

New Physician Payment Reforms: Opportunities and Challenges for Many Stakeholders as CMS Seeks Comments to the 2016 Physician Fee Schedule Proposed Rule

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On April 16, 2015, President Obama signed into law legislation (H.R. 2, “Medicare Access and CHIP Reauthorization Act of 2015” or “MACRA”)¹ that permanently replaces the sustainable growth rate (“SGR”) formula used for calculating payments to physicians under the Medicare Physician Fee Schedule (“MPFS”). Now that the looming threat of large physician pay cuts that have been projected every year since 2002, and which Congress has acted 17 times to override, is a thing of the past, stakeholders must turn their attention to how to prepare for what comes next.

Indeed, the Centers for Medicare & Medicaid Services (“CMS”) already has started to consider how it will implement the complex payment reforms included in MACRA. On July 8, 2015, CMS issued the Medicare Physician Fee Schedule Proposed Rule for calendar year (“CY”) 2016 (“MPFS Proposed Rule”). CMS seeks comments on a number of issues related to the development of the merit-based incentive payment systems (“MIPS”) program and physician participation in alternative payment models (“APMs”).² **Comments to the MPFS Proposed Rule are due to CMS by 5 p.m. on September 8, 2015.**³

¹ Pub. L. 114-10 (enacted Apr. 16, 2015).

² The MPFS Proposed Rule will be published in the *Federal Register* on July 15, 2015. The pre-publication version of the MPFS Proposed Rule is available at https://www.federalregister.gov/articles/2015/07/15/2015-16875/medicare-programs-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions?utm_campaign=pi+subscription+mailing+list&utm_medium=email&utm_source=federalregister.gov.

³ Another example of recent rulemaking by CMS that impacts physician payments, while not the focus of this Client Alert, is the proposed rule seeking comments on the proposed establishment of a new Comprehensive Care for Joint Replacement (“CCJR”) Model. CMS issued this proposed rule on July 9, 2015, and comments to the proposed rule are due by 5 p.m. on September 8, 2015. The proposed rule will be published in the *Federal Register* on July 14, 2015. The pre-publication version of the proposed rule is available at <https://www.federalregister.gov/articles/2015/07/14/2015-17190/medicare-program-comprehensive-care-for-joint-replacement-payment-model-for-acute-care->

The elimination of the SGR and the push towards pay-for-performance programs and provider participation in quality MIPS and APMs presents new opportunities and challenges not only for physicians but also for the entire health care industry—from hospitals understanding how to engage with physicians in APMs, to other providers, suppliers, and drug/device manufacturers learning how to impact measure development and program design in a manner that allows them to forge partnerships with physicians participating in these programs; from vendors and suppliers offering products and services to help physicians be successful under the new physician payment mechanisms, to professional societies advocating on behalf of their members so that they can be successful participants in these new programs; and from private payers implementing their own innovative payment mechanisms, to a broader understanding for all stakeholders of how to achieve legislative goals in the post-SGR world. For all these entities, there will be no shortage of complex and evolving rules and requirements to understand and act upon as the health care delivery and payment landscape continues to change in the coming years.

In considering how to engage with CMS in the implementation process, and whether to submit comments to the MPFS Proposed Rule, stakeholders should think about the following questions:

- How will physicians be paid going forward?
- What is the timeline for the overhaul of the physician payment system?
- What issues is CMS seeking comment on now, and what will future rulemaking address?
- Who will be influential to CMS, as the agency implements the payment reforms included in the new law?

The answers to these questions are addressed below.

How Will Physicians Be Paid Going Forward? A Summary of the New Medicare Physician Payment Mechanisms Under MACRA

Congress has established a three-phased approach to transitioning away from the SGR and basing physician payments instead on quality performance and participation in APMs.

Phase 1: Five-Year Period of Consistent Updates

The first phase is a period of consistency in Medicare physician payments, as CMS ramps up to implement the new payment system. MACRA provides for annual updates of 0.5% for a five-year period, from July 1, 2015, through the end of 2019. This moves

[hospitals?utm_campaign=pi+subscription+mailing+list&utm_medium=email&utm_source=federalregister.gov](https://www.fda.gov/hospitals?utm_campaign=pi+subscription+mailing+list&utm_medium=email&utm_source=federalregister.gov). Additional information about the CCJR Model is available at <http://innovation.cms.gov/initiatives/ccjr/>.

physician payments away from the SGR formula, which was created to limit Medicare expenditures for physician services if such payments exceeded an annual spending target tied to overall economic growth.

Phase 2: Opportunity for Payment Adjustments or Bonus Payments

In the second phase, there will be no annual updates to the Medicare payment rates from 2020 through the end of 2025. However, physicians have two opportunities for payment adjustments or bonus payments: (1) through participation in the MIPS program, or (2) through participation in a qualifying APM.

