The Future Of Medicare Physician Reimbursement

Law360, New York (May 13, 2016, 4:16 PM ET) --

On April 27, 2016, just over a year after the Medicare Access and CHIP Reauthorization Act (MACRA) was signed into law, the U.S. Department of Health and Human Services unveiled the long-awaited proposed rule to begin its implementation. The 962-page notice offers important insight for health care providers into how the Centers for Medicare and Medicaid Services will link physician payments to quality care through MACRA.

On April 16, 2015, President Obama signed MACRA into law, marking the end to the unpopular sustainable growth rate and transforming Medicare by moving away from traditional fee-for-service payments. MACRA will limits aggregate Medicare physician payments to a 0.5 percent increase per year through 2019, and will tie 4 percent of a physician's annual Medicare payments to one of two paths: (1) a merit-based incentive payment system (MIPS) for MIPS-eligible professionals, or (2) participation in alternative payment models (APMs).

The expansive April 2016 proposed rule sets forth the details on how CMS proposes to establish these two paths and what will be required of health care providers under each.

10 Major Takeaways

1. The first performance period will occur in 2017.

Under MACRA, beginning in 2019, "MIPS-eligible clinicians" will receive a composite performance score of 0-100 based on an assessment under the four weighted performance standards, described below, which would be compared to a performance threshold. MIPS-eligible clinicians would then receive either positive, negative, or no adjustments based on their composite performance score. CMS proposes to begin measuring performance for doctors and other clinicians through MIPS in 2017, with payments based on those measures to begin in 2019. Similarly, 2017 will be the first performance year for qualified professionals (QPs) participating in APMs.

2. Most covered professionals must report MIPS data in 2017 as such data will be used to determine which clinicians are QPs.

Most Medicare clinicians will submit data in the Quality Payment Program through MIPS in 2017. CMS will use that MIPS data to determine which clinicians meet the requirements for the APM track as QPs.
3. **CMS proposes a broader definition of who will qualify as a "MIPS-eligible clinician."**

The proposed rule defines a "MIPS-eligible clinician" to be a Medicare Part B clinician, including physician, a physician assistant, a nurse practitioner, a clinical nurse specialist, a certified registered nurse anesthetist, and a group that includes such professionals." Medicare Part B clinicians may be exempted from the payment adjustment under MIPS if they are newly enrolled in Medicare, have less than or equal to $10,000 in Medicare charges and less than or equal to 100 Medicare patients, or are significantly participating in APMs.

CMS also distinguishes between "patient-facing" and "non-patient facing" encounters to give consideration to the circumstances of professional types who typically furnish services that do not involve face-to-face interaction with a patient. The proposed rule defines a "non-patient facing MIPS-eligible clinician" as an individual MIPS-eligible clinician or group that bills 25 or fewer patient-facing encounters during a performance period. "Patient-facing" encounters include general office visits, outpatient visits, and surgical procedural codes under the physician fee schedule. CMS also proposes to include telehealth services in the definition of patient-facing encounters. CMS intends to publish the proposed list of patient-facing encounter codes on its website.

4. **Aggregate payment adjustments under MIPS will increase over time.**

The law requires MIPS to be budget neutral, therefore clinicians' MIPS scores will be used to compute a positive, negative, or neutral adjustment to their Medicare Part B payments. Both positive and negative adjustments will increase over time, as follows:

- For 2019, 4 percent
- For 2020, 5 percent
- For 2021, 7 percent
- For 2022 and after, 9 percent

5. **MIPS will pay physicians based on four weighted performance categories.**

Under MACRA, MIPS combined the existing electronic health record (EHR) and meaningful use incentive program, the physician reporting system, and the value-based modifier in hopes of streamlining and reducing the reporting burden and to add flexibility in physician practices. MIPS will assess physicians' performance across four weighted categories, with respective percentage weights changing periodically. The proposed rule further defines these performance categories:

- **Quality (50 percent of total score in year one):** For most MIPS eligible clinicians, clinicians must report a minimum of six measures (versus the nine measures currently required under the physician quality reporting system) with at least one cross-cutting measure (for patient-facing MIPS eligible clinicians) and an outcome measure. If an outcome measure if not applicable, the clinician must instead report one other high priority measure, i.e., appropriate use, patient safety, efficiency, patient experience, or care coordination.

- **Advancing Care Information (25 percent of total score in year one):** Formerly recognized as "meaningful use," clinicians choose to report customizable measures that reflect how they use technology in their day-to-day practice,
with a particular emphasis on interoperability and information exchange. The overall score will be made up of a base score and a performance score.

- **Clinical Practice Improvement Activities (15 percent of total score in year one):** Clinicians are afforded flexibility in selecting activities that match the goals of their practice. CMS proposes that clinicians participate in CPIAs for at least 90 days, with points assigned to over 90 activities. There is no required minimum number of activities to meet this requirement. Clinicians are rewarded for clinical practice improvements, such as activities focused on care coordination, beneficiary engagement, and patient safety.

- **Resource Use (10 percent of total score in year one):** MIPS will calculate scores based on Medicare claims, meaning there is no additional reporting requirement. CMS will continue two measures from the current value-based payment modifier: total cost per capita for all attributed beneficiaries and the Medicare Spending per Beneficiary measure, with adjustments. CMS proposes 40 episode-specific measures to account for differences among specialties.

