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HIDDEN OPPORTUNITIES IN THE SGR FIX: WHY PHYSICIANS MAY NEED HOSPITAL PARTNERS MORE THAN EVER

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AHLA ANNUAL MEETING

June 27-29, 2016

Agenda

- History of physician payment
- Payment impact of MACRA
- “MIPS” eligible clinicians
- Performance categories
- Scoring and Payment
- Advanced APMs
- Interaction with hospital payment mechanisms
- Implications for physician compensation models

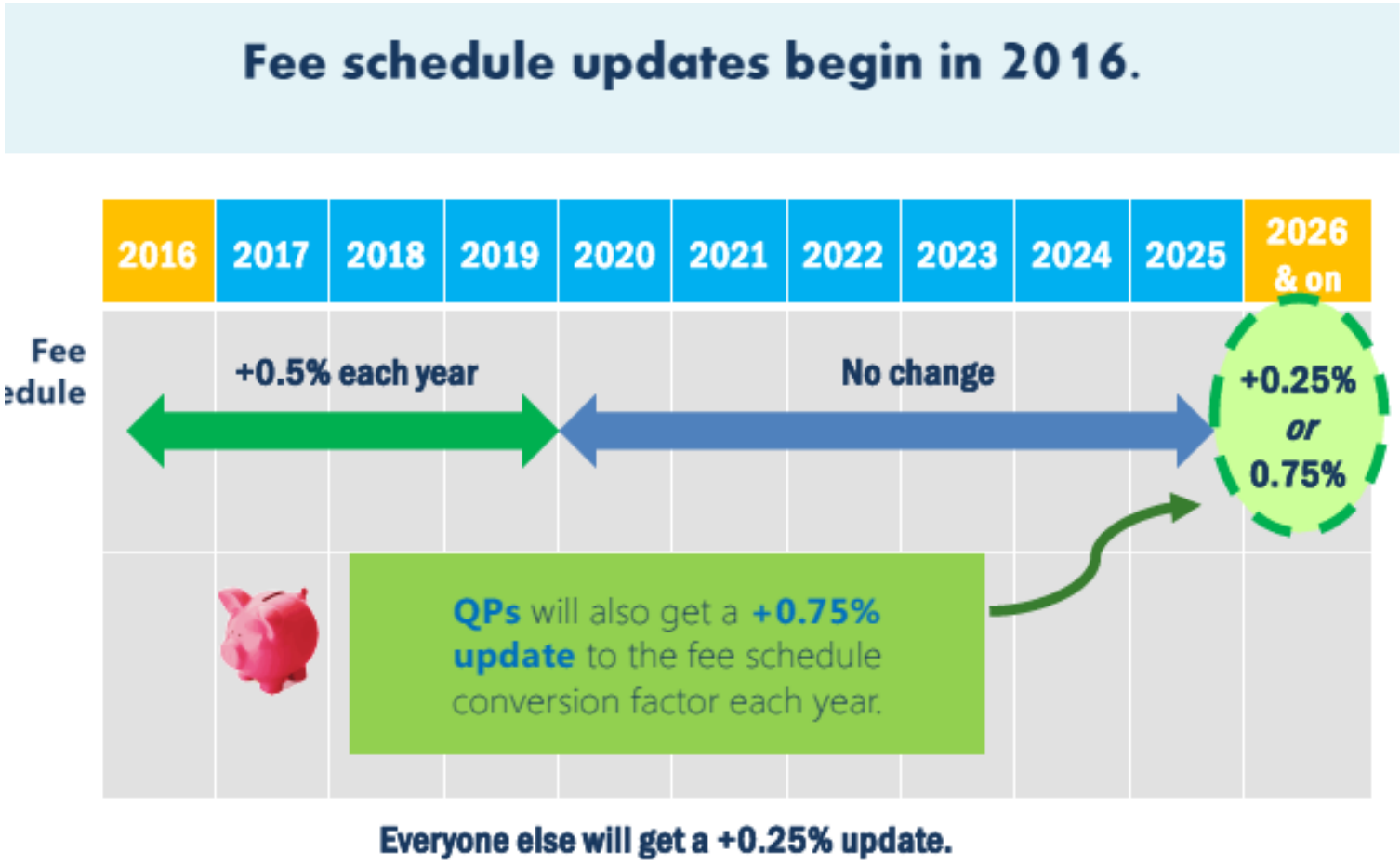
History of Medicare Payment for Physician Services

- Physicians initially paid on the basis of customary, prevailing and reasonable charges
- Moved to an "RVU" model that rewarded productivity in 1992
- "SGR" created in 1997
  - Temporary fixes implemented every year since 2003, usually with an associated "pay for"
- MACRA enacted on April 16, 2015
  - Proposed Rule published in Federal Register on May 9, 2016, and comments due on June 27, 2016