Merit-Based Incentive Payment System

For payments on or after January 1, 2019, physicians will have the opportunity to receive adjustments to their traditional fee-for-service (“FFS”) Medicare payments through participation in MIPS, an incentive-based payment program that rewards quality performance related to four assessment categories:

- Quality of care measures,⁴
- Resource use,⁵
- Meaningful use of electronic health records (“EHRs”),⁶ and
- Clinical practice improvement activities.⁷

Physicians will receive a positive or negative payment adjustment based on how their composite performance score for each of the four assessment categories compares to a base performance threshold. Namely, physicians will be eligible for incentive payments if they achieve high-quality performance and continue to improve their performance annually, when compared to the base performance threshold. Providers falling below the base performance threshold will be subject to negative adjustments at increasing percentages.

Negative payment adjustments are capped at 4% in 2019, 5% in 2020, 7% in 2021, and 9% in 2022 and beyond. Positive payment adjustments, which must be paid out in an amount equal to the total negative payment adjustments across all providers, can reach up to a maximum of three times the annual cap for negative payment adjustments in a

⁴ This would include measures currently in use under the Physician Quality Reporting System.

⁵ This would include measures of resource use established for the Value-Based Payment Modifier Program and, as feasible and applicable, accounting for the cost of drugs under Medicare Part D.

⁶ This would include the requirements established under current law for determining whether an eligible professional is a meaningful user of EHRs.

⁷ These activities would be specified by the Secretary of Health and Human Services (“HHS”). See Clinical Practice Improvement Activities, pp. 8-9 of this Client Alert, for further details.

particular year (i.e., 12%, 15%, 21%, and 27%, respectively).⁸ There also is an opportunity for “exceptional performers” to receive additional incentive payments, up to 10% of their FFS Medicare payments per year. These additional incentive payments for “exceptional performers” will be capped at \$500 million per year for each of 2019 through 2024. Physicians who do not report any MIPS quality metrics will automatically be given the lowest score and see the maximum downward adjustment, unless one of the applicable exceptions applies.⁹

Alternative Payment Models

Alternatively, physicians who receive a significant share of their revenue through participation in a qualifying APM from 2019 through 2024 will receive an annual lump-sum bonus of 5% of estimated MPFS payments for the preceding year. The bonus payment would be in addition to any shared savings bonuses or fees that the physician might receive for participating in the APM.

APMs are defined in MACRA to include models being tested by the Center for Medicare and Medicaid Innovation (“CMMI”) (other than health care innovation awards), accountable care organizations (“ACOs”) participating in the Medicare Shared Savings Program, models tested under the Health Care Quality Demonstration Program, and other demonstrations required by federal law.

Further, qualifying APMs are those that require participating providers to take on “more than nominal” financial risk,¹⁰ report quality measures that are comparable to the measures adopted under MIPS, and use certified EHR technology.

To qualify as an APM participant, providers must meet increasing thresholds for the percentage of their revenue that they receive through qualifying APMs. The APM requirements are phased in as follows:

- In 2019 and 2020, 25% of Medicare payments for covered professional services must be attributable to services furnished through an APM.

⁸ The Secretary may apply a scaling factor of up to 3.0 times the applicable percentage adjustment (i.e., 4%, 5%, 7%, or 9%) in order to ensure budget neutrality.

⁹ These exceptions include participants in APMs; certain providers that partially qualify as APM participants and who did not report on applicable MIPS measures in the performance year; and certain providers that meet the “low-volume threshold,” to be defined by the Secretary based on a combination of minimum number of Medicare beneficiaries, service volume, and/or allowed charges. Further, providers that enroll in Medicare for the first time during a performance year are exempt from MIPS until the subsequent performance year.

¹⁰ As an alternative to the financial risk requirement, providers participating in medical homes may qualify as an APM participant if the medical home meets the criteria for expansion of CMMI demonstration programs under Section 1115A(c) of the Social Security Act (i.e., that the program is expected to reduce Medicare spending without reducing the quality of care, or improve the quality of patient care without increasing spending; that the Chief Actuary of CMS certifies that such expansion would reduce (or would not result in any increase in) net program spending; and that the Secretary determines that such expansion would not deny or limit the coverage or provision of benefits for applicable individuals).

- In 2021 and 2022, 50% of Medicare payments for covered professional services must be attributable to services furnished through an APM or 50% of all-payer revenue (of which at least 25% is from Medicare payments for covered professional services) must be attributable to services furnished through an APM.
- In 2023 and beyond, 75% of Medicare payments for covered professional services must be attributable to services furnished through an APM or 75% of all-payer revenue (of which at least 25% is from Medicare payments for covered professional services) must be attributable to services furnished through an APM.¹¹

Providers that receive a bonus payment for participation in an APM are excluded from participation in MIPS. Providers that are below but close to the required level of APM revenue also may be exempted from participation in MIPS; however, they will not receive a bonus payment for participation in an APM.

