

MACRA Physician Payment Reform: Time to Take Stock of What Is Working and What Changes Are Needed

By Lesley R. Yeung; Helaine I. Fingold; Philo D. Hall; M. Brian Hall, IV; and
Timothy J. Murphy

August 2017

Executive Summary

The first performance period is currently underway for clinicians subject to the Medicare Part B physician payment reforms enacted under the Medicare Access and CHIP Reauthorization Act of 2015 (“MACRA”). Comments on a new proposed rule are due next week. Therefore, now is the time for stakeholders to take stock of how things are working so far and to consider if any changes should be suggested to the Trump administration regarding how it should approach the Quality Payment Program (“QPP”) in future years.

In November 2016, the Centers for Medicare & Medicaid Services (“CMS”) published a final rule implementing MACRA’s physician payment reforms for the first performance year through the newly created QPP, starting in 2017.¹ In accordance with that final rule, clinicians should now be actively engaged in their QPP participation strategy for the first performance year. Performance in 2017 will determine payment adjustments made under the Medicare Physician Fee Schedule in 2019, based on the “pick your own pace” options that CMS provided in the final rule to ease the transition to the new program for clinicians.

CMS, under the new administration, also recently released a proposed rule addressing continued implementation of the QPP for the second performance year, starting in 2018.² This proposed rule was the new administration’s first opportunity to lay out its vision for the QPP going forward. The proposed rule largely maintains the same course that CMS established in last year’s final rule, with the goals of further easing use, providing stability and meaningfulness, and emphasizing simplicity and scoring that is

¹ 81 Fed. Reg. 77,008 (Nov. 4, 2016).

² 82 Fed. Reg. 30,010 (Jun. 30, 2017).

understandable for participating clinicians. **Comments on the proposed rule are due to CMS by August 21, 2017.**

Background on MACRA's Physician Payment Framework

In April 2015, Congress established a new framework for Medicare Part B physician payments through the passage of MACRA, which CMS has implemented through the QPP. MACRA allows Medicare Part B clinicians to take part in the QPP in one of two ways: through the Merit-Based Incentive Payment System ("MIPS") or through Advanced Alternative Payment Models ("Advanced APMs").

MIPS modifies and consolidates key components of several existing Medicare quality programs: the Physician Quality Reporting System, the Value-Based Payment Modifier Program, and the Medicare Electronic Health Record ("EHR") Incentive Program. MIPS combines these existing programs into a single program that assesses performance across four categories: quality, cost, improvement activities, and advancing care information (related to the electronic exchange of interoperable health information). Beginning in 2019, MIPS-eligible clinicians will receive a positive, neutral, or negative payment adjustment based on how their performance on MIPS-reported measures and activities compares to a baseline performance threshold. Importantly, these payment adjustments will be based on clinician performance data from 2017. Clinicians can choose how much they want to participate in MIPS in 2017 by submitting (i) only a minimum amount of data (i.e., one quality measure or one improvement activity), (ii) 90 days' worth of data, or (iii) a full year's worth of data by the submission deadline. Note that, for the first performance year, ***performance may begin anytime between January 1 and October 2, 2017***, and the ***data submission deadline is March 31, 2018***. Information about a clinician's MIPS participation status for 2017 is available on the QPP website, <https://qpp.cms.gov>.³

An APM is an approach to paying for medical care that incentivizes quality and value through care coordination. Accountable care organizations ("ACOs"), patient-centered medical homes, and bundled payment models are examples of APMs that are currently being tested by CMS. Beginning in 2019 through 2024, Medicare will offer a 5 percent bonus payment to clinicians reaching set thresholds for revenues derived from APMs that qualify as Advanced APMs.⁴ Clinicians eligible for the Advanced APM bonus payment will be exempt from MIPS payment adjustments and, beginning in 2026, will receive a higher annual payment update under the Medicare Physician Fee Schedule than clinicians not participating in an Advanced APM. In the proposed rule, CMS also lays out the process for allowing clinicians to be eligible for the Advanced APM bonus through participation in both Medicare and Other Payer Advanced APMs (called the "All-Payer Combination Option"), which will be available starting in performance year 2019 (for bonus payments in 2021).

³ Note that CMS will be updating the look-up tool on the QPP website to reflect MIPS participation status for 2017 based on claims data from September 1, 2016, through August 31, 2017.

