

Physician Leadership Institute

Pay for Performance, What's Next

Learning Objectives

1. Provide a summary of current Medicare physician incentives & penalties
2. Discuss Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
 - The new incentives and penalties structure
 - Timeline for implementation
 - Beyond Medicare
3. Strategies for preparing your practice
 - Scenarios and choices

Current Medicare Incentives & Adjustments

Meaningful Use

- Fixed sum incentives
- Adjustments(-) begin in 2015 – based on 2013 - 2 years look back
- Maximum downward adjustment: 3% to 5%

PQRS

- Incentives expired
- Adjustments(-) for reporting quality measures to CMS begin in 2015 based on 2013 reporting (2 years look back)
- Maximum downward adjustment: 1.5% → 2% years 2 and up

VBPM

- Adjustments(+/-) based on quality per resource utilization
- 2015 - large groups(100), 2016 - medium(10), 2017 – solo and small, 2018 – non physicians (based on 2 years look back)
- Maximum downward adjustment: 2% (4% groups ≥ 10)

MSSP

- Accountable Care Organizations
- Shared Savings Programs based on quality measures and total cost per beneficiary – lumped payments, NOT claim adjustments

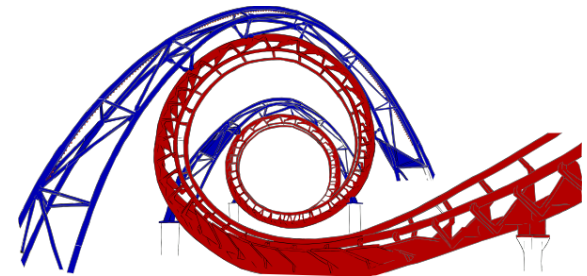
Adjustments are applicable **ONLY** to services paid under MPFS

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

SGR formula was permanently repealed and replaced with:

- 0.5% yearly increase to MPFS starting July 1st 2015 through 2019
- Two tracks to obtain incentives (penalties)
 - Alternative Payment Models (APM)
 - Merit-Based Incentives Payment System (MIPS)

Goal: Transition to value-based payment system



Vast majority of details not defined in the law and will be defined through regulations mid-2016

Alternative Payment Models (APM)

Starts in 2019 – ends in 2024

Flat 5% of estimated MPFS incentive to all eligible professionals

What is an APM?

- A patient centered medical home/specialty practice
- Medicare shared savings program (MSSP - ACO)
 - Medicare alone
 - Medicare + similar risk-bearing arrangements with private payers
 - Medicare + entity that makes quality payments and requires meaningful use
 - May include Medicaid only if the State has a medical home program
 - VA and DoD are excluded
 - Percent of patients covered increases over time
 - 2019-2020: 25% Medicare
 - 2021-2022: 50% Medicare (or 25% Medicare + 25% private or Medicaid per above)
 - 2023-2024: 75% (may be distributed as above)
- Certain demonstration programs are also eligible



Merit-Based Incentives Payment System (MIPS)

Starts in 2019 – no end date specified.....

Composite performance scores across 4 domains:

0  100 for each domain



1. Quality (30% weight)

- Measures to be selected/defined
- Emphasis on “outcomes”

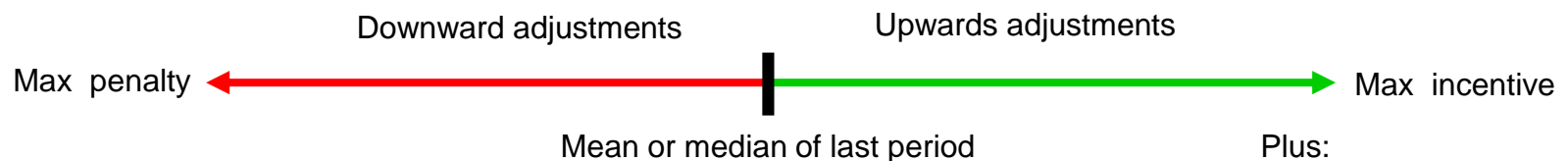
2. Resource use (30% weight)