Phase 3: Updates Based on Participation in Alternative Payment Models

In the third phase, starting in 2026 and subsequent years, annual updates will differ based on whether a physician is participating in an APM that meets certain criteria. Physicians participating in qualifying APMs will receive a 0.75% update, and all other physicians will receive a 0.25% update. This two-track system creates an incentive for physicians to accept risk-based payments, instead of the traditional FFS Medicare payments, because the differential annual update is cumulative from year to year and therefore APMs would be paid increasingly more each year relative to non-APMs.¹²

What Is the Timeline for the Overhaul of the Physician Payment System? A Summary of MACRA Implementation Considerations Over the Next Five Years

Timeline for Implementation of Payment Reforms: Key Activities Over the Next Five Years

2015	Enactment of MACRA
	<ul style="list-style-type: none"> • CMS must start to consider how to combine existing Medicare quality/pay-for-performance programs into the MIPS program and how to test new APMs to encourage widespread physician participation <ul style="list-style-type: none"> ◦ CMS is seeking comments in the MPFS Proposed Rule for CY 2016 on (1) developing the MIPS program and (2) identifying qualifying APMs ◦ CMS also plans to issue a Request for Information (“RFI”) addressing implementation of the lump-sum bonus payments and higher payment updates for physicians participating in APMs

¹¹ CMS has the discretion to use counts of patients, instead of percentages of Medicare and/or other payer revenue, for purposes of identifying qualifying APM participants.

¹² CMS Office of the Actuary, Letter from Paul Spitalnic, Chief Actuary, Estimated Financial Effects of the Medicare Access and CHIP Reauthorization Act of 2015 (H.R. 2) (Apr. 9, 2015), *available at* <http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/2015HR2a.pdf>.

- The Comptroller General must make initial appointments to the Physician-Focused Payment Models Technical Advisory Committee by October 13, 2015
- During this time, physicians/interested stakeholders should be assessing:
 - Current data collection and quality measure reporting capabilities,
 - Potential investments in technology/EHRs,
 - Implementation of practice changes and process improvements to facilitate participation in MIPS or an APM,
 - Capacity to report quality measures and/or participate in risk-bearing APMs, and
 - Potential recommendations for new quality measures and/or APMs
- Physicians/interested stakeholders also should consider the submission of comments to the MPFS Proposed Rule by September 8, 2015

2016	Stakeholder Input
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- CMS is likely to identify 2017 as the first performance period¹³ for the MIPS program and therefore must engage in rulemaking to implement aspects of the MIPS program related to quality measures and reporting requirements (the MPFS proposed and final rules for CY 2017 will be published in late June/early July 2016 and early November 2016, respectively)
- CMS also must identify APM criteria for use by the Physician-Focused Payment Models Technical Advisory Committee to assess physician-focused payment models by November 1, 2016
- CMS may begin providing technical assistance and guidance to small practices and practices in health professional shortage areas with respect to the MIPS performance categories or how to transition to the implementation of and participation in an APM
- Physicians/interested stakeholders should be:
 - Reviewing/assessing CMS proposals related to the implementation of the MIPS program and identification of qualifying APMs,
 - Submitting comments in response to these CMS proposals, and
 - Continuing to improve quality reporting capabilities, implement technology/EHRs, and engage in process improvement activities

2017	First Performance Period Under MIPS
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- CMS must provide feedback to MIPS-eligible professionals on quality and resource-use performance starting on July 1, 2017; information on the clinical practice improvement activities and meaningful EHR use categories could also be provided
- CMS may start providing detailed responses on the CMS website to comments and recommendations provided by the Physician-Focused Payment Models Technical Advisory Committee in response to proposals for physician-focused payment models that individuals and stakeholder entities believe meet the APM criteria
- CMS must determine how to establish:
 - The threshold options for determining if a professional is a qualifying or partial-qualifying APM participant (including the Medicare payment

¹³ The performance period for a payment year must begin and end prior to the beginning of the year in which the incentive payments would be paid.

