experience report.* Baltimore, MD: CMS. http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-VM-Program-Experience-Rpt.pdf.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2015c. Affordable Care Act payment model saves more than $25 million in first performance year. Press release. June 18. https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-06-18.html.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2015d. Medicare program; revisions to payment policies under the physician fee schedule and other revisions to Part B for CY 2016. Final rule with comment period. *Federal Register* 80, no. 220 (November 16): 70886–71386.

Choi, J. J., D. Laibson, B. C. Madrian, et al. 2002. Defined contribution pensions: Plan rules, participant choices, and the path of least resistance. In *Tax Policy and the Economy, volume 16.* Cambridge, MA: MIT Press.

McCall, N., S. Haber, M. V. Hasselt, et al. 2015. *Evaluation of the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration: First annual report.* Prepared for the Centers for Medicare & Medicaid Services. Research Triangle Park, NC: RTI International.

Medicare Payment Advisory Commission. 2016. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2015. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2014a. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2014b. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2012. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2011. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2001. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.

Miller, M., J. M. Richardson, and K. Bloniarz. 2010. More on physician cost profiling. *New England Journal of Medicine* 363, no. 21 (November 18): 2075–2076; author reply 2076.

Taylor, E. F., S. Dale, D. Peikes, et al. 2015. *Evaluation of the Comrehensive Primary Care Initiative: First annual report*. Prepared for the Centers for Medicare & Medicaid Services. Princeton, NJ: Mathematica Policy Research Inc.