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# SGR Repeal: What Are the Implications to Academic Medicine?

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Association of
American Medical Colleges

# Agenda

- SGR Eulogy
- High Level Issues in HR2 Important to Academic Medicine
- Overview of the SGR Replacement

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# 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.

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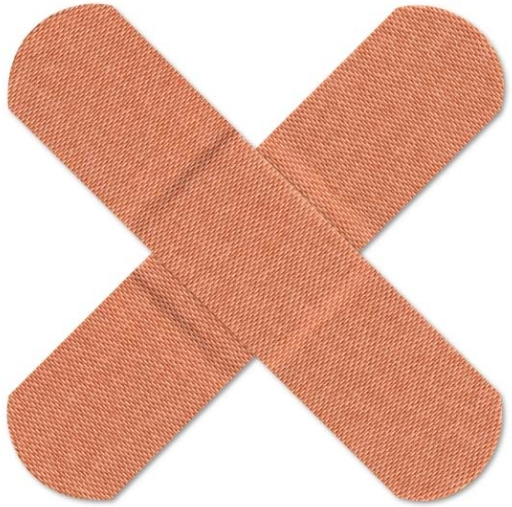
# An SGR Patch Eulogy



- 2003 Consolidated Appropriations Resolution of 2003
- 2004 & 2005 Medicare Modernization Act 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
- July-Dec. 2008 Medicare Improvement for Patients and Providers Act of 2008
- 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
- Dec. 1-Dec. 31, 2010 Physician Payment and Therapy Relief Act of 2010
- 2011 Medicare and Medicaid Extenders Act
- Jan. 1-Feb. 29, 2012 Temporary Payroll Tax Cut Continuation Act of 2011
- March 1-Dec. 31, 2012 Middle Class Tax Relief and Job Creation Act of 2012
- 2013 American Taxpayer Relief Act
- Jan. 1-March 31, 2014 Pathway for SGR Reform Act of 2013
- Apr. 1-March 31, 2015 Protecting Access to Medicare Act of 2014

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# 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.

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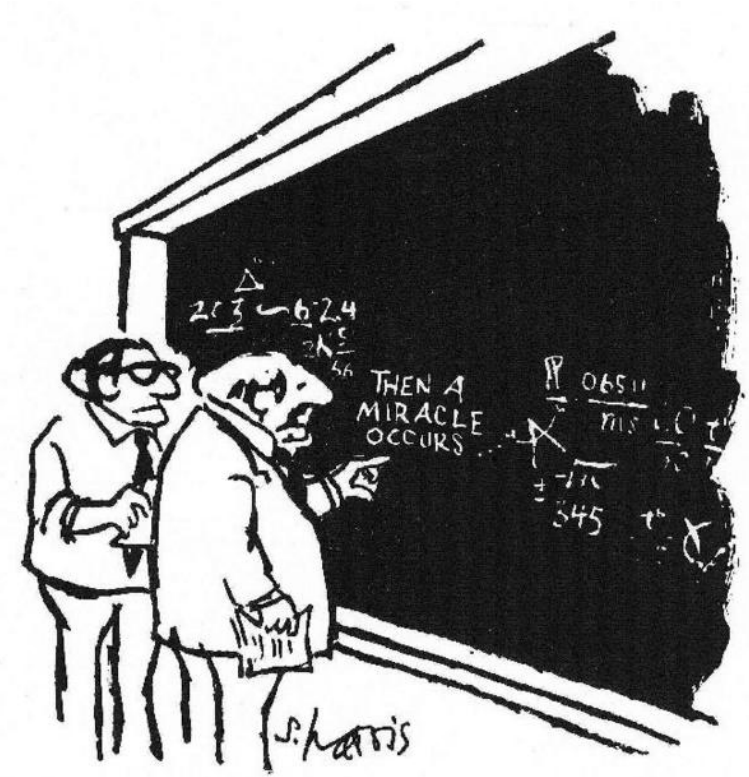
# SGR: How Did We Get Here?




"I think you should be more explicit here in step two."

- **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**

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# 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

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## 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

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# Implementing the SGR Replacement

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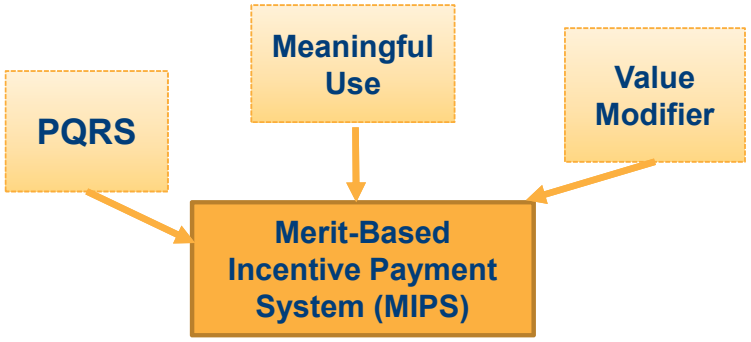
# Three Main Parts of the SGR Replacement

## 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

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# 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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# SGR Replacement
# Part 1: Predictable Updates

## 1) Predictable Updates

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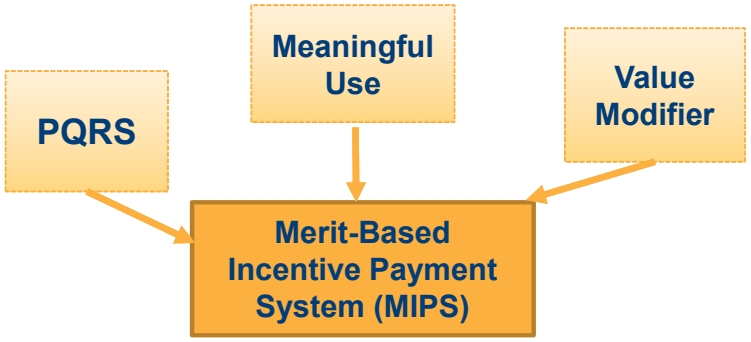