<ul style="list-style-type: none"> threshold option and the combination all-payer and Medicare payment threshold option); <ul style="list-style-type: none"> ○ The time period used to calculate eligibility for qualifying and partial-qualifying APM participants, eligible APM entities, quality measures, and EHR use requirements; and ○ The definition of “nominal financial risk” for eligible APM entities • Physicians/interested stakeholders planning to participate in the MIPS program should be considering which measures they will report for purposes of assessment for the first performance period, and how they will report them—as an individual, as part of a group practice, or as part of a virtual group 	
2018	Performance Evaluation and Second Performance Period Under MIPS
<ul style="list-style-type: none"> • CMS must make available to each MIPS-eligible professional information about items and services furnished to the professional’s patients by other suppliers and providers of services, beginning July 1, 2018 • CMS must evaluate the performance of MIPS-eligible professionals for the first performance period and determine the applicable payment adjustments to those professionals under the MIPS program to be applied in 2019 <ul style="list-style-type: none"> ○ Physicians must be notified of their MIPS adjustment factor for 2019, including any additional adjustment for exceptional performance, no later than December 2, 2018 • CMS must determine which professionals are eligible for the lump-sum bonus payment as qualifying APM participants, and whether a professional is a partial-qualifying APM participant and therefore not subject to the MIPS adjustment factor 	
2019 and Beyond	Payment Adjustments/Bonuses and Ongoing Performance Periods
<ul style="list-style-type: none"> • CMS must make payment adjustments for MIPS-eligible professionals and lump-sum bonus payments for APM participants • CMS and physicians/interested stakeholders must continue to evaluate and adjust the MIPS and APM payment programs 	

What Issues Is CMS Seeking Comment on Now? A Summary of the MPFS Proposed Rule

While MACRA provides the framework for revisions to the physician payment system, there are a lot of details about how the revisions will be implemented that have been left to CMS’s discretion to establish through rulemaking and stakeholder input. CMS has started the process of developing the MIPS and APM payment programs by soliciting comments on a few defined areas in the MPFS Proposed Rule. However, CMS also invites comments more broadly on any topics related to the implementation of these programs.

Considerations for Implementation of MIPS

In the MPFS Proposed Rule, CMS is seeking comments on the following provisions related to implementation of the MIPS program:

Low-Volume Threshold

Eligible professionals may be excluded from the MIPS program if they meet the low-volume threshold adopted by CMS. The low-volume threshold may be based on one or more or a combination of the following factors: (1) the minimum number of Medicare Part B beneficiaries who are treated by the eligible professional for the performance period involved, (2) the minimum number of items and services furnished to Medicare Part B beneficiaries by such professional for such performance period, and (3) the minimum amount of allowed charges billed by such professional under Medicare Part B for such performance period.

CMS seeks comments on how to establish the low-volume threshold, including what would the appropriate thresholds be for each factor, which factors should CMS use, and whether CMS should use only one factor or a combination of factors to establish the threshold. CMS suggests, for example, that it could consider excluding eligible professionals who do not have at least 10% of their patient volume derived from Medicare Part B encounters from participating in MIPS. CMS modeled this example off of the Medicaid patient volume thresholds established for participation in the Medicaid EHR Incentive Program, and CMS seeks comments on this approach as well as the applicability of already existing low-volume thresholds used in other CMS reporting programs.

Clinical Practice Improvement Activities

CMS must identify clinical practice improvement activities to be included in the fourth performance category that will be used in determining composite performance scores under the MIPS program. “Clinical practice improvement activities” are defined as activities that relevant eligible professional organizations and other relevant stakeholders identify as improving clinical practice or care delivery and that are likely to result in improved outcomes.

In the MPFS Proposed Rule, CMS seeks comments on what activities should be classified as clinical practice improvement activities under the following subcategories defined in MACRA:

- Expanded practice access, such as same-day appointments for urgent needs and after-hours access to clinician advice;
- Population management, such as monitoring health conditions of individuals to provide timely health care interventions or participation in a qualified clinical data registry;
- Care coordination, such as the timely communication of test results, timely exchange of clinical information to patients and other providers, and use of remote monitoring or telehealth;

- Beneficiary engagement, such as the establishment of care plans for individuals with complex care needs, beneficiary self-management assessment and training, and use of shared decision-making mechanisms;
- Patient safety and practice assessment, such as through use of clinical or surgical checklists and practice assessments related to maintaining certification; and
- Participation in an APM.

Considerations for Developing and Encouraging Participation in APMs

CMS anticipates publishing an RFI later this year specifically addressing implementation of the lump-sum bonus payments and higher payment updates for physicians participating in APMs. CMS lists the following topics to be addressed in the forthcoming RFI:

- The criteria for assessing physician-focused payment models;
- The criteria and process for the submission of physician-focused payment models for consideration as qualifying APMs;
- The threshold options for determining if a professional is a qualifying or partial-qualifying APM participant (including the Medicare payment threshold option and the combination all-payer and Medicare payment threshold option);
- The time period to use to calculate eligibility for qualifying and partial-qualifying APM participants, eligible APM entities, quality measures, and EHR use requirements; and
- The definition of “nominal financial risk for eligible APM entities.”

In the meantime, CMS invites comments through the MPFS Proposed Rule on approaches to implementing the APM-focused revisions to the physician payment system, including addressing the topics listed above or other related concerns.

