

What Does Medicare's Shift to Value-Based Payment Mean for my Practice?



The Centers for Medicare & Medicaid Services (CMS) has announced that it intends to link 85% of Medicare Part A and Part B payments to quality and value rather than volume by the end of 2016 and 90% by 2018. CMS has based these goals on the payment reform framework in the table below, which shows a progression from payment based on volume of services to payment for quality and value:

Table 1: CMS Framework for Progression of Payment Reform

Category 1	Fee for Service; No Link to Quality	<ul style="list-style-type: none"> Note: Limited in Medicare fee-for-service; majority of Medicare payments now are linked to quality
Category 2	Fee for Service; With Link to Quality	<ul style="list-style-type: none"> Hospital Value-Based Purchasing Physician Value-Based Modifier Readmissions/Hospital Acquired Condition Reduction Program
Category 3	Alternative Payment Models Built on Fee for Service Architecture	<ul style="list-style-type: none"> Hospital Value-Based Purchasing Physician Value-Based Modifier Readmissions/Hospital Acquired Condition Reduction Program
Category 4	Population-Based Payment; No Link to Volume	<ul style="list-style-type: none"> Eligible Pioneer ACOs in years 3-5 Next Generation ACO Model

2016:

85% FFS payments tied to quality and value | 2018: 90%

End of 2016:

30% FFS payments in alternative payment models | End of 2018: 50%

This White Paper will discuss how CMS will achieve these goals through Medicare physician payment reforms currently in place and value-based payment models that are on the horizon while providing practical and strategic steps that physician practices may can take to adjust to the reforms.




Evolution Toward Value-Based Payment for Physician Services

Category 1: Medicare Physician Fee Schedule (MPFS)

The MPFS first took effect in 1992. It was designed to assign different values to physician services (by CPT code) depending on the cost of providing the service, and does not contain any component that measures the quality or cost effectiveness of the care being provided (see Table 2). As a result, providers are reimbursed under the MPFS typically receive the same reimbursement regardless of patient outcome or cost efficiency of the care provided. CMS seeks each year to identify and review potentially misvalued

services within the MPFS, and makes adjustments where appropriate in the MPFS update for the following year.¹

Table 2: Components used to determine reimbursement for services under the MPFS

	Time and intensity required to perform the service
	Direct and indirect practice expenses associated with the service
	Cost of malpractice insurance to furnish the service

Congress became concerned that the MPFS was rewarding the delivery of a high volume of services rather than the delivery of cost-effective and quality care.² In 1997, Congress tried to contain costs under the MPFS system through the “Sustainable Growth Rate” or “SGR”.³ The SGR attempted to improve cost efficiency by tying reimbursement to providers under the MPFS to a target growth level. If the actual growth of Part B reimbursements exceeded the target growth level, all providers would receive lower reimbursements. Rather than implement the increasingly punitive lower reimbursement rates mandated by the SGR, however, Congress continuously voted to delay implementation of the cuts.⁴ As the SGR proved to be an ineffective mechanism to tie reimbursement to value, Congress sought other ways to change from a system that rewards the quantity of services provided to a performance-based system. Congress elected to permanently repeal the SGR on April 14, as part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).⁵

PQRS Ties Reimbursement to Quality Reporting

Category 2: Physician Quality Reporting System (PQRS) and EHR Incentive Program

One of major barriers that prevented CMS and private payers from tying reimbursement to quality and value was that there was no uniform system to measure and report the quality of care delivered by physicians and non-physician providers. In 2006, Congress directed CMS to establish a quality reporting program and authorized CMS to make incentive payments to providers reimbursed under the MPFS that voluntarily reported quality measures approved by the National Quality Forum.⁶ Congress gradually decreased the incentives available under the program and instead, starting in 2015, created penalties for providers that fail to report nine quality measures to CMS (see Table 3). According to data recently released by CMS, while participation in PQRS has been increasing, only 51% of all providers reimbursed under the MPFS successfully reported quality measures during the 2013 reporting period.⁷

Table 3: PQRS Reporting Incentives and Penalties

PQRSReporting

Reporting Period	Incentive Payment for Reporting	Penalty for Not Reporting
2013	0.5% of 2013 MPFS services	1.5% of 2015 MPFS services
2014	0.5% of 2014 MPFS services	2.0% of 2016 MPFS services
2015	None	2.0% of 2017 MPFS services
2016	None	2.0% of 2018 MPFS services

The incentives and penalties under PQRS are not actually tied to quality, as actual performance under the quality measures does not affect reimbursement. Instead, PQRS simply incentivizes the successful reporting of quality data to CMS. The implementation of PQRS, however, was a key step in creating a framework in which CMS and Congress could implement Category 2 payment methodologies, which tie payment partially to quality. Without a mechanism to measure and collect quality data, CMS would not be able to tie payments under the MPFS to quality.

