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CMS Allays Concerns Regarding Medicare Quality Payment Program Reporting Starting January 1, 2017

By Mazen Asbahi, Partner

In an effort to allay concerns raised by physicians and other stakeholders in healthcare, the Center for Medicare & Medicaid Services ("CMS") announced four options that will allow physicians and other providers to "pick their pace of participation" in the new Medicare Quality Payment Program that gets underway this coming January 1, 2017. In a blog post late last week, CMS Acting Administrator Andrew Slavitt detailed how these options would allow physicians to avoid a negative payment adjustment in 2019 (the first year payment adjustments are slated to be implemented under the new law).[1]

As you know, significant changes in Medicare reimbursement are just around the corner for physicians and other healthcare providers. The new Medicare Quality Payment Program (the "Program") is the result of the 2015 Medicare Access and CHIP Reauthorization Act ("MACRA"), which finally repealed the oft-criticized sustainable growth formula ("SGR") for determining Medicare reimbursement rates.

At its core, the Program is a comprehensive incentive payment model that incorporates a modified set of Electronic Health Record ("EHR") Meaningful Use requirements, new quality of care metrics, new cost efficiency goals and clinical practice improvement activities. For the physician, clinical practice improvement activities mean care coordination, beneficiary engagement, and patient safety. Ultimately, the Program sets up a new architecture that dramatically changes the Medicare payment model for practitioners – one that goes a long way in achieving CMS's goal of moving away from fee-for-service ("FFS") to value-based reimbursements. Recall that CMS made news in January 2015 when it announced its goal that 90% of Medicare FFS would be tied to quality or value by the end of 2018.[2]

The Program establishes two separate pathways that providers must choose between: (1) the Merit-Based Incentive Payment Systems ("MIPS") and (2) Alternative Payment Models ("APMs"). The APMs pathway is aimed at providers and networks already taking advantage of the more advanced payment models, such as Accountable Care Organizations. The default track is MIPS, which will replace, and in effect, consolidate CMS's three current alternative payment models: the Physician Quality Reporting System ("PQRS"), Value Based Modifier ("VBM"), and the Electronic Health Record ("EHR") Incentive Program (also referred to as Meaningful Use). Physicians participating in MIPS will have their Medicare payments increased or decreased based on their relative performance as compared to other participating physicians. Because the law requires the Program to be "budget neutral," incentive payments made to high performing providers must be offset by the penalties levied by the poorer performing providers. Rewards will be provided through fee adjustments to the Medicare Physician Fee Schedule. The first year of payment adjustments will be 2019, and will be based on data from the 2017 reporting year. For 2019, the reward paid to or penalty levied against any provider may not exceed a 4% adjustment. However, the limits will increase annually reaching a maximum of 9% in 2022.

The May 9, 2016 Proposed Rule generated a flurry of activity among various stakeholders in healthcare, resulting in various comment letters to the Department of Health and Human Services ("HHS") detailing objections and recommendations on how MACRA should be implemented. Most stakeholders are actively lobbying CMS to delay implementation given the tight timeline between publication of the MACRA Final Rule (expected in October) and

[1] Slavitt, Andrew. "Plans for the Quality Payment Program in 2017: Pick Your Pace." Web blog post. *The CMS Blog*. Centers for Medicare & Medicaid Services, 8 Sept 2016. Retrieved at https://blog.cms.gov/2016/09/08/qualitypaymentprogram-pickyourpace/

[2] U.S. Department of Health and Human Services. (2015). *Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value* [Press Release]. Retrieved from http://www.hhs.gov/about/news/2015/01/26/better-smarter-healthier-in-historic-announcement-hhs-sets-clear-goals-and-timeline-for-shifting-medicare-reimbursements-from-volume-to-value.html

the beginning of the proposed performance measurement period, January 1, 2017. The American Medical Association ("AMA") consolidated comments from a number of national specialty and state medical societies and presented CMS with a series of recommendations with a focus on extending the transition period for implementation, simplifying reporting burdens and providing more flexibility for solo and small group practitioners.[3] Similarly, in its Comments Letter, the Medical Group Management Association ("MGMA") argued that the Proposed Rule implementing MACRA would detract from patient care by increasing rather than decreasing the amount of time providers spend on paper work and reporting requirements. [4]

Congress earmarked $100 million to help small practices transition into the Program over the next five years, recognizing that MACRA was likely to result in additional hardship for solo and small group practitioners. However, late last week, CMS Acting Administrator Andrew Slavitt went a long way in allaying the concerns of many critics of the speed at which CMS was moving forward to implement MACRA. In his blog post, he described four options that would allow physicians to pick their pace of participation, including the first option, which seemed designed for smaller practices that may not be ready to provide a full year's worth of reporting information. In that option, a physician practice need only submit "some data" to "test the Program" and avoid a negative payment adjustment. The second option would permit a practice to submit a partial year's worth of data, including data that might relate to a performance period beginning after January 1, 2017. In this scenario, a practice could still qualify for a positive payment adjustment. The third option is to participate for the full calendar year in order to qualify for the positive payment adjustment. The fourth and final option is to participate in an Advanced Alternative Payment Model, such as the Medicare Shared Savings Track 2 or 3 in 2017. These options related to reporting in 2017 are indeed very helpful but only address one key element of the Program. We anxiously await publication of the final rules expected next month to determine how difficult implementation of MACRA will be for practices of all shapes and sizes.

If you have any questions regarding this topic, please contact one of the listed Roetzel attorneys below.

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[3] More information on MACRA including a PDF of the AMA's Comment Letter may be found at: http://www.ama-assn.org/ama/pub/advocacy/topics/medicare-physician-payment-reform.page
[4] Wright, Halee Fischer, MD. "Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; Proposed Rule." Letter to Andrew M. Slavitt Acting Administrator Centers for Medicare & Medicaid Services. 24 June 2016. MS. N.p. Retrieved from http://www.mgma.com/government-affairs/advocacy/mgma-advocacy-archive/2016/mgma-comments-on-the-mips-apms-proposed-rule

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