### 6. Physicians can expect greater public reporting and transparency.

CMS proposes a process for public reporting of MIPS information regarding the performance of MIPS-eligible clinicians or groups through Physician Compare. Beginning July 1, 2017, CMS also proposes to provide clinicians with performance feedback on the quality and resource use categories of MIPS. This is meant to ensure that MIPS results are useful and accurate. The rule also proposes to adopt a targeted review process under which a MIPS eligible clinician may request that CMS review the calculation of the adjustment factor and, as applicable, the calculation of additional MIPS adjustment factors applicable for a given year. There is no further judicial or administrative review available.

### 7. Qualifying for the APM path will become increasingly challenging.

MACRA established that Medicare physicians who participate to a sufficient extent in various APMs could be exempt from the MIPS reporting requirements and qualify for financial bonuses. However, "qualifying participants" (QPs) must meet increasing thresholds for the percentage of their revenue that is received through qualifying APMs. Broadly speaking, APMs are payment models such as accountable care organizations (ACOs) and patient-centered medical homes (PCMHs). The proposed rule defines an "advanced APM" as those in which clinicians accept risk for providing coordinated, high-quality care. An advanced APM must (1) require participants to use certified EHR technology, (2) provide payment for covered professional services based on quality measures comparable to those used in the quality performance category, and (3) be either a medical home model expanded under section 1115A of the Social Security Act or bear more than a nominal amount of risk for monetary loses.

An advanced APM would meet the financial risk requirement if CMS would withhold payment, reduce rates, or require the entity to make payments to CMS if its actual expenditures exceeded expected expenditures. The total amount of risk must be at least 4 percent of the APM spending target. CMS states that it will notify the public on its website of which APMs qualify as advanced APMs prior to the annual performance period, starting no later than 2017.

### 8. Starting in 2021, CMS will include the all-payer combination option.
Starting in performance year 2021, clinicians can qualify for incentive payments based in part on participation in advanced APMs developed by Medicare Advantage plans and non-Medicare payers, such as private insurers or state Medicaid programs. If clinicians do not meet the required percentage of payments provided or patients cared for through an advanced APM through Medicare alone, then payments and patients under payers beside Medicare, called "other payer advanced APMs" will also be able to count towards their participation status. Similar to an advanced APM, an other payer advanced APM must (1) require participants to use certified EHR technology, (2) provide payment based on quality measures comparable to those used in the quality performance category of MIPS, and (3) be either a Medicaid medical home that is comparable to medical home models expanded under section 1115A of the Social Security Act or bear more than a nominal amount of risk for monetary loses.

9. There is flexibility designed to make it easy for clinicians to move between the MIPS track and the advanced APM track.

All eligible clinicians that participate in APMs are considered MIPS-eligible clinicians unless and until they are determined to be either QPs or partial qualifying APM participants (Partial QPs) who elect not to report under MIPS. In QP performance period 2017, CMS defines partial QPs to be an advanced APM participant that has at least 20 percent but less than 25 percent of their Medicare Part B payments for covered professional services through an advanced APM entity, or at least 10 percent, but less than 20 percent, of their Medicare patients served through an advanced APM entity. If an eligible clinician does not meet either of those standards, the eligible clinician would be subject to MIPS and receive the corresponding payment adjustment.

Partial QPs will have the option to elect whether or not to report under MIPS, which determines whether or not they will be subject to MIPS adjustments. An eligible clinician who is a partial QP for a year and reports on applicable measures and activities as required under the MIPS is considered to be a MIPS eligible clinician for the year. CMS proposes that an advanced APM entity can change its election about whether or not to report under MIPS for a year at any time during the QP performance period, but the election will become permanent at the close of the QP performance period.

CMS also strives to provide flexibility for MIPS-eligible clinicians and expects the number of clinicians who participate in APMs to grow as the program matures. For example, MIPS participants who participate in APMs would receive credit toward scores in the clinical practice improvement activities category, which provides clinicians the opportunity to experiment with participation in APMs.

10. CMS provides budget estimates for MIPS and APM paths.

CMS estimates that MIPS would distribute payment adjustments to between 687,000 to 746,000 eligible clinicians in 2019 based on MIPS eligible clinicians’ performance in the four performance categories. CMS hopes to achieve budget neutrality with equally distributed negative payment adjustments ($833 million) and positive payment adjustments ($833 million), with approximately $500 million distributed in exceptional performance payments.

For APMs, CMS estimates that between 30,658 and 90,000 eligible clinicians will become QPs through participation in Advanced APMs, with between $146 million and $429 million APM incentive payments estimated to be distributed in 2019.

Conclusion
Value based payment for physicians in Medicare is no longer an elusive goal, and the actions in 2017 will determine 2019 payment. Any organization operating or managing physician services of any size need to decide how they will respond, and, in particular, if it is feasible to get to QP status. The cost burden of compliance, in the context of overall Medicare payment increases over the next four years that will be substantially less than the rate of inflation, may make it increasingly difficult for smaller practices to survive, and may increase the number of doctors who opt out of Medicare in some high end urban markets. Hard and important decisions need to be made soon.

HHS has already received a high level of interest from commentators in preparing the proposed rule. The current 60-day comment period, set to expire June 27, 2016, will provide more opportunity for constructive recommendations from affected stakeholders.

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