- Utilization (including inpatient/ED)
- Various levels of patient attribution – *ACO gets half the points (15%)*

3. Clinical practice improvement (15% weight)

- Access; population management; care coordination; patient engagement; patient safety; alternative payment
- Multiple ways to accomplish – *PCMH/PCSP gets all 15%*

4. Meaningful use of certified EHR (25% weight)



Plus:
Exceptional Performance
incentive

Additional MIPS Details

Percentage allocations for each domain

- Resource use – up to 10% in year 1, 15% in year 2, and 30% thereafter
- Quality domain assigned the difference:
 - Quality year 1 = at least 50% of total score
 - Quality year 2 = at least 45% of total score
 - Start tracking your quality measures because initially they will make or break your incentives
- If more than 75% of EPs are meaningful users, MU weight will go down from 25% to 15% and the 10% difference will be split among the other 3 domains

Adjustment calculations

- Adjustments are in linear proportion to scores – to get the maximum adjustments, you have to excel, not just be above the threshold
- Maximum penalty is assessed if your score is $\frac{1}{4}$ of threshold or lower
- The total adjustments are budget neutral – the more low performers there are, the larger the incentives for high performers

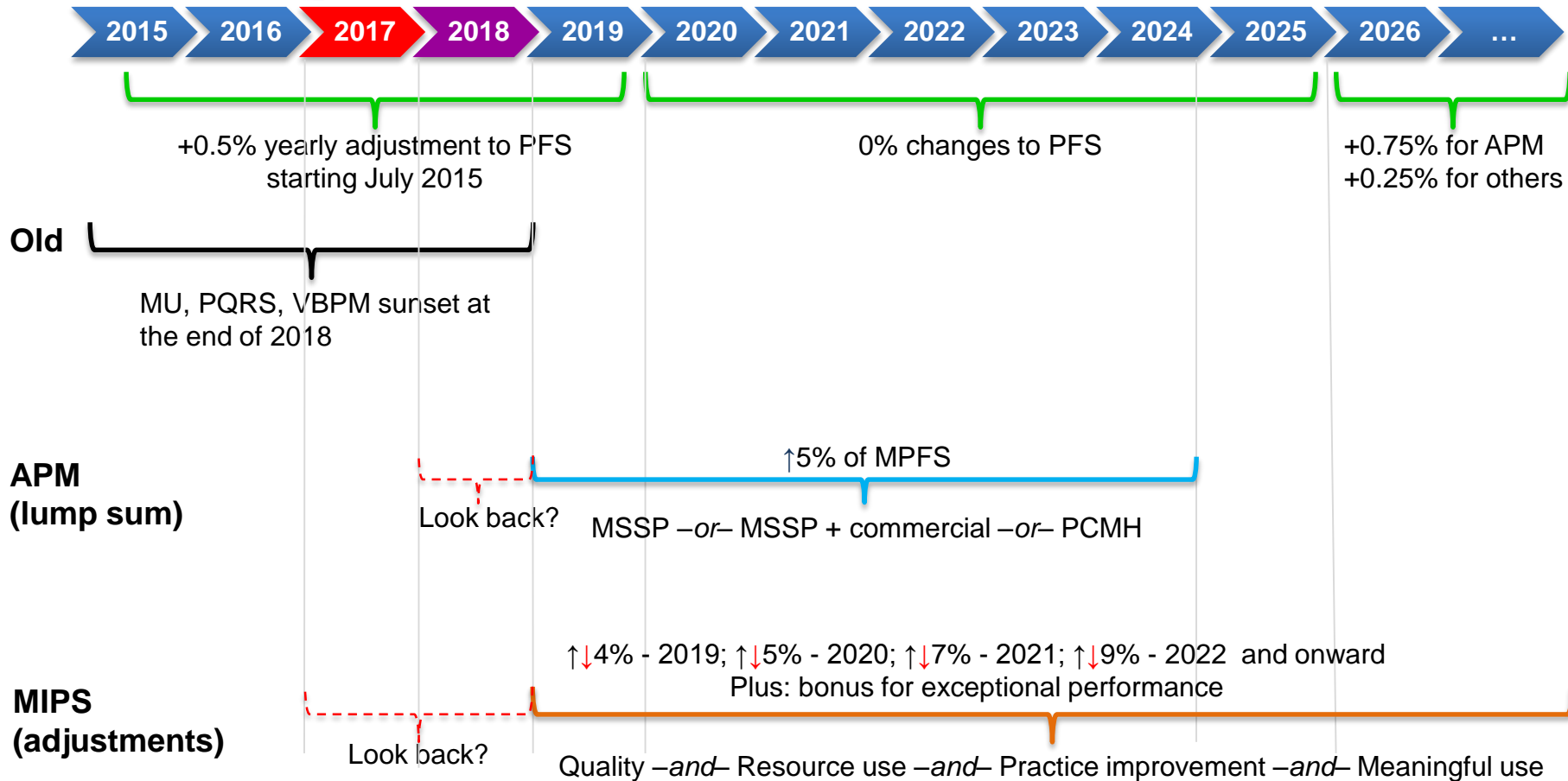
Exceptional Performance

- \$500 million set aside per year for top 25th percentile of performers, but not to exceed 10% of MPFS for each recipient

MACRA Implementation Timeline



"performance periods" are left to the Secretary of Health and Human Services to define for adjustments applied in 2019 and onwards. Historically Medicare used a 2 years look back period for claim adjustments



MACRA Goes Beyond Medicare

- Commercial insurance ACOs are counted under APM
- Medicaid medical homes may be counted under APM
- States will be lobbied to set up medical home programs for Medicaid/CHIP
- In general commercial payers follow Medicare's lead on payment structure
- Transition to value-based contracting (total cost risk or capitation) are already in wide use with private insurers
- The private insurance market may actually move faster than the Medicare timeline set by the MACRA

Strategies for Your Practice



- Can you choose right now between APM and MIPS?
- Should you choose?
- Are you in an ACO or planning to join?
- Are you a PCMH/PCSP?
- Are you participating in MU and PQRS?