Federal Fraud and Abuse Laws

Further, CMS is required to undertake two studies relating to the impact of federal fraud prevention laws and regulations on the promotion of APMs and gainsharing arrangements.¹⁴ To help inform these reports, CMS solicits comments in the MPFS

¹⁴ Section 107(e)(7) of MACRA requires the Secretary, in consultation with the Office of Inspector General (“OIG”), to study and report to Congress on fraud related to APMs under the Medicare program. Section 512(b) of MACRA requires the Secretary, in consultation with OIG, to submit to Congress a report with options for amending existing fraud and abuse laws and regulations through exceptions, safe harbors, or other narrowly tailored provisions to permit gainsharing arrangements that would otherwise be subject to civil money penalties in paragraphs (1) and (2) of Section 1128A(b) of the Social Security Act and similar

Proposed Rule on the impact of the physician self-referral law¹⁵ on health care delivery and payment reforms, as well as perceived barriers to achieving clinical and financial integration posed by the physician self-referral law and the need for guidance with respect to physician compensation that is unrelated to participation in APMs. CMS has identified the following topics and questions for public comment:¹⁶

- Does the physician self-referral law pose barriers to or limitations on achieving clinical and financial integration?
- Do the “volume or value” standard (i.e., the requirement that the compensation paid under an arrangement is not determined in a manner that takes into account the volume or value of referrals by the physician who is a party to the arrangement) and the “other business generated” standard (i.e., the requirement that compensation is not determined in a manner that takes into account other business generated between the parties) pose barriers to or limitations on achieving clinical and financial integration?
- Which exceptions to the physician self-referral law apply to financial relationships created or necessitated by APMs?
- Is there a need for new exceptions to the physician self-referral law to support APMs?
- What conditions should CMS place on such financial relationships to protect against program or patient abuse?
- Which aspects of APMs are particularly vulnerable to fraudulent activity?
- Is there a need for new exceptions to the physician self-referral law to support shared savings or “gainsharing” arrangements?
- Should certain entities, such as those considered to provide high-value care to Medicare beneficiaries, be permitted to compensate physicians in ways that other entities may not?
- Could existing exceptions, such as the exception at 42 C.F.R. §411.357(n) for risk-sharing arrangements, be expanded to protect certain physician compensation, for example, compensation paid to a physician who participates in

arrangements between physicians and hospitals that improve care while reducing waste and increasing efficiency.

¹⁵ Section 1877 of the Social Security Act (42 U.S.C. §1395nn), commonly referred to as the “Stark Law.”

¹⁶ Additional details and questions related to these topics are discussed in Section III.N.9.d. of the MPFS Proposed Rule and available at https://www.federalregister.gov/articles/2015/07/15/2015-16875/medicare-programs-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions?utm_campaign=pi+subscription+mailing+list&utm_medium=email&utm_source=federalregister.gov.

an alternative care delivery and payment model sponsored by a non-federal payer?

- Have litigation and judicial rulings on issues such as compensation methodologies, fair market value, or commercial reasonableness generated a need for additional guidance from CMS on the interpretation of the physician self-referral law or the application of its exceptions?
- Is there a need for revision to or clarification of the rules regarding indirect compensation arrangements or the exception at 42 C.F.R. §411.357(p) for indirect compensation arrangements?
- Given the changing incentives for health care providers under delivery system reform, should certain compensation be deemed not to take into account the volume or value of referrals or other business generated by a physician?

What Will Future Rulemaking Address?

Additional Considerations and Opportunities for Stakeholder Input

Although CMS has started soliciting comments on the implementation of the MIPS and APM programs, there will be ample opportunity in the coming years for stakeholders to help shape these programs. The biggest areas for stakeholder input include numerous operational details related to the implementation of MIPS, the selection of metrics to be used under the MIPS program, and the identification of qualifying APMs.

Operational Considerations for Implementation of MIPS

Physicians participating in the Medicare program are currently subject to a number of incentive programs, including the Physician Quality Reporting System (“PQRS”) that incentivizes professionals to report on quality of care measures, the Value-Based Modifier (“VBM”) that adjusts payment based on quality and resource use in a budget-neutral manner, and the Meaningful Use of Electronic Health Records (“EHR MU”) program that requires physicians to meet certain requirements in the use of certified EHR systems.

MACRA requires CMS to streamline these various incentive programs and bring them all under MIPS, starting in 2019. CMS must determine how to aggregate quality metrics from the three programs into a combined MIPS score; establish performance standards based on historical performance, improvement, and opportunity for continued improvement; define a performance period for the reporting of quality metrics; and offer a single incentive payment based on how a provider’s MIPS score compares to that of the provider’s peers.