History of Medicare Payment for Physician Services – Quality Initiatives

- PQRS
  - Created by TRHCA in 2006
  - Made permanent by MIPPA in 2008
  - Penalties created by ACA, maxing out at 2% in 2016
- Value-Based Modifier
  - Created by ACA
  - Could result in a downward adjustment of 2%
- Meaningful Use
  - Created by ARRA
  - Maximum penalty was to reach 5% in 2018
- All sunset by 2019

Replacement to SGR



Eligibility for MIPS

- For 2019-2020 (and related performance periods), applies to physicians, NPs, PAs, CNSs, and CRNAs
  - Can be expanded later to others reimbursed under PFS
- Eligibility can be on an individual basis or as a group
  - All members of the group are generally treated the same for payment purposes, irrespective of individual data
  - CMS has created proposed processes for weighting scores for individual practitioners moving from one group to another

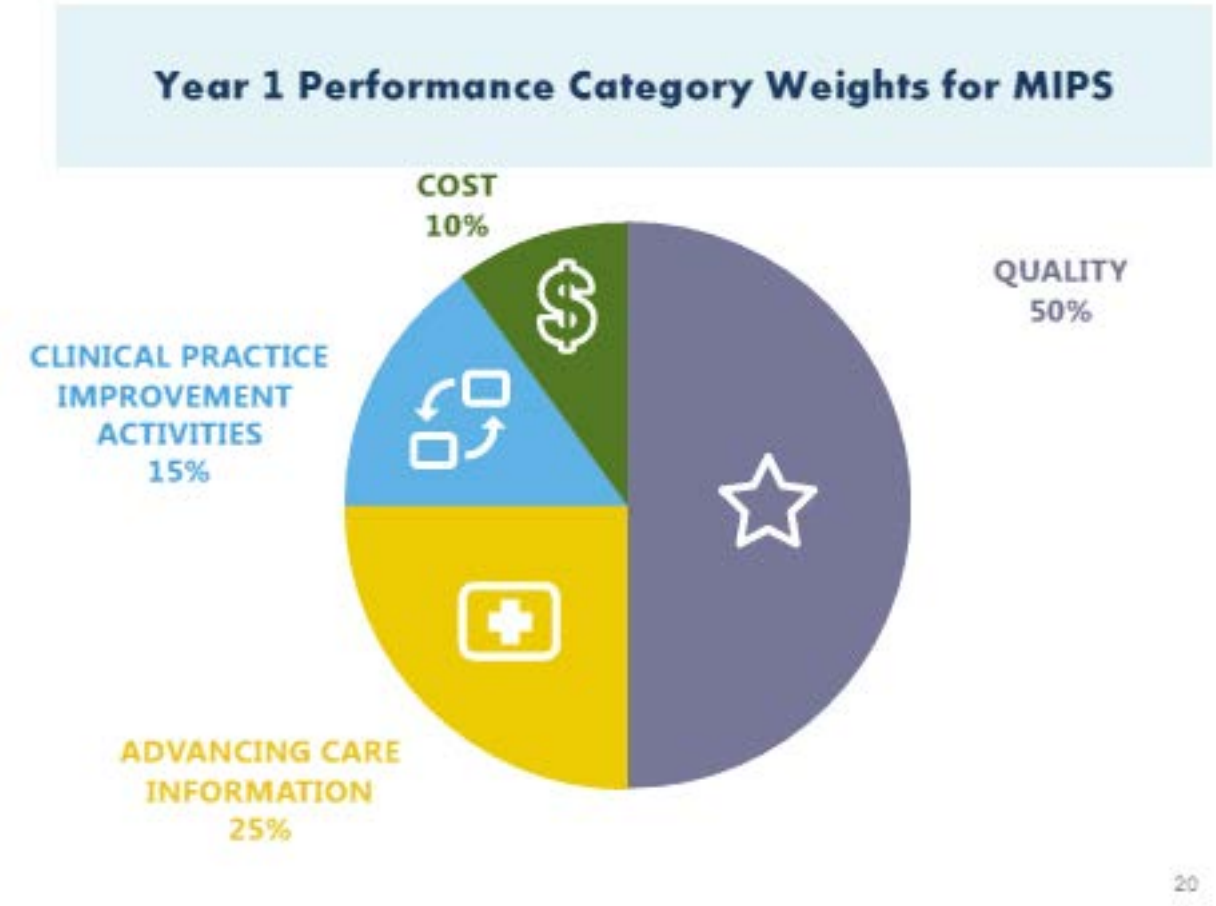
Eligibility for MIPS *(cont.)*

- Excludes
  - Physicians in first year of Medicare Part B billings
  - Physicians with low volume or value of claims
    - Proposed to be less than $10,000 in Part B charges and fewer than 100 Part B enrollee patients in the performance year
  - Physicians qualifying as Qualifying Professionals (or "QPs") in an Advanced APM
    - "Partial QPs" can opt out of MIPS

