

# **The SGR Fix: A Pathway to Fundamental Physician Payment Reform?**

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**Center on Health Care Effectiveness  
Mathematica Policy Research  
Washington, DC  
March 11, 2015**

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# Moderator

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**Eugene Rich**

**Director, Center on Health Care Effectiveness**

**Mathematica Policy Research**

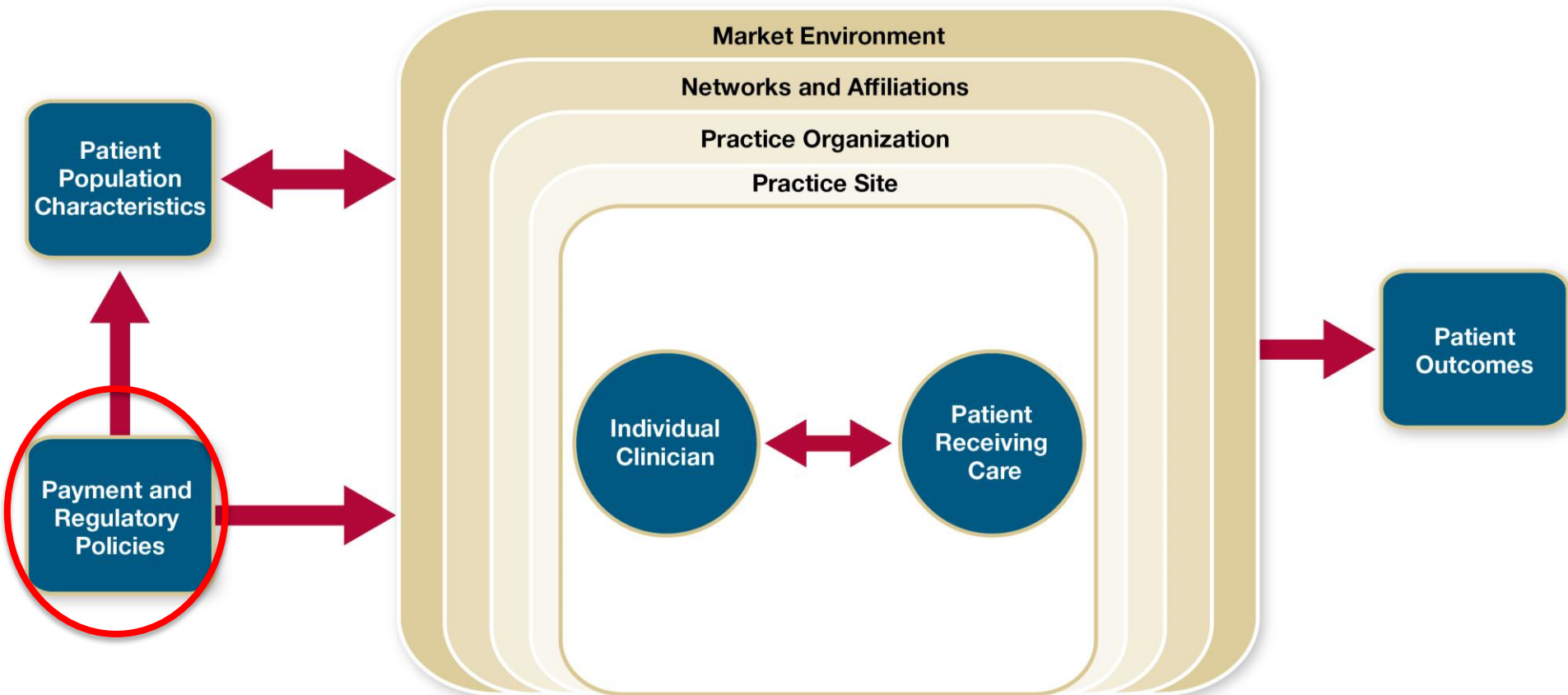
# About CHCE

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The Center on Health Care Effectiveness (CHCE) conducts and disseminates research and policy analyses that support better decisions at the point of care. Our focus is on the delivery systems and policy environments that help clinicians and patients make more informed decisions, using information on outcomes and effectiveness.

For more information about CHCE, please visit <http://chce.mathematica-mpr.com/>.

# Decision Making at the Point of Care



# The SGR

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- The SGR is a mechanism to control Part B spending under the Medicare fee schedule (MFS)
- How the SGR formula works
  - Sets annual per-beneficiary spending target based on GDP growth, changes in Medicare laws/regulations
  - Annually adjusts physician fees up or down, depending on whether actual spending growth falls below or above the target
- History
  - Operated as intended from 1998 to 2002
  - 2002: 4.8% SGR cut in physician fees
  - Since 2002, Congress has overridden SGR fee cuts
  - In 2015, SGR would cut physician fees by ~21%

# Replace the SGR?

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- **Physician fee cuts are politically untenable**
- **Annual SGR overrides are a source of political struggle, angst, and inefficiency**
- **SGR (without congressional overrides) is not effective policy**
  - **Targets prices but places no control over the volume/intensity of services**
  - **Alters fee updates, thus equally affecting:**
    - **Efficient and inefficient providers**
    - **Effective and ineffective services**
    - **Services with high and low margins (overvalued and undervalued)**
- **Reform can promote evolution from fee-for-service system toward value-based payment**
- **SGR fix (H.R. 4015/S. 2000) was agreed to by key House and Senate committees in 2014**
  - **Fix now costs \$174.5 billion from fiscal year 2015 to 2025**

# Welcome

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**Sarah Dine**  
**Senior Deputy Editor**

HealthAffairs

# Today's Speakers

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**James Reschovsky, Mathematica**



**Stuart Guterman, The Commonwealth Fund**



**Mai Hubbard, Mathematica**



**Robert Doherty, American College  
of Physicians**





# **Solving the Sustainable Growth Rate Formula Conundrum Continues Steps Toward Cost Savings and Care Improvements**

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**Center on Health Care Effectiveness Forum**

**March 11, 2015**

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James Reschovsky • Lara Converse • Eugene Rich

