Has there been actual Medicare reform?

Recent articles, including several of mine, have criticized the current version of Medicare reform for lack of substance. Perhaps it would be more informative to actually summarize these developments.

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New Medicare reform

The most recent Medicare reform is the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The basic tenants of MACRA are:

1. The sustainable growth rate (SGR) fix;

2. The establishment of the "new" Medicare payment theory, i.e., Merit Based Incentive Payment System (MIPS); and

3. The encouragement of physician participation in Alternate Payment Models (APM).

SGR fix

We all basically understand the SGR problem. SGR was a formulaic methodology embedded in the Medicare Resource Based Relative Value System (RB-RVS) which mandated decreases in the Medicare conversion factor (which is the dollar value for each relative value unit of a procedure) which in turn would automatically reduce Medicare physician payments if volume exceeded the budgetary prediction used to create the Medicare Physician Fee Schedule (PFS). Ironically, although SGR threatened PFS reduction, many times, it was overridden by Congress and the president in 17 of the last 18 years.

The MACRA SGR fix does repeal this annual threat and establish PFS stability, but at the cost of essentially eliminating any potential increase in the underlying Medicare physician fee schedule for the next 10 years.

- Physician fee schedule increases will be fixed at ½ of 1 percent (0.5 percent) annually for the five years following adoption, i.e., 2015, 2016, 2017, 2018 and 2019.
- Thereafter, there will be no increases for the years 2020-2025.

MIPS

Concern with this component of Medicare reform is that it is more theory than substance at this point; no actual program has been devised. Instead, Congress has directed the Centers for Medicare and Medicaid Services (CMS) to develop MIPS to begin implementation in 2019, at which time CMS will terminate three current incentive programs and design a new incentive program based upon four physician performance categories (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html).

The three programs that will be eliminated are:

- PQRS – Physician Quality Reporting System;
- Value Based Modifiers (VBM); and
- EHR meaningful use.

The new performance categories will be:

- Quality Performance;
- Resource Use (cost effectiveness);
- Clinical Practice Improvement Activities; and
- Meaningful Use of Certified EHR programs.

One cannot help being a little cynical when recognizing that the performance measurements being eliminated are, at least nominally, the same performance indicators that will be used. The financial impact is that these four performance categories will be used to either penalize or reward physicians by applying either the discounts or the bonuses to the already existing Medicare Physician Fee Schedule (PFS), using the following ranges:

- 2020: 4 percent reduction – 4 percent bonus
- 2021: 5 percent reduction – 5 percent bonus
- 2022: 7 percent reduction – 7 percent bonus
- 2023 and thereafter: 9 percent reduction – 9 percent bonus

Alternative Payment Model

Medicare reform is based on the transition by physicians from regular Medicare PFS payments to Medicare APM payments which, if successful, will exempt physicians from MIPS and make physicians eligible for a 5 percent bonus, again based upon the existing Medicare Physician Fee Schedule, which remains in effect throughout this period except for the elimination of the SGR penalties as described above. In order to qualify for the 5 percent bonus (and avoid the potential MIPS decreases) physicians must transfer volume from regular Medicare Physician Fee Schedule payments to the APM payment models, in the following parameters:

- 2019 and 2020: At least 25 percent of the physician's Medicare Physician Fee Schedule payments must be via APMs.
- 2021 and 2022: The physician must either (a) generate 50 percent of Medicare revenue from APMs or (b) 50 percent of total revenue from any APMs and at least 25 percent of the Medicare revenue from APMs.
- 2023 and thereafter: the physician must generate (a) at least 75 percent of Medicare revenue from APMS or (b) at least 75 percent of total revenue from APMs and at least 25 percent of that revenue from Medicare APMs.

CMS is still in the process of identifying APMs which qualify for this last component. Eligible APMs will include the Medicare Shared Savings Programs (MSSP) for ACOs, other health care ACO payment models, health care quality demonstration programs, and any other demonstration required by federal law.

One of the early examples of an APM that will qualify as eligible is Medicare's Comprehensive Care for Joint Replacement model (CJR – https://innovation.cms.gov/initiatives/cjr). CJR will bundle payment to acute care hospitals for hip and knee replacement surgery, and it will be implemented on a mandatory basis in 67 geographic areas across the country including Pittsburgh. The model would hold participant hospitals financially accountable for the quality and cost of a CJR episode of care that continues for 90 days following discharge. All of the providers and suppliers involved would be paid under the usual Medicare Physician Fee Schedules and, following the end of a model performance year, actual spending for the episode would be compared to the Medicare episode price for the responsible hospital. Depending upon the participating hospital's quality and episode spending performance, the hospital could either receive additional payments from Medicare or be required to repay Medicare for a portion of the episode spending.

The model proposes to waive certain existing payment system requirements, with the potential application of Stark and Fraud and Abuse laws (to incentivize participation by non-employed physicians), and other requirements such as the three-day prior inpatient stay as a condition for Skilled Nursing Facility (SNF) coverage, payments to physicians for telehealth home visits, and payments for certain types of physician-directed home visits for non-homebound beneficiaries.

Conclusion

Therefore, it appears that the only definitive development from MACRA is the elimination of the SGR threat in return for a standard Medicare physician fee schedule payment that will only rise 2.5 percent over the next 10 years. Although MIPS promises significant potential bonuses, it also comes with equal payment disincentives. The APM would exempt physicians from the MIPS risk and allow potential incentives of up to 5 percent, but the conditions for those alternative payment programs remain to be developed.

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