Issue Brief

Health Economics and Market Access
Office of Medical Affairs

Physician Payment

2019

Medicare's Quality Payment Program

Medicare continues its implementation of a relatively new program for updating its payment rates for physicians. Called the Quality Payment Program, the system determines annual payment changes based on how well physicians perform on outcomes, quality, and cost measures.

- This means some physicians could see significant increases or decreases in payment levels.
- The Centers for Medicare & Medicaid Services (CMS) began implementing the first elements of the new system in 2017 and will start making payment changes in 2019.

Background

Physicians and other providers who care for Medicare patients are paid under the Physician Fee Schedule. This system sets payment levels based on the amount of resources used for a treatment or procedure. Each year, CMS updates those levels to take into account changes in costs, treatments, and other factors. Medicare has traditionally used a formula known as the Sustainable Growth Rate (SGR) for making payment updates to reflect these changes. But in 2015, Congress passed the Medicare Access and CHIP Re-Authorization Act (MACRA) which repealed the SGR and introduced the new pay-for-performance system.

Basic Elements

Annual updates and adjustments under the Quality Payment Program have three basic elements.

1. All physicians will receive a minimal annual update in base payments.
2. All physicians must then choose one of two new payment tracks which provide additional annual payment incentives for improving quality and cost.

Annual Update in Base Payments

Applies to all physicians

Basic Update:
0% or 0.5% payment adjustment, 2016–2025.

After 2025, physicians in MIPS get +0.25% annually; AAPM physicians get +0.75% annually.

+

Two New Payment Tracks Provide Additional Annual Incentives

Physicians must choose one

Merit-Based Incentive Payment System (MIPS): Payment adjustment based on how well physicians perform in four areas: quality, cost, clinical practice improvement, and interoperability.

- Payments can be adjusted **+/- 4%** in 2019; **+/- 9%** in 2022

OR

Advanced Alternative Payment Models (AAPM): Payment adjustment based on whether physicians participate sufficiently in Advanced Alternative Payment Models (coordinated care models) which share financial risk for possible losses.

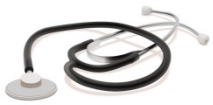
- Payments adjusted **+5% annually** 2019-2024

How MIPS Works

Physicians are paid more for high-quality performance on outcomes, cost, and quality measures and less for lower-quality performance. The MIPS program:

Streamlines previous physician quality programs

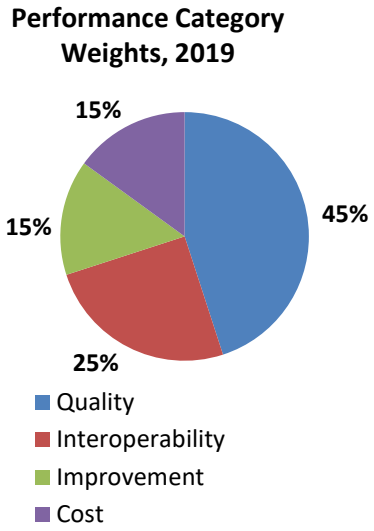
- Several physician quality programs are rolled into MIPS:
  - Physician Quality Reporting System
  - Value-Based Physician Payment Modifier Program
  - Electronic Health Record Meaningful Use Program



Evaluates physician performance on measures in four categories

Quality

- 200+ measures in such areas as asthma, kidney disease, breast cancer, heart failure, falls
- Physicians choose 6 measures for which they report performance
- Accounts for 45% of performance score in 2019 (which affects payment in 2021)



Promoting Interoperability

- Measures reflect how physicians use electronic health records (EHR) in day-to-day practice
- Physicians report on 4 – 5 measures in such areas as secure information exchange, patient EHR access, and e-prescribing. Also, 2015 Edition of CEHRT required.
- Accounts for 25% of 2019 performance score

Improvement Activities

- Rewards clinical improvements such as care coordination, patient safety, shared decision making, patient access
- Physicians must report performance on 2 – 4 of 100+ improvement activities
- Extra weight for activities that support patient-centered medical homes, transform clinical practice, or are a public health priority
- Physicians receive extra points for consulting appropriate use criteria when using advanced diagnostic imaging
- Accounts for 15% of MIPS score in 2019

Cost

- 2019 measures focus on total cost per Medicare patient, as well as total costs per patient for 8 types of care episodes, including stroke, knee replacements, and pneumonia
- CMS calculates scores based on Medicare claims; physicians do not have to report
- Accounts for 15% of performance score in 2019

Calculates payment adjustments from performance scores

- Physicians receive positive, negative, or neutral adjustments based on their scores.
- Payment can be adjusted up or down each year, based upon the overall score.
- Maximum adjustments in 2019 are plus/minus 4%, rising to plus/minus 9% in 2022.

Maximum plus/minus adjustments per year:

2019	2020	2021	2022+
4%	5%	7%	9%

- During the first six years, exceptional performers may also qualify for an extra bonus.