- Are you planning for VBPM?
- Are you taking risk right now (global or just capitation)?
- Are you tracking your quality measures (just reporting will not be enough)?
- Are you getting utilization data from payers?
- Do you have plans on how to improve your numbers?
- Are you a meaningful user of a certified EHR?
- **Or are you just tired and want all these things to go away?**

Option 1: Do Nothing

What happens next?

- Starting on July 1st all your Medicare claims will be paid 0.5% more
- Commercial fees for service will similarly remain flat
- You will be penalized for MU if you did not attest
- You will be penalized for PQRS if you did not report
- By 2018
 - With MU and PQRS you will see a 2% increase in Medicare fees
 - Without MU and PQRS you will see a drop of 3% to 5%
- By 2022 the drop will be 9%

When should I consider this option?

- If you plan on retirement in the next few years
- If you plan on selling your practice in the next few years (and if there are buyers)
- If you see very few Medicare patients and are happy with your current income levels

Option 2: The Easy Button



Get PCMH or PCSP recognition

- Go for Level III (if you do NCQA) just to be safe
- Keep up on Meaningful Use and PQRS
- By mid 2017 if you go after the APM track of 5%
- By the end of 2016 if you prefer MIPS, or are not sure, and chose to be prepared for either one
- Contact your other payers and see if there are payments for PCMH/PCSP practices (these will be increasingly larger and more available now)
- **Keep an eye on upcoming CMS regulations: there are open questions regarding this option, and many other issues**

Easy is a relative concept.... 😊

Option 3: Join an ACO

- Easier said than done
- Unless you already belong to one, and plan on staying, in which case you are on the APM track already
- Otherwise, do a bit of research on ACOs in your area and/or plans to create ACOs
- Note to specialists: if you contract with multiple ACOs, or private payer entities, you can add them all up for calculating required APM percentages

Long term considerations for Options 2 & 3:

- The APM track ends in 2024
- The MIPS track has additional performance bonuses
- Starting in 2021 the MIPS track has higher potential upside
- However the MIPS track has potential downside as well
- If all your APM numbers look good, you may want to switch early
- Many things can change between now and then.....

