SGR Fix: Implications for Physician Payment
Physician Leadership Forum
July 1, 2015
MACRA Overview

• Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) signed April 16, 2015

• Historic bipartisan, bicameral effort to repeal the Medicare physician sustainable growth rate (SGR) formula after 18 years and 17 temporary “patches”

• First major piece of health care legislation since the 2010 Affordable Care Act (ACA)
Provider Payment Changes

- Replaces flawed SGR formula with specified payment updates
- Creates new payment system for physicians, PAs, NPs, CNSs, CRNA in 2019; CMS may expand to other professionals in 2021
- Rewards participation in alternative payment models (APM) and ties a greater percentage of payment to value

-21%
Annual Payment Updates

- 4/1/15: 0.0%
- 7/1/15: 0.5%
- 0.5% annually
- 2016
- 2017
- 2018
- 2019 (sunsets penalties for MU, PQRS, VBM)
- 2020

MIPS

APM
Merit-based Incentive Payment System

• Merit-based Incentive Payment System (MIPS): default payment system

• MIPS-exempt:
  – Qualified APM participants
  – “Partial” APM participants
  – Professionals who do not meet a low-volume threshold (TBD by Secretary of HHS)
Alternative Payment Models

• APMs defined as:
  – A model tested by the CMMI, other than a health care innovation award
  – An ACO under the Medicare Shared Savings Program
  – The Health Care Quality Demonstration Program
  – A demonstration required by federal law
Qualifying APM Professional

• Measured by:
  – Percentage of Medicare PFS payments or total payments made through an eligible APM entity
  – Eligible APM entity must:
    • Require use of certified EHR technology
    • Bears financial risk for monetary loss (more than nominal amount) or is a medical home
    • Provides payment based on quality measures comparable to those in MIPS quality category (for non-Medicare payments)
Qualifying APM Professional

Percentage of Payments Through an APM

- % total payments
- % Medicare payments

American Hospital Association
**Payment Under APMs**

2019: 0.5% annually
2020: 0.0% annually

APM: Bonus of 5% of PFS payments annually

American Hospital Association
Payment Under MIPS

MIPS: Bonus for high performers (<10%)
Payment Under New Systems

2025

2026

0.0%

APM: 0.75% annually

MIPS: 0.25% annually

MIPS: Penalties or incentives of up to ± 9%
MIPS Performance Evaluation

• Professionals scored on:
  – **Quality** using measures from existing law programs and / or other measures
  – **Resource Use** using current value-modifier cost measures and / or other measures
  – **Clinical Practice Improvement activities** such as population management, patient safety assessment
  – **Meaningful Use** using current law requirements

• All receive composite scores of 0 to 100 (100 is best)
  – Will receive lowest possible score for categories where required reporting not completed satisfactorily
  – CMS must establish performance standards
  – Standards must recognize historical performance, improvement (somewhat like hospital VBP)
## MIPS Composite Score

<table>
<thead>
<tr>
<th>Category</th>
<th>CY 2019</th>
<th>CY 2020</th>
<th>CY 2021 and beyond</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>50%</td>
<td>45 %</td>
<td>30%</td>
</tr>
<tr>
<td>Resource Use</td>
<td>10%</td>
<td>15 %</td>
<td>30%</td>
</tr>
<tr>
<td>Clinical Practice Improvement</td>
<td>15 %</td>
<td>15 %</td>
<td>15 %</td>
</tr>
<tr>
<td>Meaningful Use</td>
<td>25 %</td>
<td>25 %</td>
<td>25 %</td>
</tr>
</tbody>
</table>

- Quality and resource use must make up 60 percent of score
- CMS can vary the percentages based on factors like EHR adoption, or lack of appropriate measures or activities
Translating the MIPS Composite into Incentives and Penalties

- Exceptional performance threshold (2019 – 2024 only)
  - Exceptional performance bonus (up to 1 percent)
  - Positive adjustment on sliding scale
  - Negative adjustment on sliding scale

- Performance Threshold (Determined annually)
  - 25 percent of performance threshold
  - Maximum Negative Adjustment