# Key Features of 2014 SGR Fix

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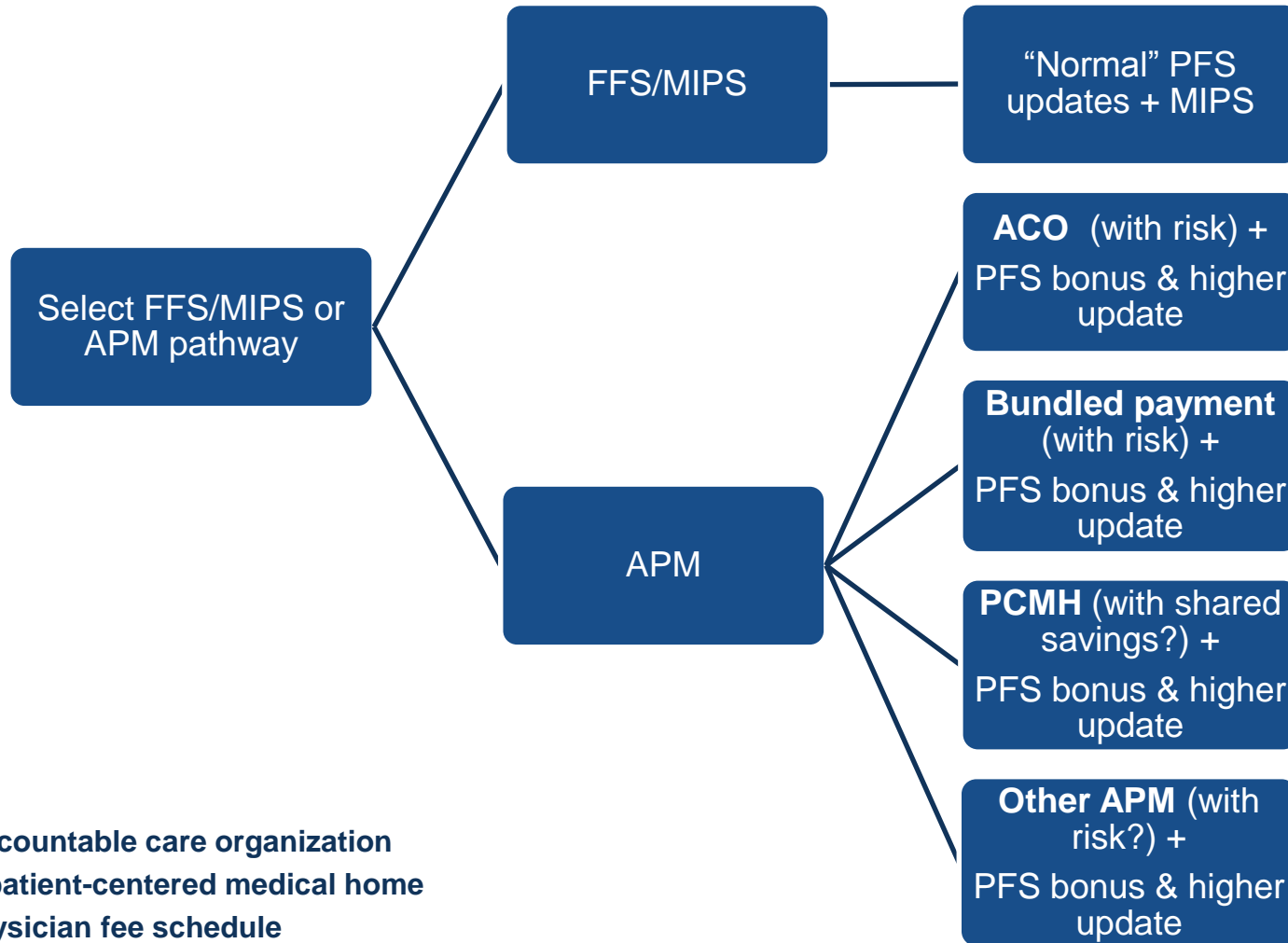
- **Would repeal SGR and replace it with small but legislatively specified payment updates**
- **Eligible providers could choose one of two pathways:**
  1. Stay with FFS, with enhanced, two-sided pay-for-performance system: a merit-based incentive payment system (MIPS)
  2. Significantly participate in alternative payment models (APMs)
- **Structure creates incentives for choosing the APM pathway**

# Legislation's Goal and Key Evaluation Questions

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- Goal is to move Medicare away from fee-for-service to a more patient-centered, value-based payment and delivery system
- Key questions:
  - Would MIPS improve quality and lower costs on the FFS/MIPS pathway?
  - Will APMs improve quality and lower costs?
  - Does the SGR fix provide ample incentives to choose the APM pathway as well as sufficient APM opportunities?

# Provider Choices



ACO = accountable care organization  
PCMH = patient-centered medical home  
PFS = physician fee schedule

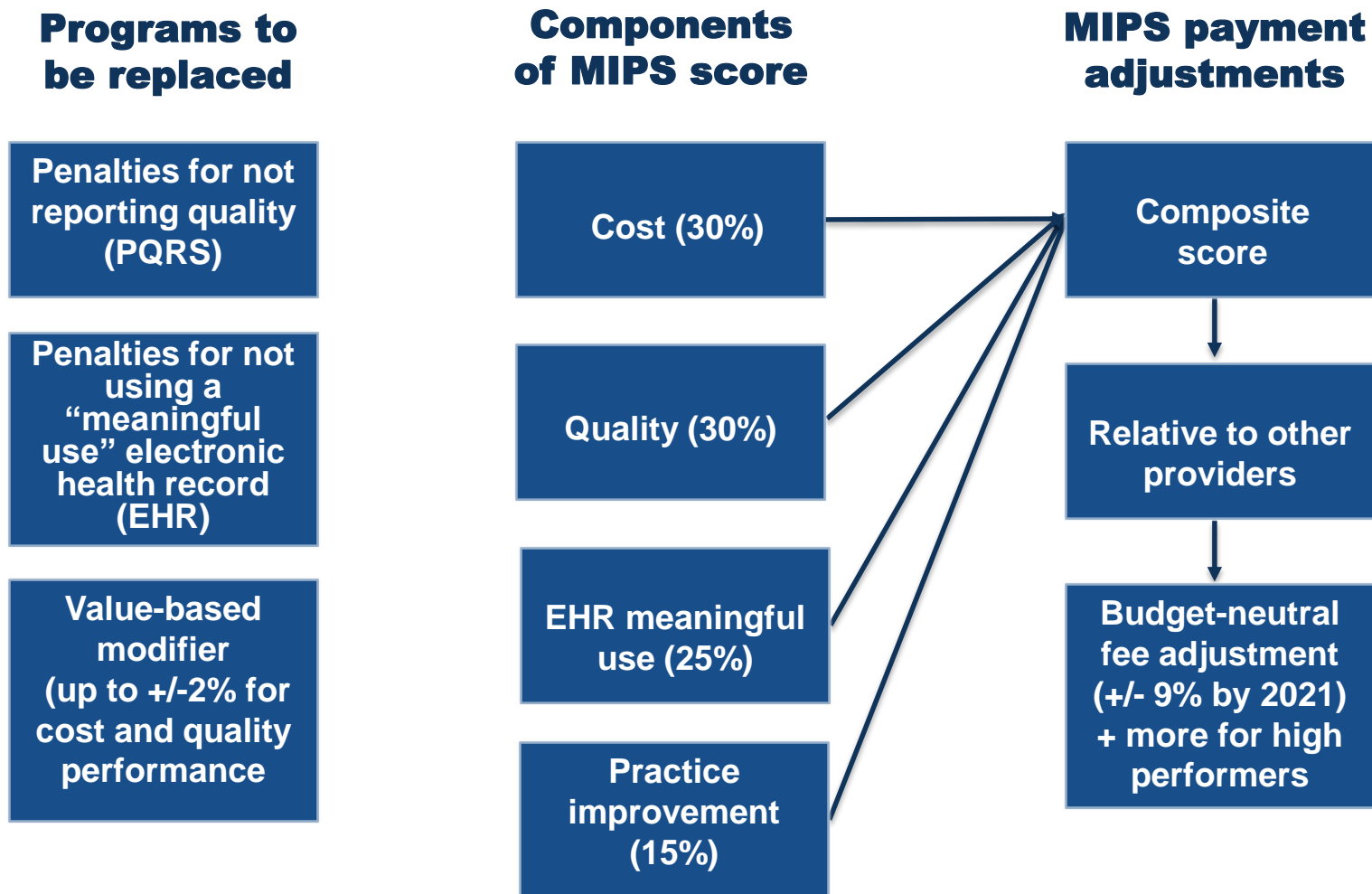
# Proposed Fee Updates and Bonus Payments Under the Two Pathways