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## Predictable Updates

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

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# 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

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# SGR Replacement
# Part 2: Pay-for-Performance

## 1) Predictable Updates

- Repeals SGR formula
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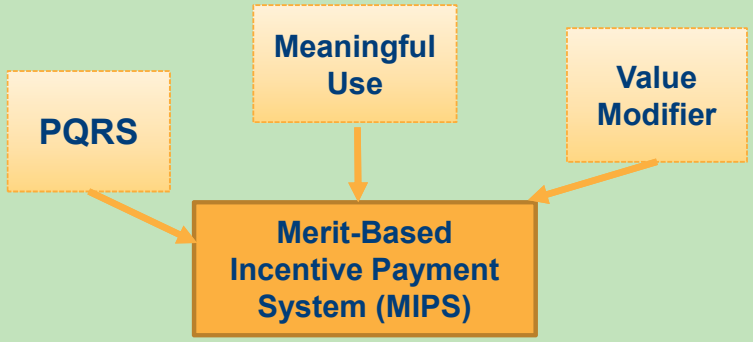


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# Merit-Based Incentive Payment System (MIPS)

- 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.



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# Quality and Resource Use Count for Majority of Score

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

| Performance Categories* | Year 1 (2019) | Year 2 (2020) | 2021-forward |
|---|---|---|---|
| Quality | 50% | 45% | 30% |
| Resource Use | 10% | 15% | 30% |
| Clinical Practice Improvement Activities | 15% | 15% | 15% |
| Meaningful Use of EHR* | 25% | 25% | 25% |
| | | | |
| Maximum MIPS Reduction | 4% | 5% | 7% (2021) 9%(2022-forward) |

* 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



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# 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

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## 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)

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# 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



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# 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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# SGR Replacement
# Part 3: Alternative Payment Models

## 1) Predictable Updates

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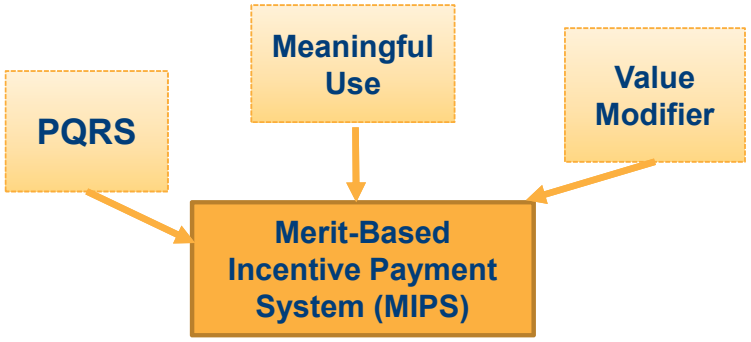


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# Key APM Definitions

| Term | |
|---|---|
| Alternative Payment Model (APM) | • Model under CMMI (except innovation awards)<br>• MSSP ACO<br>• CMS demonstration projects<br>• Demonstration required under law |
| Eligible APM Entity | Entity that meets the following requirements:<br>• Participates in an APM that requires<br>  • use of CEHRT AND<br>  • payment is based on quality measures comparable to MIPS<br>And<br>  • Entity bears financial risk for monetary losses OR<br>  • Is a medical home expanded under section 1115A(c) |
| Qualifying APM Participant | 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. |
| Partial Qualifying APM Participant | Eligible professional who participates in an eligible APM, but meets a lower threshold |

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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

| Years | Min Thresholds for Qualifying APM Participant (In payments or patients) | | | Min Thresholds for Partial Qualifying APM Participant (in payments or patients) | | |
|---|---|---|---|---|---|---|
| | Medicare Only | | Combination Medicare & All-Payer | Medicare Only | | Combination Medicare & All-Payer |
| 2019-2020 | 25% Medicare | | n/a | 20% Medicare | | n/a |
| 2021-2022 | 50% Medicare | **OR** | 50% Total/ 25% Medicare | 40% Medicare | **OR** | 40% Total/ 20% Medicare |
| 2023 and beyond | 75% Medicare | **OR** | 75% Total / 25% Medicare | 50% Medicare | **OR** | 50% Total/ 20% Medicare |

**Qualifying APM Participants are eligible for 5% bonus from 2019-2024**

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# SGR Replacement Timeline

| | Jul-Dec 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 and beyond |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Annual Updates | +0.5% | | | | | +0.0% | | | | | | 2 Options: Qualifying APM: +0.75% Other: +0.25% |
| PQRS Penalty | (2%) | | | | Penalties transition to MIPS | | | | | | | |
| Medicare EHR Penalties | 1% or 2% | 2% | 3% | 3% or 4% | | | | | | | | |
| VM Max Penalty* | Up to 1% | Up to 2% | Up to 4% | TBD | | | | | | | | |
| Merit-Based Incentive Program System (MIPS)* (Only max reduction listed; incentives available, see notes) | | | | | 4% at risk | 5% at risk | 7% at risk | 9% at risk | | | | +0.25% update + (9%) at risk |
| Exclusions from MIPS | | | | | | | | | | | | |
| Qualifying APM Participant | | | | | Bonus: 5% lump sum payment (based on services in preceding year); No MIPS risk | | | | | | No Bonus; No MIPS risk | +0.75% update; No MIPS risk |
| Other MIPS Exclusions (Low volume; Partial Qualifying APM w/ no MIPS reporting) | | | | | No Bonus, No MIPS risk | | | | | | | +0.25% update; No MIPS risk |

* 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.



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# 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.

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## Questions?

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