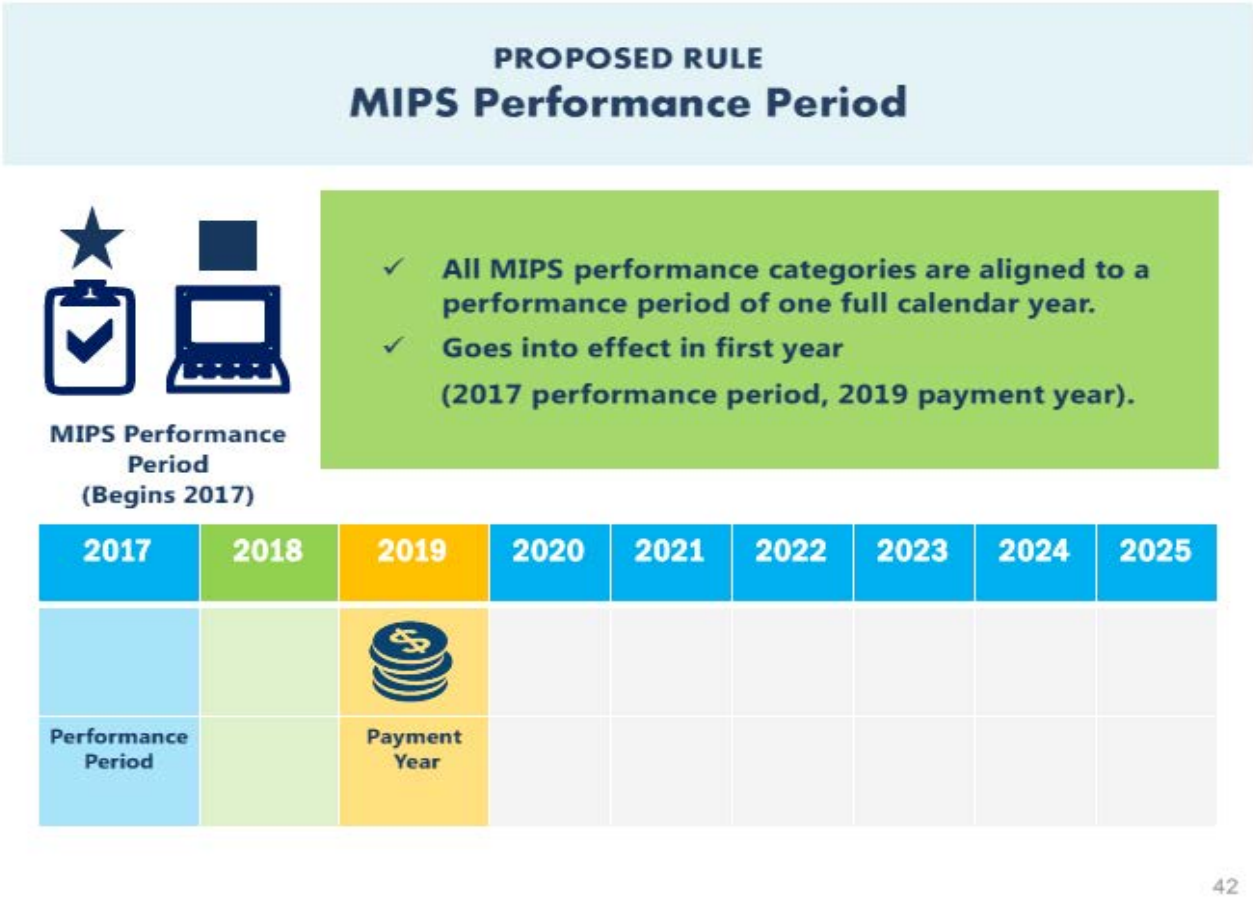
MIPS Payment Concepts

- 4 Performance Categories
  - Each one has its own list of potential measures
- Scoring is performed for each performance category based on data from a performance period
- The performance categories are weighted
- A composite score is generated
- The scores are compared to every other eligible clinician's score
  - Bonuses are available for super-performers
- Relative payment reductions and increases are effectuated in a payment year on a budget neutral basis

Performance Categories and Initial Weightings



Scoring Based on Performance Period



Quality Performance Category

- Physicians must choose 6 measures
  - 1 must be a “crosscutting” measure and 1 must be an outcome measure
  - Additional population measures are calculated automatically using claims data
    - These include readmissions data
  - If data submitted does not reach threshold of 20 cases, then not included in the scoring
    - If using claims data, must report on 80% of eligible patients treated in the performance year
- Bonus points are available for certain high priority measures
- Each reported measure is then compared to national performance on the measure to develop a point value, and the total of all points is then divided by total possible points
- Available measures updated annually with stakeholder input