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Years*	FFS/MIPS pathway	APM pathway
2014–2018	0.5% annual fee update	0.5% annual fee update
2019–2023	No fee updates	No fee updates 5% fee bonus
2024 onward	0.5% annual fee update	1.0% annual fee update

\*Year as specified in 2014 legislation, likely to be pushed forward under 2015 version.

# Proposed MIPS



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# **1. Would MIPS improve quality and lower costs on the FFS/MIPS pathway?**

# MIPS: Promising Features

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- Two-sided rewards based on performance relative to other providers
- Penalties and rewards are substantial
- Greater resources for quality measure development
- Results will be publicly reported
- Encourages practice improvements that make APM participation easier
- Medicare is the largest payer; other payers may emulate



# MIPS: Features That Could Compromise Effectiveness

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- Meaningful and effective quality metrics are difficult to develop
- Opportunities for gaming
- Complexity of MIPS score could compromise actionability
- Technical challenges (e.g., risk adjustment, imprecise estimates) could threaten credibility

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## **2. Will APMs improve quality and lower costs?**

# APMs Intended to Correct Problems with FFS

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- **FFS payment increases costs and can compromise quality**
  - Rewards unnecessary and expensive care
  - Fragments care delivery
  - Fails to reward quality-enhancing activities
- **Rewarding providers for high quality and efficient delivery of services is seen as a logical way to alter physician incentives**

# Despite Mixed Evidence on APM Efficacy, CMS Is Committed to Expansion

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- HHS recently announced ambitious goals to expand APMs
  - Tying 50% of payments to APMs by 2018
- ACOs: Some Medicare cost savings, but most ACOs are far from being able to accept downside risk
- Medical homes: Some promising and some very mixed results from early CMS medical home pilots
- Bundled payment: Too early to assess CMS bundling pilot, but literature generally points to positive results
- Across all types of APMs, commercial insurance applications have shown success at times

# For Most APM Initiatives, Still Too Early to Assess Success

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- Care transformation will be slow and evolutionary
  - Implementation/interoperability of health information technology
  - New data analytics to target patient needs
  - Negotiation of contractual arrangements
  - Hiring of new staff
  - Learning to work in teams
  - New clinical mindsets needed
  - Etc.

# Considerable APM Activity by Other Payers Enhances Chance of Medicare APM Success

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- Substantial APM activity in commercial insurance and some state Medicaid programs
  - Some Center for Medicare & Medicaid Innovation (CMMI) programs are multipayer in design
- Fixed costs of transformation spread over more patients
- Changed clinical practice patterns resulting from APMs will likely spill over to care provided to patients not in APMs

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**3. Does the SGR fix provide ample incentives to choose the APM pathway as well as sufficient APM opportunities?**

# Which Pathway Will Physicians Take?

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- **Hard to assess; depends on:**
  - **Income possibilities and risks (based on CMS implementation, local market, etc.)**
  - **Intrinsic rewards from improving quality**
  - **Many see APMs as inevitable and are preparing for the future**
- **To date, a large and growing participation in many CMS APM initiatives**



# Will Physicians Have Enough Opportunities on the APM Pathway?

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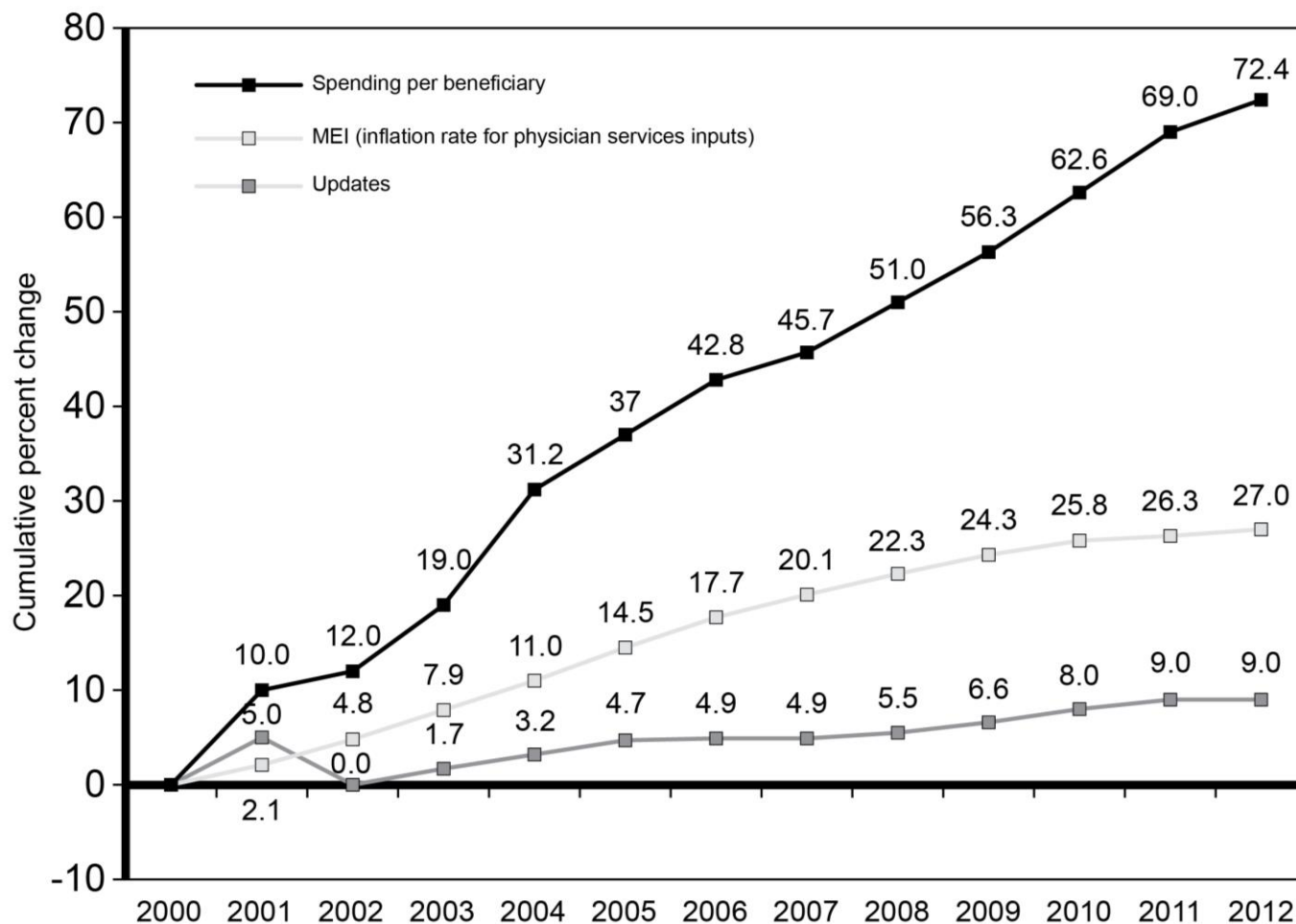
- **Some specialists will have trouble finding places in existing APMs**
  - **CMS already exploring options for specialty-oriented APMs**
    - Outpatient bundled payment (e.g., End-Stage Renal Disease (ESRD) Prospective Payment System)
    - Specialty medical homes (e.g., oncology)
    - Condition-oriented ACOs (e.g., Comprehensive ESRD Care initiative)
- **Small practices often lack resources for care transformation**
- **2014 SGR fix devotes resources and directs CMS to find APM opportunities for these providers**
- **Need to ensure specialty- or disease-oriented APMs don't fragment care delivery, compromising the whole-person, population-based ACO approach**

