American Society of Anesthesiologists®

Timely Topics
PAYMENT AND PRACTICE MANAGEMENT

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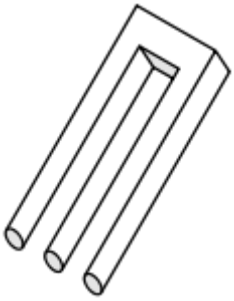
How Do You See the Payment Landscape Post SGR?

Not that long ago, there was a good deal of discussion and debate in our offices – and likely in yours as well – whether a particular dress was blue/black or white/gold. Everyone has seen optical illusions that can trick the mind and the eye. Some common examples as found at http://en.wikipedia.org/wiki/List_of_optical_illusions include:

Delboeuf illusion

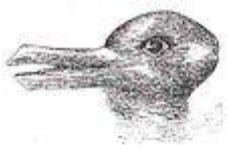
An optical illusion of relative size perception. The two black circles are exactly the same size; however, the one on the left seems larger.

Bivet



Also known as "poiuyt" or "devil's fork", this illusion is an impossible image because in reality the shape cannot exist.

Ambiguous image



These are images that can form two separate pictures. For example the image shown forms a rabbit and a duck

Repeal of SGR is becoming less an illusion and more a reality. Recent action by the U.S. House of Representatives demonstrates that the way in which payment for services provided to Medicare beneficiaries is determined is going to change. As this article is written, we still await Senate action. Assuming H.R. 2 – The Medicare Access and CHIP Reauthorization Act passes the Senate and is signed by the President, we can anticipate a plethora of accompanying regulatory actions in the implementation process. However, it is not too early for anesthesia and pain practices to start becoming familiar with the road ahead. A change in viewpoint is in order.

Listed below are some terms and concepts that are in place now along with what we can expect to see in a "post-SGR" world.

Currently		Post-SGR	
Sustainable Growth Rate (SGR)	The formula used to calculate annual changes to the Medicare conversion factor (CF). Under this method, actual Medicare spending is compared to targets that are established by considering estimated: – Percentage change in fees for services – Percentage change in average number of Medicare FFS beneficiaries – 10 year average annual percentage change in real GDP per capita – Percentage change in expenditures due to new law/regulation Other factors include: – Medicare Economic Index (MEI): inflation in the costs associated with running a practice – Update Adjustment Formula (UAF): represents an adjustment to consider any differences between the established targets and actual spending – Budget Neutrality (BN): a rescaling that is required when changes in the fee schedule result in a difference greater than +/- $20M	Statutorily determined updates to the conversion factor (CF)	Under H.R. 2, there would be a 0.5% annual update to the CF starting with services provided on/after July 1, 2015. We would see a 0.5% update annually for 2016 – 2019. There would be a 0.0% update for 2020 – 2025. Starting in 2016, the annual update would be 0.25% unless the provider qualifies for a 0.75% update based on participation in an Alternative Payment Method (APM).

Currently		Post-SGR	
Physician Quality Reporting System (PQRS)	The Centers for Medicare and Medicaid Services (CMS) describes PQRS as, *"a reporting program that uses a combination of incentive payments and negative payment adjustments to promote reporting of quality information by eligible professionals (EPs)"*. This program was first established in January 2006 and originally known at the Physician Voluntary Reporting Program (PVRP). It was transitioned to the Physician Quality Reporting Initiative (PQRI) in 2007 and renamed PQRS for the 2011 fee schedule. A significant change was implemented in 2015 when the program changed from providing positive payment incentives to EPs who successfully report to applying negative payment adjustments to those who do not satisfactorily report on established quality measures.	Merit – Based Incentive Payment System (MIPS)	PQRS, VPM and MU along with Clinical Practice Improvement Activities would be combined into a single program. Under MIPS, providers would be scored on quality, resource use, meaningful use of electronic health records and clinical practice activities. If that score is greater than a threshold determined by the Secretary of Health and Human Services, the provider receives a positive incentive. A negative adjustment is applied if the provider scores below the threshold. The maximum negative adjustment is 4% for the first year of the MIPS program (2019) and it will incrementally increase to 9% for 2022 and onward.
Value-Based Payment Modifier (VPM)	The Affordable Care Act (ACA) requires that CMS modify the payments it issues to providers under the Medicare Physician Fee Schedule based on the provider's performance of quality measures and on the provider's costs or resource use. Those classified as providing care of higher quality and lower cost would see a positive modification while those who are seen to offer care that is of lower quality and higher cost would see a negative modification. Implementation of the VPM started in 2015 and the transition will continue through 2018 when it is applicable to all physicians and to all non-physician providers.		
Meaningful Use (MU)	As described on the CMS website, MU is program intended to encourage EP's to *"adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology."* Like PQRS, the program will include negative payment adjustments starting in 2015.		

Currently		Post-SGR	
Accountable Care Organization (ACO)	As defined by CMS, "*Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients".* If the ACO provides quality care at a lower cost, it is eligible to share any savings it generates.	Alternative Payment Models (APM)	EPs who participate in qualified APMs and receive a specified amount of their revenue from that APM would be eligible for a 5% bonus in 2019 - 2024 and a 1% bonus in 2025 and onward. The ASA Perioperative Surgical Home model may very well serve as a pathway to an APM for anesthesiologists and other physicians.
Patient Centered Medical Home (PCMH)	According to the National Committee for Quality Assurance (NCQA), which operates a PCMH Recognition Program, *"The patient-centered medical home is a way of organizing primary care that emphasizes care coordination and communication to transform primary care into 'what patients want it to be.' Medical homes can lead to higher quality and lower costs, and can improve patients' and providers' experience of care."*		

For more information, please visit the ASA website at http://www.asahq.org/advocacy/fda-and-washington-alerts/washington-alerts/2015/03/house-passes-sgr-permanent-repeal-legislation