⁴ Information about the APMs that qualify as Advanced APMs, including links to information about how to apply for these models, is available on the QPP website, <https://qpp.cms.gov/apms/overview>.

MIPS Program Details and Opportunities for Public Comment for 2018

Are you required to participate in MIPS?

CMS has not changed the definition of a “MIPS-eligible clinician,” which was finalized in last year’s final rule. However, CMS proposes to clarify which Part B services are included for eligibility determinations and subject to MIPS payment adjustments. For example, when a MIPS-eligible clinician prescribes Part B drugs or orders durable medical equipment that are billed by another supplier, charges related to those types of services may not be attributed to the MIPS-eligible clinician for purposes of eligibility determinations and payment adjustments.

For group practices, CMS proposes to clarify that a “group,” for purposes of performance assessment, is either an entire single tax identification number (“TIN”) or a portion of a TIN that (i) is participating in MIPS while the remaining portion of the TIN participates in an APM subject to the MIPS APM scoring standard and (ii) chooses to participate in MIPS at the group level. CMS seeks comments on options for permitting portions of groups to report and be assessed as a separate subgroup on measures and activities that are more relevant to that subgroup.

Starting in 2018, CMS proposes to allow clinicians to participate in MIPS through virtual groups. CMS proposes to define a “virtual group” as a combination of two or more TINs composed of a solo practitioner who bills under a TIN (with no other National Provider Identifiers (“NPIs”) billing under such TIN), or a group with 10 or fewer eligible clinicians under the TIN that elects to form a virtual group with at least one other such solo practitioner or group for a performance period.⁵ Eligible clinicians and groups participating in a virtual group would receive a MIPS payment adjustment based on the virtual group’s combined performance assessment. Virtual groups would be required to meet reporting requirements for each measure and activity. The virtual group would have to ensure that its measures are aggregated across the virtual group. CMS proposes that eligible clinicians and groups elect to be in a virtual group by December 1 of the calendar year preceding the applicable performance period.⁶

A MIPS-eligible clinician is identified by a unique billing TIN and NPI combination used to assess performance and includes any of the following:

- (1) A physician*
- (2) A physician assistant, a nurse practitioner, and clinical nurse specialist*
- (3) A certified registered nurse anesthetist*
- (4) A group that includes such clinicians*

CMS also proposes to modify its definition of “non-patient facing MIPS-eligible clinician” to include individual MIPS-eligible clinicians who bill 100 or fewer patient-facing encounters (including Medicare telehealth services) during the determination period, and a group or virtual group, provided that more than

⁵ Clinicians and groups are not eligible to join a virtual group if they do not exceed the low-volume threshold.

⁶ There are no restrictions on the size of a virtual group. Virtual groups that are comprised of 15 or fewer eligible clinicians may qualify as small practices that are eligible for the small practice bonus.

75 percent of the NPIs billing under the group's TIN or within the virtual group meet the definition of a "non-patient facing MIPS-eligible clinician."

Are you excluded from MIPS?

*Clinicians **excluded** from MIPS include the following:*

- (1) Qualifying APM participants ("QPs") in an Advanced APM*
- (2) Partial QPs who choose not to report under MIPS*
- (3) Low-volume threshold clinicians*
- (4) New Medicare-enrolled clinicians*

The categories of clinicians who are excluded from participation in MIPS have not changed. However, CMS proposes to modify the low-volume threshold policy to increase the applicable dollar amount and beneficiary count in order to allow for more clinicians to be excluded from MIPS participation in 2018. Individual eligible clinicians or groups that have Medicare Part B allowed charges less than or equal to \$90,000 or that provide care for 200 or fewer Part B-enrolled Medicare beneficiaries would be excluded from MIPS for that year's performance period. Note that there are no exceptions in 2017 for clinicians who are not currently excluded from MIPS but would

be excluded in 2018 based on the new low-volume threshold.

How and when do you report MIPS data?

For 2017, MIPS-eligible clinicians must submit measures and activities for the quality, improvement activities, and advancing care information performance categories using only one submission mechanism per performance category. For 2018, CMS proposes to allow individual MIPS-eligible clinicians and groups to submit data on applicable measures and activities via multiple data submission mechanisms for a single performance category.

For the 2020 payment year, the performance period for the quality and cost performance categories is January 1, 2018, through December 31, 2018. The performance period for the improvement activities and advancing care information performance categories is a minimum of a continuous 90-day period within 2018, up to and including the full calendar year. The data submission deadline is March 31, 2019.

