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Medicare Physician Payment Reform: Securing the Connection Between Value and Payment

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Established in 2007, the Engelberg Center for Health Care Reform at Brookings is dedicated to providing practical solutions to achieve high-quality, innovative, affordable health care. To achieve its mission, the Center conducts research, develops policy recommendations, and provides technical expertise to test and evaluate innovative health care solutions.

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Executive Summary

Last year, Congress reached agreement in principle on legislation that would move Medicare's payment of physicians and other clinicians away from fee-for-service (FFS), which pays based on the volume and intensity of services they provide. Instead, Medicare would begin paying clinicians for providing better care, keeping patients healthy, and lowering overall costs – a "pay for value" approach. The bill also would end the sustainable growth rate (SGR) formula that has been ineffective in limiting physician spending growth or supporting better care. The proposed legislation represents a once-in-a-generation opportunity for Medicare to move away from volume-based payment to value-based payment and better support clinician-led efforts to improve care. At the same, we believe that some specific modifications to the legislation would enable it to do more to support better care and more value in Medicare. Our recommended modifications are in three major categories:

1. **Encourage the movement to effective alternative payment models (APMs)** by providing bigger rewards for APMs that are strongly related to value.
   - APMs that qualify for the bonus should require providers to make a meaningful shift from FFS payment, either by accepting "downside risk" or reduced FFS rates.
   - APMs should cover multiple services, ideally spanning sites of care and providers.
   - Qualifying APMs should be supported by evidence that they can reduce overall spending, including pilots.
   - Organizations that use APMs with more advanced measures of performance should receive additional bonus incentives.

2. **Improve Medicare's physician FFS payment system** by instituting policies that will achieve a higher-value set of services for Medicare beneficiaries, reducing costs without harming the quality of care.
   - Medicare's bonuses for care improvements and lower costs should not be multipliers on FFS payments.
   - Physicians who report on more meaningful, outcome-oriented performance measures in the new Merit-based Incentive Payment System (MIPS) should receive larger bonuses.
   - The payment differences for physician services provided in hospitals v. an office setting should be removed.
   - A test of utilization review tools for selected high-cost, discretionary procedures/ services should be implemented.
   - Revised documentation guidelines should be evaluated and considered as a replacement for the current rules governing billing for office visits.

3. **Improve and simplify the quality measures used in MIPS and APMs,** by implementing more meaningful performance measures and better support systems for clinicians to improve performance.
   - Initially, reporting and payment adjustments for physicians should be based on patient experience and engagement, as well as a limited number of core measures reflecting the patient conditions they treat. The measures should progress over time toward measures of appropriateness, clinical outcomes, patient-reported outcomes, and total patient cost/resource use.
   - In both MIPS and APM programs, physicians should be eligible for a higher bonus payment if they report on more meaningful measures.
   - Centers for Medicare & Medicaid Services (CMS) should provide additional support for developing and implementing better performance measures in APMs, including improved Medicare data sharing with physicians to enable them to take action to improve care.
   - The selection of core measures for use in payment and public reporting should be based on input from an independent, multi-stakeholder process.

These steps would not require major revisions in the bipartisan legislation, and in some cases could potentially be addressed through comments in the legislative history or CMS implementation. They would also help offset the costs of the legislation. Addressing these modifications now will enable Congress to achieves the goals of providing necessary support for clinicians to improve care, while avoiding excess Medicare costs and ineffective reforms.

Part 1

INTRODUCTION AND OVERVIEW

The U.S. health care system is on the verge of historic change. Since Medicare was passed in 1965, physicians have been paid on a FFS basis, building on the way they had been paid through commercial insurance for many decades. Last year, however, Congress reached agreement in principle on legislation that would move Medicare's payment of physicians away from FFS, which pays doctors based on the volume and intensity of services they provide. Instead, Medicare would begin paying physicians for providing better care, keeping patients healthy, and lowering overall costs – a "pay for value" approach.[1] The bill also would have ended the "sustainable growth rate" (SGR) formula that ineffectively attempted to cap physician payment rates. Although the legislation stalled due to disagreements about how it would be paid for, it will be considered again within the next year; one-year "patch" to avoid SGR cuts expires in March 2015.[2]

Key elements of the proposed legislation include:

- Termination of the SGR formula and provision of a 0.5% increase in payment rates over the next 5 years.
- Combination of three current physician payment programs into a new "Merit-based Incentive Payment System" (MIPS). Under MIPS, physicians in the traditional FFS program would receive a multiplier on their FFS payments based on a combined measure of performance on quality, "meaningful use" of electronic health records (EHRs), clinical practice improvement activities, and resource use (cost).
- Encouragement of physicians to participate in "alternative payment models" (APMs) via a 5% bonus for physicians who receive a significant portion of their revenue from an APM. Key elements of APMs include risk of financial loss if financial performance targets are not met, as well as quality measurement and improvement.
- Provision of funding for the development of quality measures. The measures would be developed and selected for use by CMS with input from multiple stakeholders, with heavy reliance on physician specialty societies. Certain types of measures, including resource use measures and those extracted from clinical registries, are exempt from the multi-stakeholder process.

Altogether, the reforms include not only the development of a new set of payment alternatives to FFS built into the traditional Medicare program. They also include some improvements in the FFS payment system that could also support higher-value care. And they include both positive incentives (e.g., payment bonuses) and negative incentives (e.g., relatively low updates to physicians staying in FFS payment) to encourage the shift to APMs.

The stakes are high. This is a once-in-a-generation opportunity to move away from volume-based payment to value-based payment in Medicare – a step for which policy experts, patients and many providers have been advocating for many years. If we get it right, Medicare physician payment reform can have a significant positive impact on: quality of care for patients; affordability for beneficiaries and taxpayers; and physician payment arrangements in commercial insurance, including the new health insurance exchanges.

Although the proposed legislation is an important step in the right direction, we believe it could be strengthened. The purpose of this paper is to identify specific improvements in the physician payment segment of the SGR replacement bill. We do not fully address the important issue of how to pay for the legislation here, though some of our proposals could offset part of the costs of the legislation. We recognize the limits on the political feasibility of making changes in the legislation at this stage, but we believe these proposals are key modifications required for the legislation to achieve its intended goals.

In developing our recommendations, we were guided by **four primary objectives**:

1. Make improvements in Medicare's FFS payment system that reinforces the goals of physician payment reform.
2. Accelerate movement to alternative payment models that represent feasible and substantial enhancements in care delivery and that cannot be achieved through current CMMI pilot authority.

3. Encourage meaningful measurement and transparency regarding quality and cost.
4. Reinforce other needed reforms in Medicare and the US health care system -- in particular, reforms to achieve sustainable spending trends and improved health outcomes.

Our recommendations fall into **three major categories**:

1. **Encouraging the movement to effective APMs** by assuring that bonuses for APM adoption are: 1) based on clear measures of shifting from FFS to episode- and person-level payment with financial risk; and 2) likely to produce higher quality care with better health outcomes.
2. **Improving Medicare's physician FFS payment system** by correcting payment differences for physician services provided in hospitals vs. an office setting; by testing utilization review tools for selected high-cost, discretionary procedures and services; and by changing the MIPS formula so that it does not reward and encourage higher volume.
3. **Improving and simplifying the quality measures used in MIPS and APMs**, with better outcome measures and stronger incentives and support for using them.

Each of these reforms includes elements that promote system-wide improvement; in addition, as Congress identifies ways to pay for physician payment reform, we encourage other reforms that reinforce the same goal.

Part 2

ALTERNATIVE PAYMENT MODELS THAT SUPPORT BETTER, LESS COSTLY CARE

The SGR replacement bill has clinicians who adopt an APM can qualifying for a payment bonus equal to 5% for a qualifying plan, if a minimum share of their payments are not traditional, unconstrained FFS. While the bonus is an important incentive for shifting from FFS payments, it will not have the intended effects on driving substantial changes in payment to enable higher quality and lower costs. The bonus is a fixed percentage of total payments if a payment system qualifies, which means that APMs with very different implications for reforming care may potentially qualify for the same bonus payments. For example, a physician group receiving shared savings on its overall costs for all of its payers could claim that this is 100% of payments in an APM, even though the group is at no financial risk and the vast majority of its payments remain FFS-based. In contrast, a physician group that has 25% of its patients paid on a capitation basis could be scored at 25% and not qualify, even though this payment reform represents a significantly larger share of revenue that could enable much more substantial changes in care. It is imperative to define an APM bonus system that moves away from unconstrained FFS, and that provide larger rewards for larger shifts, as opposed to offering new revenue opportunities without encouraging a meaningful transformation of the business model. Finally, having a bonus that is proportional to the change from unconstrained FFS also addresses how to determine a bonus for organizations participating in multiple APMs.

