Major Payment Policy Reform on the Near Horizon

Understanding the new system and adapting your practice for reporting and documentation.

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Since the 1960s, almost every generation has seen a major change in payment policy for Medicare patients. Medicare itself was revolutionary when it was introduced in the 1960s. In the early 1990s, payment methodology for Medicare was changed from a "reasonable and customary" fee for service to the resource-based relative value scale fee for service still used today, which was revolutionary and disruptive at the time. We are now on the cusp of the next major payment reform, with legislation passed in 2015 called MACRA (Medicare Access and Children's Health Insurance Program Renewal Act), which lays out specifications for moving to a different and again revolutionary payment system. In an attempt to move away from fee for service, which has encouraged more care (higher volumes of procedural care) rather than the most efficient and effective care, Congress has set a system in place that bases payment on quality and outcomes.

In April 2016, the Centers for Medicare & Medicaid Services (CMS) published a 962-page proposed rule on how they plan to implement this legislation. CMS received over 1,000 sets of comments during the public comment period and is reviewing and considering those comments, with the final rule due later this year. This document will direct how payment will be made beginning in 2019. However, the methodology requires data submission by providers in 2017, which is then reviewed during 2018, with payments in 2019 based on the data received in 2017. This review will determine whether individual providers or groups receive a bonus or a penalty in addition to the base amount owed them for their services. In this plan, bonuses will not be awarded to every provider—there will be winners and losers, and failing to meet (or document) the expected performance levels will result in lower payments (either through a smaller bonus, no bonus, or even penalty payments). Therefore, it is important to start learning about MACRA and the changes in payment and rapidly plan on how your practice will adjust to the new requirements, scheduled to start January 1, 2017.

There has been some indication that CMS is considering pushing back the implementation of MACRA. However, this policy is legislatively mandated, and although there may be some leeway on implementation, do not expect that the entire policy change will be delayed or abandoned. If some parts are delayed, it will likely occur to allow national specialty societies and individual practices more time to prepare and may be very short. With or without a delay, practices will need to move quickly to be ready for this policy change.

Although the thought of further payment cuts is disheartening and worrisome, there are also opportunities in this system. For those willing to work on understanding the driving motivation for the reform, opportunities to improve patient care and thrive in the new environment are abundant. Most of the details regarding how this system will work are not fully fleshed out by CMS. Opportunity may also exist for those who find ways to help CMS solve the problems of cost, efficiency, and quality outcomes.

Private payers are moving quickly to implement similar changes to their payment policies. Although there may be some variation of policy from payer to payer, it is expected that private payers will adopt much of CMS' methodology or may actually lead some aspects of payment change reform, which then will be adopted by CMS.

SUMMARY OF UPCOMING CHANGES

The changes made by Congress and CMS in payment policy have numerous motivations. Of course, cutting

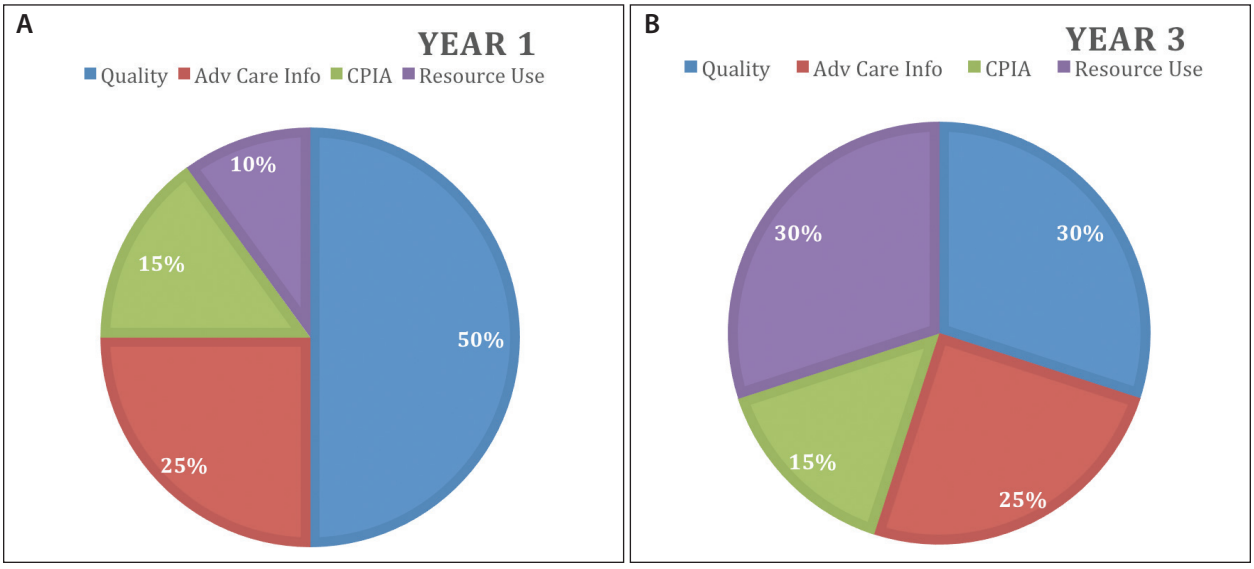

Figure 1. Expected weighting for each of the four elements of MIPS in 2017 (A) as compared with 2019 (B).

health care spending is a high priority. In addition, the proposed changes are designed to reward more efficient care and improved outcomes. As physicians, we have the opportunity to use our expertise in patient care to help define "most efficient care" and the goals for improved outcomes.