How will performance category reporting change?

Reporting will change in each category as follows:

- **Quality**—for 2018, the quality performance category will have a weight of 60 percent of a clinician's final performance score (as opposed to 50 percent, as discussed in last year's final rule). CMS proposes to revise the previously established data completeness criteria for 2018. Clinicians and groups must submit quality measure data using the Qualified Clinical Data Registry, qualified registry, or EHR submission mechanism on at least 50 percent of the patients that meet the measure's denominator criteria, regardless of payer. Measures that

do not meet data completeness standards will receive one point, except that small practices would continue to receive three points for measure submission, even if the data is not complete.

CMS proposes to add new quality measures, remove quality measures, and revise the specialty measure sets for 2018. These changes to the quality measures are described, in detail, in tables included in the appendix of the proposed rule.⁷ CMS also proposes to remove cross-cutting measures from most of the specialty sets, except for cross-cutting measures in the Family Practice, Internal Medicine, and Pediatrics specialty sets. Further, CMS proposes to allow facility-based clinicians (those who furnish 75 percent or more of their covered professional services in an inpatient hospital or an emergency room) to use their institution's performance rates from the Hospital Value-Based Purchasing Program as a proxy for their quality score.

- **Cost**—CMS proposes to change the weight of the cost performance category from 10 percent to zero for 2018. CMS will continue to determine performance based on the “total per capita cost” measure and the “Medicare spending per beneficiary” measure. However, for 2018, CMS proposes to not include the 10 episode-based measures that were adopted for 2017 because CMS is developing new episode-based measures that will be adopted for future performance periods.
- **Improvement Activities**—for 2018, improvement activities will have a weight of 15 percent of a clinician's final performance score and will be scored based on a clinician's selection of different medium and high-weighted activities. CMS is not proposing to change the number of activities that a clinician must report to receive a full score (40 points). But CMS proposes to add more improvement activities for clinicians to choose from and to make changes to existing improvement activities listed in the Improvement Activities Inventory.⁸ CMS seeks comment on whether it should establish a minimum threshold for clinicians who must complete an improvement activity in order for an entire group to receive credit in the improvement activities performance category, and on recommended minimum thresholds based on group size.
- **Advancing Care Information**—for 2018, the advancing care information performance category will have a weight of 25 percent of a clinician's final performance score. However, CMS proposes to reweight this category to zero for various clinicians, including clinicians:
 - in small practices (15 or fewer individuals) who qualify for a significant hardship exemption; non-patient facing clinicians;
 - who provide 75 percent of their services at an ambulatory surgical center;

⁷ See 82 Fed. Reg. 30,261-30,478 (Jun. 30, 2017).

⁸ See 82 Fed. Reg. 30,479-30,500 (Jun. 30, 2017).

- who are hospital-based, including clinicians at an off-campus outpatient hospital;
- who use certified EHR technology (“CEHRT”) that was decertified by the Office of the National Coordinator’s Health IT Certification Program during the performance period or in the preceding year; and
- who are nurse practitioners, physician assistants, clinical nurse specialists, and certified registered nurse anesthetists.

CMS proposes to allow the use of EHR technology certified to either the 2014 or 2015 Edition certification criteria, or a combination of the two, for 2018. The proposed rule would offer a bonus to MIPS-eligible clinicians who report only using 2015 Edition CEHRT.

How will performance scoring change?

CMS proposes to add an improvement scoring standard to the quality and cost performance categories. Starting in 2018, CMS will measure improvement with respect to quality reporting if the clinician’s quality achievement score exceeds 30 percent. Because clinicians can elect the submission mechanisms and quality measures that are most meaningful to their practice, and these choices can change from year to year, CMS proposes a flexible methodology that allows for improvement scoring even when clinicians change the quality measures they use. CMS hopes that this will encourage clinicians to move away from topped-out measures and toward more outcome measures. The agency proposes to add an explicit regulatory provision that an improvement percent score cannot be negative. CMS will not calculate a cost improvement score until a clinician is scored on the same cost measure(s) for two consecutive performance periods.

