Physician Compensation Reform: How You Will Get Paid

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TOPICS TO COVER

- Sustainable Growth Rate and The "Fix"
- ICD-10
- Pay-For Performance
- Accountable Care Organizations
- Technology Incentive Payments
- Patient-Centered Medical Homes
- Trends In The Physician Business Model

SUSTAINABLE GROWTH RATE AND THE "FIX"

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THE SGR STANDARD

- Medicare payments for physicians services previously adjusted annually upward or downward by a conversion factor known as "SGR."
- Purpose: ensure expense per Medicare beneficiary did not surpass the gross domestic product (GDP).
- Effect: By April 1, 2015, cut in reimbursement for physician services of 21.2%

THE "FIX"

- Medicare Access and CHIP Reauthorization Act of 2015 ("HR2").
- Signed into law on April 16, 2015.
- Legislative Assumption: The goal is to move away from a "fee-for-service" model.

THE HR2 EFFECT

- Avoided the massive decline of 21.2% in physician reimbursement by freezing the current conversion factor to 0% (no upward or downward adjustment) through June 2015.
- July 1, 2015 to June 30, 2019: Conversion Factor is 0.5%
- July 1, 2020 to June 30, 2025: Conversion factor returns to 0.0%

NOT CATCHY ENOUGH FOR THE HEADLINES

- As of 2026, HR2 begins to implement the movement toward paying for "quality."
- Dichotomy in Conversion Factors:

  - ✓ Delivery of care under a "Qualifying Alternative Payment Model."
  - ✓ Delivery of care under a "Nonqualifying Alternative Payment Model."

QUALIFYING ALTERNATIVE PAYMENT MODEL

- Types:

  - ✓ Innovative Payment Models
  - ✓ Shared Savings Program
  - ✓ Demonstrations
  - ✓ Demonstration Project Required by Federal Law

BENEFIT OF PARTICIPATING IN A QUALIFYING APM

- A Provider (physician, physician assistant, nurse practitioner, clinical nurse specialist and other qualifying professional) who provides a particular threshold of his services under a qualifying APM depending on the year and starting in 2019, will receive an upward conversion factor of .75%.
- Caveat: Must certify electronic health record technology, specific quality measures, and either bear financial risk for participation or be a Patient-Centered Medical Home (PCMH)

OTHER PAYMENT INCENTIVES

- HR2 sunsets other payment incentive programs by 2018, including physician quality reporting, value-based payment modifier, and meaningful use programs.
- HR2 replaces these programs with the Merit-based Incentive Payment System ("MIPS") in 2019, merging all three programs into one.
- Relative values for (a) quality (30%); (b) resource use (30%); (c) clinical practice improvement activities (15%); and EHR meaningful use (25%)

THE PROVIDER "FIX"

- Be prepared for a complex system
- Thoroughly review your internal quality data monitoring and make adjustments
- Improve practice management and evaluate synchronicity of your standards to government standards
- Analyze your technology security and use to ensure proper use of EHR
- Understand and comply with current trends in physician reimbursement

ICD-10

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ICD-10

- Deadline for ICD-10 implementation was October 1, 2015
- Major differences:
    - ICD-10 has 68,000 codes, as opposed to 13,000 in ICD-9
    - The code set has been expanded from five positions to seven positions; the codes use alphanumeric characters in all positions, not just the first position as in ICD-9
    - ICD-10 provides a significant increase in the specificity of the reporting
    - Codes are a combination of diagnoses and symptoms, so fewer codes need to be reported to fully describe a condition
    - The terminology is modernized and made consistent throughout the code set

ICD-10

- Example of changes in coding
  - 26-year-old female with “ankle sprain”:
    - ICD-9: 845.00 sprains and strains of ankle, unspecified site
    - ICD-10: S93.401 sprain of unspecified ligament of right ankle
      - PLUS required 7th digit to identify the encounter:
        - A – initial
        - D – subsequent
        - S – sequel

ICD-10

- How does this relate to reimbursement?
  - Coding professionals may code "unspecified" when physician's documentation does not give us the specifics needed to select a more specific code
  - This practice may cause issues in a few years when coded files will not have the specificity needed to justify higher levels and better reimbursement
    - Example
      - If notes state that it is the first encounter for a right ankle sprain:
        - S93.401A
      - If notes also state that patient slipped on ice while going to mailbox:
        - W00.0xxA: Fall on sale level due to ice and snow, first encounter
          - **"xx" are placeholders and can describe how injury happened**

ICD-10

- Tips for smooth implementation and maximizing reimbursement
    - Preparation and payer testing
        - Studies show the average cost for implementing ICD-10 for a small physician practice is a few thousand dollars
    - Prepare a cheat sheet
        - Prepare cheat sheets for internal usage to simplify process and ensure highest reimbursement
        - Providers with a solid grasp on documentation requirements will be able to optimize reimbursement
    - Identify gaps in documentation now
        - Correct areas where documentation is lacking to enable coders to maximize reimbursement and avoid audits

ICD-10

- Tips for smooth implementation and maximizing reimbursement
    - Coder and physician collaboration
        - If possible, enable coders to assist physicians to execute a greater long-term understanding and awareness of needed documentation
    - Identify negative impacts on revenue cycle
        - Significant uncertainty regarding lost productivity
        - As reimbursement models continue to move toward bundled or capitated payments, providers must utilize models of specificity and improved documentation
    - Pay close attention to metrics
        - Metrics must be closely monitored and documented to prevent glitches in reimbursement

ICD-10

- Claim denial rate following implementation
  - Since October 1, 2015, CMS has received 4.6 million Medicare fee-for-service claims per day
  - In total, 10.1% of the claims processed have been denied
  - Approximately 20% of the denials were due to incomplete or invalid information
  - Approximately 9% of the denials were due to invalid IDC-10 codes
  - Approximately 11% of the denials were due to invalid ICD-9 codes
  - CMS stated that it will take several more pay cycles to determine success of the transition

PAY FOR PERFORMANCE

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"PAY FOR PERFORMANCE"

- Generic term for initiatives aimed at improving quality, efficiency, and overall value of health care
- Affordable Care Act expands the use of pay-for-performance approaches in Medicare and encourages experimentation to identify designs and programs that are most effective.

FOUR CATEGORIES OF QUALITY MEASURES

- Process: assess performance of specific activities that have been demonstrated to contribute to positive outcomes.
- Outcome: effect of particular care on patient.
- Patient Experience: patient's perception of quality of care and their satisfaction with such care.
- Structure: facilities, personnel, and equipment used for treatment.

Overall Goals of Value-Based Purchasing in Medicare

Financial viability	The financial viability of the traditional Medicare fee-for-service program is protected for beneficiaries and taxpayers
Payment incentives	Medicare payments are linked to the value (quality and efficiency) of care
Joint accountability	Providers have joint clinical and financial accountability for health care in their communities
Effectiveness	Care is evidence based and outcomes driven to better manage diseases
Ensuring access	Restructured fee-for-service system provides ensured access to high-quality, affordable care
Safety, transparency	Beneficiaries receive information on the quality, cost, and safety of their care
Smooth transitions	Payment systems support well-coordinated care across providers and settings
Improved technology	Electronic health records help providers deliver high-quality, efficient, and coordinated care

SOURCE Centers for Medicare and Medicaid Services.