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MACRA QUALITY PAYMENT PROGRAM: TO YEAR 2 AND BEYOND

On June 30, 2017, CMS published in the Federal Register a proposed rule ("Proposed Rule") to update the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA") Quality Payment Program ("QPP") for CY 2018 and future years. CMS has stated that it endeavors to increase flexibility, decrease administrative burden and overall simplify the QPP, particularly for small, independent and rural practices, while facilitating quality care and fiscal sustainability.[1] CMS hopes to "keep what's working" and use stakeholder feedback to improve policies finalized in year one of the QPP 2017. The Proposed Rule can be found here, and a summary of the Proposed Rule can be found here.

BACKGROUND

In 2015, MACRA abolished the vexatious and unworkable Medicare Part B Sustainable Growth Rate formula for updating the physician fee schedule ("PFS") and replaced it with the QPP. The QPP was designed to link physician reimbursement to participation in payment reform initiatives aimed at improving beneficiary outcomes and facilitating data sharing. Under the QPP, currently in its inaugural year, physicians and other "Eligible Clinicians,"[2] choose to participate in either an advanced alternative payment model ("APM") or the Merit-Based Incentive Payment System for Eligible Clinicians and groups ("MIPS"). MIPS consolidated and replaced the Physician Quality Reporting System, the Medicare EHR Meaningful Use Incentive Program and the Value-Based Modifier Program, individual forerunner programs also intended to tie payment to quality. The majority of physicians and others paid under the PFS elected to sign on to MIPS as most are not yet ready to participate in an advanced APM,[3] which requires, among other things, assuming a certain amount of financial risk for failing to meet performance metrics or target expenditures.

MIPS scores Eligible Clinicians on four performance categories consisting of Quality, Cost, Clinical Practice Improvement Activities and Advancing Care Information. Beginning in Payment Year 2019 (linked to clinical performance in 2017), Eligible Clinicians participating in MIPS will experience payment adjustments (negative, neutral or positive) depending on the level of data submission and the composite performance score.

CMS's stated goal in Year 1 is to provide flexibility for Eligible Clinicians in how they transition into MIPS by allowing them to "pick [their] pace": test (i.e., submit a minimum amount of data) to avoid negative payment adjustment; partially participate to potentially receive a partial payment adjustment; fully participate to receive a moderate to exceptional payment adjustment; or participate in an advanced APM. Eligible Clinicians who sufficiently participate in advanced APMs will earn five percent annual payment bumps.

CMS finalized a rule on November 4, 2016 to implement the QPP for the initial performance year that began on January 1, 2017 ("CY 2017 QPP Final Rule").

For other articles addressing the currently in progress MACRA QPP, see here, here, here, here and here.

DETAILS OF THE PROPOSED RULE

The recently Proposed Rule provides for updates and changes to the QPP for performance year 2018 and beyond. CMS believes that the second year of the QPP should build upon the established foundation that provided a "trajectory for clinicians to value-based care." Highlights of the Proposed Rule follow.

MIPS Proposals

1. *MIPS Low-Volume Threshold Exclusion for Small Practices Expanded*. For the MIPS performance periods occurring in the original year of the program, 2017, CMS provided a "low-volume threshold" exclusion for small practices exempting them from reporting obligations under MIPS. Recognizing that small practices, particularly those in rural and health professional shortage areas, still have difficulty participating in MIPS, CMS has proposed to increase the low-volume threshold exception to ≤ $90,00 in Medicare Part B allowed charges (currently the threshold is ≤$30,000 in Medicare Part B allowed charges) *or* ≤ 200 Medicare Part B patients (currently the threshold is ≤ 100 Medicare Part B patients). If an Eligible Clinician meets either of the low-volume threshold criteria, s/he is exempt from mandatory participation in MIPS.

