

# Medicare Physician Payment Reform:

## Implications and Options for Physicians and Hospitals

### Background

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was signed into law on April 14, 2015. MACRA reforms the way Medicare pays for physician services, permanently retiring the sustainable growth rate (SGR) formula in favor of a predictable and sustainable model for future physician payments.

One of the goals of healthcare reform was to change the current volume-based payment incentives by shifting to payment based on value. As depicted in figure 1, payment incentives have been restructured into two approaches. Providers can continue with the traditional fee-for-service (FFS) system (track 1), but a portion of their fee-for-service payment will be influenced by their performance on quality and outcomes measures. Increasingly these measures will align across the different payment silos (physician, hospital or post-acute care provider). The second option for providers (track 2) is to shift all, or part, of their Medicare payment to an alternative payment model (APM). The alternative payment models encourage providers to organize under different governing structures and work across the payment silos and reengineer the care delivery process to reduce costs and improve quality and outcomes.

The new law follows this overall structure of payment reform and specifies annual updates. Eligible providers who bill under the physician fee schedule can continue with FFS payment but have payment tied to quality performance (track 1) or receive a 5 percent bonus for payment from 2019 to 2024 for participation in an alternative payment model (track 2). The details of how the changes required by MACRA will be implemented is subject to rulemaking in a number of areas, including the definition of “alternative payment model,” which will determine the models that qualify as a value-based payment system.

Figure 1 – Payment Model tracks

		TRADITIONAL PAYMENT MODELS						
TRACK 1	Physician	Outpatient Hospital and ASCs	Inpatient Acute Care	Long Term Acute Care	Inpatient Rehab	SNFs	Home Health Care	
	2014 RBRVS*	APC	2015 MS-DRG*	MS-DRG	RICs	2008 RUGs*	2015 HHRGs*	
	CY2013 PFS-Value modifier; CY2015 - P4R; CY2019 - MIPS	P4R in CY2013; ASC VBP impl. plan submitted to Congress on 4/18/11	VBP commenced 10/1/12	P4R in FY2014; VBP test pilot by 1/1/16	VBP test pilot by 1/1/16	VBP starting 10/1/18	VBP testing in 9 states CY2016-2022 (proposed)	
		ALTERNATIVE PAYMENT MODELS						
TRACK 2	ACCOUNTABLE CARE ORGANIZATIONS							
	ACUTE AND POST-ACUTE CARE EPISODE BUNDLING							
				POST-ACUTE CARE EPISODE BUNDLING				
	ACUTE CARE BUNDLING							
	MEDICAL HOME							

\* Five-Star Quality Rating System exists for the payment system



Figure 2 – Volume to value: Percentage of all Medicare payments



### HHS Initiatives

On January 26, the secretary of HHS set payment reform goals for the nation that follow the track 1 and 2 framework. HHS’ initiative focuses on broad areas which include:

**Incentives to promote value-based payment systems to providers:** HHS has set a goal of tying 30 percent of Medicare payments to track 2 alternative payment models (see figure 2), such as ACOs and bundled payments, by 2016 and 50 percent of payments to these models by the end of 2018. According to HHS, 20 percent of Medicare reimbursement is currently paid to providers through APMs.

In addition, HHS aims to have 85 percent of FFS Medicare, track 1, payments tied to quality and value by 2016 and 90 percent by 2018. While a portion of hospital payments are already based on quality and value through the Hospital Value-based Purchasing Program and the readmissions and hospital-acquired condition reduction programs, the other provider groups, post-acute care and physicians, are moving to pay-for-performance value-based purchasing. This will enable HHS to meet their 2018 target.

**Improving care delivery:** HHS continues to encourage patient engagement through shared decision making and more effective care delivery through greater integration and coordination of clinical care services. Additionally, HHS seeks to improve the overall health of the population by focusing on prevention and wellness.

**Information sharing:** HHS continues to expand transparency efforts to provide consumers greater access to cost and quality information (see stars on figure 1 above that depict which of the payment programs already have star rating programs that provide consumers with a simple comparative metric on provider comparative quality) to equip them to make better decisions about their care and to improve the interoperability of health information technology so that relevant data is available at each point of care across the continuum.

### MACRA payment tracks

Beginning in 2019, with some exceptions, eligible providers that wish to remain in fee-for-service will be subject to a new Medicare Merit-based Incentive Payment System (MIPS - track 1).

