Medicare's Physician Payment System Changes: Impact on Critical Care

A recent article in the *New England Journal of Medicine* describes the evolving reimbursement changes mandated by Medicare as a "coming battle" between primary care physicians and specialists.[1] There has been very little to date in the critical care literature about these changes or how they might affect intensivists. In this article, we provide an overview of the legislative changes to Medicare, how they may affect physician reimbursement, and specifically how they might affect intensivists. It will be up to the critical care community to determine appropriate responses to this changing environment.

Beginning in 2012, the Centers for Medicare and Medicaid Services (CMS) began implementing new and innovative payment methods mandated in the Patient Protection and Affordable Care Act. Accountable care organizations (ACOs) and patient-centered medical homes were first, followed by various bundled payment programs. To qualify as an ACO, an organization must agree to be accountable for the overall care of its Medicare beneficiaries through primary care providers, emphasize and support evidence-based medicine, report on quality and costs, and utilize care coordination. These organizations are reimbursed through both public and private programs and can be organized by either hospitals or provider groups. They generally have a primary care provider and a preventative and chronic disease-based approach to managing care and capitated risk for a population.

CMS recognizes that the emphasis on primary care and population health management is a necessary but insufficient approach to addressing rising healthcare costs while improving healthcare quality. Primary care providers account for only 6% of healthcare expenditures, while specialists outnumber primary care providers in the United States by 26%.[2] A typical Medicare patient sees five specialists and three primary care providers in four different practices each year.[3]

Bundled payment programs, including the voluntary Bundled Payments for Care Improvement initiative and the mandatory Comprehensive Care for Joint Replacement model, have helped CMS move 30% of Medicare payments away from traditional fee-for-service with a goal of 50% by 2018.[4] Bundled payment programs are attractive to providers who are very good at one or a few procedures and who care for otherwise healthy patients, since to date there is no risk adjustment used in the reimbursement methodologies. However, for that same reason, these programs are limited as methodologies that could be extended to all of Medicare.

What Is MACRA?

In April 2015, President Obama signed the Medicare Access and CHIP Reauthorization Act (MACRA), which repealed the Sustainable Growth Rate (SGR) mechanism for Medicare physician reimbursement and mandated that CMS develop alternative payment methodologies to "reward health care providers for giving better care, not just more care."[5] MACRA makes three major changes to Medicare reimbursements: (1) it ends the SGR formula, (2) it establishes a new framework to reward physicians based on performance and health outcomes rather than volume, and (3) it aims to combine existing quality reporting programs into one streamlined system. MACRA establishes an annual physician fee schedule update of 0.5% from 2016 to 2019. After that, the Medicare physician fee schedule will remain at 2019 levels through 2025. Beginning in 2019, physicians must enter one of two new tracks for payment: the Merit-Based Incentive Payment System (MIPS) or Alternative Payment Models (APMs).[6]

What Are MIPS and APMs?

CMS is developing MIPS as traditional fee-for-service Medicare with improved-quality metrics and streamlined reporting requirements. The maximum MIPS payment adjustment will be 9% +/-. MIPS will subsume the Physician Quality Reporting System, the Value-Based Payment Modifier and the Medicare Electronic Health Record Incentive Program for eligible providers.

