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CLIENT ALERT

New Opportunity to Comment on Key Components of Medicare Physician Payment Reform: CMS Issues 30-Day Request for Information on MIPS and APMs

by Lesley R. Yeung

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On September 28, 2015, the Centers for Medicare & Medicaid Services ("CMS") issued a request for information ("RFI")[1] seeking comments on two key components of the physician payment reform provisions included in the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA"), the law enacted on April 16, 2015, repealing the sustainable growth rate formula used to update payment rates under the Medicare Physician Fee Schedule.[2] A more detailed discussion of the implementation of the physician payment reforms enacted under MACRA is included in the Epstein Becker Green Client Alert entitled "New Physician Payment Reforms: Opportunities and Challenges for Many Stakeholders as CMS Seeks Comments to the 2016 Physician Fee Schedule Proposed Rule."[3]

> "The implementation of these new physician payment models is critical to CMS's goal of moving away from straight fee-for-service to value-based payments under the Medicare program. Physicians need to focus now on what they will need to do in order to succeed under MIPS and/or APMs. They should take advantage of the opportunity to comment on the RFI so that they are engaged in shaping how these value-based payment models will look over time."
>
> Leslie Norwalk
> Former CMS Acting Administrator

Pursuant to the new Medicare physician payment mechanisms established in MACRA, CMS is currently seeking comments on the implementation of the Merit-Based Incentive Payment System ("MIPS") as well as policy considerations related to physician participation in alternative payment models ("APMs") and the development of physician-focused payment models. The public comment period is open for 30 days. **Comments are due to CMS on October 30, 2015.** CMS also will be hosting two webinars

[1] The RFI was published in the *Federal Register* on October 1, 2015, at 80 Fed. Reg. 59,102, and is available online at http://www.gpo.gov/fdsys/pkg/FR-2015-10-01/pdf/2015-24906.pdf.
[2] Pub. L. 114-10 (Apr. 16, 2015).
[3] The text of this Client Alert is available at http://www.ebglaw.com/content/uploads/2015/07/HCLS-Client-Alert_Implementation-of-the-Medicare-Access-and-CHIP-Reauthorization-Act.pdf.

to provide stakeholders with an opportunity to learn more about CMS's efforts to solicit public comments through the RFI, on October 8, 2015, and October 15, 2015.[4]

CMS has identified a substantial number of areas for stakeholders to comment on, and has only provided a brief window for the submission of such comments. The publication of this RFI is in addition to a request for comments related to the MIPS and APMs that CMS already included in the calendar year 2016 Medicare Physician Fee Schedule Proposed Rule published in July 2015.[5] The need for multiple solicitations for comments demonstrates that the new payment mechanisms are complex and require a good deal of consideration on how to structure them properly, as well as CMS's desire to learn from the experiences that stakeholders already have had with existing performance-based quality reporting programs and APMs.

> "Stakeholders in all areas of health care need to understand how this fundamental shift in physician payments will impact them. In addition to submitting comments to CMS about their experiences with value-based payments, stakeholders should participate in the CMS RFI webinars on October 8 and 15 to get more insight into CMS's current thinking about the implementation of MIPS and the promotion of APMs."
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> Lesley Yeung

Accordingly, all stakeholders (not only physicians but also hospitals, other providers, suppliers, and drug/device manufacturers, technology vendors, professional societies, and private payers, among others) should consider providing their perspective to CMS on the implementation of these physician payment reform provisions. Comments on stakeholders' experiences with what has worked in the past, what could work in the future, and what practical limitations should be taken into account throughout the reform process will help shape the new Medicare physician payment mechanisms going forward.

I. The Implementation of MIPS

Section 101 of the MACRA sunsets payment adjustments under three existing physician quality reporting programs, including the Physician Quality Reporting System ("PQRS"), the Value-Based Payment Modifier, and the Medicare Electronic Health Records ("EHR") Incentive Program, and consolidates these three programs into a new performance-based quality reporting program called MIPS. Positive or negative adjustments will be applied to physician payments under the Medicare Physician Fee Schedule, beginning with payments for items and services furnished on or after January 1, 2019, based on an eligible professional's performance under MIPS.