2. *Implementing Virtual Groups Provisions*. After delaying for a year while it explored how to successfully implement and operationalize the

virtual group provisions in MACRA, CMS proposed to implement for performance year 2018 the "virtual group." A virtual group is defined as a combination of two or more tax identification numbers ("TIN") composed of solo practitioners and/or groups of 10 or fewer Eligible Clinicians who choose to ally themselves for the purpose of participating and reporting under the MIPS program. If a group elects to join a virtual group, all Eligible Clinicians under the TIN would be part of the group. Virtual groups are beneficial, particularly for smaller practices who can pool resources to participate in MIPS. To join a virtual group, the participants would have to enter into formal agreements with one another to ensure that the expectations and requirements of participation in MIPS are clearly understood and agreed upon. Following are other requirements for formation of a virtual group:

a. A "designated virtual group representative" would be required to confirm that an agreement is in place between each member of the virtual group;

b. An agreement would be executed for at least one performance period;

c. An agreement would be executed on behalf of the TINs and the national provider identifier[s] ("NPI") (i.e., each clinician has an NPI and is described under MIPS as an NPI) by individuals with the appropriate authority;

d. Virtual groups would be required to update their agreements and notify the CMS Quality Payment Program Service Center of any significant changes affecting the virtual group such as a legal business name change or the addition or loss of an NPI from a TIN;

e. The only parties to the virtual group agreement would be TINs and NPIs—the agreement may not be between a virtual group and an independent practice association, management company or other third party;

f. Each member of the virtual group (including all NPIs under each TIN) would be required to agree to participate in MIPS and comply with the requirements of MIPS as well as all applicable laws including, but not limited to, federal criminal laws, the False Claims Act, the Anti-kickback Statute, the Stark Law, HIPAA and the Civil Monetary Penalties Law (see Practical Takeaway #2 below);

g. The virtual group agreement would need to articulate the NPI's rights and obligations in, and representation by, the virtual group, including reporting requirements;

h. An individual MIPS Eligible Clinician or group would elect to be in no more than one virtual group for a performance period, and, in the case of a group, the election would apply to all MIPS Eligible Clinicians in the group; and

i. Solo practitioners or a group of 10 or fewer Eligible Clinicians would need to make their election to participate as a virtual group prior to the start of the applicable performance period and would not be permitted to change their election during the performance period. **For the 2018 performance period, the election would need to be made by December 1, 2017** (see Practical Takeaway #3 below). CMS intends to publish the beginning date of the virtual group election period for the 2018 and subsequent year performance periods in sub-regulatory guidance.

Generally, virtual groups will report as a group across all four performance categories. To make virtual group formation purportedly easy, CMS proposed to allow group members to join together regardless of their geographic location or medical specialty. At this time, CMS has chosen not to limit the number of virtual group participants. All participants in a virtual group would receive their MIPS payment adjustment based on the virtual group score. However, CMS is proposing to waive certain statutory requirements so that if a TIN/NPI moves to an APM, CMS can use the APM score instead of the virtual group score for purposes of calculating MIPS payment adjustments.

3. *Significant Hardship Exception*. In the CY 2017 QPP Final Rule, CMS finalized a policy making Eligible Clinicians eligible for a "significant hardship exception" if they faced extreme and uncontrollable circumstances, insufficient internet connectivity, the unavailability of certified electronic health record technology ("CEHRT") or a lack of face-to-face interactions with patients that prevent Eligible Clinicians from completing a sufficient number of measures under the MIPS "advancing care information" ("ACI") performance category. Under the exception, CMS assigns a zero percent weighting to the ACI performance category in the final score, and there is no limit on the total number of MIPS payment years eligible for this exception. CMS also automatically reweights the ACI performance category to zero percent for a MIPS eligible clinician who lacks face-to-face patient interaction and is classified as a non-patient facing MIPS Eligible Clinician, [4] without requiring an application. Under the Proposed Rule, CMS is not making any substantive changes to the hardship exception policy, but it proposes to rely on authority provided in the 21st Century Cures Act instead of authority provided under a

different section of the Social Security Act to support the exception. The Proposed Rule also includes a new significant hardship exception for small practices for the ACI performance category.

4. *Technical Assistance Support*. For practices with 15 or fewer clinicians, CMS would provide guidance and assistance on the MIPS performance categories or transition to APM participation. Priority would be given to rural or medically underserved areas and practices with low MIPS final scores. See here.