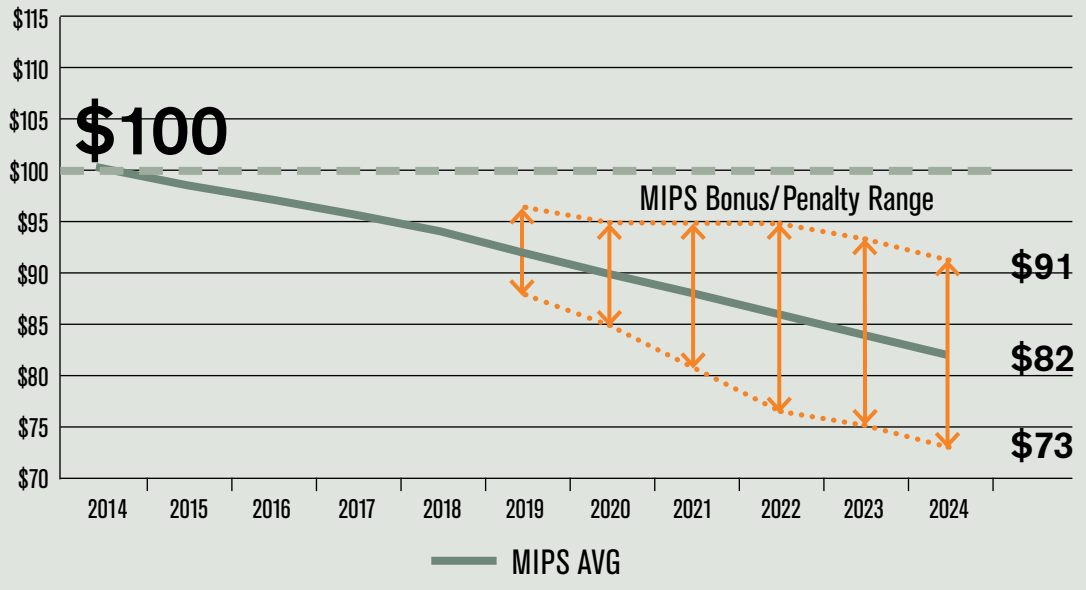
However, CMS wants to continue to move providers into greater than nominal risk-bearing arrangements. To that end they are also developing APMs in which providers can earn higher rewards for better care, but also have greater risk of financial loss if care costs exceed expectations. Payment adjustments for participants in qualifying APMs will include both a 5% incentive payment plus any shared savings achieved by the APM—with potential payment adjustments available through APMs far exceeding those available through MIPS. Under MIPS, physicians can expect, based upon the fee schedules defined in the MACRA legislation, a progressive reduction in reimbursement even if all quality metrics are met. Incentives in the APM program provide the possibility of increasing physician reimbursement over the first five years of the program.

Neither MIPS nor APMs are completely defined, let alone implemented; over the next five years, CMS will be developing the final structures and policies for these payment methodologies. Some experts have already voiced significant concern that these innovative payment and delivery models may not be the keys to cost control and quality improvement.[7] Provider groups can propose Physician-Focused APMs to an independent Physician-Focused Payment Model Technical Advisory Committee that will review them and make recommendations to CMS on whether or not to adopt them.

The "Advanced APMs" under development in this arena comprise much more complex and comprehensive plans that include coverage for acute and chronic conditions, sophisticated risk adjustment, advanced tools to measure quality and resource use, and methods to assign risk and rewards to large panels of providers. These APMs will likely use both administrative and clinical data, will analyze both acute and chronic episodes of care, and consequently will include a much broader array of providers than bundled payment plans. Provider organizations and specialty societies are actively working to develop APM models to present to CMS. Despite CMS being the prime mover in this work, private payers will be expected to follow Medicare's lead, and all-payer APMs will follow. Ongoing improvements in both electronic health records and billing and coding methodologies will make that development even more likely.

Figure 1.