Further, CMS must determine the weights given to the various components of the MIPS score, and how those weights will evolve over time. The weighting associated with the four assessment categories used to calculate the overall MIPS score may change as follows:

- Quality of care measures—50% (or greater, depending on the total adjustment related to the resource use measures) of the total adjustment in 2019, 45% (or greater) of the total adjustment in 2020, and 30% of the total adjustment in 2021;
- Resource use—up to 10% of the total adjustment in 2019, up to 15% of the total adjustment in 2020, and 30% of the total adjustment in 2021;
- Meaningful use of electronic health records—25% of the total adjustment;¹⁷ and
- Clinical practice improvement activities—15% of the total adjustment.

The types of health care professionals eligible to participate in MIPS also may evolve over time. In the first and second year of the MIPS program, only physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists (including groups that include such professionals) would be eligible for the MIPS program incentives. CMS has the authority to add other health care professionals who would be eligible for the MIPS program in subsequent years, including physical or occupational therapists, speech-language pathologists, audiologists, certified nurse midwives, clinical social workers, clinical psychologists, and registered dietitians or nutrition professionals.

Selection of MIPS Quality and Clinical Practice Improvement Metrics

CMS has the discretion to determine the quality measures and clinical practice improvement activities that will be required under the MIPS program, but CMS also must accept input on these metrics from all stakeholders (not just physicians).

Further, in identifying appropriate metrics and establishing the MIPS program, CMS must address a number of considerations, including (among others) how it will:

- ensure that all “quality domains” (defined as clinical care, safety, care coordination, patient and caregiver experience, and population health and prevention) are addressed;
- encourage the use of qualified clinical data registries;
- emphasize the application of outcome measures, and adopt global outcome measures and population-based measures;
- develop care episode and patient condition groups and classification codes, as well as patient relationship categories and codes, to improve the measurement of resource use;

¹⁷ If the proportion of eligible professionals who are meaningful EHR users is 75% or greater, the Secretary may reduce the percent applicable to the meaningful use assessment category, but not below 15%. If the Secretary makes a reduction to the percentage applicable to the meaningful use assessment category for a year, the percentages applicable to one or more of the other assessment categories must be increased by an amount equal to the reduction made to the meaningful use assessment category.

- use measures from other payment systems, where appropriate;
- assess the performance of group practices;
- give consideration to the circumstances of small practices (consisting of 15 or fewer professionals) and practices located in rural areas and in health professional shortage areas;
- establish capabilities for providers to participate as part of virtual groups;
- give consideration to the circumstances of professionals who do not typically provide services that involve face-to-face interactions with patients; and
- determine appropriate adjustments (to scores for measures, activities, or performance categories; composite performance scores; or payment adjustments) under the MIPS program based on health status of individuals and other risk factors.

Once CMS establishes the final list of quality measures for a performance period (the first of which is likely to be included in the MPFS final rule, which will be published in November, 2016), MIPS eligible professionals will have the ability to choose which measures they will report for purposes of assessment for that performance period. This is an important decision, because not only will their performance on these measures determine their eligibility for payment adjustments, but their performance score will also be publicly reported on the CMS Physician Compare website. Therefore, eligible professionals will have to carefully consider which metrics they choose to report, and how they will report them—as an individual, as part of a group practice, or as part of a virtual group.

For providers, suppliers, and drug/device manufacturers that want to influence the metrics used for the MIPS program, it will be important for them to understand what metrics are currently in use under the various quality programs, what existing metrics may no longer be meaningful or may need to be updated, what additional metrics may be relevant to their practice area or expertise, and the process established by MACRA for identifying metrics for the MIPS program.¹⁸ Vendors and other entities that support physician practices also should consider how they can help physicians improve performance related to the quality metrics identified under the MIPS program and to successfully report those applicable metrics.

Selection of Qualifying APMs

CMS has the discretion to determine which APMs qualify for lump-sum bonus payments and the higher payment update starting in 2026. CMS does not have to choose from

¹⁸ Priorities and funding for quality measure development are addressed in Section 102 of MACRA, including the required development of a plan for identifying measure development priorities and consideration of stakeholder input.

already existing demonstrations but can identify new or modified APMs as qualifying APMs. As such, MACRA encourages the development of new APMs in several ways.

First, MACRA amends the Social Security Act to add new physician-focused payment and service delivery models to the list of models to be tested by CMMI. These new models include those that focus primarily on specialist physicians' services; those that focus on practices of 15 or fewer professionals; those that focus on risk-based models for small physician practices, which may involve two-sided risk, prospective patient assignment, and relevant and appropriate clinical measures; and those that focus on Medicaid.

Further, CMS must establish the "Physician-Focused Payment Model Technical Advisory Committee" to review and make recommendations on the development of APMs.¹⁹ By November 1, 2016, CMS must establish, through notice and comment rulemaking, criteria that the committee could use for making comments and recommendations on physician-focused APMs. Once these criteria are established, individuals and stakeholder entities may submit proposals to the committee for consideration of physician-focused APMs that meet the criteria. The committee, in turn, will review the stakeholder-submitted APMs and make recommendations to CMS about those models. CMS will have to publish detailed responses to those recommendations on the CMS website.