5. *Certified Electronic Health Record Technology ("CEHRT")*. CMS proposes to allow continued use of 2014 Edition CEHRT while encouraging the use of 2015 edition CEHRT through, for example, adding bonus points in the scoring methodology for the exclusive use of 2015 edition CEHRT, which better supports interoperability across the continuum of care.

6. *Facility-Based Measurement*. CMS proposes to implement an optional voluntary facility-based scoring mechanism based on the Hospital Value-Based Purchasing Program. This scoring option would be available only to facility-based Eligible Clinicians who render ≥ 75 percent of their covered professional services in an inpatient hospital setting or emergency department.

7. *Complex Patients and Small Practice Bonuses*. CMS proposes to apply an adjustment of up to 3 bonus points based on the medical complexity of patients Eligible Clinicians treat. CMS also would add 5 points to the final score of any Eligible Clinician who practices in a small practice consisting of 15 or fewer clinicians, providing the Eligible Clinician or group submits data on at least 1 performance category in an applicable performance period.

8. *Scoring Changes*. For performance year 2018 (correlates to payment year 2020), the MIPS performance year final score would be weighted as follows.
    a. Quality: 60 percent, Cost: 0 percent, Clinical Practice Improvement Activities: 15 percent and Advancing Care Information: 25 percent. Currently, the scoring is flexible with shifting from one performance category to another depending on what type of data the Eligible Clinician did (and didn't) submit (e.g., if no Advancing Care Information performance category then reassignment of credit to the Quality performance category).

9. *Performance Threshold/Payment Adjustment*. Currently, the performance threshold is 3 points. CMS would increase the threshold to 15 points and seeks comments as to whether the threshold should be higher or lower. Related, the payment adjustment for the 2020 payment year (relates to the 2018 performance year) would range from negative 5 percent to positive (5 percent x scaling factor) and would apply to the amount Medicare paid for Part B claims. Presently, the payment adjustment ranges from negative 4 percent to positive (4 percent x scaling factor).

10. *Performance Period*. CMS proposes to make the Quality and Cost performance measures subject to a 12-month calendar year performance period. Advancing Care Information and Clinical Practice Improvement Activities would be subject to a 90-day minimum performance period. Currently, a minimum 90-day performance period applies to Quality, Advancing Care Information and Clinical Practice Improvement Activities performance measures with certain exceptions. For the 2017 performance year, Cost is measured for 12 months but no data submission is required because data is calculated from adjudicated claims. Notwithstanding the full-year measurement, Cost is weighted at 0 percent.

APM Proposals

CMS is keeping many of the APM policies finalized for the 2017 performance year. CMS proposes to:

1. Extend through performance year 2020 the revenue-based nominal amount standard that allows an APM to meet financial risk criterion to qualify as an advanced APM if participants are required to bear total risk of ≥ 8 percent of their Medicare Parts A and B revenue;

2. Change the nominal amount standard for medical home models so the minimum required amount of total risk increases at a slower pace;

3. Provide more details about the "All-Payer Combination Option" that will, starting in performance year 2019, permit Eligible Clinicians to become Qualifying APM Participants through a combination of Medicare participation in advanced APMs and participation in Other Payer Advanced APMs; and

4. Provide more detail on how Eligible Clinicians participating in certain APMs will be assessed under the APM scoring standard.

PRACTICAL TAKEAWAYS

1. CMS invites stakeholders and other interested parties to submit comments on the Proposed Rule for its consideration. Comments must be submitted no later than 5 PM on August 21, 2017. We are happy to assist with the drafting and submission of comments.

2. This Proposed Rule provides a fairly strong indication that payment system reform will continue, if not accelerate, under the Trump administration. CMS chose to provide flexibility as a way to include more health care providers in MIPS. Health care providers that employ Eligible Clinicians should accelerate internal discussions addressing how their employment, credentialing and quality assurance activities intentionally further the quality, coordination and cost containment goals that successful MIPS and APM participation will require.