Legislation should modify the criteria for APM bonus determination to include some specific criteria. Our legislative recommendations involve six key points to support effective APMs:

1. **The bonus should be a fixed payment, not a multiplier on fees.** This is important because a fee multiplier would increase FFS incentives and thus offset the intended effect of the reform.
2. **In determining whether an APM qualifies for a bonus, what matters is how Medicare pays the provider organization**. The organization may allocate the payments and any bonus as they see fit; those decisions do not affect our definition of the APM.
3. **APMs that qualify for the bonus should require providers to make some meaningful shift from unconstrained FFS payment, either by accepting "downside risk" or reduced FFS rates with bundled or per-member per-month payments**. This criterion is important to prevent providers from getting bonuses in models that still

remain essentially status quo FFS-based payment. For example, a supplemental payment for participation in a PCMH would not qualify as an APM by itself. Nor would a shared savings model without a transition to downside risk. However, qualifying APMs that include downside risk could still rely on FFS payment, to manage day to day operations and allocate funds across different providers in the organization. The point is that the FFS payments would be constrained by the shared accountability. The shift from unconstrained FFS should be large enough so that if physicians do not improve the care that they deliver, their total payments (excluding the bonus) should be lower under the APM.

4. **APMs should cover multiple services, ideally spanning sites of care and providers.** For example, a global budget model, episode payment, or partial capitation payment would meet this criterion.

5. **To be implemented nationally, qualifying APMs should be supported by evidence that they can reduce overall spending.** For example, while episode based bundled payments may meet other criteria, they may encourage an increase in the number of episodes, offsetting cost savings within the episode. In the absence of evidence that the bundled payment would not increase spending, it should qualify for the bonus only as a pilot APM not a national APM.

6. **Organizations that use APMs with more advanced measures of performance should receive additional bonus payments,** such as those reflecting the outcome and patient experience priorities outlined in the National Quality Strategy or the NQF Measure Application Partnership.

The legislation or legislative history could include a specific illustrative formula to accomplish these principles. The formula would link the size of the payment bonus to the magnitude of the payment reform's movement toward greater accountability for patient costs and quality of care. The Appendix describes a general formula for determining the APM bonus payment amount (not a multiplier of fees) for a provider or group.

Part 3

IMPROVEMENT IN MEDICARE'S FEE-FOR-SERVICE PHYSICIAN PAYMENT SYSTEM

Medicare's FFS payment system, as modified in the legislation to include payment adjustments based through MIPS, will likely remain a major part of Medicare physician payment for a long time. For this reason, Congress and CMS should continue to focus on ways to improve the accuracy and the function of Medicare FFS. The MIPS payments related to quality and efficiency should also align with Medicare's broader payment reform goals. A well-designed FFS payment system can help physicians move toward alternative, more effective payment and delivery models when they are available.

Avoid providing MIPS payment adjustments in proportion to FFS rates where possible

If MIPS is a multiplier on FFS rates, then physicians will receive more payment when their volume and intensity increases, undermining the goal of providing more support for physicians providing better, more efficient care. One approach is to provide a per-practice or per-beneficiary adjustment. This could be based on Medicare payments to the physician or practice in a base period (e.g., one to three years preceding the measurement period for calculating MIPS). Another approach is to provide the MIPS payment as a per-beneficiary or per-episode payment in the specialty, for example as an expanded version of the chronic care management fee for primary care physicians, or in conjunction with (but not as a multiplier of) the procedure fee for surgeons and other specialists. Beneficiaries should not be responsible for copays on these payments. While a volume-related MIPS payment may be unavoidable in some cases, CMS should be encouraged to use other approaches that are more aligned with the goal of moving payments away from volume and with the episode- and beneficiary-based payments that will be used in the APMs.

