John I. Allen, Section Editor

Surviving the Waning Days of Fee-for-Service Payments

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Roadmap to the FUTURE of PRACTICE

By now, most gastroenterologists have heard that Medicare and commercial insurers would like to end the traditional method of paying for medical services as they are performed (called "fee-for-service") and make payments contingent on health outcomes of our patients (called "value-based reimbursement"). The AGA has worked diligently to educate members about this new methodology by arguing against payment formulas that are unfair to gastroenterologists and developing tools to help members survive this transition. See "The Roadmap to the Future of GI Practice" at http://www.gastro.org/practice/roadmap-to-the-future-of-gi. This month, Dr Spencer Dorn defines, in clear language, each part of Medicare's value-based payment model. Practices would do well to adapt to this change since it will influence our practices' financial future.

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In 2010, a White House Commission reported that "federal health care spending represents our single largest fiscal challenge over the long-run."[1] Cost growth has since slowed to the lowest rate in decades,[2] yet attempts to rein in costs continue to intensify. Central to this effort is reforming how physicians are paid. Although novel payment models—particularly bundled payments and accountable care organizations—have received the bulk of the attention, over the short term, changes to the fee-for-service (FFS) system will have a far greater effect on most gastroenterologists.[3]

Fee-for-Service

Most physicians are paid under the FFS model, which pays for discrete services rendered. Since 1992 these payments have been linked to the Medicare Physician Fee Schedule, which assigns each service a certain number of relative value units (RVUs), based on geographically adjusted estimates of the work (time and intensity), practice expenses, and malpractice insurance costs associated with providing the service. Critics contend that the fee schedule is distorted and inappropriately favors recently developed procedures over evaluation and management services. In response to these concerns, the Centers for Medicare and Medicaid Services (CMS) has begun to adjust the fee schedule, largely to the detriment of procedural-based specialists such as gastroenterologists.[3] For instance, in 2010, CMS eliminated payments for specialist consultations and increased fees for nonconsultative office visits. More recently, the Affordable Care Act included a 10% bonus for primary care evaluation and management services, and directed the Secretary of Health and Human Services to establish a formal process to review potentially misvalued codes, including upper endoscopy, colonoscopy, flexible sigmoidoscopy, and endoscopic ultrasound. Two organizations contracted by CMS currently are studying the times required to perform these procedures. Because time estimates currently used to determine work requirements for these procedures (Supplementary Table 1) are likely shorter than real-world time requirements, Medicare reimbursement for these procedures almost certainly will decrease. With nearly two thirds of gastrointestinal (GI) practice revenue derived from procedures (particularly colonoscopy), the effects may be severe.[4]

The fee schedule tells only half the story. Once established, RVUs are multiplied by a conversion factor (CF) to derive the actual dollar payment amount for a given service. This CF is determined through the controversial sustainable growth rate (SGR) mechanism, which was implemented in 1992 to reduce growth in Medicare physician expenditures. The SGR compares actual spending with a target benchmark that is based primarily on growth in the overall economy, as well as estimates of medical inflation, and increases in the number of Medicare beneficiaries.[5] If actual spending is less than targeted spending the CF is adjusted upward. Conversely, if actual spending exceeds targeted spending, the CF is adjusted downward and payments are cut, unless Congress intervenes, as it has done each year since 2003, most recently on January 2, 2013, with a doc fix that averted a 30% fee reduction.

No one likes the SGR, especially the Medicare Payment Advisory Commission, which called it a "fundamentally flawed" mechanism that paradoxically has exacerbated—rather than constrained—cost and volume growth. The challenge is that replacing the SGR will cost between $130 and $300 billion. The Medicare Payment Advisory Commission recommends funding this by freezing current primary care payments, and cutting specialist payments (including gastroenterologists) by 5.9% annually for 3 years and then freezing them for 7 years. In the long term, any grand compromise to fix the SGR may push providers away from FFS to newer payment models, such as bundled payment and shared savings models.[6] In the meantime,

Resources for Practical Application
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Abbreviations used in this paper: **CF, conversion factor; CMS, Centers for Medicare and Medicaid Services; FFS, fee-for-service; GI, gastrointestinal; PQRS, Physician Quality Reporting System; RVU, relative value unit; SGR, sustainable growth rate.**

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Medicare, Medicaid, and many private payers have created a series of programs to encourage greater value from the FFS system. We discuss the most noteworthy federal programs later.