Options 4: Safety in Numbers

(ACO Lite)

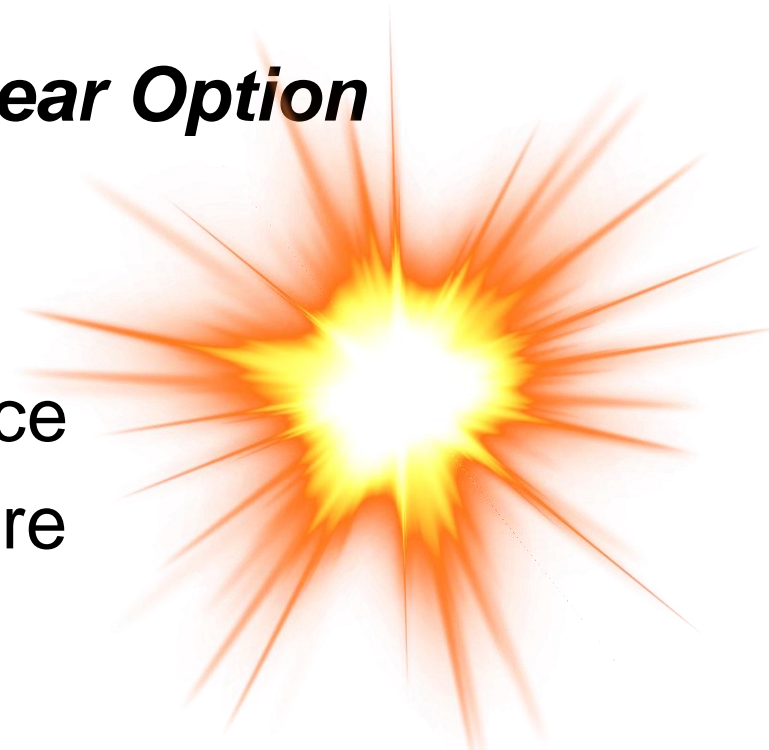
- The MIPS track has an option to create virtual groups using multiple grouping criteria, including geographic
 - Practices with 10 or less MIPS eligible professionals
 - Need formal agreements in writing
- Main advantage – more robust and reliable calculation of quality and resource use measures due to larger population
- Caution: everybody sinks or swims together – seek likeminded partners – an IPA is a good place to start



Option 5: The Nuclear Option

- If this is all too much....
- You can stop taking insurance
- More feasible for primary care
 - Concierge on your own
 - Join a DPC* company
 - Contract with a DPC management company
 - You can transition gradually (hybrid model)
- Do your homework first – it's not as easy as it sounds

**DPC – Direct Primary Care*



Reference & Resources

1. The Medicare Access and CHIP Reauthorization ACT of 2015 (MACRA), <https://www.congress.gov/bill/114th-congress/house-bill/2/text#toc-H8707FE64FFCF4CE2A98F9C4CCCD16645>
2. AAFP - Medicare Payment Reform Resources, <http://www.aafp.org/practice-management/payment/medicare-payment.html>
3. MLN Connects® National Provider Call Program, up-to-date information from CMS, <http://www.cms.gov/Outreach-and-Education/Outreach/NPC/index.html>
4. ACP MACRA Handout for Internists, http://www.acponline.org/advocacy/where_we_stand/assets/macra_handout_hr2_2015.pdf
5. ACP Crosswalk of the Medicare Access and CHIP Reauthorization Act of 2015 (H.R. 2), (very good summary), http://www.acponline.org/acp_policy/policies/crosswalk_medicare_access_chip_reauthorization_hr2_2015.pdf
6. AMA Medicare Physician Payment Reform (timeline and summaries) <http://www.ama-assn.org/ama/pub/advocacy/topics/understanding-medicare-physician-payment-reform.page>



Contact info: Mike Fondell
mfondell@bizmedsolutions.com
Mobile: 636.346.6803

For more information and assistance:

On the web: www.bizmedsolutions.com

Email: support@bizmedsolutions.com

Phone: 1-866-861-0160