Reward use of more meaningful performance measures in MIPS

We previously described how physicians who participate in APMs that use more meaningful performance measures

should be eligible for a higher bonus payment. Physicians who use patient-reported outcomes in MIPS should receive higher potential payment for reporting these measures, transitioning to higher payment for superior results. An initial bonus of around 2% would support significant progress toward meaningful performance measurement. CMS should aim to align both MIPS and APMs around meaningful outcome measures, as we describe in more detail below.

Address site of service differentials for services not uniquely provided in hospital outpatient settings[3]

One problem with the current system of relative prices is that differences in prices across care settings are causing distortions in provider incentives. In particular, hospital outpatient department rates are not aligned with rates paid for the identical services in physicians' offices; for common services including physician office visits and cardiac imaging, Medicare pays as much as twice as much to the hospital because it pays both a hospital facility fee and a physician service fee, whereas it pays just a physician service fee for the service when billed by a physician's office. The payment for the service provided in the physician's office does include an amount for the office's incurred practice expense but that amount is far less than the facility fee, which is based on hospital cost reporting.

The result of this "provider-based payment" policy is that hospitals have an incentive to acquire physician practices to receive the higher payment, while physicians who order and perform affected services can demand a commensurately high compensation package from the hospital in exchange for a flow of relatively higher paid outpatient services. The provider-based policy applies whether or not the employed physician practice is located physically in close proximity to the hospital, serving an extension of the hospital and thereby to some extent assuming some of the unique hospital obligations independent physicians don't have, or, alternatively practice some distance away and functioning equivalent to an independent practice. In short, the physician employee of a hospital often continues to practice in the very same location with the same cost structure as when they were independent practice, but the employment arrangement permits the hospital to bill the physician's service as a Hospital Outpatient Department (HOPD) service.

The Medicare Payment Advisory Commission (MedPAC) has recommended that higher rates for HOPD services should be limited to select services for which the hospital does bear unique costs, such as for standby emergency and operating room services and for certain other services provided to HOPD patients who are systematically more medically complex than patients receiving the services in a freestanding physician office. In MedPAC's analysis, 66 of 450 conditions in the Ambulatory Payment Classification coding system for HOPD services did not require standby capacity, have extra costs associated with clinical complexity, and otherwise did not require additional overhead associated with their provision. MedPAC divided the identified services into those for which HOPD services could equal physician office payment rates and those for which a higher rate can be supported but at a substantially reduced amount compared to current levels. [4]

MedPAC estimates that changing payment rates for ambulatory payment classifications (APCs) for the designated conditions would, on net, reduce program spending and beneficiary cost sharing by a total of $1.1 billion in one year – about $0.9 billion in program spending and $0.2 billion in cost-sharing.

Implement a Prior Authorization Pilot Program

Prior authorization is widely used by private payers for advanced imaging services, including CT, MRI, and PET scanning and nuclear imaging, but has not been adopted by Medicare. Indeed, Medicare's legislative authority to engage in prior authorization programs is unclear. Many policy experts have recommended that Congress provide CMS with clear authority to administer prior authorization programs not only for advanced imaging services but also perhaps for other rapidly growing, elective services, like physical and radiation therapy and for particular high cost, non-urgent services for which there is evidence of or likelihood for inappropriate provision. [5]Inappropriate provision of services raises program and Medicare beneficiary costs and, sometimes, compromises the quality of care.

Medicare would face some distinct administrative and policy challenges in applying even the most successful private insurance prior authorization approaches. A pilot program testing prior authorization for advanced imaging services, which has been a mostly successful application in recent years by private insurers, could be a model for expansion

nationally for imaging but also as a model for other clinical areas to reduce inappropriate care and improve quality, especially for rapidly growing elective services that exhibit significant practice variation.

In 2008, the Government Accountability Office recommended that CMS examine the feasibility of imaging prior authorization, based on success of the approach by private plans contracting with Radiation Benefit Managers. In 2011, MedPAC suggested a modified approach that would require only well-documented, high-use practitioners to participate in a prior authorization program for advanced imaging. [6] Medicare would pilot in a region of the country an approach that would require physician outliers – those who order a significantly greater number of advanced imaging services than other physicians who treat clinically similar patients – to participate in a prior authorization process. The approach to targeting only outlier physicians for prior authorization is referred to as "gold-card" recognition, because the majority of physicians who have patterns of high approval rates would receive automatic approval when they order studies. This gold card approach permits targeting of scarce administrative resources, while avoiding any new burdens on most physicians, a very important attribute for use in Medicare. The targeting approach would also encourage all physicians to be more prudent in their use of imaging to avoid being subject to the new oversight.