To implement MIPS, the Secretary of Health and Human Services ("HHS") is required to: (1) develop a methodology for assessing the total performance of each MIPS-eligible professional according to performance standards for a performance period for a year; (2) using that methodology, provide for a composite performance score for each MIPS-

[4] Registration for these webinars is required. *See* http://innovation.cms.gov/Webinars-and-Forums/index.html for registration details.
[5] 80 Fed. Reg. 41,686 (Jul. 15, 2015).

eligible professional for each performance period; and (3) use the composite performance score of the MIPS-eligible professional for a performance period for a year to determine and apply a MIPS adjustment factor to the MIPS-eligible professional for the year. The composite performance score is determined using four performance categories: quality, resource use, clinical practice improvement activities, and meaningful use of certified EHR technology.

Areas for Comment Related to the Implementation of MIPS

CMS has identified 12 areas for comment related to the implementation of MIPS. Examples of the types of questions that CMS has raised, and the areas where CMS is seeking additional information, are included below.

(1) **MIPS-Eligible Professional Identifier and Exclusions—**CMS seeks comments on what specific identifiers (e.g., tax identification number ("TIN"), national provider identifier, unique identifier, etc.) should be used to determine eligibility, participation, and performance under the MIPS performance categories for eligible professionals and virtual groups (i.e., groups of individual eligible professionals or small group practices that can choose to have their MIPS performance tied together).

(2) **Virtual Groups—**CMS seeks comments on requirements for establishing virtual groups, including how to determine the appropriate size, proximity, and number of such virtual groups; how to deal with members of a TIN who elect not to join the virtual group; what type of information to require for the virtual group election process; and how to assess eligibility, participation, and performance of virtual groups.

(3) **Quality Performance Category—**CMS seeks comments on the use of currently available quality data reporting mechanisms, quality data accuracy, and the use of certified EHR technology for reporting quality data. Specifically, CMS questions whether all current reporting mechanisms used under the PQRS should be maintained;[6] how many measures should be used to determine MIPS performance; whether performance should be determined based on the number of National Quality Strategy domains covered or types of measures reported; whether data should be stratified by demographic characteristics such as race, ethnicity, and gender; whether customer satisfaction measures should be considered as part of the quality performance category or as part of the clinical practice improvement activities performance category; how performance criteria should be applied to eligible professionals who do not have enough measures to report; and what data integrity requirements and reporting standards should be implemented to ensure the accuracy, completeness, and reliability of quality data. With respect to the submission of quality data, CMS also questions what

[6] Current reporting mechanisms under PQRS include claims-based reporting; qualified registry reporting; qualified clinical data registry ("QCDR") reporting; direct EHR products; EHR data submission vendor products; Consumer Assessment of Healthcare Providers and Systems ("CAHPS"); and the Group Practice Reporting Option ("GPRO") Web Interface.

12 Areas Where CMS Is Seeking Public Comments:

MIPS-Eligible Professional Identifier and Exclusions

Virtual Groups

Quality Performance Category

Resource Use Performance Category

Clinical Practice Improvement Activities Performance Category

Meaningful Use of Certified EHR Technology Performance Category

Other Measures

Development of Performance Standards

Flexibility in Weighting Performance Categories

MIPS Composite Performance Score and Performance Threshold

Public Reporting

Feedback Reports

should constitute certified EHR technology, and whether the EHR needs to be used to transmit quality data or just to capture and/or calculate quality data metrics.

(4) **Resource Use Performance Category—**CMS seeks comments on what cost or resource use measures should be considered, in addition to the three cost measures currently in use under the Value-Based Payment Modifier program;[7] how Part D drug costs should be measured and calculated under cost or resource use measures; how performance should be assessed under the resource use performance category; and how resource use measures should be aligned with clinical quality measures.

(5) **Clinical Practice Improvement Activities Performance Category—**CMS seeks comments on potential clinical practice improvement activities, on the criteria that should be applicable for all clinical practice improvement activities, and on how measures or other demonstrations of activity may be validated and evaluated under the following subcategories: Promoting Health Equity and Continuity, Social and Community Involvement, Achieving Health Equity, Emergency Preparedness and Response, and Integration of Primary Care and Behavioral Health. CMS also seeks comments on how clinical practice improvement activities should be reported and validated, how performance should be assessed by CMS, and how this performance category should be applied to small practices (with 15 or fewer professionals) and practices located in rural areas and in health professional shortage areas.