# Fixing Valuations in the Fee Schedule Would Improve Prospects for Success

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- Profitability of services varies greatly due to misvaluations in the physician fee schedule, contrary to the intent of the RBRVS system
  - Misvalued services generally help proceduralists, hurt cognitive specialists (especially primary care)
- Fixing valuations in the fee schedule would:
  - Make it harder for physicians to increase Medicare revenue despite low fees in FFS/MIPS pathway (in spite of MIPS takeback)
  - Improve efficiency and quality of care on both pathways
    - FFS still predominant payment method under current APMs
  - Increase resources available for medical home transformation
  - Improve APM operation through better benchmarks used in shared risk/savings

# During Period of Low Medicare Fee Increases, Spending Soared



Note: MEI (Medicare Economic Index)

Source: A Data Book: Health Care Spending and the Medicare Program, MedPAC, June 2014

# Conclusions

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- **2014 SGR fix affords physicians a level of certainty regarding Medicare fees that has been missing for past 13 years**
  - **Rids Congress of political albatross**
- **Fix is built upon reforms currently being implemented and tested**
  - **Would accelerate the move away from FFS towards value-based payment systems (in Medicare and beyond)**
- **Success will significantly rest on CMS's agility in adapting MIPS and APMs to ensure successful implementation**
- **SGR fix is costly, but cost is small relative to the total cost of Medicare, and perhaps the potential savings from reforms**

# **Observations from the Physician Feedback/Value Modifier Program**

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**Center on Health Care Effectiveness Forum**

**March 11, 2015**

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Mai Hubbard • Jeffrey Ballou • Wilfredo Lim  
Eugene Rich • Anna Collins

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# Overview of Presentation

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- **Discuss the Physician Feedback/Value Modifier (VM) Program (“Physician Value Program”)**
- **Explain how the current program relates to the priorities in the legislation**
  - **HHS is specifically encouraged to test APMs relevant to:**
    - Specialty physician services
    - Professionals in small practices of 15 or fewer professionals
  - **HHS will identify the potential challenges of and vulnerabilities in APMs**

# An Overview of the Physician Value Program

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- **What is the purpose of the Physician Value Program?**
  - The program is being implemented under Sections 3003 and 3007 of the Affordable Care Act
- **Who is eligible for Quality and Resource Use Reports (QRURs) and the VM?**
  - QRURs are sent to all solo practitioners and physician groups
  - Groups of 100 or more eligible professionals are affected by the VM
- **Beneficiaries are attributed to groups based on primary care services**

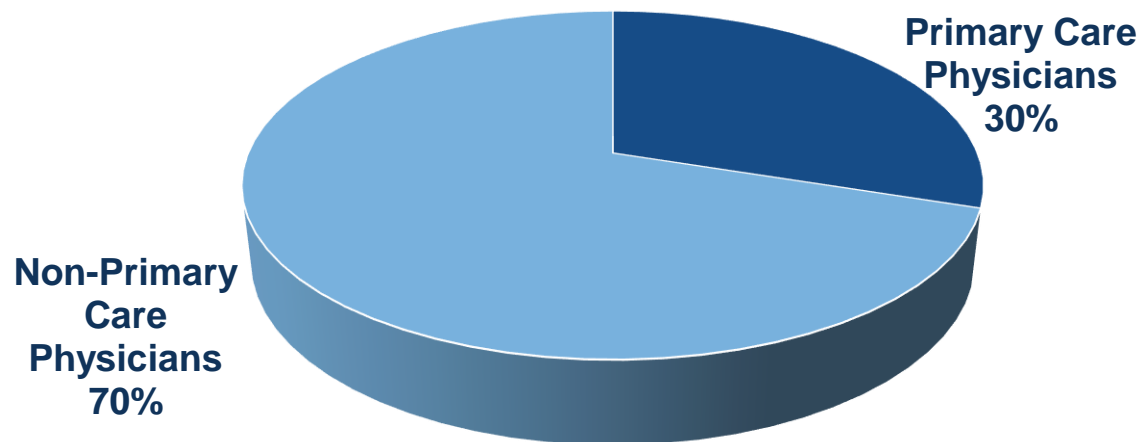
For more information about the program, see <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html>.

# Specialists Are Also Affected by the Program

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- 3,411 groups received a QRUR in 2013
  - 1,032 (27%) were large groups of 100 or more eligible professionals
  - 961 (25%) were groups where most eligible professionals were in a single specialty

Category of Majority Single-Specialty Groups



Source: Experience Report for the Performance Year 2012 Quality and Resource Use Reports, January 2014.



# Special Care Is Needed in Assigning Patients to Groups and Physicians

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- Meaningful quality and resource use metrics are difficult to provide to specialty groups and physicians when attribution is based on primary care services
- Half of groups with 25 or more eligible professionals do not have enough patients attributed to compute meaningful performance measures
- Many of these groups were predominantly specialty groups that did not provide primary care services
  - Radiologists and anesthesiologists

Source: Experience Report for the Performance Year 2012 Quality and Resource Use Reports, January 2014.