MIPS will put a portion of a physician’s Medicare FFS payment at risk, contingent on their performance in four areas: quality, resource use, clinical practice improvement activities, and meaningful use. Eligible providers can stay in track 1, but will be required to improve performance in a way that will deliver savings that could have been shared in track 2.



The new program will gradually increase the amount of Medicare payment at risk, from 4 percent to 9 percent of physician FFS pay. Eligible providers that choose to participate in alternative payment models (track 2) will be exempt from MIPS and will be eligible for bonus payments of up to 5 percent of total pay. After 2025, APM participants will also receive higher annual pay updates of 0.75 percent a year, compared to 0.25 percent for MIPS. Similarly to those in MIPS, however, providers participating in APMs will also participate in performance measurement and payment adjustment.

Figure 3 – MACRA implementation timeline

	'15	'16	'17	'18	'19	'20	'21	'22	'23	'24	'25	'26
	Permanent repeal of SGR											
	Updates in physician payments											
	0.5% (July 2015-2019)					0.0% (2020-2025)						
TRACK 1	PQRS Pay for Reporting											
	-1.5%		-2.0%									
	Meaningful Use Penalty (up to %)											
	-1.0%	-2.0%	-3%	-3.0%								
	Value-based Payment Modifier											
	+/-1.0%	+/-2.0%	+2/+/-4.0%	+2/+/-4.0%								
	Merit-Based Incentive Payment System (MIPS) adjustments											
	Measurement Period		+/- 4%	+/- 5%	+/- 7%	+/- 9%						
	MIPS exceptional performance adjustment; <10% Medicare payment (2019-2024)										0.25% update	
TRACK 2	Measurement Period		APM participating providers exempt from MIPS; receive annual 5% bonus (2019-2024)								0.75% update	



## Merit-based Incentive Payment System – Track 1

Eligibility:

Figure 4 – MIPS eligible professionals

TYPES OF ELIGIBLE PROFESSIONALS	TRACK 1		TRACK 2
	Value-Modifier	MIPS	APM
<b>Medicare Physicians:</b> Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatric Medicine, Doctor of Optometry, Doctor of Oral Surgery, Doctor of Dental Medicine, Doctor of Chiropractic	<b>2017</b> (2015 performance)	<b>2019</b>	<b>2019</b>
<b>Practitioners:</b> Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist, Certified Registered Nurse Anesthetist	<b>2018</b> (2016 performance)	<b>2019</b>	<b>2019</b>
<b>Practitioners:</b> Certified Nurse Midwife, Clinical Social Worker, Clinical Psychologist, Registered Dietician, Nutrition Professional, Audiologists	<b>N/A</b>	<b>2021</b>	<b>2019</b>
<b>Therapists:</b> Physical Therapist, Occupational Therapist, Qualified Speech-Language Therapist	<b>N/A</b>	<b>2021</b>	<b>2019</b>

Not all EPs are subject to MIPS in year 1, but all EPs can receive a bonus if they meet the APM threshold.

For 2019 through 2024, EPs who are qualifying APM participants receive a lump sum 5 percent bonus payment (based on services furnished in the preceding year, which may be estimated). This is in addition to payments otherwise made under the APM. The bonus payments will not be taken into account in determining actual expenditures under the APM or in determining or rebasing related benchmarks. Bonus payments must be determined without regard to currently available bonus payments for certain primary care and general surgery services.

- 2019-2020: MIPS is restricted to Medicare physicians, physician assistants, nurse practitioners, clinical nurse specialists and certified registered nurse anesthetists (“eligible professionals” – EPs).
- For 2021 and beyond, the program also applies to other eligible professionals, to be determined through rulemaking. Those newly eligible in 2021 could include certified nurse-midwives, clinical social workers, clinical psychologists, registered dietitians/nutrition professionals and therapists.
- MIPS excludes:
  - Qualifying APM participants
  - Partial qualifying APM participants who do not report MIPS data
  - Eligible professionals who do not exceed the low-volume threshold selected by the secretary

