Evolving Physician Reimbursement Structures: Moving the Medical Group to Value-Based Success

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Now that the Medicare Sustainable Growth Rate (SGR) formula has been repealed, physicians and other providers must prepare for the Merit-Based Incentive Payment System (MIPS). We address several important questions about evolving physician reimbursement structures and provide guidance on how to succeed under the new programs.

With passage of the Medicare Access and CHIP Reauthorization Act, what changes can physicians expect with regard to payment incentive models?

Repeal of the Medicare SGR formula and passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) are bringing about significant changes to the Medicare physician fee schedule and reimbursement methodology (Centers for Medicare & Medicaid Services [CMS], 2015). MACRA established annual positive or flat fee updates for 10 years and implemented a two-track fee update thereafter. In addition, MACRA created MIPS and consolidated the current Medicare fee-for-service incentive initiatives. The law also provides a mechanism for physicians to participate in alternative payment methods, including the patient-centered medical home model and others to be defined. In repealing the SGR and passing MACRA, Congress’s intent was to move away from the fee-for-service payment methodology and toward a value-based payment system.

In preparation for changes to current fee-for-service incentive models, physicians and physician groups should be aware that 2016 is the last reporting period under the current Physician Quality Reporting System (PQRS) methodology. The 2016 reporting period will affect 2018 reimbursement, meaning that providers who do not meet reporting and participation requirements in 2016 will experience a 2% reduction in Medicare reimbursement in 2018 (CMS, 2016b). Satisfactory participation currently includes reporting on nine measures in three quality domains, as defined by CMS. Changes for 2016 include adding measures where gaps exist and eliminating measures that have topped out, are duplicative, or have been replaced by more robust measures.

Legislative changes to the Electronic Health Record (EHR) Incentive Program are leading to a stricter definition of certified EHRs. These changes will align with the Office of the National Coordinator for Health Information Technology and govern
the requirements for information and how it can be submitted. In addition, the current Meaningful Use (MU) program will be restructured and consolidated into MIPS.

CMS will continue a phased approach to public reporting on the Physician Compare website. In addition to providing access to all individual- and group-level reported measures, Physician Compare will post scores for providers who report satisfactory performance on the new PQRS Cardiovascular Prevention measures and received a positive adjustment for the Value-Based Payment Modifier (VBPM) program. By including the downloadable VBPM database, Physician Compare will provide consumers with information regarding performance (i.e., high, low, or neutral on cost and quality) and indicate if a provider or group did not report data on these measures.

Implementation of MACRO will drive the consolidation of the current incentive plans. Beginning in 2017, MACRA will include elements of each of the three programs (PQRS, MU, and VBPM) as well as a fourth—clinical practice improvement activities (CPIA)—currently under development. These programs will be rolled together and result in a composite score for practitioners and practices. Each provider or practice will receive a positive, neutral, or negative adjustment in reimbursement on the basis of the score in relation to a threshold. The incentive or penalty will be based on reporting and performance 2 years earlier, meaning the 2019 incentive or penalty will be based on reporting and performance in 2017. Providers or groups above the threshold will receive positive adjustments, whereas those below the threshold will receive negative adjustments. The payment adjustments will gradually increase from 4% in 2019 to 9% in 2022. CMS projects that this system will be budget neutral, meaning poor performers will pay for above-average performers. In the event that everyone is above the threshold, CMS has built in an additional $500 million in funding for the top performers between 2019 and 2024.

What is the difference between an alternative payment model (APM) and MIPS?