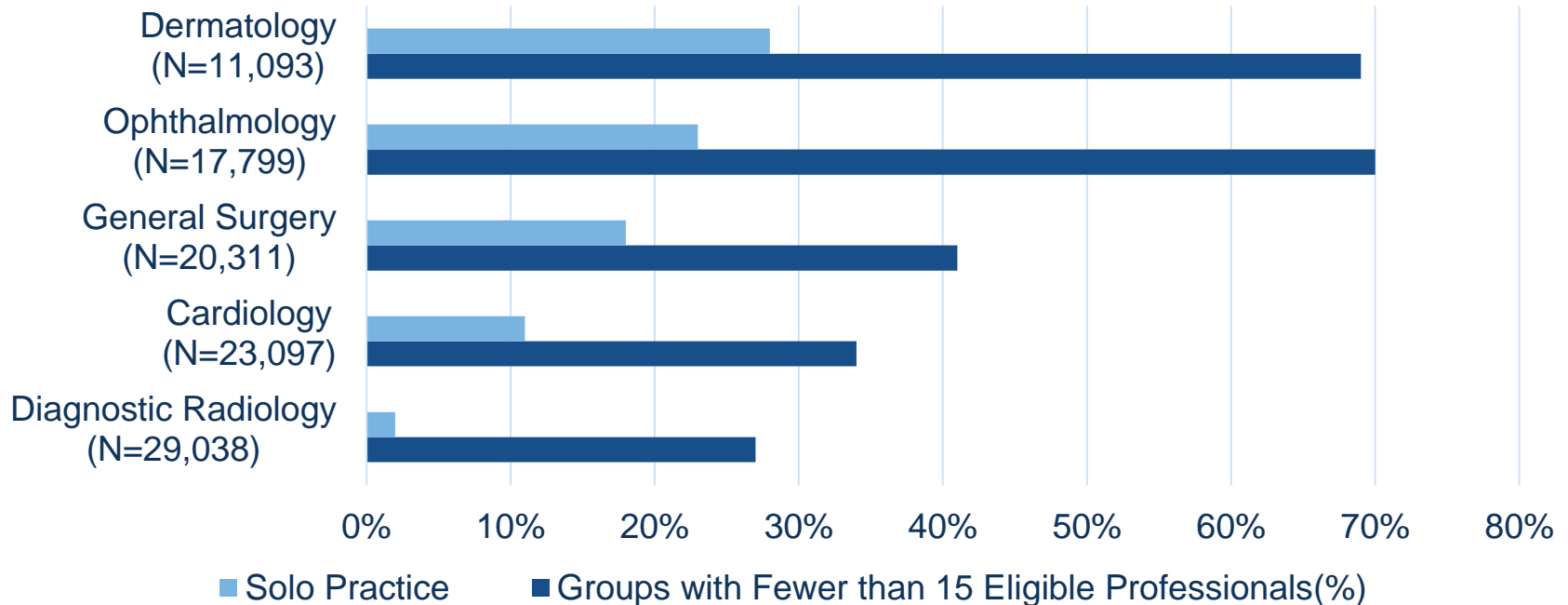
# What About Smaller Physician Practices? Findings from Physician Compare

The screenshot shows the Medicare.gov Physician Compare website. At the top, the logo reads "Medicare.gov | Physician Compare" with the tagline "The Official U.S. Government Site for Medicare". Below this are five navigation buttons: "Physician Compare Home", "About Physician Compare", "About the Data", "Resources", and "Help". A breadcrumb trail shows "Physician Compare Home" with a "Share" button. A large banner image features a group of diverse healthcare professionals in front of a map of the United States. Below the banner are three search options: "Find Physicians and Other Healthcare Professionals" (highlighted), "Find Group Practices", and "Search Another Way". A search form below contains the instruction "A field with an asterisk (\*) is required." and two input fields: "\* Location" (with placeholder "ZIP Code/City, State/Address/Landmark") and "\* What are you searching for?" (with placeholder "Doctor Last Name or Specialty or Medical Condition"). A green "Search" button and a link for "Additional Search Options" are also present.

Source: <http://www.medicare.gov/physiciancompare/staticpages/aboutphysiciancompare/about.html>.

# Practice Modes of Specialists

- Solo practices and “smaller” groups with 15 or fewer eligible professionals are common
- Researchers testing APMs will need to pay particular attention to a group’s practice mode



Source: <http://www.medicare.gov/physiciancompare/staticpages/aboutphysiciancompare/about.html>.

# Challenges of Using APMs with Specialists, Small Practices

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- As HHS encourages physicians to participate in APMs, it will also need to identify potential challenges and vulnerabilities
- Challenges that have been observed through the Physician Feedback Program and Analysis of Physician Compare include:
  - Addressing practice configurations
  - Understanding practice configurations by group size

# Challenges and Vulnerabilities: Can Practice Configurations Change?

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- The Physician Value Program applies payment modifications to the group whose performance was evaluated, based on the group's size
  - A group's performance in 2013, for example, affects the group's physician payments in 2015
- Many specialists work in more than one group: cardiologists, 66%; ophthalmologists, 54%; diagnostic radiologists, 62%
- Variation exists in the group size of specialists who bill under multiple groups
  - Solo practitioners who bill under multiple groups: 20% of dermatologists compared with 1% of radiologists
- APMs will want to consider how group composition, particularly of specialty and smaller groups, may be affected

Source: <http://www.medicare.gov/physiciancompare/staticpages/aboutphysiciancompare/about.html>.

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# Summary

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- Findings from the Physician Value Program and Physician Compare provide a better understanding of the organization of specialists and smaller practices
- Applying the APM to specialists and smaller practices is complex
  - As APMs are developed and tested, careful consideration of a group's practice mode will be important

# Acknowledgments

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I would like to thank my colleagues who have worked to make this project a success, including Jeffrey Ballou, Wilfredo Lim, Gene Rich, Mike Rudacille, and Aimee Valenzuela.

A big thank you to Anna Collins, who conducted the analysis for this presentation.



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# **The SGR: Why It Should Be Replaced**

