SGR Repeal: What Are the Implications to Academic Medicine?

Len Marquez
Mary Wheatley
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Agenda

• SGR Eulogy
• High Level Issues in HR2 Important to Academic Medicine
• Overview of the SGR Replacement
An SGR Eulogy: How Did We Get Here?

• The Balanced Budget Act of 1997 created the sustainable growth rate (SGR) formula.

• Beginning in 2002, the SGR formula dictated a reduction in the physician fee schedule.

• Reductions have been called for every year since 2002 but Congress has passed legislation overriding (or patching) the cuts each year.

• Since 2002, the SGR has been patched 17 times at a cost of nearly $170 billion.
An SGR Patch Eulogy

- 2003 Consolidated Appropriations Resolution of 2003
- 2006 Deficit Reduction Act of 2005
- 2007 Tax Relief and Health Care Act of 2006
- Jan.-June 2008 Medicare, Medicaid, and SCHIP Extension Act of 2007
- Jan. 1-Feb. 28, 2010 Department of Defense Appropriations Act
- Mar. 1-Mar. 31, 2010 Temporary Extension Act
- Apr. 1-May 31, 2010 Continuing Extension Act
- June 1-Nov. 30, 2010 Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010
- 2011 Medicare and Medicaid Extenders Act
- March 1-Dec. 31, 2012 Middle Class Tax Relief and Job Creation Act of 2012
- 2013 American Taxpayer Relief Act
SGR: How Did We Get Here?

• In early 2011, the House Ways & Means and Energy & Commerce Committees sought stakeholder feedback on how to reform Medicare physician payment.

• On April 21, 2011, AAMC holds first in a series of webinars with members to analyze proposals, solicit feedback, and formulate comments.

• In February 2014, after countless hearings, requests for comments, and SGR patches, the Senate Finance, House Ways & Means, and House Energy & Commerce Committees released the “SGR Repeal and Medicare Provider Payment Modernization Act of 2014.”

• The 113th Congress was ultimately unable to agree on how to pay for the legislation and the 17th (and final) SGR patch was passed in March 2014.
SGR: How Did We Get Here?

- Total cost = $213 billion
- Total offsets = $70 billion
  - Medicare means testing - $34.3B
  - Medigap reforms - $0.4B
  - PAC reform - $15.4B
  - DSH rebasing - $4.1B
  - Documentation & coding - $15.1B
- Net cost = $141 billion*

* Cost of freezing PFS rates for 10 years
Medicare Access and CHIP Authorization Act of 2015 (H.R. 2)

Provisions of Interest to Academic Medicine

- Introduced March 24, passed House March 26, and passed Senate April 14
- Repeals Medicare Sustainable Growth Rate (SGR) formula and prevents scheduled 21 percent cut due April 1, 2015 @ $175.4 B
- Phases in a scheduled one-time 3.2 percentage points IPPS payment increase (due in FY 2018) between FY 2018 and 2023 (saves $15.1B)
- Delays scheduled Medicaid Disproportionate Share Hospital (DSH) cuts until FY 2018 (saves $4.1B)
- Extends the prohibition on patient status reviews for inpatient claims by RACS through FY 2015
- Extends National Health Service Corps (NHSC), Community Health Centers (CHC), and Teaching Health Center (THC) program funding through FY 2017 @ $8B
- Limits application of beneficiary inducement CMP to reductions or limits on medically necessary care
- Reverses CMS regulation to transition to 0-day global surgery payment bundles @ $1.5B
- Extends CHIP funding through FY2017 @ $7B
What is NOT in the Bill?

There are no:

• GME cuts
• Provisions on site-neutrality between HOPD and physician offices
• Cuts that disproportionately affect academic medicine
Implementing the SGR Replacement
Three Main Parts of the SGR Replacement

1) Predictable Updates
- Repeals SGR formula
- 0.5% update through 2019
- 0.0% update through 2020-2025
- 2026 and beyond, two conversion factors:
  - 0.75% update for Qualifying APM
  - 0.25% for all others

2) New Consolidated Pay-for-Performance Program
- Performance based on quality, resource use, clinical practice improvement activities, and meaningful use of EHRs (starting 2019)
- Does not apply to low-volume providers, qualifying APM participants, and partial qualifying APM participants (that did not report the necessary information.)