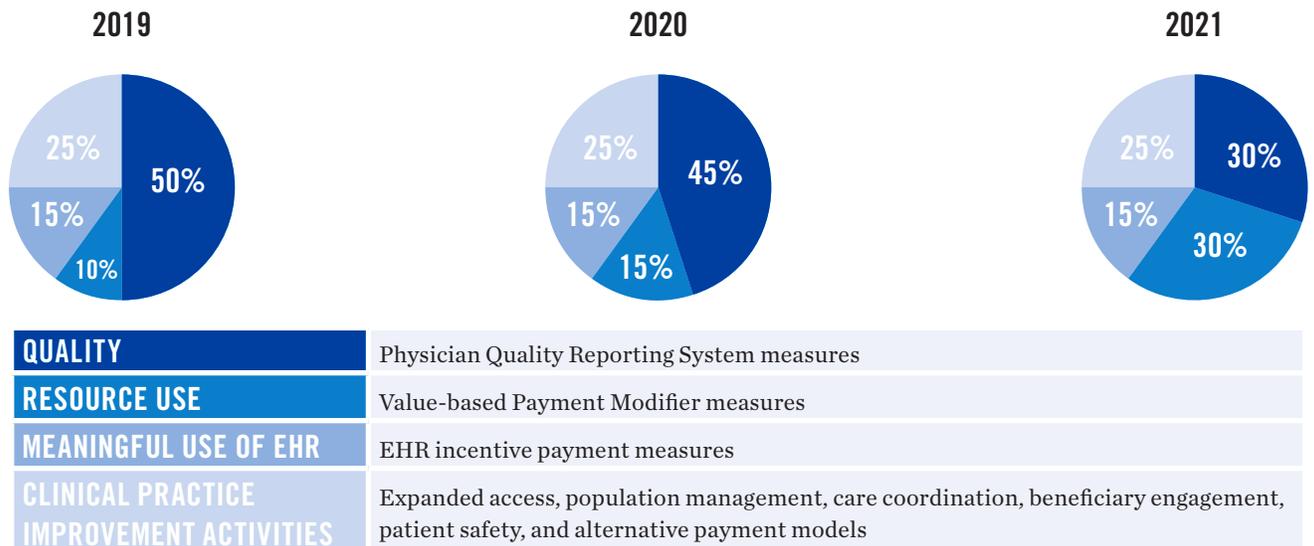


The law provides variable, performance-based incentive payments under MIPS beginning January 1, 2019, based on four performance categories, as seen below and in figure 5:

- **Quality:** Existing Physician Quality Reporting System (PQRS) is a source of measures (including measures collected by qualified clinical data registries). There are more than 250 PQRS measures addressing a wide array of topics including preventive care, treatment, safety and appropriateness.
- **Resource Use<sup>1</sup> :** Existing cost measures used in the value-based payment modifier (VM) is a source of measures. Potential measures could include Medicare Spending per Beneficiary, total per capita costs and condition-specific per capita costs.
- **Meaningful Use of EHRs:** Existing objectives and measures in the meaningful use program.
- **Clinical Practice Improvement Activities:** New performance category. MACRA requires inclusion of at least the following six subcategories in the measure:
  - Expanded access (e.g., same day appointments)
  - Population management (e.g., participation in a qualified clinical data registry)
  - Care coordination (e.g., use of remote monitoring or telehealth)
  - Beneficiary engagement (e.g., use of shared decision-making)
  - Patient safety and practice assessment (e.g., use of surgical checklists)
  - Alternative payment model participation

MACRA sunsets separate PQRS and EHR meaningful use payment adjustments, and application of the VM to physicians, after 2018.

Figure 5 – MIPS Performance



<sup>1</sup> MACRA requires further development of episode-based resource use measures.



In a given year a negative MIPS payment adjustment to the otherwise payable amounts under the Medicare physician fee schedule may not exceed the amounts in figure 6 below.

The performance period under MIPS must begin and end prior to the beginning of a year for which the MIPS payments will apply (no length specified), and must be as close as possible to such year.

Things to remember about MIPS measures:

- Each MIPS performance category will have a set of underlying measures or activities.
- Stakeholders will play an important role in recommending measures.
- Each performance category will be weighted.
- HHS will establish performance standards for measures and activities (considering historical performance standards, improvement and opportunity for improvement).
- The end result for each eligible provider will be a composite performance score of 0-100.
- MACRA encourages the use of Qualified Clinical Data Registries, and clarifies groups can use them as of 2016.
- Providers can form virtual groups for assessment purposes.
- Measures used to evaluate provider performance can be based on all-payer data (not just Medicare data)
- An EP failing to report relevant measures or activity data will receive the lowest potential score applicable to the measure or activity.