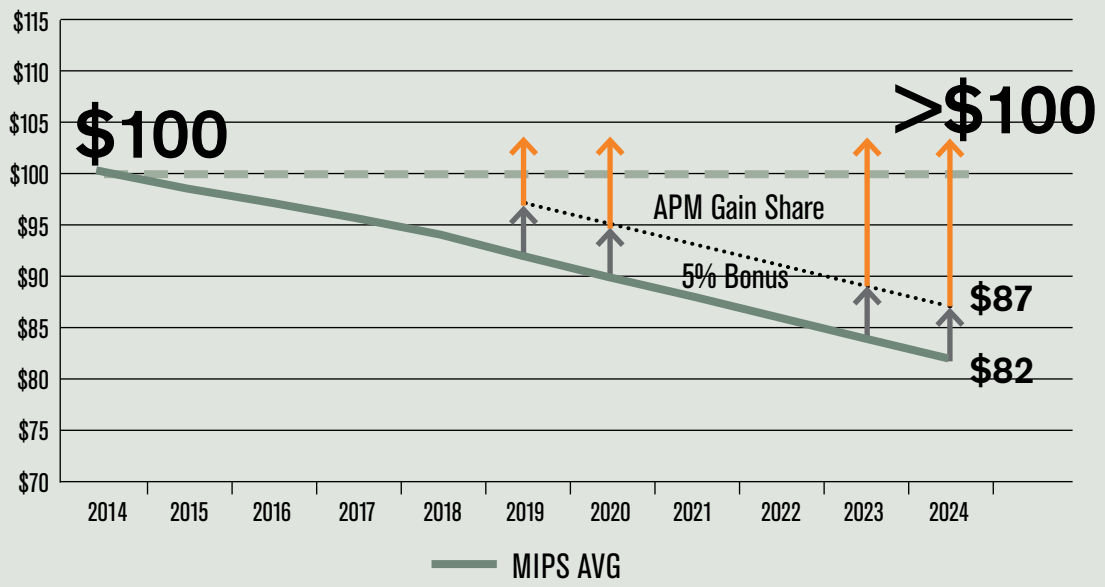
INFLATION-ADJUSTED 10-YEAR CHANGE IN PHYSICIAN PAYMENT UNDER MIPS



Note: Inflation is projected CPI-U from Congressional Budget Office 2016 Economic Outlook

Figure 2.

INFLATION-ADJUSTED 10-YEAR CHANGE IN PHYSICIAN PAYMENT UNDER APMs



Note: Inflation is projected CPI-U from Congressional Budget Office 2016 Economic Outlook

How Do MACRA, MIPS and APMs Impact Critical Care Services?

For CMS, the intent is not just to eliminate waste and unnecessary care, but to provide incentives to providers and organizations for care redesign. The allocation of care, and thus reimbursement, between primary care providers and specialists will depend upon the new and innovative organizational structures that arise in this effort, and on how both primary care providers and specialists can demonstrate their value to the organization. Intensivists, in functioning as both specialists and primary care providers for their patients in the intensive care unit (ICU), have a unique professional role that will need to be defined clearly and appropriately in new reimbursement methodologies.[8]

With the passage of MACRA, there is now an opportunity to have physician and society input into the development of the APMs and quality measures that are relevant to critical care and specific patient populations in our ICUs. The development of MIPS performance measures specific to critical care would be an excellent advance within this new framework. The changing incentives contained within the MACRA legislation will spur both reimbursement redesign and care redesign that will affect all providers. That redesign will influence provider roles and provider relationships.

The ICU is the locus of high-cost healthcare in this country—the place where care quality and care coordination are paramount, both for improving outcomes and controlling costs. Intensivists are best positioned to inform the development of appropriate quality measures to accurately and comprehensively evaluate critical care services in the ICU. Furthermore, intensivists work at the place where the coming integration of hospital and provider reimbursement will have the largest impact. The reimbursement changes outlined here will likely have a significant effect on intensivists and how we care for our patients—and how we interact with our colleagues and are paid for those interactions. Determination of appropriate physician reimbursement for critical care services will be important in MIPS and especially in the APMs.