**Stuart Guterman  
Vice President, Medicare and Cost Control  
The Commonwealth Fund**

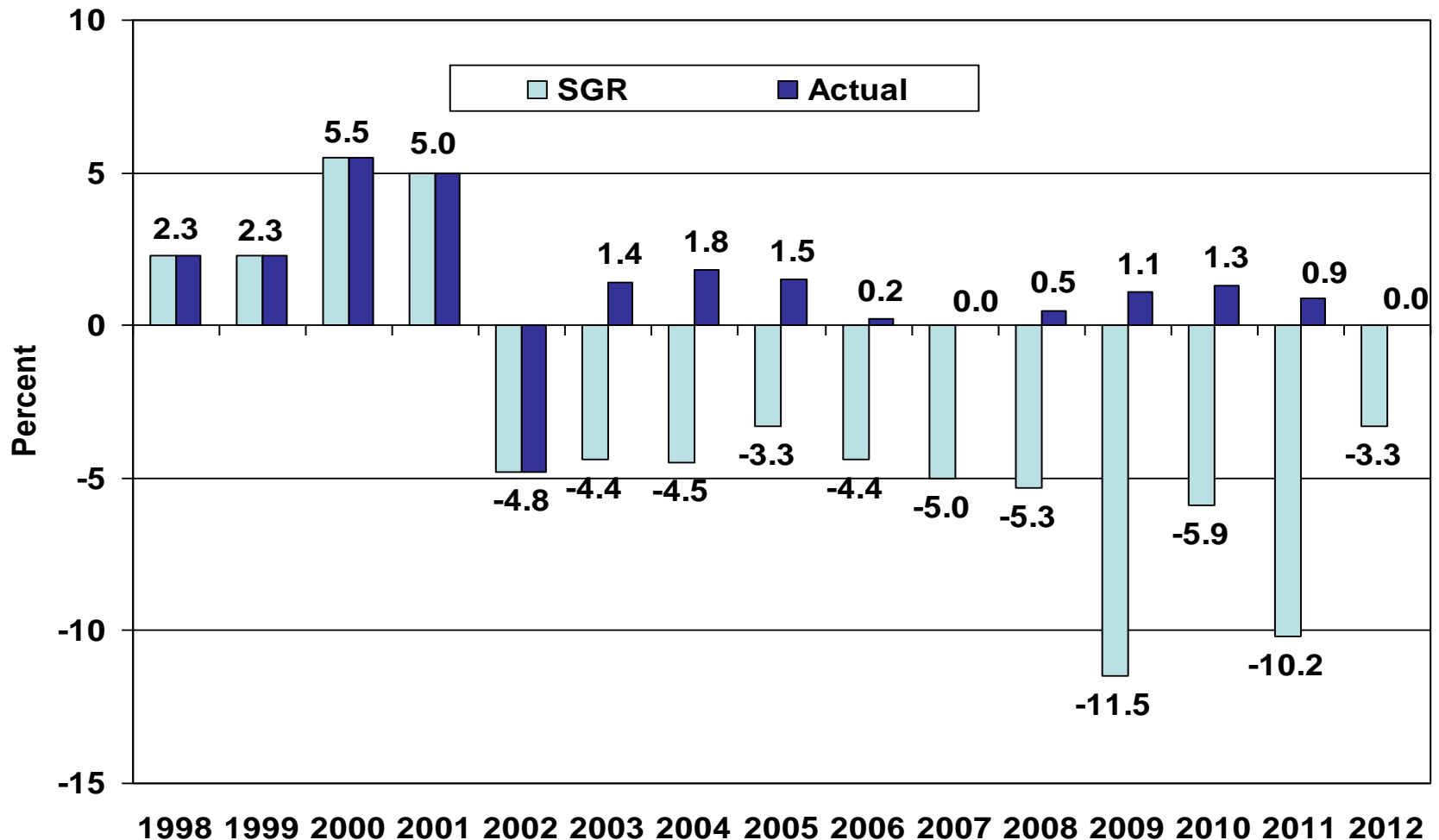
**Mathematica Forum  
The SGR Fix:  
A Pathway to Fundamental Physician Payment Reform?  
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# The SGR Quandary

- **The SGR is intended to control Medicare spending**
  - **Total payments to physicians based on volume and intensity of individual services**
  - **Volume and intensity determined directly by physician decisions**
  - **SGR formula reduces fees for all services if total physician spending exceeds target**
- **But...**
  - **As spending continues to exceed target, SGR formula produces large cuts in physician fees that may threaten Medicare beneficiaries' access to care**
  - **Large cuts produced by SGR formula make it “costly” to repeal, so Congress has deferred cuts**

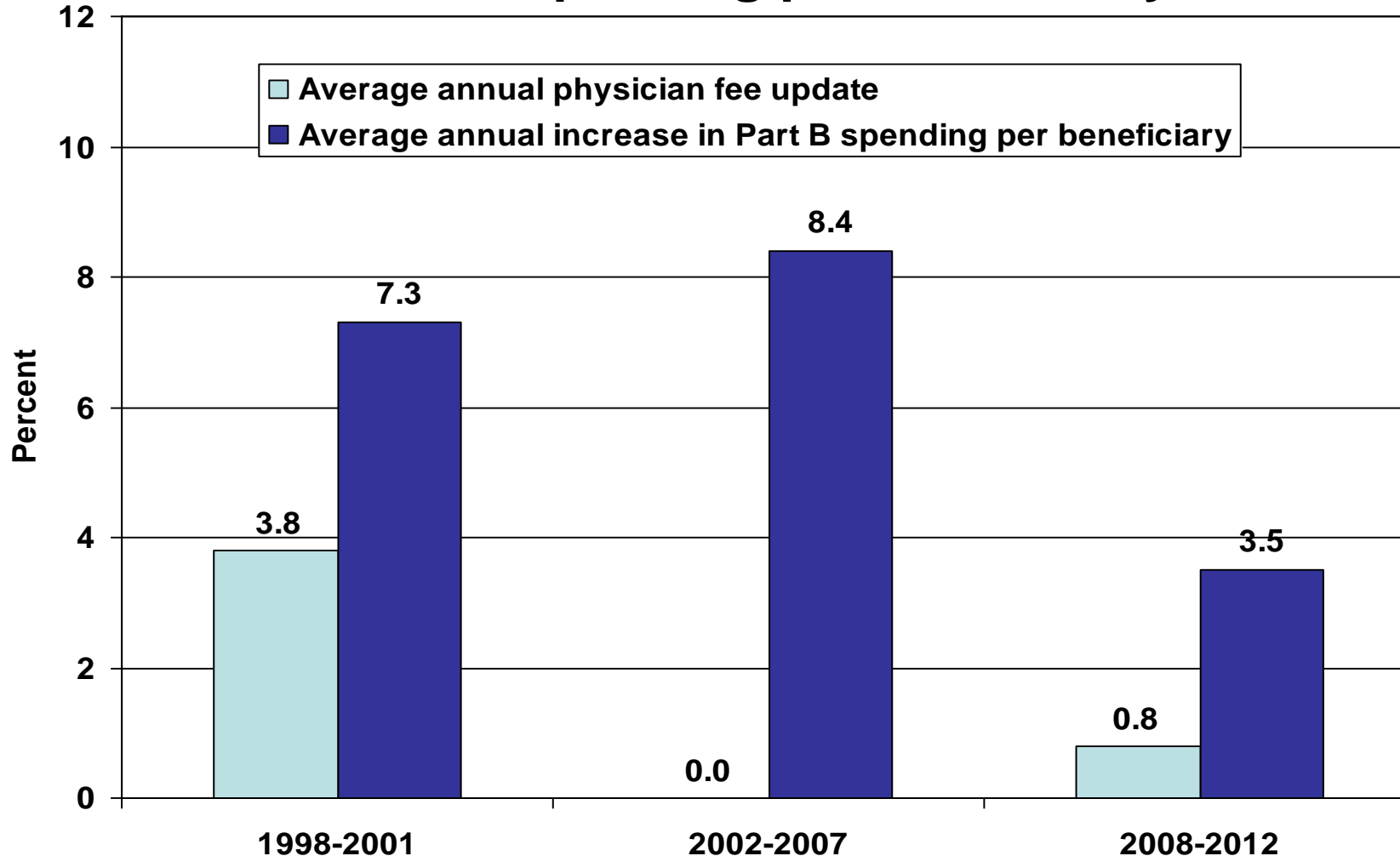
# Medicare Physician Fee Updates: SGR Formula vs. Actual, 1998–2012



Note: SGR = Pre-legislation conversion factor update for calendar year; Actual = weighted average annual update for calendar year.