The existing fee schedule will remain in place for the next few years, and fee-for-service payments will continue with automatic increases of 0.5% in 2016 to 2019. However, in 2020, the automatic fee schedule increases stop. Bonuses and penalties based on the merit-based incentive payment system (MIPS) begin in 2019, with initial bonuses/penalties of ± 4% of payments. This rate gradually increases until it becomes ± 9% in 2022. These bonuses/penalties are calculated based on MIPS reporting 2 years prior (eg, 2019 bonuses or penalties are calculated based on 2017 MIPS reporting).

The incentives intended to drive lower costs and higher quality are embedded in the payment policy changes. Two methods for reporting to CMS have been laid out by the MACRA legislation: MIPS and alternative payment models (APMs). Initially, CMS has focused on primary care APMs. The result is that MIPS will initially be the reporting method for most interventionists. However, the future seems to be clearly pushing toward APMs, which will ultimately have a higher payment. Thus, while the immediate task is to understand and use MIPS, it is also a high priority to learn how to be involved in APMs within the next few years.

Merit-Based Incentive Payment System (MIPS)

MIPS is a quality reporting system that will replace the current Physician Quality Reporting System (PQRS). Although CMS has stated that it doesn't intend to increase reporting burden on physicians and practices, the amount of reporting required will increase from that required in 2016 (Figure 1A and 1B). MIPS will have four elements for each physician to report:

- **Quality.** Defined quality measures similar to the currently used PQRS measures will be reported. Some measures from PQRS will be retained, and new measures are being devised by CMS. National specialty societies are working to add enough measures to allow all physicians to be able to adequately report quality measures. CMS has allowed for these measures to be reported through qualified clinical data registries (QDCRs), and participation in these registries should make this reporting much simpler.
- **Resource use.** Use of resources by individual providers will be measured and compared in an effort to gather data on how efficiently care is given. For instance, it may measure whether there are significant differences in costs from physician to physician to treat the same conditions. Data such as frequency of testing or use of expensive drugs/devices to treat a disease entity may be compared to other physicians in your cohort. This measure will likely require the provider to identify their relationship with the patient (eg, primary care giver, primarily responsible for an acute episode of care, providing care ordered by another physician only), which most likely will require additional documentation for all patients.
- **Clinical practice improvement analysis (CPIA).** This will be reported based on a choice of topics published by CMS.
- **Electronic health record (EHR) usage.** This will replace the current meaningful use program but will continue to encourage the use of EHRs, as well as the ability to share patient data across all EHR systems.

These elements have been given different weights in the coming years as CMS tries to push providers toward specific goals, but familiarity with and attention to each element will be important. These elements are still being fully defined, with more details to come in the final rule. For most providers, there will be a learning curve on how to report all of these measures. Fortunately, CMS has indicated that reporting through QDCR will satisfy many of the requirements (up to 70% of reporting may be done through QDCRs), and it is likely that many providers will find this avenue the most efficient.

For providers who are self-employed, learning about these changes is imperative in order to get optimum payment for the services provided. For providers who are employed by hospitals or large multispecialty clinics, many of the reporting burdens for PQRS and meaningful use have been borne by the hospital or clinic employer. The employer may continue to be responsible for understanding and implementing the reporting for employed physicians, but the requirements for reporting and bonus payments will require some changes to individual practice and documentation, so even employed physicians will need to learn about the required changes and be ready to adapt.

Alternative Payment Models (APMs)

APMs are still in early stages of definition, but the basic premise is to identify a patient or group of patients (eg, based on a defined disease state, episode of care, or time of care) that can be managed in ways to improve efficiency of care and outcomes. This group of patients could be managed by a primary physician or by a group of physicians/providers, looking at all aspects of related care. Care would be contracted for a set fee, with CMS requiring that the providers substantially share in the potential risks/losses associated with care of that patient.

In order to participate in APMs, individual providers need to know their costs and outcomes for providing care in order to negotiate a reasonable rate or know whether the offered rate is going to be profitable for their practice. Historically, individual providers have had difficulty identifying specific costs and gathering individual outcomes data. However, the financial incentives of APM participation will make it almost imperative to have accurate data.

When a group of providers is responsible for the care of patients, the APM should encourage the most efficient care of individual patients because everyone's payment is dependent on the patients' outcomes. In this model, the most qualified provider should give the most appropriate treatment to the patient at the most appropriate time. Turf battles could be replaced by coordinated care that is focused on best patient outcome and lowest costs.

Physician Responsibility

As the movement to cut costs rolls along, physicians must still assume the role of patient advocate. Costs can be decreased by simply denying care to patients. It is imperative that physicians use their expertise to determine the most cost-effective treatment to gain the best patient outcome, and then to advocate for coverage of those types of therapies for patients.

SUMMARY

Major changes to payment policy for health care are coming very quickly. This will affect every health care provider in the United States—physicians, ancillary providers, hospitals, and clinics. Physician income will depend on learning the specific requirements for achieving the best payments, and physicians will need to take appropriate steps to ensure that requirements for reporting and documentation are being met. Although these changes take effect in 2019, the year to focus on is 2017, because data reported in 2017 determine the bonus or penalty payments for 2019, and will thus significantly affect 2019 income.

Now is the time to start to understand these changes and make plans for adapting your practice. Additional resources can be found on the CMS website (www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html), American Medical Association website (http://www.ama-assn.org/ama/pub/advocacy/topics/medicare-physician-payment-reform.page), and specialty society websites. ■

CONTACT US

If you have any questions or topics you would like Dr. Krol to address in a future column, please contact us at evteditorial@bmctoday.com.

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Disclosures: None.