To further promote cost-effectiveness, the pilot program would attempt to apply the prior authorization only to imaging services that account for a significant share of spending and service volume, have evidence-based guidelines for appropriate use, and exhibit substantial variations in use among ordering physicians and across geographic areas. The pilot could include both high and low use areas to learn whether physician receptivity to prior authorization and operational issues vary across high and low use areas. Further, the pilot could explore the approach if delegation of determining appropriateness to hospitals and other organizations using decision support systems (DSS), which has undergone preliminary testing by CMS. DSS are decision aids that provide real-time feedback to ordering physicians on the appropriateness of ordered imaging studies based on clinical guidelines and administered by the organizations themselves.

The pilot test would be conducted under the authority of the Centers for Medicare and Medicaid Innovation. Using rapid cycle evaluation, CMS would determine whether the approach shows savings and stable or improved quality, in which case it promptly would be expanded broadly. Also, based on findings from the demonstration, CMS might be in a position to recommend statutory provisions for expansion of prior authorization to other services while preserving the commitment to the targeting the approach to outlier clinicians based on valid analysis of their ordering practices, consistent with recommendations made by MedPAC.

Further, as with other provisions in the SGR Repeal legislation, if the pilot testing is found successful and the concept expanded more broadly in Medicare, physicians who participate in a meaningful alternative payment model, such as those described above that involve assuming financial risk for attributed patient populations, would be excluded from the prior authorization program.

As a pilot program, we do not assume programmatic savings from this initiative. In 2008, CBO estimated that a prior authorization program applied to all Medicare physicians for advanced imaging services would reduce spending by $220 million over 5 years and about $1 billion over 10 years. [7]

Review Documentation Guidelines for Office Visits

We propose that the physician payment legislation include a provision to reexamine the "documentation guidelines" that physicians must follow for coding office visits. For nearly 20 years, CMS has relied on these guidelines to assist physicians and auditors in coding properly for office visits under the Medicare Physician Fee Schedule, payment for which constitute almost half of spending under the Fee Schedule. The guidelines were developed because of concerns that the ambiguity in the five levels of Current Procedural Terminology (CPT) code descriptors for office visits was permitting substantial up-coding of services being performed and billed for.[8] They require health professionals to document in the medical record specific elements of patient histories, physical examinations, and clinical decision-making to justify the specific code level for which payment is being claimed.

Unfortunately, the application of the documentation guidelines likely has not reduced up-coding. In fact, they may facilitate up-coding because the widespread adoption of EHRs encourages "cut-and-paste," permitting practices to document clinical activities that may not accurately reflect the content of the office visit for which payment is being sought. In addition, the documentation requirements may cause clinicians actually to over-document, making the medical record an ineffective source of communication among clinicians. To address the elements of care associated with different code levels that are specified in the guidelines, some clinicians may engage in extraneous clinical activity that does not benefit patients but supports the higher than necessary code for payment purposes. Other clinicians, fearing sanctions for misrepresenting the contents of a medical visit, may down-code their services. Finally, concerns have risen in recent years that the transformative potential of EHRs has been seriously hindered because software developers have been oriented toward providing documentation needed to support coding rather than developing important functions, especially clinical decision support that would improve the quality, safety and efficiency of patient care. [9]

While there is widespread agreement among physicians and other health professionals that the documentation guidelines are misguided, they remain in place, unchanged for more than 15 years, largely because there has been no consensus about how to fix the underlying CPT office visit code descriptors. Yet, for at least the last decade, there have been no attempts to consider developing alternative office visit code descriptors or systematically assess whether the current application of the documentation guidelines are counterproductive, with negative impacts on the integrity of the clinical record, the potential of EHRs, while increasing costs.