Accordingly, providers that are not already participating in a CMMI demonstration should now consider what their options are. Should they make investments in the process changes and systems necessary to participate in such demonstrations? Is now the right time to apply to participate in an existing CMMI demonstration or for proposing and/or testing a new or modified APM? Or will they focus on quality performance and reporting efforts in order to be successful under the MIPS program?

Further, providers need to consider when, and to what extent, they are willing to take on "more than nominal" financial risk. For example, 99% of ACOs participating in the Medicare Shared Savings Program currently participate in Track 1 and therefore are not subject to downside financial risk.²⁰ CMS recently published a final rule allowing participants to remain in Track 1 for a second performance period in order to encourage ACOs to stay in the program without being required to take on financial risk before they are ready to do so.²¹ Therefore, for providers already participating in an ACO, they must weigh the options of continuing in an ACO under Track 1 for another three years (thereby potentially forfeiting the 5% bonus payment for participation in an APM in at

¹⁹ Initial appointments to this committee (composed of 11 members appointed by the Comptroller General) must be made by October 13, 2015, and committee members will generally serve three-year terms. Committee members must include individuals with national recognition for their expertise in physician-focused payment models and related delivery of care; no more than five members can be providers of services or suppliers, or representatives of providers of services or suppliers, and no members can be federal employees.

²⁰ CMS, Fast Facts, All Medicare Shared Savings Program (Shared Savings Program) ACOs (Apr. 2015), available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/All-Starts-MSSP-ACO.pdf>.

²¹ See Medicare Shared Savings Program Final Rule, 80 Fed. Reg. 32,692 (Jun. 9, 2015).

least the first year for which bonus payments will be paid, depending on the time period identified for calculating eligibility for qualifying APM participants), moving now to a two-sided risk ACO under Track 2 or the new Track 3, or participating in a different APM.

Professional societies also may play a valuable role in developing and shaping the APMs that qualify for lump-sum bonus payments and the higher payment update starting in 2026. The professional societies should be actively engaged with their membership in determining how to increase participation in APMs, in a manner that makes sense and is feasible for those members. This could include providing education on available APMs, commenting on the criteria that will be used to identify qualifying APMs, helping to establish the quality measures that APMs will be required to report, and potentially providing technical assistance or resources to help members transition to participation in an APM.

Who Will Be Influential to CMS? Ongoing Congressional Oversight

The repeal of the SGR came about as the result of a deal struck between House Speaker John A. Boehner (R-Ohio) and Minority Leader Nancy Pelosi (D-Calif.). Although the bill contained significant compromises on both sides of the aisle, the legislation passed the Senate on April 14, 2015, by a 92-8 vote and passed the House March 26, 2015, by a vote of 392-37. This overwhelming support shows how much Congress wanted to stop being forced to legislate on the SGR each year to avoid pay cuts to physicians. However, it is not likely that Congress is going to remain out of the fray as implementation of the physician payment reforms get underway. Given what members had to agree to or give up in order to get this done, there is likely to be high interest and continued oversight of CMS's implementation to ensure that the reforms are carried out as intended by Congress.

As summarized below, Congress has required a number of reports be provided to it on the implementation of the MIPS program and the process of transitioning providers to participation in APMs, as well as other provisions in MACRA that could impact how care is delivered. These reports will allow Congress to understand how implementation is progressing and consider recommendations for changes to the new physician payment mechanisms in the future.

Table 1: Summary of MACRA-Required Reports to Congress

Due Date	Reporting Entity	Subject of Report
Apr. 16, 2016	HHS Report to Congress	Ways to help providers compare and select certified EHR technology
Apr. 16, 2016	HHS/OIG Report to Congress	Options for amending existing exceptions, safe harbors, or other narrowly targeted fraud and abuse provisions to allow for gainsharing arrangements or other similar arrangements between physicians and hospitals that reduce waste, increase efficiency, and improve care