How AAPMs Work

Physicians can receive significant financial incentives for participating in Advanced Alternative Payment Models which bear risk for financial loss. Such physicians are exempt from MIPS and qualify for financial bonuses. The AAPM program:

Requires physicians to join "advanced" alternative payment models (AAPM)

CMS defines "advanced" models as those which:

- Base payment on quality measures equivalent to those of MIPS;
- Require physicians to use EHRs; and
- Bear a specific degree of financial risk or are medical homes recently expanded by CMS.

Requires AAPMs to share in financial risk for losses

- Alternative payment models qualify as AAPMs if they are required to pay CMS back when they exceed their spending targets.
- They must also take on more than a nominal degree of financial risk.
- CMS specifies the percentage of losses AAPMs must be willing to share.

Medicare approves 10 payment models as AAPMs

Medicare Shared Savings ACOs,[1] Track 2	Medicare Shared Savings ACOs, Track 3
Next Generation ACOs	Medicare Shared Savings ACO Track 1+
Comprehensive Primary Care Plus (CPC+)	Oncology Care Model (two-sided risk)
Comprehensive Care for Joint Replacement Payment Model, Track 1	Comprehensive End Stage Renal Disease Care Model (risk-sharing options)
Bundled Payment for Care Improvement - Advanced	Vermont Medicare ACO Initiative

[1] Starting in 2019, CMS is implementing additional changes in its Shared Savings Accountable Care Organization program, including introducing two new types of ACOs—Basic ACOs and Enhanced ACOs. Of these, all Enhanced ACOs and those Basic ACOs in Year 5 will quality as AAPMs. See Issue Brief on ACOs.

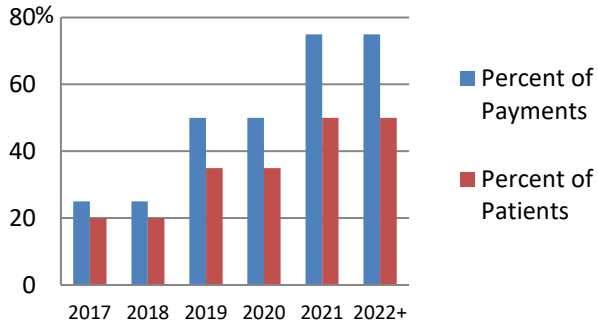
Provides payment incentives on top of AAPM incentives

- Physicians receive 5% payment bonuses from 2019–2024.
- This is separate from any payments they receive as part of their contractual arrangements with the AAPM itself.

Specifies how much physicians must participate in AAPMs

Physicians must receive a minimum percentage of their payments—or see a minimum number of patients—through Medicare AAPMs. (see graph).

- In 2019, physicians can also count patients they see or payments they receive via AAPMs offered by other payers.



New Flexibility

The Quality Payment Program introduces many complexities into the physician payment process. For that reason, CMS has added flexibility to ease the transition and new incentives to encourage physicians to participate.

Many small physician practices are exempt

CMS allows physicians to remain exempt from MIPS if they:

- Care for ≤200 Medicare Part B beneficiaries annually
- Bill Medicare ≤$90,000 in annual Medicare Part B charges OR
- Provide ≤200 covered Part B services annually

Solo practices can join "virtual" groups

- Solo practitioners and groups of ≤10 clinicians can come together "virtually" to participate in MIPs.
- Virtual groups must aggregate their performance data, and are scored as a group.

New flexibility in "MIPS" eases transition for many practices

CMS will:

- Award extra points for practices treating complex patients
- Award points to small practices even if they do not report all quality data
- Award extra points in the final performance scores for small practices
- Remove "low-value" process measures, as well as duplicative or "topped out" measures, thus reducing collection/reporting burden for physicians

New flexibility in "AAPMs" eases transition for many practices

CMS will:

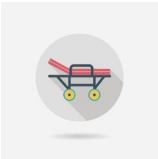
- Allow physicians to qualify for AAPM incentive payments by counting the services they provide in non-Medicare AAPMs
- Ease paperwork and reporting requirements for clinicians who provide services in non-Medicare AAPMs
- Streamline the definition of what constitutes quality measures that are comparable to those used by MIPS

Key MACRA Issues

Not Just Docs

Includes all Part B providers, including physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists

Across Care Settings



Includes physician services wherever they practice: offices, hospitals, imaging centers, etc.

2-Year Performance/Pay Lag

CMS adjusts payment 2 years after physicians report performance

Information technology

Essential for collecting & analyzing data; for EHR; for tracking outcomes, performance, reimbursement

Greater Financial Risk

Pushes physicians toward accepting greater financial risk

Frequent Changes

CMS adjusts details of MIPS/AAPM rules annually

As noted above, CMS makes annual changes in the MACRA program, not just in payment levels, but also in the rules of how the program operates. This can be expected to continue as the Quality Payment Program is implemented and matures. This Issue Brief reflects the program requirements as of December 2018.

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