To address this problem, Congress should ask the Medicare Payment Advisory Commission (MedPAC) to conduct a study of documentation guidelines and the underlying CPT codes to which they apply to be completed within 12 months. The study should include an assessment of the impact of the guidelines on:

- The accuracy of codes being submitted for payment;
- The accuracy of information and usefulness of clinical records, both paper and electronically-based;
- The potential of EHRs to improve clinical care and efficiency rather than facilitate coding for payment.

The study also would provide an assessment of the feasibility of adopting other coding structures and descriptors would obviate the need for documentation guidelines and what additional work would be needed to accomplish such alternative coding structures. Finally, the MedPAC study would consider whether the current application of documentation guidelines might be waived for clinicians qualifying for participation in Alternative Payment Models.

Part 4

BETTER AND SIMPLER PERFORMANCE MEASURES FOR PHYSICIANS

The proposed legislation addresses many of the problems with the current measures used in Medicare's public reporting and physician payment programs, including:

- Complexity due to the use of multiple reporting and payment incentive programs: Physician Quality Reporting System (PQRS), Electronic Health Records/Meaningful Use (MU), and the value-based payment modifier (VBM);
- Over-reliance on process measures that are often unrelated to outcomes;
- A dearth of standardized outcomes measures;
- A lack of comparative data on physician performance;
- Providers' lack of access to timely, actionable that can help them improve their performance.

In particular, in 2018, the MIPS program would replace the current programs for quality measurement (PQRS, Meaningful Use, and the Value-based Modifier). Performance reporting and payment incentives under the MIPS would be based upon four categories: quality, resource use, meaningful use of EHR, and clinical practice improvement activities. Providers would select which quality measures (from an annual list published by CMS) on which to report and be assessed.

The bill would provide $15 million/year from 2014-2018 for the development of better performance measures. The Secretary would be required to develop a measure development plan, using the following criteria to set priorities:

- Outcome measures
- Patient experience measures
- Care coordination measures
- Measures of appropriate use of services
- Consider gaps
- Consider applicability of measures across health care settings

The proposed legislation also references the use of a multi-stakeholder consensus-based entity, such as the National Quality Forum (NQF), to endorse measures and make recommendations for their use in public reporting and Medicare payment programs. Under the proposed bill, however, measures might be selected for MIPS regardless of whether they were endorsed or recommended by a consensus-based entity. Furthermore, certain types of measures, including resource use measures and those extracted from clinical registries, would be exempt from the multi-stakeholder process.

Simplifying the measure reporting process in MIPS and accelerating the movement to population-based and condition-specific outcomes measures that are most meaningful to patients and physicians are a key part of the proposed legislation. We believe they should be more prominent parts with more substantial financial support. Success will mean physicians will have measures that they believe should be the object of efforts to improve practice (and data showing them how to improve on the measures), the measures can be consistently applied to a variety of alternative payment models and Medicare's other payment systems, and consumers and others will be able to compare providers, all with less administrative burden. These are all very important steps for the success and sustainability of payment reform, but we believe that achieving success will require additional implementation steps and more financial support.

Our proposed approach is based on the following principles:

- Physicians with core activities amenable to accurate measurement without undue administrative burden should be recognized and rewarded or penalized for better performance mostly on measures of outcomes and patient experience.
- Measures and complementary payment rewards and penalties should be strategically applied to focus on priority quality and safety problems amenable to accurate assessment by measurement of outcomes. Other important quality problems not currently amenable to accurate outcome measurement should also receive attention and should be addressed through quality improvement approaches that do not rely primarily on measurement.
- Measure development and endorsement should be focused on a limited set of key, outcome-oriented measures, reflecting a set of principles for meaningful progress on measurement such as those used by the NQF Measure Application Partnership.
- The measures should be standardized to ensure fair comparisons among providers
- Measures should be designed to facilitate the transition from FFS to APMs.
- Measures used in public reporting and payment should be based on input from an independent multi-stakeholder consensus group that uses objective criteria for endorsement and recommendations.
- Providers should receive timely data related to their performance on the measures, so that they have a meaningful opportunity to improve care or address measurement problems, before the measures are publicly reported or used for payment.
- Providers should be rewarded for shifting to the use of meaningful, outcomes-based, comprehensive measures.