Resource Use Performance Category

- Based on claims, not submitted data
- Goal is to assess comparative use by a physician or resources in comparable care episodes and clinical condition groups
- Can be:
  - Total per capita spending for all attributed beneficiaries (using E/M codes for attribution)
  - Medicare spending per beneficiary (MSPB)
  - Episode of care costs
- Scoring places clinician performance into deciles, translates these deciles to points, and then divides actual points by total potential points
- Clinicians in an APM, even if not an “advanced APM” are not scored on Resource Use

Resource Use Performance Category *(cont.)*

Scoring Example: Dr. Joy Smith Submitted the following:

[A] RU	[B] Type of Measure	Number of Cases	Performance	[D] Measure Perf. Threshold	[E] Points Based on Decile	[H] Total Possible Points (10 points x [F])
M1	MSPB	20	15,000	13,000	4.0	10
M2	Total Per Capita	21	12,000	10,000	4.2	10
M3	Episode 1	22	15,000	18,000	5.8	10
M4	Episode 2	10	11,000	9,000	Below Case Threshold	N/A
M5	Episode 3	0	N/A	N/A	No Attributed Cases	N/A
M36	Episode 4	45	7,000	10,000	8.3	10
TOTAL					22.3	40

Resource use performance category score = (22.3/40) or 55.8%

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Clinical Practice Improvement Activities Performance Category

- New performance category without predicates in PQRS or VM
- By statute, the measures are to focus on:
  - Increased practice access, such as same day appointments for urgent needs
  - Population management, such as monitoring health conditions of patients to ensure timely interventions
  - Care coordination, such as timely communication of clinical information to patients
  - Beneficiary engagement, such as establishment of care plans for beneficiaries with complex needs
  - Patient safety and practice assessment, such as use of clinical or surgical checklists
  - Participation in an APM
- CMS has proposed adding other priorities, such as addressing healthcare disparities, emergency preparedness, and access to mental health

Clinical Practice Improvement Activities Performance Category *(cont.)*

- Practitioners must attest on some combination of medium and high weighted measures to get to a total of 60 points (10 pts for medium, and 20 pts for high)
- APM practitioners automatically start at 50%
- Medical home practitioners receive 100%

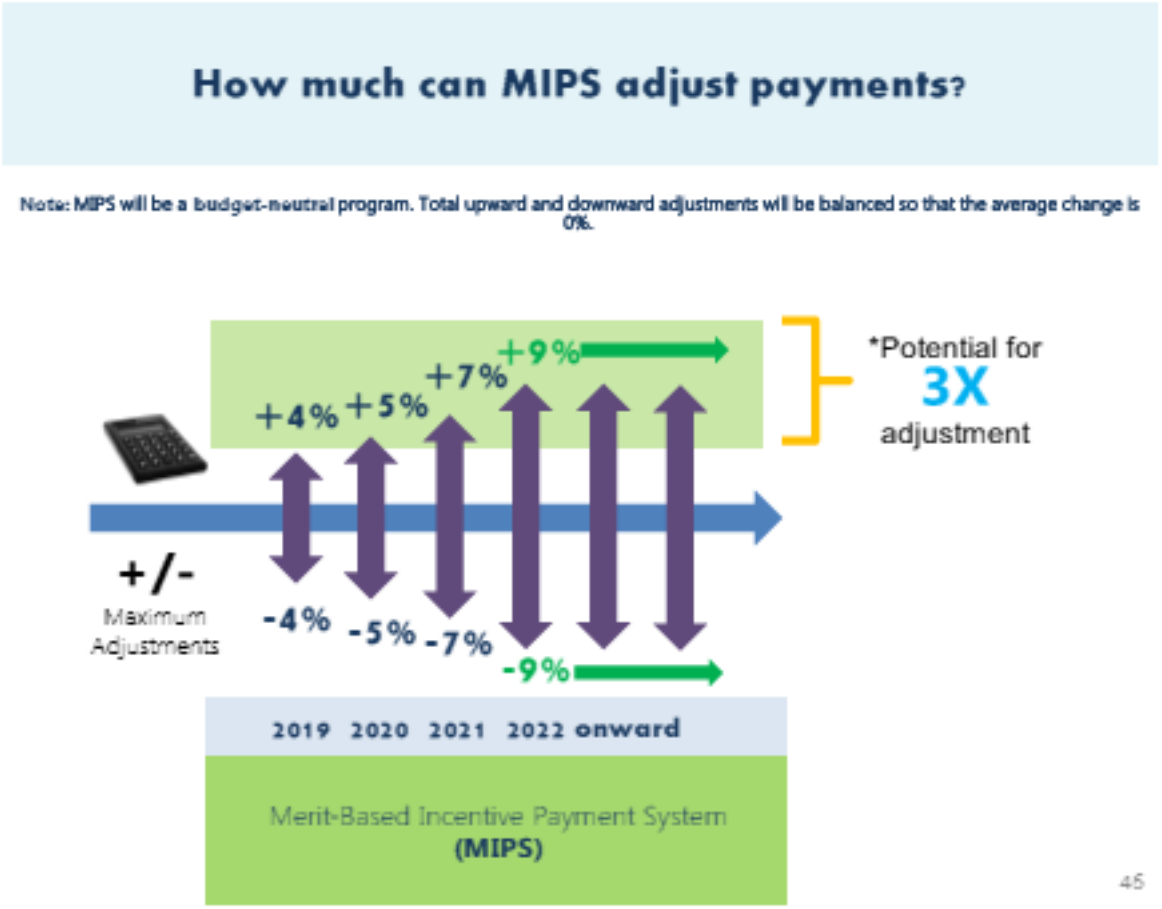
Advancing Care Information Performance Category