MIPS consolidates the current Medicare fee-for-service incentive programs (i.e., PQRS, MU, and VBPM) into one system under MACRA and adds a new clinical practice improvement measure. The APM is a second track under MACRA that provides an alternative to MIPS. To opt out of MIPS, a provider or practice needs to receive a significant portion of income through APMs that involve risk and quality reporting. While the final rule defining qualifying APMs has not been released, the proposed rule issued April 27 specifically excludes Medicare Shared Savings Program (MSSP) Track 1 (no downside risk), Bundled Payment for Care Improvement (BPCI), and Comprehensive Care for Joint Replacement (CJR) (CMS, 2016a, 2016c). Exemption from MIPS through APMs secures a 5% positive payment adjustment from 2019 through 2024. CMS is in the process of defining “significant” portion, as well as identifying approved APMs for all providers through its rulemaking process. If the proposed rule stands, many organizations actively participating in MSSP Track 1, BPCI, or CJR will have to
decide whether to proceed in MIPS or in a more advanced APM that meets the exemption requirements. More advanced APMS require a greater degree of risk, which is likely CMS’ intent, but they also require a greater extent-of-care model and infrastructure development. Under the proposed ruling, MSSP Tracks 2 and 3, Next Generation, and Pioneer models are approved APMS, but it is unclear whether CMS will allow current Track 1 participants to change tracks related to this requirement.

**How do APMs provide higher quality at lower cost while maintaining physician reimbursement levels?**

The goal of APMS is to enable physicians to provide better-quality care at a lower cost and remain financially viable. The American Medical Association and Center for Healthcare Quality & Payment Reform (2015) highlight three criteria for success in an APM. First, care delivery must be flexible, allowing practices to provide the services needed in an efficient and effective way. Second, payment predictability—including risk adjustments based on patient characteristics and limits on the financial risk that providers must shoulder—must be established to address how a practice will be reimbursed to cover the cost of care. Finally, physicians will be held accountable for cost and quality that are within their control.

All advanced APMS must meet certain criteria, including payment based on quality measures comparable to those in MIPS; use of certified EHR technology; and either bearing more than nominal financial risk for monetary losses or following a medical home model expanded under Center for Medicare & Medicaid Innovation authority.

Not all providers and physician specialties are currently eligible to participate in advanced APMS. CMS is encouraging innovation in creation of APMS that exhibit the Institute for Healthcare Improvement’s Triple Aim and meet the legal criteria. Eligible APMS will expand over the next 3 years to include additional specialists and programs.

**PQRS, MU, and VBPM are combined in MIPS along with a new measurement—CPIA. How will the measures be defined in 2017?**

Beginning in 2017, eligible professionals will be measured on the basis of the new MIPS methodology. Performance in 2017 will determine the MIPS score for 2019; therefore, providers’ performance affects their payment 2 years later. Figure 1 shows the timeline for transitioning to MIPS and the gradual increase in incentives and penalties.

The MIPS score ranges from 0 to 100. To date, the final rule has not been released regarding how points are earned in each category. CMS expects to issue a final rule in October 2016, which does not leave much time for organizations to prepare, but the proposed rule provides insight regarding the general direction of the programs. Groups that have implemented proactive steps for success under the existing programs will be better prepared for MIPS. Thus, providers should organize and streamline processes in 2016 in support of the CMS incentive programs. As noted earlier, eligible providers will be compared with a performance threshold under MIPS.
Eligible providers above the threshold will earn an incentive, whereas those below the threshold will incur a penalty. The initial threshold for 2019 and 2020 will be based on performance and reporting in 2017 and 2018, respectively.

**What can practices do now to succeed in 2019?**

As mentioned earlier, performance affects payment 2 years later. In addition, because the new MIPS program will consolidate the existing incentive programs—PQRS, MU, and VBPM—and add the new CPIA, provider organizations that are not pursuing the APM exemption should optimize their performance under these programs by embedding criteria under the existing incentive programs into their care model. In addition, organizations should be familiar with the changes to these programs under the proposed rule and track their progress through the final rule. Provider organizations also should align the quality components of the CMS programs with the quality metrics of their other value-based contracts to develop one care model for the entire population served. As the reimbursement structures change, provider compensation must also evolve to incentivize behavioral change and promote adherence to quality and service metrics.

Repeal of the SGR is the biggest fundamental change to the physician reimbursement structure in many years. Success in the new value-based world requires the commitment of the entire care team and a highly optimized medical practice.
Identifying physician champions to lead the value transformation will be integral to success. We are all learning at the same time, and not all of the rules have been finalized. However, those who embrace change and create a strategic road map to align incentives across programs and evolve the care model in support of the reimbursement changes will ultimately succeed.

REFERENCES


For more information about the concepts in this column, contact Dr. Bosko at tbosko@sg2.com.