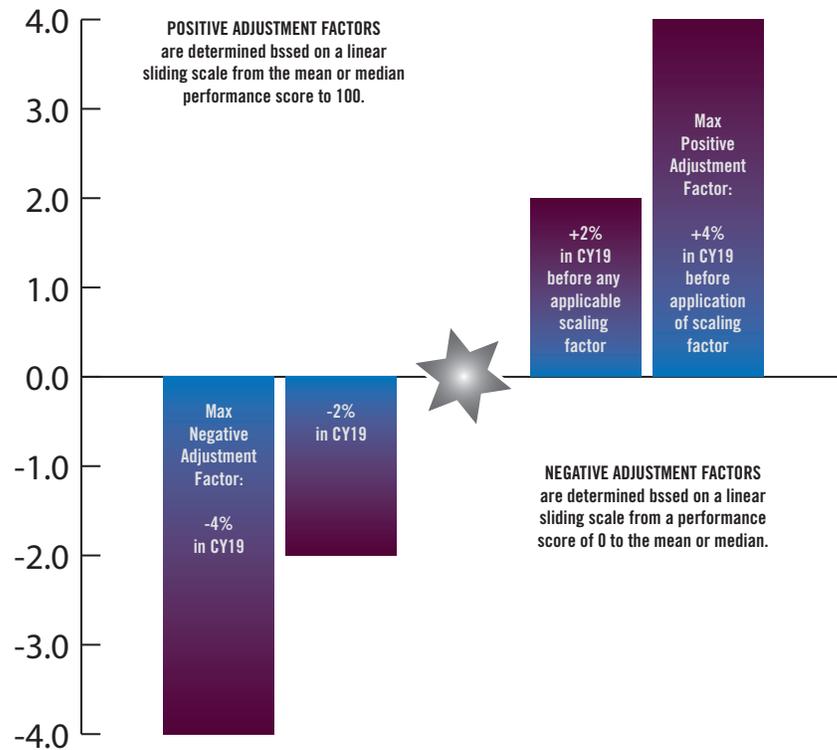
The maximum upward payment adjustments will be parallel to these, except that a scaling factor will be applied to keep the MIPS adjustments budget neutral in the aggregate. Regardless, the maximum upward payment adjustments can never be more than three times the size of the maximum negative adjustment. Thus, some high-performing physicians could receive significantly enhanced Medicare payment based on their performance on the quality and outcomes measures. See MIPS payment adjustments in figures 6 and 7 below.

Figure 6 – MIPS payment adjustment factors

	Maximum positive adjustment before budget neutrality scaling factor	Maximum negative adjustment factor	Maximum positive adjustment after budget neutrality scaling factor
CY 2019	4%	-4%	12%
CY 2020	5%	-5%	15%
CY 2021	7%	-7%	21%
CY 2022	9%	-9%	27%



Figure 7 – MIPS payment adjustment factors



Not later than 30 days prior to January 1 of a year, eligible professionals on track 1 must be informed of the MIPS adjustment factor that will apply to them in the coming year<sup>2</sup>.

MACRA provides an additional funding pool of \$500 million per year for 2019 through 2024 to reward exceptional performance through an additional MIPS adjustment factor. The threshold for awarding these additional amounts could be set at either the 25th percentile of the range of possible composite performance scores above the applicable performance threshold or at the 25th percentile of the actual composite performance scores at or above the performance threshold for a prior period. The resulting MIPS additional adjustment factor for a physician may not exceed 10 percent; therefore, there may be years in which the funding pool is less than \$500 million.

Future rulemaking, with the opportunity for public comment, will assess appropriate adjustments to quality, resource and other MIPS measures, and will assess and implement appropriate payment adjustments, composite performance scores, scores for performance categories, or scores for measures or activities under MIPS.

An annual publication of the list of quality measures will be released no later than November 1 of the year prior to the start of a MIPS performance period.

Beginning on July 1, 2017, eligible providers will receive confidential feedback on their performance on quality and resource use measures, building on existing physician feedback programs. Beginning on July 1, 2018, the feedback will include information on services received by patients from other suppliers and providers.