Performance Threshold

*To avoid a **negative 5 percent payment adjustment** in 2020, CMS proposes a performance threshold of 15 points (as opposed to three points in 2019).*

*A clinician can **achieve 15 points** by:*

- (1) Reporting all required improvement activities*
- (2) Meeting the advancing care information base score and submitting one quality measure that meets data completeness*
- (3) Meeting the advancing care information base score and submitting one medium-weighted improvement activity*
- (4) Submitting six quality measures that meet data completeness criteria*

CMS also proposes to adopt complex patient and small practice bonuses that would be added to a clinician’s overall performance score:

- **Complex Patient Bonus**—while CMS continues to seek comments on how to account for social risk factors under MIPS, the agency also proposes an interim adjustment for patients with numerous, complex factors that impact health

outcomes. CMS proposes to calculate the average Hierarchical Conditions Category risk score for a clinician or group and award one to three bonus points to clinicians if their patient population is deemed particularly complex. CMS seeks comment on an alternative complex patient methodology, under which a bonus would be applied based on a clinician's ratio of dual-eligible patients.

- **Small Practice Bonus**—CMS proposes to add a five-point bonus for clinicians, group practices, virtual groups, or “APM Entities” that consist of 15 or fewer clinicians who participate in MIPS by submitting data on at least one performance category in 2018. This is intended to be a short-term, transition strategy for 2018 only. However, CMS will assess, on an annual basis, whether and how to continue the bonus.

Advanced APM Program Details and Opportunities for Public Comment for 2018

CMS continues to encourage clinician participation in Advanced APMs, and estimates that the number of eligible clinicians who are determined to be “Qualifying APM participants” (“QPs”) will increase in 2018. This increase is due to new Advanced APMs expected to be available for participation in 2018, including the Medicare ACO Track 1 Plus Model, and the reopening of the application process for some current Advanced APMs, such as the Next Generation ACO Model and the Comprehensive Primary Care Plus Model.

CMS has determined that Track 1 of the Comprehensive Care for Joint Replacement Model (“CJR”) is an Advanced APM for the 2017 performance period. Therefore, CMS will include episodes ending on or after January 1, 2017, in determinations of QP status. The agency issued a **proposed rule on August 15, 2017**, that would make participation in CJR voluntary in half of the regions that were selected for participation in the bundled payment model.⁹ On one hand, this could decrease the number of hospitals participating in CJR and thus the number of clinicians who could gain QP status through participation in this model. On the other hand, CMS proposes to change the criteria for participant hospitals to identify to CMS those clinicians who perform CJR model activities and who are affiliated with the hospital in order to broaden the number of clinicians who could gain QP status through participation in CJR. CMS proposes to cancel other bundled payment models related to acute myocardial infarction, coronary artery bypass graft, surgical hip/femur fracture, and cardiac rehabilitation that were expected to be implemented this year. But the agency states in the proposed rule that the CMS Innovation Center expects to develop new voluntary bundled payment models during 2018 that would be designed to meet the criteria to be an Advanced APM. This signals that CMS is not moving away from its commitment to continue to increase the number of models that qualify as Advanced APMs.

⁹ See <https://www.federalregister.gov/documents/2017/08/17/2017-17446/medicare-program-cancellation-of-advancing-care-coordination-through-episode-payment-and-cardiac>.

What are the requirements to be an Advanced APM?

To be considered an Advanced APM, an APM must:

- require at least 50 percent of participants to use CEHRT,
- base payment for covered professional services on quality measures comparable to MIPS quality measures (including one outcome measure if there is an applicable outcome measure on the MIPS quality measure list), and
- either require that participating APM Entities bear more than a nominal amount of risk for monetary losses under the APM or be a Medical Home Model expanded under the CMS Innovation Center's authority.

Currently, the total potential risk that APM Entities must bear must be equal to at least either:

- 8 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities for the applicable performance periods (from January 1 to August 31) in 2017 and 2018 (the "revenue-based standard"), or
- 3 percent of the expected expenditures that an APM Entity is responsible for under the APM for all performance years (the "benchmark-based standard").

CMS proposes to extend the 8 percent revenue-based standard for the applicable performance periods in 2019 and 2020. The agency seeks comment on the amount and structure of the revenue-based standard, and whether a different standard should apply to small practices and those in rural areas that are not participating in a Medical Home Model.

What is the timeframe for QP and Partial QP determinations?