Initially, CMS only permitted quality measure reporting through special quality data codes on Medicare paper and electronic claims. CMS has since expanded the available reporting methods to include reporting through qualified

registries and electronic health record (EHR) systems, and has implemented a group reporting option that allows providers to report quality measures as a group.

EHR Incentive Program Rewards Use of Certified EHR Technology

The Medicare EHR Incentive Program incentivizes physicians to calculate and report electronic clinical quality measures (eCQMs), a subset of PQRS quality measures, to CMS using certified EHR technology.⁸ To earn incentive payments and avoid downward MPFS payment adjustments under the Medicare EHR Incentive Program, physicians must use certified EHR technology consistent with certain meaningful use measures developed by CMS⁹ and report nine eCQMs calculated through certified EHR technology.¹⁰ CMS permits individual providers or practice groups to report eCQMs once to achieve Meaningful Use and report successfully for PQRS.¹¹ Some providers, however, have found that there are not nine eCQMs available through their certified EHR technology that are relevant to their practices. These providers may instead elect to separately report nine quality measures through another method, such as a qualified registry, to meet the requirements of PQRS.

CMS announced last year that it would gradually make PQRS quality data reported by select group practices and ACOs available to the public on the CMS Physician Compare Website.¹² CMS believes that the public release of PQRS data will incentivize better care quality, although the American Medical Association has questioned this use of PQRS data as an accurate tool to compare practice performance.¹³ CMS has requested further comment on the development of a benchmark to compare performance on quality measures through Physician Compare.¹⁴

Category 2: Value-Based Payment Modifier (VBPM)

The Affordable Care Act requires CMS to apply the VBPM to make performance-based adjustments to MPFS reimbursement to physicians and other providers reimbursed under

the MPFS. Under the VBPM, a portion of providers' MPFS reimbursement is tied to a provider's performance on quality and cost measures calculated each reporting year (see table 4).¹⁵

The VBPM quality measure score is calculated based on the PQRS quality measures reported by solo practitioners or provider group practices as well as three outcomes measures.¹⁶ The three outcomes measures evaluate providers on their ability to prevent certain hospital admissions and readmissions of Medicare patients (attributed to the practice by CMS) based on the level and type of services provided to the patient. Providers that fail to report quality measures are subject to downward MPFS payment adjustments under both the PQRS and VBPM programs.

The VBPM cost measure score is based on the following three measures:¹⁷

- Total Medicare costs of all attributed beneficiaries
- Total Medicare costs for all attributed beneficiaries with COPD, Heart Failure, Diabetes, and Coronary Artery Disease
- Total Medicare costs associated for attributed beneficiaries spanning three days prior to and 30 days after a hospital admission

CMS standardizes and risk adjusts the three cost measures to level the playing field among providers with sicker or healthier patient populations.

During the reporting period, CMS makes available a mid-year Quality and Resource Report to solo practitioners and group practices.¹⁸ The report provides the provider's performance on the quality and cost measures, the basis for MPFS payment adjustments and a comparison to other providers.

CMS has gradually phased in the VBPM.¹⁹ While the VBPM only affects the reimbursement of providers in groups of 100 providers or more in 2015, the VBPM will apply to solo practitioners and providers practicing in groups of all sizes in 2017. CMS intends to make all MPFS reimbursement subject to the VBPM by 2018, including payments to mid-level practitioners.²⁰

Table 4:
Payment Adjustments to the MPFS based on the VBPM

	Cost Performance		
	Low Cost	Average Cost	High Cost
High Quality	+4.0x	+2.0x	+0
Average Quality	+2.0x	+0	-2.0
Low Quality	+0	-2.0	-4.0

The 'x' represents the "upward payment adjustment factor", which CMS will use to ensure budget neutrality.

Physicians in groups of 2-9 healthcare providers will only be eligible for upward adjustments of +1.0x in CY 2017, but will not face downward payment adjustments unless they fail to report PQRS measures.