<sup>2</sup> There will be an opportunity for an informal review of physicians' MIPS adjustment factor.



## APMs – Track 2

To qualify as an APM, eligible providers must use certified electronic health records technology and adhere to quality measures comparable to those used under MIPS. In addition, they must assume more than “nominal” financial risk or be part of a Medicaid medical home. APMs will be defined through rulemaking, but programs such as those being tested by the CMS Innovation Center will likely qualify as eligible APMs.

Eligible APMs may include programs in the following areas:

- Accountable care organization (ACO) under the Medicare Shared Savings Program
- A demonstration through the Innovation Center (CMMI)
- A demonstration through the Health Care Quality Demonstration Program
- Or another demonstration program authorized through federal law

For 2019 through 2024, qualifying APM participants will receive a lump sum 5 percent bonus payment (in addition to other APM payments). Bonus payments will not be taken into account in determining actual expenditures or in determining or rebasing related benchmarks under the APM. Bonus payments must be determined without regard to currently available bonus payments for certain primary care and general surgery services.

Participating providers need to meet minimum requirements for the amount of revenue at risk through an APM, which ratchets upward over time. They also include APMs organized by non-Medicare payers, which is designed to incent private payers to model the Medicare programs:

- For 2019-2020, eligible providers must have at least 25 percent of Medicare payments tied to APMs (during the most recent period for which data are available).
- For 2021-2022, eligible providers must have at least 50 percent of Medicare payments or 50 percent of total payments (and at least 25 percent of Medicare payments) tied to APMs.
- For 2023 and beyond, eligible providers must have at least 75 percent of Medicare payments or 75 percent of total payments (and at least 25 percent of Medicare payments) tied to APMs.

Note that counts of patients may be used in lieu of payments to determine threshold.

Partial qualifying APM participants:

EPs participating in APMs who meet somewhat lower payment thresholds than those for qualifying APM participants. Those partially qualifying do not receive a bonus payment but are not required to participate in MIPS. If they decide to participate in MIPS, they do get credit under the clinical practice improvement domain for involvement in an APM. Thresholds for this lower tier are:

- For 2019-2020, 20 percent of Medicare payments
- For 2021-2022, 40 percent of Medicare payments or 40 percent of total payments (and at least 20 percent of Medicare payments)
- For 2023 and beyond: 50 percent of Medicare payments or 50 percent of total payments (and at least 20 percent of Medicare payments)



APMs must include more than “nominal risk”<sup>3</sup> and private contracts must include comparable quality measurement.

Total payments exclude payments made by the Secretaries of Defense/Veterans Affairs and Medicaid payments in states without medical home programs or Medicaid APMs.

## Public Reporting

- The list of measures used by qualified clinical data registries will be published on the CMS website.
- Physician performance on MIPS will be published on the Physician Compare website and will include the composite score for each EP and his or her performance on quality, resource use, meaningful use of EHRs and clinical practice improvement activities.
- EPs in eligible APMs<sup>4</sup>, the names of these APMs and the performance of such models will be published publicly through the CMS website.
- Data that includes items and services provided to Medicare beneficiaries by eligible providers and other eligible professionals<sup>5</sup> will be published publicly as well. This information will be searchable by the specialty or type of physician or other eligible professional; characteristics of the services furnished, such as volume or groupings of services; and the location of the physician or other eligible professional<sup>6</sup>. This information will be integrated into Physician Compare starting in 2016.
- Reporting through qualified clinical data registries is available to physicians in a group practice reporting as a group beginning in 2016.
- Quality and Resource Use Reports (QRURs) under the existing Physician Feedback Program will not be available to physicians after December 31, 2017 (this program will be replaced by required reports under MIPS).

<sup>3</sup> Future rulemaking will determine the definition of “nominal risk.”

<sup>4</sup> EPs in eligible APMs will receive an opportunity to review and submit corrections for the information to be made public.

<sup>5</sup> Other eligible professionals include physician extenders, physical or occupational therapists, qualified speech-language pathologists, audiologists, as well as other providers such as certified nurse-midwives, and clinical social workers and psychologists.

