MEDICARE RELEASES PROPOSED RULE FOR PHYSICIAN PAYMENT OVERHAUL

On April 27, 2016, the Centers for Medicare & Medicaid Services ("CMS") released a much anticipated proposed rule ("Proposed Rule") for the transition to a new Merit-Based Incentive Payment System ("MIPS") and alternative payment models ("APMs") pursuant to the Medicare Access and Children's Health Insurance Program Reauthorization Act of 2015 ("MACRA"). As background, MACRA permanently repealed the much-derided Sustainable Growth Rate formula for calculating physician payments and, in its place, implemented two performance-based paths: (1) continue to participate under the Medicare Physician Fee Schedule and receive a bonus or penalty associated with the eligible clinician's MIPS performance; or (2) earn separate incentive payments through participation in an APM and be excluded from participating in MIPS. The Proposed Rule includes program-specific details on how CMS intends to implement payment reform through MIPS and APMs and lays the groundwork for the continuing shift from volume- to value-based payment. This alert summarizes key provisions of the Proposed Rule. Future alerts will address specific aspects of the Proposed Rule and will provide further analysis of the practical effect for the health care industry.

SUMMARY OF KEY PROVISIONS OF THE PROPOSED RULE

1. *MIPS Implementation*

When finalized, the Proposed Rule would sunset existing payment adjustments under the current quality reporting programs, which are the Physician Quality Reporting System, the Physician Value-Based Payment Modifier and the Medicare Electronic Health Record Meaningful Use Incentive Program for eligible professionals. MIPS program participants, defined as "MIPS eligible clinicians," may include physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists and groups that include such clinicians. The Proposed Rule also identifies specific Medicare-enrolled practitioners that would be excluded from MIPS.

The Proposed Rule sets MIPS performance standards for a calendar year period (January 1 through December 31) for all measures and activities applicable to four performance categories: (1) quality; (2) resource use; (3) clinical practice improvement activities; and (4) meaningful use of certified EHR technology. A MIPS eligible clinician's performance would result in either a future positive or negative adjustment to the Medicare Part B payment. The first performance period would start in 2017 for payments adjusted in 2019.

Quality measures would be selected annually and specific standards would be identified within each performance category, some of which are specifically noted in the Proposed Rule. The Proposed Rule provides that MIPS eligible clinicians would be scored using a MIPS composite performance score rather than an "all or nothing" approach, and those who participate in certain types of APMs would be scored using an APM scoring standard instead of the generally applicable MIPS scoring standard. Additionally, beginning on July 1, 2017, CMS would include information on an annual basis for quality and resource use performance categories through a performance feedback process and would also offer a targeted review process for a MIPS eligible clinician to better understand specific calculations and adjustments as they may relate to the clinician during a performance period. The Proposed Rule also includes requirements for third-party submission of data for MIPS and a public reporting process through the Physician Compare website.

Similar to previous programs like the Medicare Meaningful Use Program, MIPS eligible clinicians would be subject to audits to verify the accuracy of the annual MIPS attestation. The Proposed Rule grants CMS the power to reopen, revise and recoup any resulting overpayment and expects MIPS eligible clinicians to be able to provide substantive primary source documentation as requested.

1. *APMs*

The Proposed Rule identifies two types of APMs in which "qualifying APM professionals" or "QPs" may participate to earn APM incentive payments and avoid inclusion in MIPS: Advanced APMs and Other Payer Advanced APMs. To be an Advanced APM, an APM must meet three requirements: (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 of MIPS; and (3) be either a Medical Home Model or bear more than a nominal amount of risk for monetary loss.

To be an Other Payer, a commercial or Medicaid APM must meet similar requirements, including: (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 Model that is comparable to Medical Home Models or bear more than a nominal amount of risk for monetary loss. The Proposed Rule also describes other details related to participation in APMs, including CMS's notification to the the public of which APMs would be Advanced APMs prior to a performance period, thresholds for eligible clinicians to become QPs for a year, unique APM participant identifiers CMS may use to determine whether eligible clinicians qualify for QP status and distribution formulas for APM incentive payments.

PRACTICAL TAKEAWAY

The Proposed Rule is further evidence of CMS's desire to accelerate the transition from volume to value through targeted incentives. Going forward, health care leaders should pay close attention to these incentives and to Medicare's evolving payment structures so they can position their organizations for financial success in the new value-based world.

CMS is soliciting comments to the Proposed Rule from stakeholders, including health care providers, through June 27, 2016.

If you are interested in submitting a comment or would like additional information about the Proposed Rule or MACRA, please contact:

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