SPECIFIC RECOMMENDATIONS

Meaningful and Simplified Measures

Strengthen and streamline measures used in MIPS. We recommend reducing the scope of reporting requirements for physicians under MIPS, which are built on existing requirements under PQRS, Meaningful Use, and the Value-based Modifier. Instead, physicians in the MIPS program should be required to use patient experience and engagement measures at the individual physician level, as well as a **limited number of core measures reflecting the patient conditions they treat**.

At present, physicians can generally use individual-level Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures; suitable outcome measures are not available for most specialties, but progress is occurring and should be accelerated. The measures should progress over time from appropriateness measures toward use of clinical outcome measures, patient-reported outcomes measures and total patient cost/resource use measures. Individual outcome measures should be used only for certain specialties and procedures/services in which it is feasible and appropriate to attribute the outcomes to a specific physician.

Strengthen and streamline measures used in APMs. We recommend that physicians in APMs be expected to measure a **similar concise set of meaningful performance measures** reflecting these same priorities: clinical outcomes, patient-reported outcomes, patient experience, and appropriateness. These key quality measures should be accompanied by total cost/resource use and efficiency measures. By 2018, such measures should reflect most of the patient care that they provide, as well as for care of their total patient population.

Accelerated Measure Development

CMS should prioritize the development of measures in MIPS and APMs for the top 20 conditions/clinical areas based on high cost, high volume, variation, and opportunities for care improvement. These should include crosscutting measures for situations in which condition-specific measures may not be appropriate, e.g., for patients with multiple chronic conditions. For each of these, high priority should be placed on measures of clinical outcomes, patient-reported outcomes (e.g., Patient Reported Outcomes Measurement Information System), patient experience, appropriateness and total cost of care. CMS should aim for these measures to be available for use in the top 20 clinical areas by 2018.

Measure selection process

The selection of core measures for use in payment and public reporting should be based on input from consumers, purchaser, payers and other stakeholders. The best way to assure this is through an **independent, multi-stakeholder process**. The proposed bill language would weaken the multi-stakeholder process and does not assure stakeholder input. To assure that measures are comparable and meaningful, there should be **no exceptions for certain data sources** (e.g., clinical registries) **or types of data** (e.g., cost/resource use or appropriateness). If there are important issues or problems with the multi-stakeholder process that need to be addressed, Congress should direct CMS to do so through its process of contracting with the responsible organization.

Specialty societies should be encouraged to nominate measures to be considered, and should receive support for developing and piloting measures that can be produced interoperably by different providers and electronic record systems. There should be no requirement for review of proposed measures in peer-reviewed specialty journals. An effective multi-stakeholder review process would assure that the measures are carefully considered.

Health Information Technology

Office of the National Coordinator (ONC)/CMS should facilitate mapping of recommended measures among registries, EHR systems, and CMS reporting requirements, to encourage both reporting and improvement feedback.

ONC/CMS should assure that mechanisms are widely available to physicians who use electronic records and/or participate in electronic registries to permit widespread capture of relevant data for key performance measures. The highest priority should be capture of patient experience data and of patient-reported outcomes (PROs) for high-burden conditions by eligible providers.

Access to Data for Quality Improvement

Medicare should build on its current mechanisms for sharing claims data with physicians to give them better and timelier data to support care improvement activities. This includes providing regular, timely updates on data relevant to key performance measures (e.g., quarterly updates on, with access to underlying data to enable physicians to determine how they could improve performance), and "baseline" measures of how physicians or physician groups would fare in performance measurement and reimbursement if they chose to adopt an available APM. Such data should be available ahead of public reporting and payment, and ideally in time for physicians to make any needed practice adjustments. The highest priorities for such actionable data access are the priority measures described in this section and any measures related to resource use in MIPS.

Higher Payment for Use of More Meaningful Performance Measures.

In both MIPS and APMs, we have proposed physicians should be eligible for a higher bonus payment if they report on more meaningful measures. In particular, physicians who use outcome-oriented measures in MIPS should receive higher potential payment for reporting these measures (i.e., a 2 percent bonus), transitioning to higher payment for superior results. APMs that initially rely on meaningful outcome measures should receive a higher payment bonus (at least 2 percent) than APMs that rely mainly on process measures, and APMS should be required to transition to priority, outcome-oriented measures within five years, along the lines we have described above.