<sup>6</sup> At a minimum, the data will be required to include Information on the number of services furnished by the physician or other eligible professional under Part B of the Medicare program (which, for example, could include information on the most frequent services furnished or groups of services); information on submitted charges and payments for such services; and a unique identifier for the physician or other professional that is available to the public.



## Strategic implications

Consistent with the recent announcement of HHS' goal to shift up to 50 percent of Medicare payments from fee-for-service to alternative payments by 2018, SGR reform demonstrates unequivocally that healthcare providers are being incented to move to two-sided risk and alternative payment models (such as ACOs, bundled payment and patient-centered medical homes). There will continue to be a focus on outcomes, financial responsibility and efficiency for eligible providers and other providers.

## Understanding your risks

Figure 8 – Managing MACRA



**Assess current state, identify gaps, analyze opportunities and develop roadmap**



**Implement physician partnership strategy**



**Redesign the care delivery process**



**Develop and implement a payer management strategy**



**Performance Management**

Providers, especially health systems that employ physicians, need to understand their potential exposure under the MIPS program. They must have a strategy to assess the available opportunities and best fit of alternative payment models to get the bonus dollars. This assessment will enable decisions on which performance track is the best fit to pursue.

## Provider questions

Eligible providers will start to evaluate these two payment options and begin asking themselves strategic questions. Do I stay in fee for service or take the plunge into alternative payment? Do I have the infrastructure necessary to manage the population health or does it make sense to form strategic partnerships with those that do? Do I organize my own ACO or join one that's operated for some time? Do I join with other eligible providers and manage the care re-engineering or do I align with a hospital system?

There are many new and emerging companies and insurers organizing and educating eligible providers on these dynamics and advising them about their choices. This should cause providers to accelerate planning given that the financial implications and timeline for performance measurement start in 2017 and affect payments in 2019. For instance, only about half of providers have participated in the pay-for-reporting program for Physician Quality Reporting System (PQRS) measures to date. CMS reports that in 2013, 51 percent of eligible professionals participated in PQRS, including those that participated via an ACO. They project that this will increase to 70 percent by 2016. Many providers will be playing catch-up to understand how to drive higher performance to avoid the more significant penalties being imposed.



And while we have seen what is considered rapid growth of ACOs all over the country, there are still many markets where eligible providers operate fully in the traditional fee-for-service model. These markets will have a long way to go to participate effectively in alternative payment models and avoid significant financial repercussions.

### **Physician alignment strategy**

Eligible providers now have a clear timeline for performance-based payment. They can begin to determine how to organize themselves to perform under these new performance programs. Half of Medicare ACOs today are physician-led. Health systems need to be prepared to partner effectively with providers through clinically integrated networks (CINs) to better coordinate care and avoid being treated as a commodity by self-organizing eligible providers in their market.

Health systems must differentiate themselves as the provider of choice in their communities. In other words, they must be low-cost, high-quality organizations with a clear roadmap and value proposition for success within a value-based environment. A clear understanding of the financial implications of these performance programs and a specific action plan for managing under the new MACRA legislation will be critical next steps during the next 6-12 months to be ready for measurement periods that begin in 2017.

Here is a hypothetical model of a health system and how these reforms impact them in terms of just their employed physicians. The model assumes that each of the 250 physicians in the five-hospital system would bring in revenue of \$1.5 million and that 40 percent of that would come from Medicare. Physicians will be held accountable under pre-MACRA programs (which are EHR meaningful use, PQRS and the value-based modifier programs) through 2018. In this scenario, the system would have roughly \$3.7 million at risk, with the potential to receive \$3 million in bonus payments in 2015. This escalates to \$18 million at risk and \$9 million in potential bonus payments by 2018.

The important factor to consider is the potential financial impact at the point where providers must choose between track 1 (the MIPS program) and track 2 (APMs). Under the MIPS, the system would have upside and downside potential of \$6 million starting in 2019, which would increase to a negative or positive \$13.5 million by 2022. In contrast, under track 2, engaging in alternative payment models could bring \$7.5 million in bonuses and \$4.5 million in shared savings for a total of \$12 million. This would be without the risk of MIPS penalties for poor performance, which could be \$13.5 million by 2022. Another dynamic to consider is the potential downside risk of not meeting quality and savings thresholds and some reduced payment as a result of volume reduction.