- Encourages use of certified EHR
- Is comprised of both a base score and a performance score
  - Base score measures whether practice has appropriate EHR
  - Performance score measures whether it is being used (such as e-prescribing, patients accessing records electronically, etc.)
- Total potential points of 130, but max out at 100
- Unlike MU, not an all or nothing determination

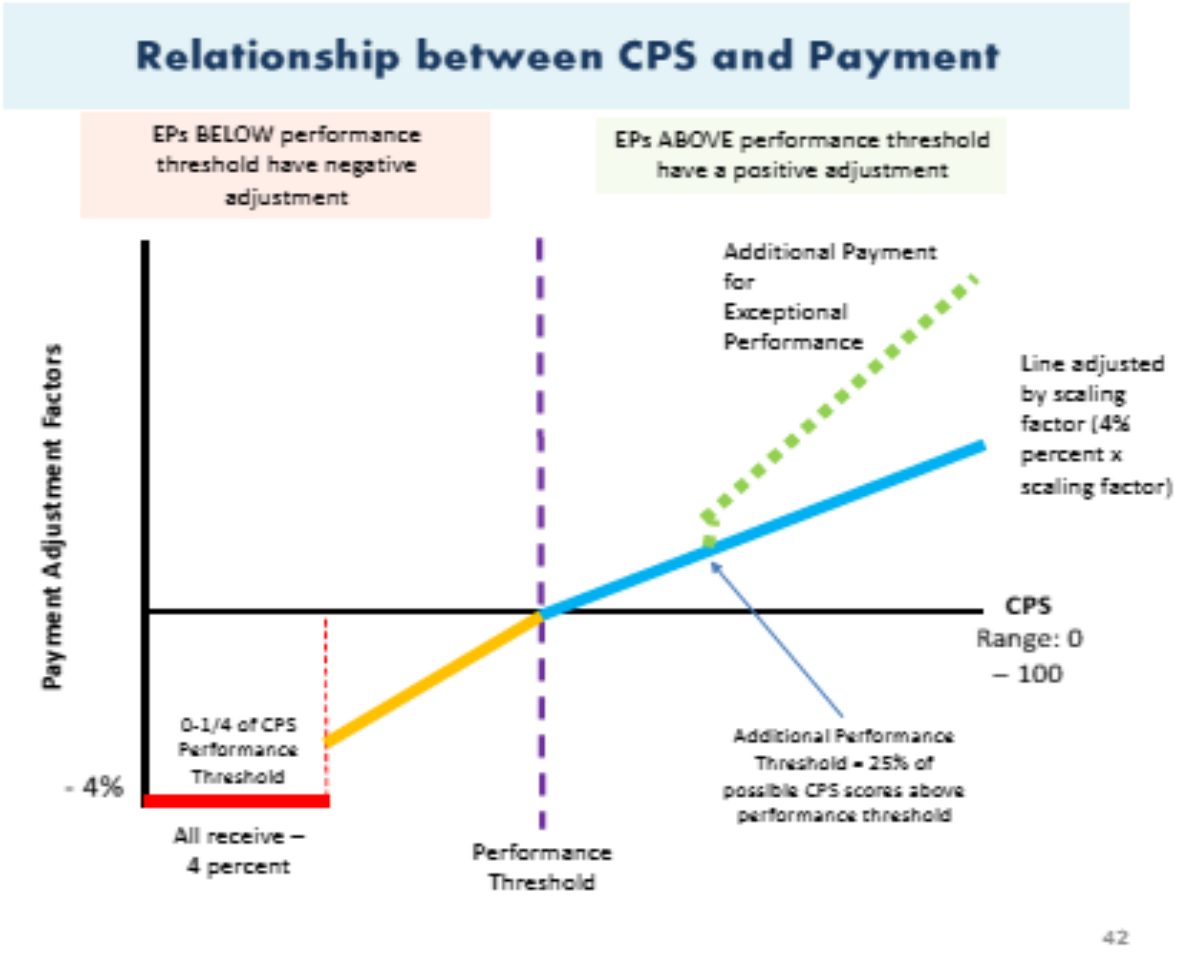
Scoring, Payment, and Review

- Weightings proposed to shift from Quality to Resource Use over time
- Super-performers are entitled to a bonus
  - CMS has proposed that this would be available on a sliding scale basis for any clinician over a specified performance threshold, currently proposed to be the 25th percentile
- In order to ensure budget neutrality, CMS may scale the upside payments by up to 3x the linear scale
- Submitted data is to be reported publicly, but CMS will be selective about which data is shared (e.g., Resource Use will not be publicized)
- Clinicians can request a "targeted review" of their data by CMS, but there is no formal appeals process thereafter
- CMS will do spot auditing, and will require medical records and other information to do so