A clinician's QP status determines whether that clinician is eligible for the 5 percent bonus payment for participation in an Advanced APM. CMS proposes that an Advanced APM must be actively tested for a minimum of 60 continuous days during the applicable performance period (from January 1 to August 31) in order for payment amount or patient count data to be used for QP determinations for the year.

What are the requirements for the All-Payer Combination Option?

Beginning in performance year 2019, an eligible clinician may qualify as a QP through the All-Payer Combination Option. An eligible clinician ***must participate in an Advanced APM with CMS as well as an Other Payer Advanced APM*** to qualify for this option (i.e., participation in a Medicare Advantage plan alone is not enough). For an eligible clinician, CMS will conduct QP determinations sequentially, so that the agency first looks at an eligible clinician's participation in a Medicare Advanced APM (the

“Medicare Option”) and then at the clinician’s participation in an Other Payer Advanced APM. CMS proposes to conduct QP determinations under the All-Payer Combination Option at the individual eligible clinician level (rather than at the group level) based on data from two time periods (January 1 to March 31 or January 1 to June 30).

To be an Other Payer Advanced APM, a payment arrangement with a payer (for example, payment arrangements authorized under Medicaid, Medicare Health Plan payment arrangements, and payment arrangements in CMS Multi-Payer Models) must meet similar criteria to those that are applicable to Medicare Advanced APMs (i.e., CEHRT use, quality measures, and more than nominal financial risk or qualification as a Medicaid Medical Home Model). CMS previously established that an Other Payer Advanced APM must have marginal risk of at least 30 percent, a minimum loss rate of no more than 4 percent, and total risk of at least 3 percent of the expected expenditures that the APM Entity is responsible for under the payment arrangement. CMS proposes to add a revenue-based standard of 8 percent, as an alternative to the benchmark-based standard.

Other Payer Advanced APMs will be identified annually based on information submitted to CMS by eligible clinicians, APM Entities, and payers through the proposed “Payer-Initiated” and “Eligible Clinician-Initiated” processes. The Payer-Initiated process would be available for Medicaid, Medicare Advantage, and CMS Multi-Payer Models for 2019. CMS intends to allow other payer types (i.e., commercial and other private payers) to request Other Payer Advanced APM determinations for 2020 and beyond.

* * *

All stakeholders are encouraged to consider how changes in the MACRA proposed rule will impact them and provide CMS with comments no later than 5 p.m. (ET) on August 21, 2017. In particular, clinicians should consider whether they have sufficient flexibility with respect to participation in MIPS (e.g., through virtual groups, as small practices, through relaxed reporting requirements) and sufficient options for participating in Advanced APMs (both through Medicare and other payers, and in light of the administration’s new proposed rule on bundled payment models). The administration will be receptive to ideas for simplifying the policies, reducing the burden of QPP on clinicians, and ensuring that QPP requirements do not interfere with patient care.

* * *

*This Client Alert was authored by **Lesley R. Yeung; Helaine I. Fingold; Philo D. Hall; M. Brian Hall, IV; and Timothy J. Murphy. Lauren Farruggia**, a Summer Associate (not admitted to the practice of law) in Epstein Becker Green’s Washington, DC, office, contributed to the preparation of this Client Alert. 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.*

This document has been provided for informational purposes only and is not intended and should not be construed to constitute legal advice. Please consult your attorneys in connection with any fact-specific situation under federal law and the applicable state or local laws that may impose additional obligations on you and your company.

About Epstein Becker Green

Epstein Becker & Green, P.C., is a national law firm with a primary focus on health care and life sciences; employment, labor, and workforce management; and litigation and business disputes. Founded in 1973 as an industry-focused firm, Epstein Becker Green has decades of experience serving clients in health care, financial services, retail, hospitality, and technology, among other industries, representing entities from startups to Fortune 100 companies. Operating in offices throughout the U.S. and supporting clients in the U.S. and abroad, the firm's attorneys are committed to uncompromising client service and legal excellence. For more information, visit www.ebglaw.com.

IRS Circular 230 Disclosure

To ensure compliance with requirements imposed by the IRS, we inform you that any tax advice contained in this communication (including any attachments) is not intended or written to be used, and cannot be used, for the purpose of: (i) avoiding any tax penalty, or (ii) promoting, marketing or recommending to another party any transaction or matter addressed herein.

If you would like to be added to our mailing list or need to update your contact information, please contact Lisa C. Blackburn at lblackburn@ebglaw.com or 202-861-1887.