The devil will be in determining the details. What is the scope of an APM model? Which providers are included within the model? Will the model cover acute episodes of care (an advanced bundled care model, perhaps with some risk adjustment) and will it also cover the management of chronic medical problems? How will financial responsibility for a patient be distributed among the various providers of care? How is quality of care assessed in the APM model? What metrics will be used for the patient who spends a period of time in a surgical ICU after surgery or in a medical ICU for an acute exacerbation of a chronic medical problem? How are these metrics translated into reimbursement rewards and penalties in the reimbursement algorithm? Will compliance with ICU staffing standards necessary to provide a minimum standard of care and patient safety in an ICU be part of the CMS quality algorithm?[9,10]

The Society of Critical Care Medicine is dedicated to educating the critical care community about reimbursement policies. Several professional organizations have provided statements regarding MACRA, some particularly focused on the development of APMs.[11,12,13,14] Appropriate reimbursement models could help pave the way for more robust and uniform standards in critical care medicine education and credentialing,[15] and could even influence federal funding for critical care education. The critical care community has a unique opportunity to be part of the discussion around developing new physician payment models specifically for critical care services. ⚠

References and disclosures are available at www.sccm.org/criticalconnections.

Charles E. Hobson, MD, MHA, FACS, is a surgical intensivist in the Department of Surgery at the Malcom Randall VA Medical Center in Gainesville, Florida, USA, and a PhD candidate in Health Services Research at the University of Florida. He is also a research scientist and fellow at the Institute on Healthcare Systems in the Heller School for Social Policy and Management at Brandeis University.

Azra Bihorac, MD, MS, FASN, FCCM, is a surgical intensivist and nephrologist. She holds the R. Glenn Davis, MD, Chair in Nephrology and is associate professor of anesthesiology, medicine and surgery at the University of Florida. She is director of the Precision and Intelligent Systems in Medicine research partnership at the University of Florida.

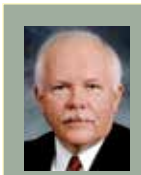
Mehrnaz Hadian, MD, JD, FCCM, is the founder of INSPIRE CCM. She serves on SCCM's Bioethics, Patient and Family, Intensivists in Practice, Fundamental Critical Care Support, and Internal Medicine Steering Committees. She is a clinical assistant professor of medicine at UCLA and a staff intensivist at Cedars-Sinai Medical Center. Her interests are focused on improving the delivery of the intensive care unit standard of care in all hospitals through the mandate of 24/7 intensivist programs and the development of uniform multidisciplinary critical care education in all academic medical institutions. She obtained her JD from Southwestern Law School in May 2016, where she has served as the president of the Law and Medicine Society.

Daniel L. Herr, MD, MS, FCCM, is associate professor of medicine and surgery at the University of Maryland School of Medicine. He is chief of Surgical Critical Care Services and director of the Cardiac Surgery and Heart-Lung Transplant Intensive Care Unit.

Thomas G. Rainey, MD, FCCM, is president and CEO of CriticalMed, a company specializing in consulting with hospitals, multi-hospital systems and physician practices on the delivery of high-quality, cost-efficient critical care. He has been a physician advisor to the Leapfrog Group, a physician leader for several workgroups for the Institute for Healthcare Improvement (IHI), chairman of Idealized Design of Intensive Care for the Veterans Health Administration/IHI and chairman of the Coalition for Critical Care Excellence. He has been active in SCCM for his entire career and served as its president in 1994-95.

Frank B. Cerra, MD, MCCM, is senior advisor for the National Center for Interprofessional Practice and Education and professor of surgery and McKnight Presidential Leadership Chair at the University of Minnesota. He served as the senior vice-president for health sciences and as dean of the medical school at the University of Minnesota from 1996 through 2010. Dr. Cerra served as president of SCCM in 1991-92.

Lena M. Napolitano, MD, FACS, FCCP, MCCM, is director of surgical critical care and trauma, professor of surgery and division chief of acute care surgery at the University of Michigan. She served as chancellor of the American College of Critical Care Medicine in 2007-08.



John W. Hoyt, MD, MCCM, is certified by the American Board of Anesthesiology and has a Certificate of Special Qualification in Critical Care. He has over 30 years' experience in critical care and has developed critical care services at many hospitals in the United States. Currently Dr. Hoyt is the president of Pittsburgh Critical Care Associates, Inc. He has been active with SCCM and served as its president in 1996-97.