Scoring, Payment, and Review *(cont.)*



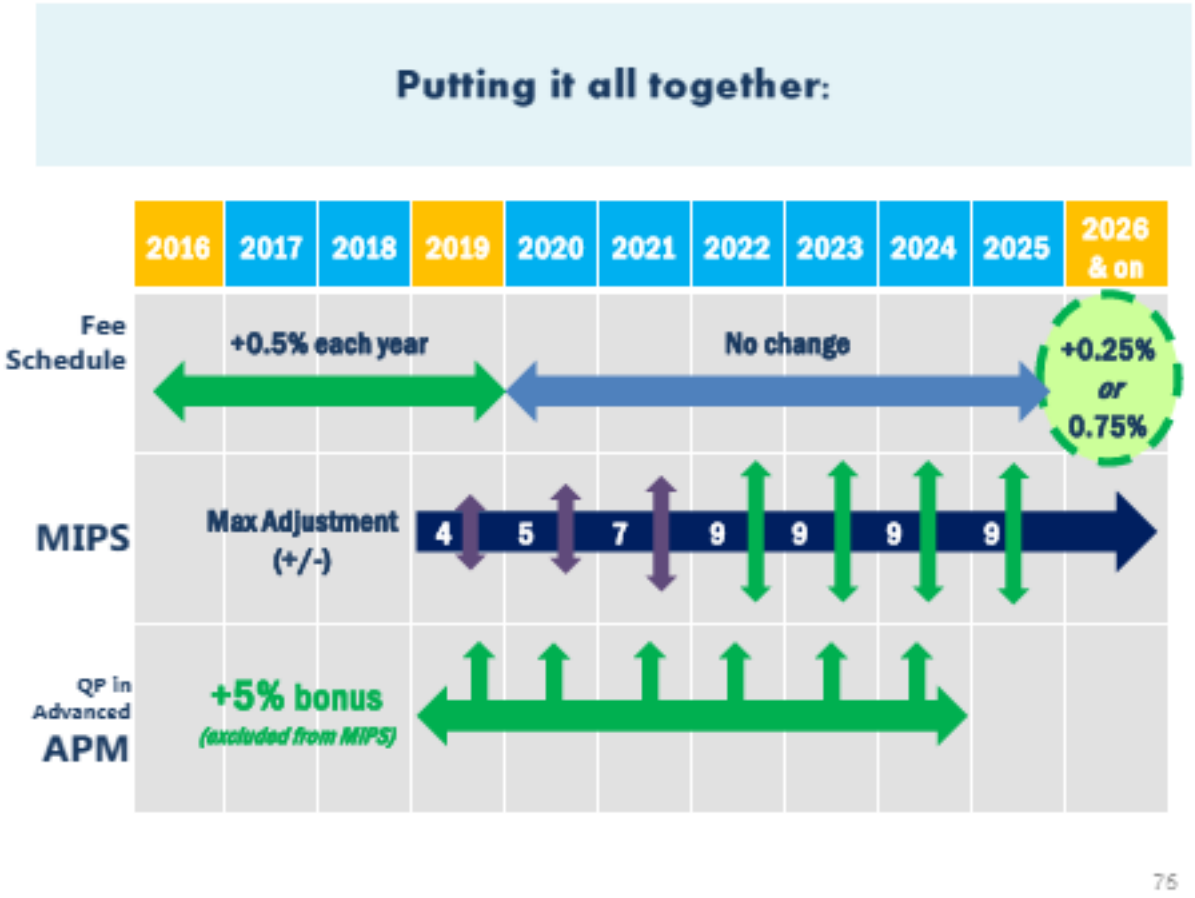
Scoring, Payment, and Review *(cont.)*



APM

- Must be one of the following types of entities:
  - A model tested by the Centers for Medicare and Medicaid Innovation (CMMI)
  - An accountable care organization (ACO) under the Medicare Shared Savings Program
  - A demonstration under the Health Care Quality Demonstration Program
  - A demonstration required by Federal law
- Merely being in an APM allows a clinician to:
  - Not have to be evaluated on Resource Use
  - Receive at least 50% of the CPIA total points
- Clinicians in an Advanced APM get other advantages
  - If a Qualified Professional (QP), exempt from MIPS and get a 5% lump sum bonus in first five years
  - If a partial QP, no bonus, but MIPS exemption