MIPS Composite Score
## MIPS Payment Adjustment Percentages

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
<th>2023 and 2024</th>
<th>2025 and beyond</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Positive Adjustment</td>
<td>+ 4.0%**</td>
<td>+ 5.0%**</td>
<td>+ 7.0%**</td>
<td>+ 9.0%**</td>
<td>+ 9.0%**</td>
<td>+ 9.0%**</td>
</tr>
<tr>
<td>Exceptional Performance Bonus</td>
<td>+1.0%</td>
<td>+1.0%</td>
<td>+1.0%</td>
<td>+1.0%</td>
<td>+1.0%</td>
<td>N/A</td>
</tr>
<tr>
<td>Maximum Negative Adjustment</td>
<td>- 4.0%</td>
<td>- 5.0%</td>
<td>- 7.0%</td>
<td>- 9.0%</td>
<td>-9.0%</td>
<td>-9.0%</td>
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</tbody>
</table>

- Scaling factor of up to 3.0 can be applied to positive payments to ensure budget neutrality.
- Exceptional performance bonus funded separately (up to $500 million per year from 2019 – 2024)
Other Considerations

- Public reporting (with opportunity for preview and corrections and potentially more frequent feedback reports from CMS)
- Quality measure development
- GAO reports on
  - Measure alignment with private sector
  - Barriers to assuming financial risk for performance
  - Overall evaluation of MIPS
- Use of clinical registries encouraged
Future Considerations in Physician Compensation

W. Bryan Gamble, MD, MS, FACS
President/CEO Florida Hospital Medical Group

Disclaimer-The views expressed are those of the presenter and not necessarily those of Florida Hospital Medical Group, Florida Hospital or the Adventist Health System
Agenda

• Post Sustainable Growth Rate (SGR) Repeal
• Healthcare marketplace and landscape
• Compliance
Compensation Impact of SGR Repeal

The Medicare Access and CHIP Reauthorization Act (MACRA) was signed into law on April 16, 2015. The legislation averted a 21% cut to Medicare physician rates and permanently repealed the flawed Medicare Sustainable Growth Rate (SGR) formula.

• Eliminating the April 1, 2015 21% Medicare physician payment cut and all future SGR-related cuts.
• Ensuring a five-year period of stable, annual physician fee schedule updates of 0.5% in order to transition to a new payment system.
• Harmonizing existing Medicare quality reporting programs into a new Merit-Based Incentive Payment System (MIPS).
• Providing for additional financial incentives for physicians who move into alternative payment models (APMs)
• Expansion of payment models to Nurse Practitioners (NP)
CMS support of health care Delivery System Reform will result in better care, smarter spending, and healthier people.

**Historical state**

**Key characteristics**
- Producer-centered
- Incentives for volume
- Unsustainable
- Fragmented Care

**Systems and Policies**
- Fee-For-Service Payment Systems

**Evolving future state**

**Key characteristics**
- Patient-centered
- Incentives for outcomes
- Sustainable
- Coordinated care

**Systems and Policies**
- Value-based purchasing
- Accountable Care Organizations
- Bundled payments
- Medical Homes
- Quality/cost transparency
- Population-based payments

**Public and private sectors**
Delivery System Reform requires focusing on the way we pay providers, deliver care, and distribute information.

Improving the way providers are incentivized, the way care is delivered, and the way information is distributed will help provide better care at lower cost across the health care system.

<table>
<thead>
<tr>
<th>Focus Areas</th>
<th>Description</th>
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</thead>
</table>
| Pay Providers     | - Promote value-based payment systems  
                   - Test alternative payment models  
                   - Increase linkage of Medicaid, Medicare FFS, and other payments to value  
                   - Bring proven alternative payment models to scale |
| Deliver Care      | - Encourage the integration and coordination of clinical and support services  
                   - Improve population health  
                   - Promote patient engagement through shared decision making |
| Distribute Information | - Create transparency on cost and quality information  
                          - Bring electronic health information to the point of care for meaningful use |

Source: Burwell SM. Setting Value-Based Payment Goals – HHS Efforts to Improve U.S. Health Care. NEJM 2015 Jan 26; published online first.
Medicare Payment Shifts

Category 1
• Fee for Service
• No Link to Quality

Category 2
• Fee for Service
• Link to Quality

Category 3
• Alt. Payment Models
• Built on FFS Architecture

Category 4
• Population-Based Payment

Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018

- All Medicare FFS (Categories 1-4)
- FFS linked to quality (Categories 2-4)
- Alternative payment models (Categories 3-4)