Groups and solo practitioners are eligible for an additional +1.0x if they report PQRS and their average beneficiary risk score is in the top 25% of all beneficiary risk scores nationwide

Value-Based Payment Methodologies on the Horizon

Along with the SGR repeal, Congress adopted new incentives under MACRA to steer physicians and other providers reimbursed under the MPFS towards payment methodologies that reward quality, care coordination, and cost containment.²¹

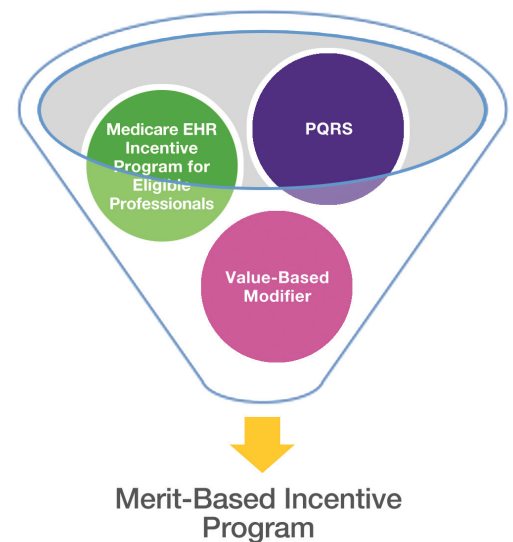
Category 2: Merit-Based Incentive Payment System

Beginning in 2019, providers reimbursed under the MPFS who receive less than 25% of their Medicare reimbursement through Category 3 payment methodologies approved by CMS, such as Accountable Care Organizations, will be subject to an upward, downward,

The maximum MIPS incentive payment or penalty will be 4% in 2019, 5% in 2020, 7% in 2021, and 9% in 2022 and subsequent years.

or neutral MPFS reimbursement adjustment under a new program called the Merit-Based Incentive Payment System (MIPS). MIPS will adjust reimbursement under the MPFS based on the provider's performance in the following four categories: quality; resource use; meaningful use; and clinical practice improvement activities.²²

While MIPS establishes a new methodology to link MPFS reimbursement to quality, it incorporates quality and cost measures developed under the existing PQRS, VBPM, and Medicare EHR Incentive programs. Providers will continue to submit PQRS quality measures and attest to Meaningful Use under the MIPS.²³ PQRS, VBPM, and the Medicare EHR Incentive Program, however, will cease to exist as independent programs and will instead continue for the purpose of calculating MIPS scores for providers.²⁴



Congress recognized in MACRA that CMS will need to significantly increase the number of approved quality measures (above those available under PQRS) for MIPS to be successful. Congress also required CMS to seek ways to incorporate quality measures used by private payers and integrated care systems.²⁵

Medicare will assess upward and downward payment adjustments under the MIPS on a sliding scale depending on the strength or weakness of a provider's score in relation to other providers. The maximum MIPS incentive payment or penalty will be 4% in 2019, 5% in 2020, 7% in 2021, and 9% in 2022 and subsequent years.²⁶ From 2019-2024, providers who perform exceptionally during those payment years may receive an additional upward MIPS adjustment factor of up to a 10% MPFS reimbursement bonus.²⁷

Alternative Payment Models Move Further Away from Fee-for-Service Medicine

Category 3: Alternative Payment Methodologies Built on FFS Architecture

CMS is exploring Category 3 alternative pay models under which payments are triggered by the provider's delivery of an item or service, but which also reward value by sharing a portion of any cost savings achieved relative to a pre-determined cost benchmark. A subset of these Category 3 alternative payment models also requires providers to assume downside risk and pay back a portion of reimbursement if actual costs exceed the benchmark.

The three most important Category 3 alternative payment models are Accountable Care Organizations (ACOs), Patient Centered Medical Homes (PCMHs), and Bundled Payments, each of which is discussed in greater detail below.

CMS has announced that Medicare expects to have 30% of fee-for-service Medicare payments in alternative payment models by the end of 2016 and 50% by the end of 2018.²⁸ Moreover, as noted above, Congress replaced the SGR formula with a combination of automatic payment increases and incentives for providers that engage in various pay-for-performance programs and alternative payment models. Most notably, providers that receive a significant share of their revenue through alternative payment models that involve downside risk and quality measurement will be eligible for up to a 5% incentive payment between 2019-2024. Beginning in 2026, providers that receive a significant share of their revenue through such models will see annual MPFS increases of 1%, compared to 0.5% increases for providers who do not participate in these models.²⁹ Participating– and crucially, understanding how to succeed – in alternative payment models will be essential for provider reimbursement in the future.

Accountable Care Organizations

ACOs are groups of physicians and other providers that have voluntarily joined together to be held accountable for the cost and quality of care for a defined patient population. The payer establishes an expenditure benchmark for the ACO. Based on financial performance relative to the benchmark, the ACO receives a share of any savings achieved (or may be required to pay back a portion of Medicare expenditures in excess of the benchmark). ACOs also must achieve strong quality and patient satisfaction measures. Medicare (or other payers) may require an ACO to meet quality thresholds before it is eligible to receive shared savings, or alternately, the amount of shared savings may be scaled based on quality and financial performance.



