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Accountable Care NEWS

The 2016 Medicare PFS Rule: Another Step towards Value

By Chris Emper

Ready or not, the new Medicare Physician Fee Schedule (PFS) went into effect January 1 with some important implications for physicians. Issued in late 2015, the Centers for Medicare and Medicaid Services (CMS) rule reflects the paradigm shift occurring in healthcare today: while traditionally the PFS rule has been a few hundred page discussion of fee-for-service (FFS) codes and payment rates, this year the rule was a whopping 1,358-page discussion and explanation of FFS payment policies and value-based reimbursement programs.

Indeed, this rule reflects the reality that FFS is giving way to value-based reimbursement. This year's rule was also unique because it was the first PFS rule since the repeal of the Sustainable Growth Rate (SGR) formula by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The most significant piece of healthcare legislation since the Affordable Care Act (ACA) in 2010, MACRA will permanently change the way Medicare pays physicians through the PFS over the next several years. With these points in mind, physicians should consider a few key takeaways from the rule.

Medicare FFS Payments are Declining. Understanding the evolving value-based reimbursement environment is not only a serious challenge, it's a business imperative because FFS payments are declining. The 2016 PFS rule implemented an across-the-board 0.29 percent reimbursement cut for all PFS services (that took effect January 1). This cut was the result of the 0.5 percent payment increase included in MACRA being offset by a 0.79 percent payment decrease that stemmed from other recent legislation focused on misvalued codes. This is significant in practice, of course, because declining FFS payments don't mix well with rising costs. This year's decline is also symbolically important because it follows MACRA's repeal of the SGR formula that, for over a decade, had threatened physicians with the prospect of annual PFS cuts.

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10 Percent of PFS Payments are now "At-risk" in Quality Reporting Programs. There are currently three quality reporting programs that adjust PFS payments: the Meaningful Use EHR Incentive Program (MU), Physician Quality Reporting System (PQRS) and Physician Value-Based Payment Modifier (VBM). While each of these programs applies non-compliance penalties to PFS payments, the financial impact of these programs has been difficult for many providers to track because there is a two-year lag between the performance period and the application of the penalties. Thus, the 2016 PFS rule governs 2016 performance in these programs, but will impact 2018 PFS payments. In terms of performance or reporting requirements for 2016, the MU requirements were specified by a separate CMS rule issued last October. In this rule, CMS finalized 2016 PQRS reporting requirements that were the same as those from 2015, which generally (depending on reporting method) require the reporting of nine measures covering three National Quality Strategy domains.

As for the penalties, prior law dictated that the 2018 MU penalty would be 4 percent (assuming fewer than 75 percent of eligible professional achieve MU) and the 2018 PQRS penalty would be 2 percent. However, CMS holds the authority to adjust VBM penalties each year at its discretion. In this particular rule, CMS chose to keep the 2018 VBM penalties at the same level as the 2017 VBM penalties: 4 percent for group practices with more than 10 physicians and 2 percent for group practices with fewer than 10 physicians, including solo practitioners.

It's also important to note that while the MU and PQRS penalties are "all-or-nothing" (meaning a provider either gets hit with the full penalty or no penalty based on meeting the program's reporting requirements), the VBM can result in a range of penalties from zero up to the maximum amount as determined by a complicated formula known as "quality-tiering."

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Based on CMS' quality-tiering calculations, the VBM also rewards good performance in the program with incentive payments -- the amount of which is determined by a linear scale and an adjustment factor. Similar to the penalties or negative adjustments, positive VBM adjustments will be capped at 4 and 2 times the adjustment factor (depending on practice size), with the adjustment factor itself being calculated to pay out all the penalties and ensure the program remains budget neutral.

CMS Will Rank Physicians by Quality with a New Star Ratings System. The Affordable Care Act required CMS to establish a public website that compares the performance of Medicare physicians on cost and quality metrics, as well as provides other relevant information to consumers. The intent of the website is to provide viewers with a "consumer reports" style report of information about Medicare providers. The implementation of the website, "Physician Compare," has been phased-in over the past several years and with the 2016 PFS rule, CMS officially established a new star ratings program. This program will assess the performance of physicians on the PQRS quality measures they submit relative to a benchmark, assign a rating of one to five stars based on that performance, and publish the ratings on the website for public consumption.

As detailed in the rule, this star rating system creates a government sponsored public website that will rank physicians based on performance of their PQRS quality measures. But in effect, the system will create a government sponsored public website that consumers will view as a ranking of physician quality. Realistically, the public is unlikely to differentiate between quality measures and quality -- they won't see these star ratings as a measure of PQRS quality measure performance; they'll view these ratings as a measure of physician quality.

Regardless of the accuracy or arbitrary nature of the measures or the ratings determinations, consumers will use Physician Compare to make consumer decisions about their healthcare, similar to how they use Yelp to choose a restaurant. This could force physicians performing poorly on their quality measures to face a double-edged sword -- penalties and public discrediting. Or on the flip-side, this system could also reward physicians performing well on their quality measures with incentive payments and the public seal of approval stemming from a five star quality rating.

Final Thoughts. Being over 1,300 pages in length and filled with complex regulations and policy changes, the PFS is a challenging document for physician practices to fully comprehend. However, when the 2016 PFS rule went into effect, Medicare took a big step towards tying payments to value over volume. Additionally, the launch of the new physician star ratings system will enable and drive a new consumerism in healthcare which will force physician practices to compete on cost and quality like never before. As a result, physician practices should view the 2016 PFS as both a challenge and an opportunity in the journey to value-based care.

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