Payment Advantages of Being in an Advanced APM



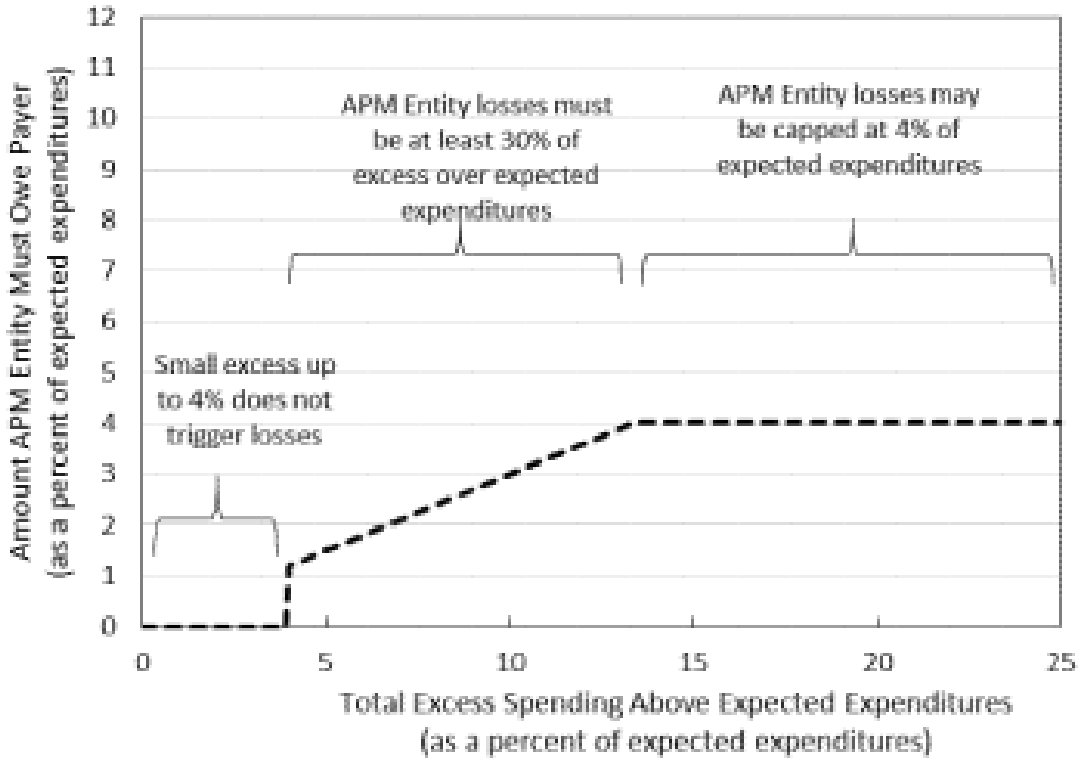
Advanced APM Criteria

- Must be an APM
- Must use certified EHR
  - CMS has proposed that only 50% of practitioners would be required to use certified EHR to meet this criterion, but increase to 75% after first year
- Bases payment on quality measures similar to MIPS
  - CMS offers a number of different ways for APM data measures to qualify
  - CMS allows an APM to also test quality measures beyond those required to qualify as Advanced APM

Advanced APM Criteria *(cont.)*

- Either:
  - Bears more than nominal risk for payments in excess of expected expenditures; or
  - Is a qualifying medical home
- CMS looks at both the structure of the risk exposure and its quantification
- Structurally, the "APM Entity" (which is an organization, but not necessarily the entire ACO itself) must be incurring risk that:
  - Results in direct payments for overages back to the payer
  - Results in reductions of payments
  - Results in withholds of payments

Advanced APM Criteria *(cont.)*



Advanced APM Criteria *(cont.)*

- CMS' assessment of current models suggests that only the following qualify under the 3 pronged test:
  - Shared Savings Program (Tracks 2 and 3 only)
  - Next Generation ACO Model
  - Comprehensive ESRD Care (large dialysis organization arrangement)
  - Comprehensive Primary Care Plus
  - Oncology Care Model (two-sided risk track to be launched in 2018)

Medical Home

- Medical Home Model is an APM that has the following features:
  - Participants include primary care practices or multispecialty practices that include primary care physicians and practitioners and offer primary care services.
  - Empanelment of each patient to a primary clinician; and
  - At least four of the following:
    - Planned coordination of chronic and preventive care.
    - Patient access and continuity of care.
    - Risk-stratified care management.
    - Coordination of care across the medical neighborhood.
    - Patient and caregiver engagement.
    - Shared decision-making.
    - Payment arrangements in addition to, or substituting for, fee-for service payments.
- Cannot have more than 50 members
- Must have received accreditation

Medical Home *(cont.)*

- Can be at risk of getting paid for certain services not directly related to Medicare revenues, such as management services
- Less stringent amounts need be at risk
- Automatically qualify for 100% of CPIA points