In MSSP's first performance year in 2012, 58 ACOs saved Medicare \$705 million and received shared savings bonus payments of over \$315 million.

Medicare's most prominent ACO program is the Medicare Shared Savings Program (MSSP). Under the MSSP, ACO providers are paid for services rendered to fee-for-service Medicare beneficiaries as they would ordinarily, but the ACO also receives a payment for a share of the Medicare's savings if the ACO achieves quality performance standards across 33 measures and generates adequate savings compared to its Medicare expenditure benchmark. The MSSP currently has two financial risk tracks:

- an upside-only risk track provides a low-risk setting for less experienced organizations to develop necessary infrastructure for population health management and begin implementing various clinical and operational pathways to succeed in value-based care
- a two-sided track offers the draw of a larger potential portion of any shared savings but in exchange for the ACO agreeing to repay a set portion of any losses incurred³⁰

In MSSP's first performance year in 2012, 58 ACOs saved Medicare \$705 million and received shared savings bonus payments of over \$315 million. On the quality side, MSSP ACOs improved in 30 of the program's 33 quality measures.³¹ Currently, 404 ACOs across 49 states plus Washington, DC and Puerto Rico are participating in the MSSP and are accountable for 7.3 million assigned Medicare beneficiaries.³²

Providers should carefully review the formulas for sharing savings and losses among the participating providers within the ACO before agreeing to participate. Participating provider groups should assure that compensation models within the group appropriately align with the ACO's formulas.



Patient-Centered Medical Homes

PCMH programs are team-based payment models of care that use primary care physicians to coordinate the care of a patient across multiple providers and care settings. The hallmarks of PCMHs are the following features:

- Patient-centered: PCMHs ensure that patients and their families are able to make informed decisions about their health.
- Comprehensive: Accountability extends to physical and mental health, including wellness, acute care and chronic care.
- Coordinated: Care is organized across the continuum of the health care system.
- Accessible: PCMHs provide “after hours” care, 24/7 electronic or telephone access, and communication through health information technology.
- Committed to quality and safety: there is a strong emphasis on quality improvement.

Medicare is currently testing the Comprehensive Primary Care initiative (CPC), which is a four-year advanced primary care model that involves both Medicare and private payers. Financially, CPC supplements existing Medicare fee-for-service payments with population-based care management fees for each beneficiary in the PCMH and additional opportunities for shared savings.

The additional payments are intended to support the provision of five “comprehensive” primary care functions that relate to the hallmarks described above:³³

- risk-stratified care management for patients with high needs
- timely, 24/7 access to care guided by medical records
- planned care for chronic conditions and preventive care, including personalized care plans and integration of behavioral health services, as needed
- patient and caregiver engagement, including through the use of decision aids
- coordination of care across the medical neighborhood.

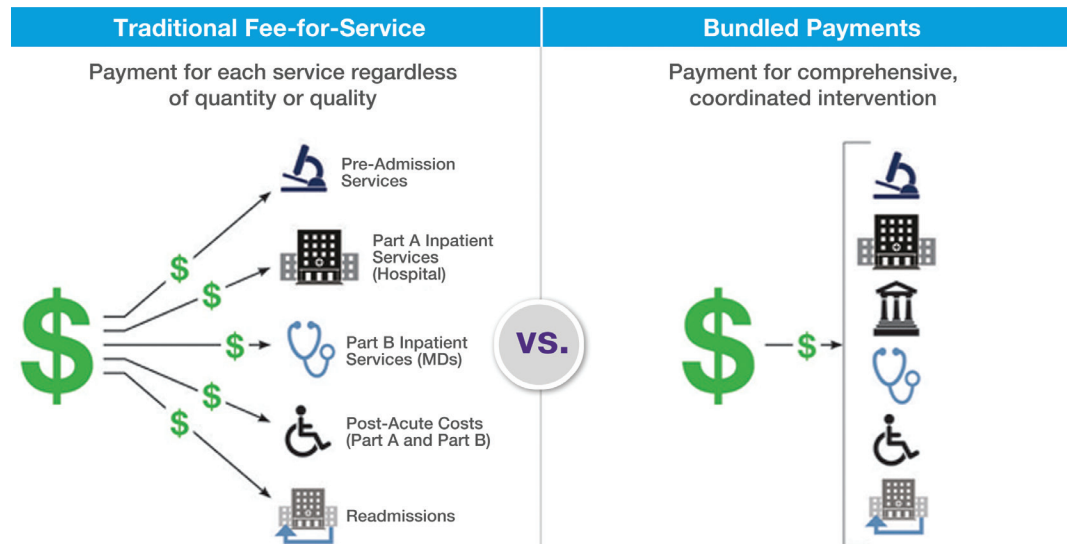
The model also places a strong emphasis on the continuous use of data to guide improvement and meaningful use of health information technology.