APPENDIX

Illustrative APM Bonus Formula That Provides More Support for More Meaningful Physician Payment Reforms

Below, we describe a general formula determine an APM bonus in a manner that reflects our principles for providing more support for more meaningful physician payment reforms. This APM flat amount per provider/group (not a multiplier to fees) based on our principles:

Bonus = (Adjustment Factor) x (Benchmark Spending) x
(Payment Shift) x (Outcome Measure Adjustment)

Adjustment Factor would be set by CMS based on overall budget target or other high-level policy guidance. This is a scaling factor.

Benchmark Spending is the (risk-adjusted) spending benchmark for the provider/group. For episode payment models, it could be the episode rate, multiplied by the expected number of episodes for the physicians involved. For primary care per member per month (PMPM) models, it could be the benchmark used to determine shared savings or losses for the primary care group. For global payment models and other payment reforms that combine physician payment with payment to other providers, it is the component of the overall spending benchmark derived from physician payments (i.e., other provider payments are not counted in the physician incentive benchmark). It could also be "baseline" Medicare spending for the physician group trended forward. Essentially, this is the expected total spending for the physicians involved in the payment reform – actual spending is not appropriate for determining the bonus, since that would reward groups that increase spending.

Payment Shift is a measure of the magnitude of the APM. It reflects two factors: "Share" and "Strength".

"Share" represents the share of payments shifting from FFS to risk-based payment under the APM. It is the ratio of payments involved in the APM (e.g. subject to risk such as episode payment or PMPM) to total baseline payments, net of any new payments in the APM. For example, if 20% of a physician's payments in a bundled payment initiative involve partial or full bundles that replace FFS payments, the share would be 0.2. If fees for office visits are replaced by a PMPM, the share equals the ratio of the eliminated FFS payments to baseline payments. For example, if the APM reduced all of the provider's FFS rates by 20%, and set up a PMPM payment equal to those expected FFS payments, the share would be 100%.

"Strength" of the APM measures the risk Medicare transfers to the provider organization. It should be computed as the 1 minus the ratio of Medicare spending change that would occurs under the APM *if* volume increases or decreases relative to the Medicare spending change that would have occurred under the previous FFS system. For example, in an APM that shifted to a fixed payment for the services involved*, if* volume of those services increases 10%, or *if* volume fell 10%, Medicare spending would not change at all, so the ratio of the Medicare spending increase under the APM to that under FFS is 0 and thus the strength of the APM is 1. In an APM with 60% loss sharing above the benchmark, the strength would be 0.6, because *if* volume of the services involved in the APM were to rise 10%, Medicare spending would increase only 4% (that is, 1-4%/10%=.6).

The same principles apply to models that combine PMPM payments with reductions in FFS payment rates. For example, consider the previous APM example that includes a PMPM along with a 20% reduction in FFS rates. If under that model volume were to increase 10% (maybe because utilization was still profitable and thus there was induced demand), the increase in volume would result in only an 8% increase in spending. Since Medicare would only pay 80% of the traditional FFS amount, the strength would be 0.2.

Payment Shift = Share * Strength

Note that this approach would apply to both episode and capitated APMs. In contrast to a partial- or fully-capitated APM, in which the share is 100%, the share in an episode APM is the proportion of physician payments covered by the episode payment. The strength measures the degree of loss sharing if the benchmark is exceeded. However, in episode models, even if the strength is 1, Medicare spending could increase if the volume of episodes increases. For this reason, we recommend not piloting episode payment models until there is supporting evidence that the volume of episodes does not increase, or including other adjustments in the APM to offset the effects of a higher volume of episodes.

Outcome Measure Adjustment is a further bonus for physicians using APMs that involve endorsed and/or validated patient outcome and experience measures as the basis for their reimbursement. The intent is to encourage continuing progress toward more meaningful performance measures in APMs. This could be implemented as a further upward adjustment in the payment bonus. For example:

- Minimum value=1 if no endorsed patient outcome and experience measures
- Maximum value=1.10 (i.e. an additional 10% increment to the bonus) if all measures are endorsed outcome and experience measures.

For systems with mixed structure/ process/ outcome/ experience measures, the value could be in proportion to the share of endorsed outcome/experience measures (or if possible, the share of APM payments tied to outcome/experience measures).

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