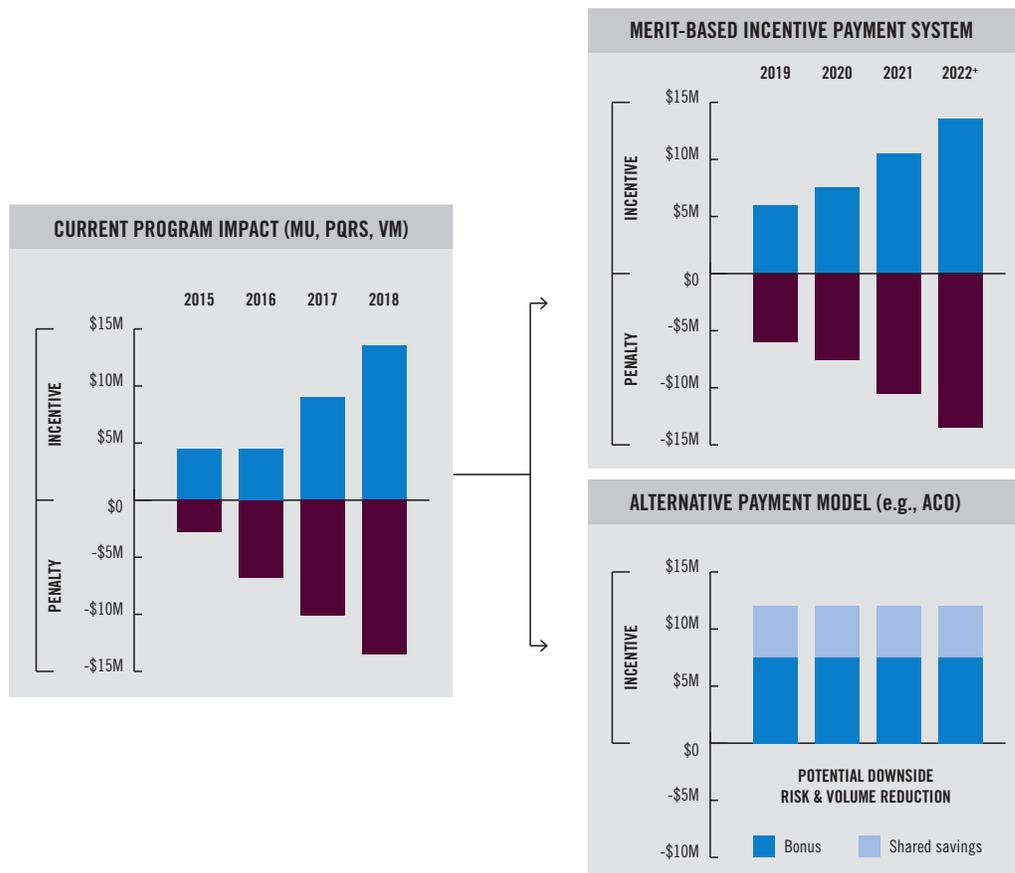


## Begin planning for the evolving payment environment and 2019 today

Figure 9 – Potential financial impact of APM participation

### MACRA Financial Impact Example:

- 5 hospital systems
- \$1.5M revenue per physician
- Employs 250 physicians
- 40% Medicare



Eligible providers will take notice of this legislation.

- Pressure will continue to grow on FFS practitioners, with continuing pushes toward track 2 and alternative payment models.
- There will be greater growth and competition around APMs, which could provide opportunity or additional friction.
- Expect to see increased physician employment and consolidation.
- Post-acute care will be an important focus for savings.



Other stakeholders will also be affected by MACRA provider payment changes. For instance, hospitals have extensive measure submission, VBP and APM experience that will be of value to practitioners. Hospitals also have stronger planning and strategic resources that can help them work with eligible providers during this transition. Moreover, the payment alignment will help hospitals incent eligible providers to align around quality and cost improvement programs.

Premier has been working with its members for more than five years to prepare for this transition. We have been testing and scaling new payment and delivery models with our members to help them succeed in alternative payment models. We have identified a number of areas of focus that are critical to success under these payment programs, which are listed in the graphic below. We urge you to begin to prepare today for this change by creating a MACRA roadmap and assessing how MACRA will impact you and your eligible providers and what track you will want to take.



T 704.357.0022 | [PREMIERINC.COM](http://PREMIERINC.COM)   @PremierHA

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