The first year results of CPC have shown reduced rates of hospital admissions and emergency department visits. The program also has generated nearly enough Medicare cost savings to offset the care management fees paid by CMS.³⁴

Bundled Payments

A bundled payment is a single payment to providers and/or health care facilities for all services to treat a given condition or provide a given treatment. The provider and/or facility assume financial risk for the costs of services associated with the particular treatment or condition. Often, risk for preventable complications for a defined period of time, such as 30 days or greater following discharge, are also included in the bundle.

BPCI consists of four bundled payment models covering various combinations of physician, hospital and post-acute services.



The CMS Innovation Center, which funds various demonstrations of delivery system transformation models, is currently testing the Bundled Payments for Care Improvement (BPCI) demonstration for potential future value-based payment reforms. BPCI consists of four bundled payment models covering various combinations of physician, hospital and post-acute services. There are bundled payments for a retrospective acute care hospital stay only; retrospective acute care hospital stay plus post-acute care; retrospective post-acute care only; and acute care hospital stay only with a single, prospectively determined payment. Notably, the retrospective models are “virtual” bundled payments which reconcile actual charges against a target price and allow providers to keep any savings they have achieved.³⁵

“Category 4” Population-Based Payment

CMS’s final payment methodology is the Category 4 population-based payment. These payments are not directly triggered by provider service delivery so volume is not linked to payment. Rather, providers are paid and held accountable for the care of a beneficiary over a longer period of time (e.g., one year or longer) through payment mechanisms such as a per-member per-month payment or a global budget. Such payments are designed to cover substantially all of the care provided to a patient or population, and are thus meant for organizations already adept in managing risk and with sophisticated population health management strategies.

While it is not part of Medicare Parts A and B, the Medicare Advantage program is an example of a population-based payment system. Medicare Advantage organizations receive a capitated per-member, per-month payment, which is then adjusted based on the member’s health status and other risk factors. Critically, premium payments to the Medicare Advantage organization do not vary based on the actual health services provided to members or claims paid by the organization.

Population-based payments have had limited use in traditional Medicare Parts A and B thus far. CMS is currently testing optional population-based payments in performance years 3-5 of the Pioneer ACO Model. In the Pioneer ACO model, the ACO sets a percentage reduction in fee-for-service payments across all or a subset of the ACO’s providers. CMS

then pays the projected total annual amount taken out of the Medicare fee-for-service rates to the ACO in monthly payments.²⁶

In March 2015, CMS announced its Next Generation ACO Model that will give participating ACOs the choice to be paid through one of four payment mechanisms. These mechanisms include a population-based payment like the Pioneer ACO Model and a pure capitation payment calculated by estimating the total annual expenditures for attributed beneficiaries and then dividing into per-member, per-month payments. As Medicare beneficiaries retain freedom of choice across all of CMS's current models, CMS will withhold a portion of the monthly payment to cover the costs of anticipated care by non-ACO providers and suppliers.²⁷

How Should Physician Practices Ready Themselves for Value-Based Payment?

The push towards tying reimbursement under the MPFS to value has understandably created anxiety for the physician community. While these programs could lead to increased MPFS reimbursement for high performers, some physician practices will need to make significant changes to their operations to effectively shift to Category 2, 3, or 4 payment models and avoid MPFS reimbursement reductions. Physicians should consider the following steps for physician practices to successfully navigate value-based payment models:

- Select an EHR, qualified registry, or qualified clinical data registry that can calculate and report quality measure data that is the relevant to the care provided by the physician practice
- Develop care management strategies for high-risk patients, as well as other patients who could become high risk in the future
- Consider implementing mobile applications and other patient engagement technologies linked to EHR technology that automate the process of identifying and communicating with patients who need extra attention to avoid expensive inpatient admissions and other bad outcomes
- Consider participation in an ACO or other Category 3 or Category 4 payment methodologies to take advantage of the available bonus payments in 2019-2024 and avoid the MIPS as well as benefit from the ACO's investment in costly data warehouses and analytics platforms
- Physician groups participating in ACOs or other alternative payment models should assure that compensation within the group appropriately aligns with the incentives created by the alternative payment model

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