Becoming a QP

- Made at Advanced APM entity level, rather than at the individual clinician
- Involves meeting certain thresholds of providing services through the APM, based on either charges or patient counts
- Attribution for QP determination purposes is the same methodology as applied to the APM itself
- The denominator are all individuals who received at least one E/M service through the APM and had Medicare FFS as their primary insurance
- Bonus based on payments in year following performance year

Becoming a QP *(cont.)*

- Partial QPs are individuals who do not meet the full threshold, but partially meet it
  - Do not get the bonus, but do get the exemption from MIPS if they choose
  - Must identify ahead of time
- From 2021, QPs can combine Medicare APMs with other non-Medicare APMs to meet the thresholds
  - Other payer APMs must meet same standards as Medicare APMs

Becoming a QP *(cont.)*

TABLE 33: QP Payment Amount Thresholds – Medicare Option

Medicare Option – Payment Amount Method						
Payment Year	**2019**	**2020**	**2021**	**2022**	**2023**	**2024 and later**
QP Payment Amount Threshold	25%	25%	50%	50%	75%	75%
Partial QP Payment Amount Threshold	20%	20%	40%	40%	50%	50%

Becoming a QP *(cont.)*

TABLE 34: QP Payment Amount Thresholds – All-Payer Combination Option

All-Payer Combination Option – Payment Amount Method										
Payment Year	**2019**	**2020**	**2021**		**2022**		**2023**		**2024 and later**	
QP Payment Amount Threshold	N/A	N/A	50%	25%	50%	25%	75%	25%	75%	25%
Partial QP Payment Amount Threshold	N/A	N/A	40%	20%	40%	20%	50%	20%	50%	20%
			Total	Medicare	Total	Medicare	Total	Medicare	Total	Medicare

Becoming a QP *(cont.)*

TABLE 35: QP Patient Count Thresholds – Medicare Option

Medicare Threshold Option – Patient Count Method						
Payment Year	**2019**	**2020**	**2021**	**2022**	**2023**	**2024 and later**
QP Patient Count Threshold	20%	20%	35%	35%	50%	50%
Partial QP Patient Count Threshold	10%	10%	25%	25%	35%	35%

Becoming a QP *(cont.)*

TABLE 36: QP Patient Count Thresholds – All-Payer Combination Option

All-Payer Combination Option – Patient Count Method										
Payment Year	**2019**	**2020**	**2021**		**2022**		**2023**		**2024 and later**	
QP Patient Count Threshold	N/A	N/A	35%	20%	35%	20%	50%	20%	50%	20%
Partial QP Patient Count Threshold	N/A	N/A	25%	10%	25%	10%	35%	10%	35%	10%
			Total	Medicare	Total	Medicare	Total	Medicare	Total	Medicare

Judicial Review Preclusion

- Judicial review is precluded for:
  - The design and application of the MIPS calculation methodology, including the bonus for extraordinary performers
  - The establishment of individual performance standards, and their performance periods
  - The identification of measures and activities specified for a performance category, as well as the posting of results on the CMS website
  - The design and application of the performance score methodology
  - A determination as to whether an entity is an Advanced APM
  - A determination that a clinician qualifies as a participant of an Advanced APM
  - A determination of the amount of the 5% lump sum to eligible participants of Advanced APMs

Decision Support Needed by Eligible Clinicians

- Which quality data items will result in the highest scores?
- What care protocols will result in the lowest resource use for my patients?
- How can I improve my clinical practice activities, by myself or with colleagues, to meet the MACRA CPIA objectives?
- Should I participate individually or through my group?
- What IT infrastructure will I need for reporting purposes, as well as for certified EHR purposes, and how much will it cost?

- Hospitals and health systems can consider offering a suite of services to help evaluate and manage these needs.

Alignment with Hospital Payments

- The new payment system aligns reimbursement between in physicians and hospitals in a couple of ways:
  - Excess readmissions results in low scoring in the Quality Performance Category for any physician group with more than 10 practitioners
  - Clinicians who have a sufficient number of inpatient cases are measured on Medicare Spending per Beneficiary (MSPB), just as hospitals are under VBP
- Physicians receive increased reimbursement for joining an ACO that qualifies as an Advanced APM

Physician Compensation Issues

- Physicians most at risk are those in small private practices
  - 87% of solo practitioners and 70% of group practices of less than 10 members are projected to have a negative adjustment
- Physicians are insulated from exposure under the new system under any of the following circumstances:
  - They are employees of a hospital
  - They are employees of a group practice that participates in MIPS as a group
  - They are in an “Advanced APM Entity” that does not trickle down financial risk

Physician Compensation Issues *(cont.)*

- Need to restructure compensation models
  - Could this fall into a "productivity bonus" under Stark?
  - Other exceptions may be the indirect compensation arrangement exception or the personal services exception
- For Resource Use performance category, is there a risk of running afoul of gainsharing arrangements?
  - May create an incentive for hospitals to enter ACOs to benefit from waivers
- Hospitals continue to become increasingly responsible for physician performance