(6) **Meaningful Use of Certified EHR Technology Performance Category—**CMS seeks comments on the methodology for assessing performance based on the meaningful use of certified EHR technology under MIPS, potential approaches for scoring an eligible professional's achievement of meaningful use objectives and measures, and how hardship exemptions should be treated.

(7) **Other Measures—**CMS seeks comments on how to incorporate measures used for other payment systems under the quality and resource use performance

[7] The three cost measures used under the Value-Based Payment Modifier program include: (1) Total Per Capita Costs for All Attributed Beneficiaries measure; (2) Total Per Capita Costs for Beneficiaries with Specific Conditions (Diabetes, Coronary artery disease, Chronic obstructive pulmonary disease, and Heart failure); and (3) Medicare Spending per Beneficiary ("MSPB") measure.

categories for MIPS; what types of global and population-based measures should be included in the quality performance category; and what consideration should be given to professional types who do not typically have face-to-face interactions with patients.

(8) **Development of Performance Standards—**CMS seeks comments on the establishment of historical performance standards, the definition and assessment of "improvement," and the identification of opportunities for continued improvement in setting the performance scoring system. CMS also seeks comments on whether improvements in health equity and reductions of health disparities should be considered in the performance scoring system, and whether the Achievable Benchmark of Care (ABC™) methodology[8] should be used to determine the MIPS performance standards for one or more performance categories.

(9) **Flexibility in Weighting Performance Categories—**CMS seeks comments on how to determine if there are sufficient measures and activities applicable and available to each type of eligible professional, and how different scoring weights should be assigned for eligible professionals that cannot be assessed for a particular performance category.

(10) **MIPS Composite Performance Score and Performance Threshold—**CMS seeks comments on how to develop a methodology for assessing the total performance of each MIPS-eligible professional based on performance standards with respect to applicable measures and activities in each of the four performance categories. Further, CMS seeks comments on how to use existing quality and resource use measure data for the establishment of a performance threshold for the first two years of MIPS and how to establish a base threshold for clinical practice improvement activities that can be incorporated into the overall performance threshold.

(11) **Public Reporting—**CMS seeks comments on using a minimum patient threshold or a minimum reliability threshold for publicly reporting MIPS measures and activities on the Physician Compare website. CMS also seeks comments on whether individual and group practice-level quality data should be stratified by race, ethnicity, and gender for purposes of public reporting.

(12) **Feedback Reports—**CMS seeks comments on what types of feedback information should be provided to eligible professionals about their performance in relation to the four performance categories, what mechanisms should be used to provide feedback reports, who should be able to access the feedback reports, and how often feedback reports should be provided.

[8] Kiefe CI, Weissman NW, Allison JJ, Farmer R, Weaver M, Williams OD. Identifying achievable benchmarks of care: concepts and methodology. International Journal of Quality Health Care. 1998 Oct; 10(5):443-7.

II. Physician Participation in APMs and the Development of Physician-Focused Payment Models

The Secretary of HHS is required to create a payment incentive program that applies to eligible professionals who are qualifying APM participants for years 2019 through 2024. Qualifying APM participants who have a specified percent of payments attributable to services furnished through an eligible APM entity may receive an incentive payment equal to 5 percent of the estimated aggregate Medicare Part B payment amounts for covered professional services for the preceding year.

The statute specifies conditions for a qualifying APM participant to receive an incentive payment. Namely, an "eligible APM" is defined to include models under section 1115A of the Social Security Act (other than health care innovation awards); the Shared Savings Program under section 1899 of the Social Security Act; demonstrations under section 1866C of the Social Security Act (the Health Care Quality Demonstration Program); and demonstrations required by federal law. Further, an eligible APM entity must require participants to use certified EHR technology and provide for payment for covered professional services based on quality measures comparable to the MIPS quality measures, and the entity must either bear a more than nominal amount of financial risk for monetary losses under the APM or be a medical home expanded under section 1115A(c) of the Social Security Act. Qualifying APM participants are exempt from participation in MIPS.