3) Alternative Payment Models (APM) Incentives
- Qualifying APM Participant
  - Significant participation in APM
  - Eligible for bonuses (2019-2024)
  - Higher update starting 2026
  - Avoid MIPS
- Partial Qualifying APM Participant
  - Slightly lower threshold for participation
  - No bonus
  - Might avoid MIPS
  - Lower annual update
Other Factors Affecting Physician Payment

- Continues several extensions through 2017
  - Ex GPCI work floor, therapy caps
- Prohibits implementation of 0-Day surgical bundles as described in PFS 2015 Final rule
  - CMS can review surgery codes on case-by-case basis and convert them to zero-day bundles on an individual basis
  - Bill authorizes Secretary to begin collecting information on surgical services January 2017;
    - Authority to withhold 5 percent of payments to physicians selected for the sample until they report the requisite data
    - The Secretary must use the data to improve the accuracy of surgical services values beginning in 2019
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Predictable Updates

Overrides SGR Formula with the following updates:

• Current CF continues through June 2015
• 0.5% update July-Dec 2015
• 0.5% annual update 2016-2019
• 0.0% update for years 2020-2025

Year 2026 and beyond, replaces SGR with two conversion factors:

• Qualifying APM CF has 0.75% annual update
• Non Qualifying APM CF has a 0.25% annual update
• Differences in CF will compound over time
Predictable Updates ≠ Predictable Payments

- RVUs changes can affect payments
  - Misvalued RVU process to identify/change RVUs
    - PAMA law sets target of 1% net reduction in expenditures under the PFS to be identified in 2016; 0.5% for 2017/2017 or face reduction in relative value units
  - Budget neutrality due to RVU changes (from new or modified services) can affect CF

- Value programs create possibility for bonuses or losses

- Other upcoming payment changes
  - No extension of Medicaid primary care bump (sunset after 2014)
  - No extension of Medicare primary care incentive payment /HPSA general surgery payment (sunsets after 2015)
  - GPCI work floor, therapy caps, and other extenders expire after 2017
SGR Replacement
Part 2: Pay-for-Performance

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Merit-Based Incentive Payment System (MIPS)

- Consolidates EHR Incentive Program, PQRS, and VM into one large pay-for-performance program
- Program budget neutral*
  - Incentives scale based on available resources
  - Maximum reduction (4-9% over 4 years) is capped
- Scoring Performance
  - Performance based on 4 categories
  - Credit for achievement or improvement (required for 2 categories; optional for others)
  - Thresholds must be set at mean or median of prior period
  - **Composites less than ¼ of the threshold get the maximum reduction!!**
- Exceptional performance adjustment available (2019-2024)
  - $500M per year funding pool to be distributed

* There are a few exceptions where budget neutrality may not apply.
Quality and Resource Use Count for Majority of Score

MIPS Performance Categories and Weights (Resource Use Ramps Up Over 3 Years)

<table>
<thead>
<tr>
<th>Performance Categories*</th>
<th>Year 1 (2019)</th>
<th>Year 2 (2020)</th>
<th>2021-forward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>50%</td>
<td>45%</td>
<td>30%</td>
</tr>
<tr>
<td>Resource Use</td>
<td>10%</td>
<td>15%</td>
<td>30%</td>
</tr>
<tr>
<td>Clinical Practice Improvement Activities</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Meaningful Use of EHR*</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Maximum MIPS Reduction</td>
<td>4%</td>
<td>5%</td>
<td>7% (2021) 9%(2022-forward)</td>
</tr>
</tbody>
</table>

* Meaningful use weight can decrease to 15% and be redistributed if EHR adoption reaches 75%. If Secretary determines an EP does not have enough measures, then CMS may change weight distribution

New Category: Clinical Practice Improvement Activities

Examples:
- Expanded access (e.g. same day appointments)
- Population management (e.g. participation in 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 checklists)
- APM participation

Maximum credit for certified PCMH practices; at least ½ credit for APM participation
MIPS Eligibility Requirements

• 2019 & 2020 –
  • Applies to all Medicare physicians, physician assistants, nurse practitioners, clinical nurse specialists, and registered nurse anesthetists

• 2021 and beyond
  • Expands to EPs as defined for PQRS (Section 1848(k)(3)(b) as specified by the Secretary)

• Exclusions
  • Qualifying APM Participant
  • Partial Qualifying APM Participant that does not report on all the MIPS measures
  • Low volume providers
    • Determined by the Secretary
    • Volume may be determined by # Medicare patients seen, # services provided, or allowed charges billed
MIPS: Group Reporting?

- Quality component of MIPS required to have a group reporting assessment
- All other categories: CMS “may establish” a process – not required!!
- Groups will have option to use the Qualified Clinical Data Registries
- Option for “virtual groups” (groups with not more than 10 EPs and at least one other such individual EP or group practice)
New Claims Reporting Requirements

• Starting 2018, new claims reporting requirements
  • Applicable care episode
  • Patient condition
  • Patient relationship code
  • Required for “services deemed appropriate” by Secretary

• Reason: To facilitate attribution for resource use measures

• Possible relationship codes:
  • Primary responsibility for a patient over extended period of time
  • Lead physician or practitioner during an acute episode
  • Supportive, rather than lead, role during an acute episode
  • Occasionally furnish services to patient, typically at request of another practitioner
  • Only furnish items and services as ordered by another practitioner
MIPS Compared to the Status Quo

• Current state:
  • No statutory limit on Value Modifier
    • Up to 9% at risk for EHR, PQRS, VM in 2017
  • Pay-for-reporting:
    • EHR Incentive and PQRS only have to report data to avoid penalties
  • Pay-for-performance:
    • Value Modifier adjusts payments for not reporting or for outlier performance