Source: Centers for Medicare and Medicaid Services, Office of the Actuary. "Estimated Sustainable Growth Rate and Conversion Factor for Medicare Payments to Physicians in 2014." March 2013. Available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SustainableGRatesConFact/Downloads/sgr2014p.pdf>.

# Medicare Physician Fee Updates and Increases in Part B Spending per Beneficiary, 1998–2012



Sources: Physician fee updates—Centers for Medicare and Medicaid Services, Office of the Actuary. “Estimated Sustainable Growth Annual RepRate and Conversion Factor for Medicare Payments to Physicians in 2014.” March 2013. Available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SustainableGRatesConFact/Downloads/sgr2014p.pdf>; Spending increases—2013 report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. May 2013. Available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2013.pdf>.

# **The Failure of the SGR**

- It reduces payment rates across the board, regardless of appropriateness**
- It maintains incentives for physicians to increase service volume and intensity**
- It does not address the undervaluation of primary care services in the physician fee schedule**
- It has not succeeded in controlling spending growth**
- It has led to increasing gaps between Medicare and private payment rates**
- It has undermined Medicare's credibility with physicians**
- It does not provide incentives to improve quality, appropriateness, and coordination of care**

# Recent Developments

- **December 2013: Ten-year “cost” of repealing the SGR (and replacing it with a freeze on physician fees) estimated at \$116.5 billion (down from \$271 billion in June 2012)**
- **July 2013: House Energy and Commerce Committee passes a bill to replace the SGR with limited updates to base payment rates and rewards based on performance and participation in alternative payment models**
- **October 2013: Leadership of Senate Finance and House Ways and Means Committees release discussion draft describing a similar approach to repeal the SGR**
- **December 2013: Both committees pass bills along the lines proposed by their leadership**

## **Recent Developments (cont'd.)**

- **March 2014: Failing to reach agreement on how to offset the “cost” of SGR repeal, Congress temporarily defers physician fee reductions—for the 17<sup>th</sup> time**
- **February 2015: Ten-year “cost” of repealing the SGR (and replacing it with a freeze on physician fees) estimated at \$137.4 billion (up from \$116.5 billion in December 2013)**

**HERE WE GO AGAIN!**

# The SGR Fix: A Pathway to Fundamental Physician Payment Reform? *ACP's Perspective*

**Robert Doherty**  
**American College of Physicians**

# ACP's Perspective on the SGR Fix

- We support the SGR repeal and Medicare Physician Payment Modernization Act because it:
  - Repeals the SGR and provides a transition period with stable and positive (0.5%) annual FFS updates.
  - Consolidates existing Medicare reporting programs into one Merit-Based Incentive Program, with incentives for primary care.
    - Measure harmonization.
    - “Certified” PCMHs receive highest possible score for practice improvement component (15% of total) of new MIPS payments.
  - Offers pathway to alternative payment models with opportunity for shared savings, supported by higher annual FFS updates.
    - PCMHs would have to demonstrate they can save \$ without harming quality, or improve quality without increasing costs—but not required to accept downside risk.

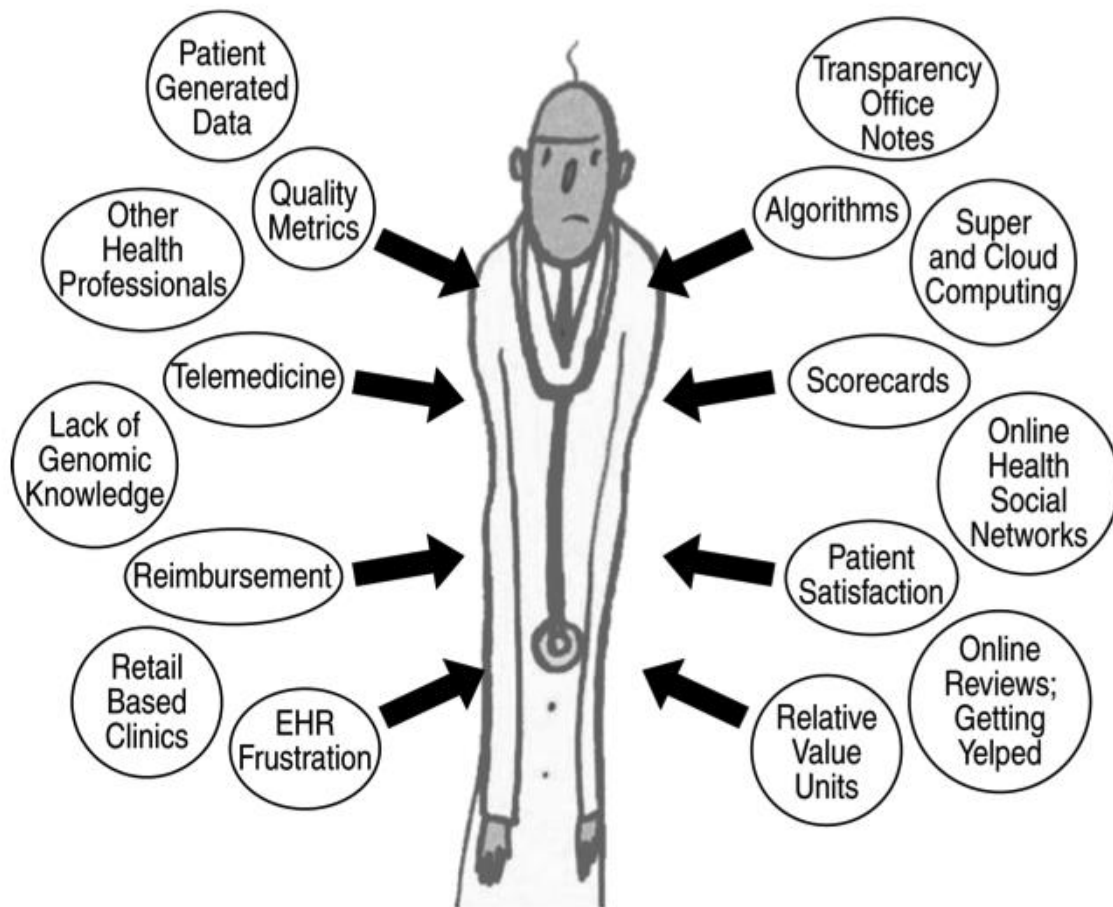


# ACP's Perspective on the SGR Fix

- We also supported Secretary Burwell's goals of "historic" transition to Medicare value-based payments within 3 years.
- *But. . .*as Medicare and other payers move to "value-based" payment and delivery models, we must be careful not to add to the *Big Squeeze* on physicians and patients.

# The Big Squeeze: The Physician Perspective

Doctors Getting Squeezed, by @HealthCareWen



# The Big Squeeze: Time Spent on EHRs = Less Time with Patients

ACP study:

Mean loss for attending physicians was 48 minutes per clinic day, 4 hours per five-day clinic week

*JAMA Internal Medicine*,  
September 8, 2014,  
<http://archinte.jamanetwork.com/article.aspx?articleid=1901114>

## Letters

### RESEARCH LETTER

#### Use of Internist's Free Time by Ambulatory Care Electronic Medical Record Systems

Physicians complain about the time costs and other effects of electronic medical records (EMRs).<sup>1-3</sup> In a small survey,<sup>4</sup> family practice physicians reported an EMR-associated loss of 48 minutes of free time per clinic day ( $P < .05$ ). We collaborated with the American College of Physicians (ACP) to revise the instrument from this study and surveyed the ACP's national sample of internists to determine the extent of this problem.