2016:
- 30% All Medicare FFS
- 85% FFS linked to quality
- 50% Alternative payment models

2018:
- 50% All Medicare FFS
- 90% Alternative payment models
<table>
<thead>
<tr>
<th>Description</th>
<th>Category 1: Fee for Service—No Link to Quality</th>
<th>Category 2: Fee for Service—Link to Quality</th>
<th>Category 3: Alternative Payment Models Built on Fee-for-Service Architecture</th>
<th>Category 4: Population-Based Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payments are based on volume of services and not linked to quality or efficiency</td>
<td>At least a portion of payments vary based on the quality or efficiency of health care delivery</td>
<td>Some payment is linked to the effective management of a population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk</td>
<td>Payment is not directly triggered by service delivery so volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g. ≥1 yr)</td>
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<table>
<thead>
<tr>
<th>Medicare FFS</th>
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<tbody>
<tr>
<td>□ Limited in Medicare fee-for-service</td>
<td>□ Hospital value-based purchasing</td>
<td>□ Accountable care organizations</td>
<td>□ Eligible Pioneer accountable care organizations in years 3-5</td>
<td></td>
</tr>
<tr>
<td>□ Majority of Medicare payments now are linked to quality</td>
<td>□ Physician Value-Based Modifier</td>
<td>□ Medical homes</td>
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</tr>
<tr>
<td></td>
<td>□ Readmissions/Hospital Acquired Condition Reduction Program</td>
<td>□ Bundled payments</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>□ Comprehensive primary care initiative</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>□ Comprehensive ESRD</td>
<td></td>
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<td></td>
<td>□ Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model</td>
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HOW We Segment The Population According To Health Needs

- **Population**
  - Top 1%
    - Dominant Chronic & single events
    - Percent of Spending: 20%
  - Top 5%
    - Severe Significant Multiple Chronic Conditions
    - Percent of Spending: 50%
  - Middle 44%
    - Chronic or Severe Chronic
    - Percent of Spending: 28%
  - Bottom 50%
    - Healthy
    - Percent of Spending: 2%
Quality and Population Health Metrics

• Physician Quality Reporting System (PQRS)
• Meaningful Use (MU)
• National Committee for Quality Assurance (NCQA)
PQRS 2015

• Quality Reporting Requirement
  • 2% penalty if PQRS reporting is unsuccessful & automatic 4% penalty for Value-Based Payment Modifier (VBPM)
  • 254 measures available (many not supported by EMR)
  • 6 National Quality Strategy Domains (NQSDs)
  • 9 measures required for reporting covering @ least 3 NQSDs
  • Required for all Eligible Professionals (EPs)
    Physicians/NPPs attached to TIN on @ least 50% of the groups patients
External to SGR Repeal, other factors are driving change and dollars in the marketplace

- With repeal of the SGR, other realities come into play
  - Pay for performance
  - Value based payments
- Federal Regulation/Legislation/Policy will set the playing rules for commercial and governmental payers
- Increasing consumerism in the market
  - Payers
  - Employers
  - Patients
- Movement from inpatient to ambulatory space
Consumerism

• Changing realities of health delivery and receipt by patient of services
  • Convenience (Urgent Care, quick clinics, etc.)
  • Technology (E-Health, miniaturization)
  • Connectivity (EHR)

• Employers
  • Cost Management
  • Shared risk-shared reward
  • Convenience

• Federal Government/Agencies
  • Health and Wellness as opposed to episodic and acute funding/access
  • Population Health

• Role of Value for Healthcare Expenditures
  • Autonomy has moved
The Largest Healthcare Payer

Medicare: 26%
Medicaid: 18%
Individual: 28%
Private Business: 21%

Commercial Payer Shifts

Forbes

PHARMA & HEALTHCARE 1/23/2015 @ 8:03AM | 88,912 views

UnitedHealth’s $43 Billion Exit From Fee-For-Service Medicine

HealthLeaders

Narrow Networks Enjoying a Resurgence

Christopher Cheney, for HealthLeaders Media, December 16, 2014

Two decades after a consumer backlash drove many health maintenance organizations out of business, narrow provider networks are back in a big way.
Employers Demanding Value
Innovators/Disruptors
Compliance

• Fair Market Value (FMV)
• Commercial Reasonableness
• Stark Law implications
• Designated Health Services
• Coding Accuracy/Audits
Questions