• Future state (MIPS):
  • Limits are in statute – starting at 4% at risk in 2019 and maxing at 9%
    • 4% at risk is less than the current 9% at risk in 2017 for the combined programs
  • No more pay-for-reporting
  • Pay-for-performance:
    • Performance based on “achievement”/”improvement” – different than current VM
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### Key APM Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Alternative Payment Model (APM)</td>
<td>• Model under CMMI (except innovation awards)</td>
</tr>
<tr>
<td></td>
<td>• MSSP ACO</td>
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<td></td>
<td>• CMS demonstration projects</td>
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<td></td>
<td>• Demonstration required under law</td>
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<tr>
<td>Eligible APM Entity</td>
<td>Entity that meets the following requirements:</td>
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<tr>
<td></td>
<td>• Participates in an APM that requires</td>
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<td></td>
<td>• use of CEHRT AND</td>
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<td></td>
<td>• payment is based on quality measures comparable to MIPS</td>
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<td>And</td>
<td>• Entity bears financial risk for monetary losses OR</td>
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<td></td>
<td>• Is a medical home expanded under section 1115A(c)</td>
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<tr>
<td>Qualifying APM Participant</td>
<td>Eligible professional who meets certain payment thresholds for being in an APM (see additional slide). Payment may be Medicare or all-payer. Secretary has the option to use patients instead of payments.</td>
</tr>
<tr>
<td>Partial Qualifying APM Participant</td>
<td>Eligible professional who participates in an eligible APM, but meets a lower threshold</td>
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Qualifying APM Thresholds

- To be classified as “qualifying APM participant” or “partial qualifying APM participant,” EPs have to meet or exceed certain thresholds related to eligible APM entities.
- Thresholds determined by payments for services in APM; Secretary has the option to create thresholds by patients instead of payment.
- Thresholds may be determined by Medicare only services or all services.

<table>
<thead>
<tr>
<th>Years</th>
<th>Min Thresholds for Qualifying APM Participant (In payments or patients)</th>
<th>Min Thresholds for Partial Qualifying APM Participant (In payments or patients)</th>
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<tbody>
<tr>
<td></td>
<td>Medicare Only</td>
<td>Combination Medicare &amp; All-Payer</td>
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<tr>
<td>2019-2020</td>
<td>25% Medicare</td>
<td>n/a</td>
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<tr>
<td>2021-2022</td>
<td>50% Medicare</td>
<td>OR 50% Total/25% Medicare</td>
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<tr>
<td>2023 and beyond</td>
<td>75% Medicare</td>
<td>OR 75% Total/25% Medicare</td>
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Qualifying APM Participants are eligible for 5% bonus from 2019-2024
## SGR Replacement Timeline

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<tr>
<td><strong>Annual Updates</strong></td>
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<td>+0.5%</td>
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<td>+0.0%</td>
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<td><strong>PQRS Penalty</strong></td>
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<td>(2%)</td>
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<tr>
<td><strong>Medicare EHR Penalties</strong></td>
<td>1% or 2%</td>
<td>2%</td>
<td>3%</td>
<td>3% or 4%</td>
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<td></td>
<td>Penalties transition to MIPS</td>
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<tr>
<td><strong>VM Max Penalty</strong>*</td>
<td>Up to 1%</td>
<td>Up to 2%</td>
<td>Up to 4%</td>
<td>TBD</td>
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<tr>
<td><em><em>Merit-Based Incentive Program System (MIPS)</em> (Only max reduction listed; incentives available, see notes)</em>*</td>
<td>4% at risk</td>
<td>5% at risk</td>
<td>7% at risk</td>
<td>9% at risk</td>
<td>+0.25% update + (9%) at risk</td>
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<tr>
<td><strong>Exclusions from MIPS</strong></td>
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<td><strong>Qualifying APM Participant</strong></td>
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<td>Bonus: 5% lump sum payment (based on services in preceding year); No MIPS risk</td>
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<td><strong>Other MIPS Exclusions</strong></td>
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<td>No Bonus, No MIPS risk</td>
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* VM and MIPS have possible upward or downward adjustments. Due to budget neutrality, incentives scale based on available funds. Maximum reduction for MIPS listed in statute.
Regulatory Issues AAMC Expects to Follow

• What will MIPS framework look like?
  • Performance period for MIPS will be before 2019 (possibly 2017?)
  • Will there be an group option?
  • How much variability will there be in benchmarks/incentives, etc?
  • Will risk adjustment be sufficient?
  • How will the EHR Incentive program be integrated?

• New APM models
  • Will academic medical centers be able to meet thresholds?

• New claims coding requirements
  • Will it improve attribution for claims-base measures?
  • Will it be feasible to operationalize?

• Other issues: program integrity, etc.
Questions?

Len Marquez (lmarquez@aamc.org)

Mary Wheatley (mwheatley@aamc.org)

Ivy Baer (ibiaer@aamc.org)