3. As noted in MIPS Proposals subsection 2(f) above, CMS proposed to require each member of the virtual group to comply with all applicable laws and regulations including the physician self-referral law (i.e., Stark Law) and the Anti-kickback Statute ("AKS"). "Virtual groups," by definition, are not "group practices" as that term is specifically defined under the Stark regulations at 42 C.F.R. 411.352 because virtual groups do not constitute a "single legal entity." Indeed, virtual groups consist of at least two legal entities. Accordingly, physician participants in a virtual group with a financial relationship with such virtual group may not be eligible to make referrals for designated health services payable by Medicare to the virtual group under the "In-office Ancillary Services Exception" (42 C.F.R. §411.355(b)), which can only be used by bona fide *group practices*. Similarly, and for the same reason, virtual group member physicians could not meet Stark's "Physician Services Exception" (42 C.F.R. §411.355(a)). Finally, the AKS "Investments in Group Practices" safe harbor (42 C.F.R. §1001.952(p)) cross-references the Stark Law and implementing regulations definition of a "group practice." Virtual group Eligible Clinicians could not fit within this safe harbor because the virtual group is not a group practice. Using the virtual group as a group practice for Stark self-referral purposes could conceivably result in a Stark violation with costly penalties and False Claims Act exposure.

4. Rural and small group practices disappointed that the virtual group measures were not adopted and implemented for the initial performance year will have the option to form or join virtual groups for 2018. There is not a lot of time between now and December 1, 2017, the proposed deadline for notifying CMS of the group's or solo practitioner's intent to join a virtual practice for the 2018 performance year. Those interested should not wait for the Proposed Rule to be finalized and should begin discussions with potential virtual group partners now. Experienced counsel can help develop, negotiate and finalize the necessary virtual group agreements.

5. For the 2017 MIPS performance year, Eligible Clinicians got to "pick their pace" and ease into the reporting obligations with a minimal amount of data submission required to avoid any downward payment adjustment. While CMS has characterized performance year 2018 as another transition year in the program, from 2018 onward the negative payment adjustment percentage will escalate making it critical that Eligible Clinicians submit data and optimize performance under the program. Eligible Clinicians who took the opportunity to slowly ramp up for the MIPS first performance year should be prepared to participate in MIPS in a more meaningful way in order to take advantage of positive payment adjustment and further become accustomed to value-based payment systems.

If you have any questions or would like additional information about this topic, please contact:

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[1] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-06-20.html
[2] "Eligible Clinicians" under MIPS include: Physicians (MDs, DOs, DDSs, DDMs, DPMs and Chiropractors); Physician Assistants; Nurse Practitioners; Clinical Nurse Specialists; Certified Registered Nurse Anesthetists; and groups that include any of these clinicians. This list may be expanded to include other clinicians beginning in program year 2019. Eligible Clinicians can be exempt from the MIPS as Medicare Part B first year participants or based on low patient volume, enrollment in an advanced APM or partial qualifying APM status with election not to report on measures/activities under MIPS.
[3] Advanced APMs are value-based payment models that meet certain CMS-dictated criteria including use of CEHRT, the assumption of

more than a nominal amount of financial risk for monetary losses (or qualification as a Medical Home Model expanded under CMS Innovation Center authority) and the reporting of quality measures similar to those used in MIPS. Clinicians who receive 25 percent of Medicare Part B payments or see 20 percent of their Medicare patients through an advanced APM in 2017 can earn a 5 percent incentive payment in 2019. CMS approved advanced APMs include: Medicare Shared Savings Program - Tracks 2 and 3; Next Generation ACO Model; Comprehensive ESRD Care Model - 2-sided risk; Comprehensive Primary Care Plus Model; Coronary Artery Bypass Graft Model - Track 1; Acute Myocardial Infarction Model - Track 1; Comprehensive Care for Joint Replacement Model; Medicare-Medicaid ACO Model - for participants in Shared Savings Program Tracks 2 and 3; and the Oncology Care Model - 2-sided risk. For more information, click here.

[4] CMS has defined a non-patient-facing MIPS Eligible Clinician as an individual who within a non-patient facing determination period bills 100 or fewer patient-facing encounters or a group in which more than 75 percent of the NPIs billing under the group's TIN meet the definition of a non-patient facing individual MIPS eligible clinician.