Due Date	Reporting Entity	Subject of Report
		<p>Consideration of:</p> <ul style="list-style-type: none"> Whether gainsharing provisions should apply to ownership interests, compensation arrangements, and other relationships How the recommendations address accountability, transparency, and quality, including how best to limit inducements to stint on care, discharge patients prematurely, or otherwise reduce or limit medically necessary care Whether a portion of any savings generated by gainsharing and other arrangements (as compared to an historic benchmark or other metric specified by the Secretary to determine the effect of delivery and payment system changes on Medicare expenditures) should accrue to the Medicare program
Jul. 1, 2016	HHS Report to Congress	Feasibility of integrating APMs in the Medicare Advantage payment system
Oct. 16, 2016	GAO Report to Congress	Alignment of quality measures used in public and private programs, and recommendations on how to reduce the administrative burden involved in applying such quality measures
Jan. 1, 2017	GAO Report to Congress	The role of independent risk managers; whether entities that pool financial risk can support small physician practices in assuming financial risk for the treatment of patients; and an analysis of any existing legal barriers to such arrangements
Apr. 16, 2017	HHS/OIG Report to Congress	<p>Applicability of the federal fraud prevention laws to items and services furnished under the Medicare program for which payment is made under an APM</p> <p>Consideration of:</p> <ul style="list-style-type: none"> Aspects of APMs that are vulnerable to fraudulent activity Implications of waivers to such laws granted in support of APMs, including under any potential expansion of APMs Recommendations for actions to be taken to reduce the vulnerability of such APMs to fraudulent activity and, as appropriate, recommendations for changes in federal fraud prevention laws to reduce such vulnerability
Apr. 16, 2017	GAO Report to Congress	<p>Consideration of:</p> <ul style="list-style-type: none"> How the various definitions of “telehealth” used in federal programs can inform the use of telehealth under Medicare Factors that can facilitate or inhibit the use of telehealth under Medicare Potential implications of expanding telehealth in the transformation of payment and delivery systems under Medicare (and Medicaid) How CMS monitors Medicare telehealth payments
Apr. 16, 2017	GAO Report to Congress	<p>Private health insurance incentives for adopting remote patient monitoring technology and services</p> <p>Consideration of:</p> <ul style="list-style-type: none"> The patients, conditions, and clinical circumstances that could most benefit from using such services The barriers to adopting such services under Medicare The challenges in placing a value on remote patient monitoring services under the MPFS in order to reflect accurately the resources involved in furnishing such services

Due Date	Reporting Entity	Subject of Report
July 1, 2017	MedPAC Report to Congress	The relationship between utilization of physician services and Medicare expenditures, and the rates of increase of total utilization and expenditures under Medicare Parts A, B, and D
Dec. 31, 2017	HHS Report to Congress	The use of chronic care management (“CCM”) services by individuals in underserved, rural populations and racial/ethnic minority populations, including the identification of barriers to receiving CCM services and recommendations for increasing the appropriate use of CCM services
July 1, 2019	MedPAC Report to Congress	The effect of 2015-2019 physician payment updates on efficiency, economy, and quality of care
Dec. 31, 2019	HHS Report to Congress	If widespread interoperability of certified EHR technology is not achieved by December 31, 2018: <ul style="list-style-type: none"> • Identify the barriers to widespread interoperability • Provide recommendations for achieving widespread interoperability, including payment adjustments for not being meaningful EHR users and criteria for decertifying certified EHR technology products
July 1, 2021	MedPAC Report to Congress	Final report describing the relationship between physician practice/ordering patterns and total utilization and expenditures
Oct. 1, 2021	GAO Report to Congress	Consideration of: <ul style="list-style-type: none"> • The distribution of composite performance scores and MIPS adjustment factors across types of provider, practice size, geographic location, and patient mix • Recommendations for improving MIPS • The impact of technical assistance funding on the ability of professionals to improve within the MIPS program or transition to an APM • Recommendations for optimizing the use of technical assistance funds
Oct. 1, 2021	GAO Report to Congress	Consideration of: <ul style="list-style-type: none"> • The transition of professionals in rural areas, health professional shortage areas, or medically underserved areas to APMs • Recommendations for removing administrative barriers to practices to participate in such models, including small practices consisting of 15 or fewer professionals, in rural areas, health professional shortage areas, and medically underserved areas

Conclusion

The elimination of the SGR and the push towards pay-for-performance programs and provider participation in APMs is part of a broader trend in the Medicare program and by other health care payers to move in the direction of value-based payment. Indeed, on January 26, 2015, Secretary of Health and Human Services Sylvia M. Burwell announced explicit goals for Medicare to pay providers based on “quality, rather than the quantity of care they give patients.”²²

²² HHS has set a goal of tying 30% of Medicare FFS payments to quality or value through APMs, such as ACOs or bundled payment arrangements by the end of 2016, and tying 50% of payments to these models by the end of 2018. HHS also set a goal of tying 85% of all Medicare FFS payments to quality or value by 2016 and 90% by 2018 through programs such as the Hospital Value-Based Purchasing and the Hospital Readmissions Reduction Programs. See HHS Press Release, Better, Smarter, Healthier: In historic

This trend toward value-based payment presents opportunities and challenges for the entire health care industry, not just physicians. Stakeholders may begin the process of engagement on implementation of these physician payment reforms by considering the submission of comments to the MPFS Proposed Rule this summer.

* * *

*This Client Alert was authored by **Lynn Shapiro Snyder and Lesley R. Yeung**. For additional information about the issues discussed in this Client Alert, please contact one of the authors or the Epstein Becker Green attorney who regularly handles your legal matters.*

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