Physician Quality Reporting System

Pay-for-performance programs use financial incentives to encourage providers to increase quality or decrease costs.[7] Leading the way is Medicare's Physician Quality Reporting System (PQRS), through which gastroenterologists can use claims data, electronic health record data, or a qualified registry (American Gastroenterological Association Digestive Health Outcomes Registry or the American College of Gastroenterology GI Quality Improvement Consortium Registry) to report performance on either 3 or more individual PQRS measures or 1 PQRS measures group (collection of related individual measures).[8] The number of quality measures, the number of patients on which to report, and the reporting time period vary depending on the reporting mechanism (claims, electronic health record, or registry) and whether reporting is at the individual physician or group level.[9] There are individual, gastroenterology-specific measures for screening and surveillance colonoscopy (PQRS Measure 320: appropriate follow-up recommendation after normal colonoscopy in average-risk patients; measure 185: appropriate surveillance interval for patients with a history of adenomatous polyps) and diagnosis and treatment of hepatitis C viral infection (measures 83–90). Gastroenterologists also may report on individual measures related to preventive care and screening (measure 128: body mass index screening; measure 226: tobacco screening and cessation intervention) and participation in a quality registry (measure 321). Finally, there is a gastroenterology-specific measures group for inflammatory bowel disease (8 related measures). In 2011, there were 2037 gastroenterologists (26.1% of those eligible) who received $3.5 million in PQRS incentives (median, $1290 per provider; range, $1–$12,950).[8] Physicians who participate in PQRS in 2013 and 2014 will receive a 0.5% bonus on Medicare fees (with an additional 0.5% bonus available to those who also successfully complete a Maintenance of Certification program). Starting in 2015, those who do not satisfactorily participate will face a 1.5% penalty, and in 2016 and beyond a 2% penalty.[10]

Value-Based Payment Modifier

The Affordable Care Act directs the Secretary of Health and Human Services to implement a budget-neutral value-based payment modifier by 2015. Initially, this modifier will be used to adjust payments made to a select number of large (100-plus providers) practices. Among those practices, those that did not satisfy PQRS requirements 2 years earlier (2013) will suffer 1% cuts to all Medicare payments. Those that satisfied 2013 PQRS will be granted the option of having payment adjusted based on quality and cost.[11] By 2017, this payment modifier will be applied to all Medicare physician payments. Higher-value providers will receive across-the-board Medicare bonuses, whereas lower-value providers will be penalized. As part of this program, CMS will provide the practice with Quality Resource and Use Reports that compare the practices' quality and cost with other similar practices. It is likely that some of the information included in these reports will be made public on the Physician Compare website.

Public Reporting: Physician Compare

Still under development, the CMS Physician Compare website currently includes the physician name, specialty, location, medical school, hospital affiliation, and whether they are accepting new Medicare patients. Soon it also will display whether the physician participated in the e-prescribing program and PQRS, and eventually it will report physician performance

Table 1. Potential Bonuses and Penalties for Not Participating in Various CMS Programs

<table>
<tr><th rowspan="2">Year</th><th colspan="2">eRx</th><th colspan="2">PQRS</th><th colspan="2">MOC</th><th colspan="2">MU</th><th colspan="2">VBPM</th></tr>
<tr><th>Incentive</th><th>Penalty</th><th>Incentive</th><th>Penalty</th><th>Incentive</th><th>Penalty</th><th>Incentive</th><th>Penalty</th><th>Incentive</th><th>Penalty</th></tr>
<tr><td>2011</td><td>1.0%</td><td>None</td><td>1.0%</td><td rowspan="4">No penalties</td><td>0.5%</td><td rowspan="4">No penalties</td><td rowspan="4">Start Medicare or Medicaid</td><td rowspan="4">No penalties</td><td colspan="2" rowspan="4">No program</td></tr>
<tr><td>2012</td><td>1.0%</td><td>-1.0%</td><td>0.5%</td><td>0.5%</td></tr>
<tr><td>2013</td><td>0.5%</td><td>-1.5%</td><td>0.5%</td><td>0.5%</td></tr>
<tr><td>2014</td><td>None</td><td>-2.0%</td><td>0.5%</td><td>0.5%</td></tr>
<tr><td>2015</td><td colspan="2" rowspan="7">Program ends in 2014</td><td rowspan="7">No incentives after 2014</td><td>-1.5%</td><td colspan="2" rowspan="7">Program ends in 2014</td><td rowspan="7">Start Medicaid only</td><td>-1.0%</td><td rowspan="7">Unknown amounts and methods</td><td rowspan="7">Unknown amounts and methods</td></tr>
<tr><td>2016</td><td>-2.0%</td><td>-2.0%</td></tr>
<tr><td>2017</td><td>-2.0%</td><td>-3.0%</td></tr>
<tr><td>2018</td><td>-2.0%</td><td>-4.0%</td></tr>
<tr><td>2019</td><td>-2.0%</td><td>-5.0%</td></tr>
<tr><td>2020</td><td>-2.0%</td><td>-5.0%</td></tr>
<tr><td>2021</td><td>-2.0%</td><td>-5.0%</td></tr>
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NOTE. Table courtesy of Margalit Gur-Arie.
MOC, maintenance of certification; MU, meaningful use; VBPM, value-based payment modifier.