Further, to encourage the creation of additional physician-focused payment models, the Secretary of HHS is required to establish a process for stakeholders to propose physician-focused payment models to an independent Physician-Focused Payment Model Technical Advisory Committee ("Committee"). This Committee will review, comment on, and provide recommendations to the Secretary of HHS on proposed physician-focused payment models. The Secretary of HHS must establish criteria for physician-focused payment models for use by the Committee for making comments and recommendations to the Secretary.

a. Areas for Comment Related to Physician Participation in APMs

CMS generally requests information on the following topic areas related to physician participation in APMs:

(1) payment thresholds used to determine if an eligible professional is a qualifying APM participant or a partial qualifying APM participant;

(2) criteria and processes for determining whether an eligible professional is a qualifying APM participant or a partial qualifying APM participant, including how to determine the amount of services furnished through an eligible APM entity;

(3) methodologies for attributing and counting patients in lieu of percentages of payments to determine whether an eligible professional is a qualifying APM participant or a partial qualifying APM participant;

(4) the appropriate type and level of financial risk that should be required to meet the "more than nominal" amount of financial risk threshold for an entity to be considered an eligible APM entity;

(5) criteria for determining which Medicaid APMs should be considered when determining the all-payer portion of the Combination All-Payer and Medicare Payment Threshold Option, including the comparability of state Medicaid medical home models to medical home models expanded under section 1115(A)(c) of the Social Security Act, and which states' models might meet this criteria; and

(6) criteria for identifying eligible APM entities, including criteria for determining the comparability of quality measures used by the entity to MIPS quality measures and criteria for defining the use of certified EHR technology to report quality measures.

b. Areas for Comment Related to the Development of Physician-Focused Payment Models

CMS states that it would like to encourage stakeholders to develop physician-focused payment model proposals that provide eligible professionals with the opportunity to become qualified APM participants and to receive the APM incentive payments. CMS acknowledges that developing and implementing such proposals will take time and resources, and therefore CMS seeks comments now on criteria that would support this development process. Specifically, CMS would like to know:

(1) how "physician-focused payment model" should be defined;

(2) what criteria the Committee should use to assess physician-focused payment model proposals submitted by stakeholders;

(3) what information stakeholders should be required to provide to the Committee for consideration of a proposal, including possible criteria related to the inclusion of participants who have not had the opportunity to participate in another physician-focused payment model; why the proposed model should be given priority and why a model is needed to test the approach; how the proposed payment methodology differs from the current Medicare payment methodology and promotes delivery system reform, background information, and assessments of similar models that have been tested or researched previously; and how the proposed model aims to directly solve a current issue in payment policy that CMS is not already addressing in another model or program; and

(4) what information should be required for a model to be tested through the Center for Medicare & Medicaid Innovation, including information such as the definition of the "target population"; the impact on quality and efficiency of care; the use of quality measures as a basis for payment; the impact on access to care for Medicare and Medicaid beneficiaries; the impact on disparities among

beneficiaries by race, ethnicity, gender, and disability; proposed geographical location(s); the scope of eligible professional participants; the use of certified EHR technology; financial opportunities for model participants; payment mechanisms used in the model; the financial risk for monetary losses; the method for attributing beneficiaries to participants; the estimated impact on Medicare spending; anticipated savings to Medicare and Medicaid; information about similar models used by private payers; the engagement of payers other than Medicare; potential approaches for evaluation of the model; and opportunities for model expansion, if successful.

III. Technical Assistance to Small Practices and Practices in Health Professional Shortage Areas

Finally, under the requirements of MACRA, the Secretary of HHS must provide guidance and technical assistance to small practices (with 15 or fewer professionals). Priority for this assistance is to be given to practices located in rural areas, health professional shortage areas, and medically underserved areas, as well as practices with low composite performance scores under MIPS. Entities such as quality improvement organizations, regional extension centers, and regional health collaboratives may provide the technical assistance, with a focus on the performance standards under MIPS and transitioning to the implementation of, and participation in, APMs, beginning in fiscal year 2016.

In the RFI, CMS seeks comments on how to organize such a technical assistance program and what kinds of support CMS should be offering to help providers understand the requirements of MIPS. Further, CMS seeks information on existing "best in class" educational and assistance efforts for small practices; significant challenges for small practices in quality measurement, the use of certified EHR technology to make practice improvements, and participation in value-based payment and APMs generally; and potential eligibility requirements for a small practice to receive technical assistance.

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This Client Alert was authored by **Lesley R. Yeung**. *For additional information about the issues discussed in this Client Alert, or if you are interested in submitting comments to CMS, please contact the author or the Epstein Becker Green attorney who regularly handles your legal matters.*

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