**Methods** | The ACP invites 1% of its members, including internal medicine attending physicians and trainees (resident and fellows), into its research panel,<sup>5</sup> narrows the candidates by random sampling to ensure balance, and then adds nonmember internists. On December 12, 2012, the ACP mailed a 19-question survey to its panelists (900 ACP member and 102 nonmember internists at that time) who provided ambulatory care, and left it in the field for 10 days. The survey (Q11-Q12) focused on free time to get a sense of the EMR's overall effect

medical record data with the EMR than without, and a similar proportion, 32.2%, that it was slower to read other clinicians' notes.

The mean time loss for attending physicians was -48 minutes per clinic day ( $P < .001$ ), or 4 hours per 5-day clinic week. The mean loss for trainees was -18 minutes per day, less than that of attending physicians ( $P < .001$ ). For the 59.4% of all respondents who did lose time, the mean loss was -78 minutes per clinic day, or 6.5 hours per 5-day clinic week.

**Discussion** | The loss of free time that our respondents reported was large and pervasive and could decrease access or increase costs of care. Policy makers should consider these time costs in future EMR mandates. Ambulatory practices may benefit from approaches used by high-performing practices<sup>6</sup>—the use of scribes, standing orders, talking instead of e-mail—to recapture time lost on EMR. We can only speculate as to whether better computer skills, shorter (half-day) clinic assignments with proportionately less exposure to EMR time costs, or other factors account for the trainees' smaller per-day time loss.

8.50 x 11.00 in.

# The Big Squeeze: Less Time, More Expense

When time is converted to dollars, practices spent an average of \$68,274 per physician per year interacting with health plans (Exhibit 3). The median value was \$51,043. Although per physician costs are lower in practices of ten or more physicians, there was not a statistically significant difference in costs by practice size. Primary care practices spent \$64,859 annually per physician—nearly one-

**EXHIBIT 3**  
**Mean Dollar Value Of Hours Spent Per Physician Per Year For All Types Of Interactions, By Practice Specialty And Size, 2006**

	1-2 MDs	3-9 MDs	10+ MDs	Weighted mean
Total per practice				
Primary care	\$72,675	\$63,611	\$57,480	\$64,859
Medical specialty	70,788	87,566	78,553	78,913
Surgical specialty	61,187	76,429	59,866	66,954

(published online May 14, 2009; 10.1377/hlthaff.28.4.w533)

*Health Affairs*, 28, no.4 (2009):w533-w543

What Does It Cost Physician Practices to Interact with Health Insurance Plans? Lawrence P. Casalino, Sean Nicholson, David N. Gans, Terry Hammons, Dante Morra, Theodore Karrison, and Wendy Levinson.

# The Big Squeeze: What Should Be Done About It?

1. Prioritize, simplify, and consolidate measures (focus on core measures relating to high-value care) and streamline reporting requirements for both public and private payers.
  - SGR repeal bill *potentially* is a step in the right direction, but it could add to the *Big Squeeze* if reporting detracts from patient care.
2. Improve EHRs and meaningful use; focus on clinical documentation, clinical decision support, and reporting.

# *The Big Squeeze: What Should Be Done About It?*

3. Reduce “hassles” associated with 3<sup>rd</sup>-party utilization review for physicians in more advanced risk-bearing APMs.
  - If physicians are going to be paid based on their efficiency and effectiveness (outcomes), then the justification for many of the more intrusive payer requirements (e.g., preauthorization) disappear.
4. Be careful where we set the bar for APMs—too high, and it will incentivize physicians to remain in FFS and just add to practice burden; too low, and the APMs may fail to achieve quality and efficiency gains.

# The Big Squeeze: What Should Be Done About It?

## 5. Improve FFS payments:

- We agree that *“Fixing inaccurate valuations in the Medicare fee schedule will be vitally important to success of the 2014 SGR fix. It is generally accepted that cognitive services (that is, evaluation and management visits) are undervalued in the fee schedule, while many procedures performed by specialists are overvalued.”* But there is a limit to what can be achieved through RVU redistribution.
- Another way: pay for work outside of face-to-face encounter; CCM and TCM codes are a step in the right direction.
- Congress needs to first “do no harm” —reauthorize 10% Medicare Primary Care Incentive Program (10% bonus payments, expires 1/1/16) and restore Medicaid Primary Care Pay Parity.

# Conclusion

- SGR repeal legislation offers a realistic pathway to fundamental physician payment reform.
- The bill can be improved—but too many changes will upend almost universal support within the medical profession.
- SGR repeal is essential, but CMS should not wait for Congress: Center on Innovation needs to go from “testing” to broad implementation of models like comprehensive primary care, bundled payments.



# Conclusion

- As we redesign physician payments to achieve value, we have to be extremely careful not to further put the *Big Squeeze* on physicians, especially in primary care:
  - By adding more requirements that take time from patients, add to practice expenses, and contribute to burn-out.

# **CMS Announcement Regarding APMs, 1/26/2015**

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- **APM goals**
  - Tie 30% of traditional, or FFS, Medicare payments to quality or value via APMs by the end of 2016
  - Tie 50% of payments to these models by the end of 2018
- **Traditional FFS goals**
  - Tie 85% of all traditional Medicare payments to quality or value by 2016
  - Tie 90% by 2018
  - **Hospital Value-Based Purchasing and the Hospital Readmissions Reduction Programs**
  - **Health Care Payment Learning and Action Network**
    - HHS working with private payers, employers, consumers, providers, states, state Medicaid programs, and other partners to expand alternative payment models.

Source: <http://www.hhs.gov/news/press/2015pres/01/20150126a.html>.

# Audience Q&A

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**James Reschovsky, Mathematica**



**Stuart Guterman, The Commonwealth Fund**



**Mai Hubbard, Mathematica**



**Robert Doherty, American College  
of Physicians**



# Forthcoming Payment Reform Products

Paper Title	Authors	Anticipated Release Date
Solving the Sustainable Growth Rate Formula Conundrum Continues Steps Toward Cost Savings and Care Improvements	James Reschovsky	March 11, 2015
After the Doc Fix: Policy Research for Implementing Medicare Alternative Payment Models	Eugene Rich, Bob Schmitz, Tim Lake, Jeff Ballou, Mai Hubbard	Spring 2015
Supporting and Evaluating Provider Payment Reforms: Lessons Learned	Mary Laschober, Tim Lake	Spring 2015
Improving Measures Used in Pay-for-Performance	Leslie Conwell, Frank Yoon	Summer 2015
How Fixing the Medicare Physician Fee Schedule Impacts Value-Based Purchasing	Nancy McCall	Summer 2015

# For More Information

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