crowell moring

CLIENT ALERT

CMS Releases Final Rules on MACRA Quality Payment Program Implementation for 2017-Onward

Oct.19.2016

On Friday, October 14, 2016, the Centers for Medicare and Medicaid Services (CMS) released the pre-publication version of the final rule with comment period (Final Rule) that, beginning January 1, 2017, will implement the provisions of the Medicare Access and CHIP Reauthorization Act (MACRA) relating to the new Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs). MIPS and APMs are collectively referred to as the "Quality Payment Program" or "QPP". Physicians, physician assistants, nurse practitioners, clinical nurse specialists and certified registered nurse anesthetists (collectively, "MIPS-eligible clinicians") are part of the QPP if they bill Medicare more than $30,000 a year or provide care for more than 100 Medicare patients a year (both higher thresholds than initially proposed by CMS in the notice of proposed rulemaking).

There is limited time to come into compliance, so to accompany the rollout of the Final Rule, CMS simultaneously launched a comprehensive Quality Payment Program website with tools and updates to help MIPS-eligible clinicians learn and prepare for participation. Failure by MIPS-eligible clinicians and entities to take steps to transition from Medicare's current fee-for-service reimbursement system to value-based reporting and payment mechanisms could make those clinicians and entities forfeit physician incentive bonuses, and could even result in Medicare reimbursement reductions beginning in 2019.

CMS established six strategic objectives that guided its final policies and will, in turn, guide future rulemaking for the QPP:

1. Improving beneficiary outcomes and engaging patients through patient-centered Advanced APM and MIPS policies.
2. Enhancing clinician experience through flexible and transparent program design and interactions with easy-to-use program tools.
3. Increasing the availability and adoption of robust Advanced APMs.
4. Promoting program understanding and maximizing participation through customized communication, education, outreach, and support that meets the needs of the diversity of physician practices and patients, especially the unique needs of small practices.
5. Improving data and information sharing to provide accurate, timely, and actionable feedback to clinicians and other stakeholders.
6. Ensuring operational excellence in program implementation and ongoing development.

Consistent with statements made last month by CMS's Acting Administrator, Andy Slavitt, the CMS Final Rule designates 2017 as a "transition year" and outlines the following four pathways for participation in the QPP:

1. If MIPS-eligible clinicians choose to begin full participation in MIPS beginning in 2017, clinicians can choose to report on all MIPS required measures for at least a full 90-day period or, ideally, the full year. MIPS-eligible clinicians who fulfill this requirement and are exceptional performers in MIPS, as shown by the practice information that they submit, could be eligible for an additional positive adjustment each year of the first six years of MIPS.

2. For CY 2017, in order to avoid a negative MIPS payment adjustment and to possibly receive a smaller positive MIPS payment adjustment in 2019, clinicians can choose to report to MIPS for at least a full 90-day period, so long as they report at least the following: (i) more than one Quality measure; (ii) more than one Improvement Activity; or (iii) more than the required measures in the Advancing Care Information performance category.
3. For clinicians that only seek to avoid a negative MIPS payment adjustment in 2019, CMS will allow the reporting of the following for a period of less than 90 days in 2017: (i) one measure in the Quality performance category; (ii) one activity in the Improvement Activities performance category; or (iii) all of the required measures of the Advancing Care Information performance category.
4. MIPS-eligible clinicians can still participate in an Advanced APM beginning in 2017, and if they receive a sufficient portion of their Medicare payments or see a sufficient portion of their Medicare patients through the Advanced APM, they will qualify for a 5 percent bonus incentive payment in 2019. Participation in an Advanced APM exempts a MIPS-eligible clinician from the reporting requirements they would otherwise need to fulfill under the MIPS track of the QPP.

If a MIPS-eligible clinician or group is not ready to begin full reporting on MIPS performance measures on January 1, 2017, they have the option to begin doing so anytime between January 1 and October 2, 2017 to meet the 90-day period minimums imposed by the above pathways. If a MIPS-eligible clinician chooses not to report any data under the performance categories during this time period, CMS will impose the full four percent negative payment adjustment in 2019. Electing to participate in MIPS through any one of the above four pathways will allow physicians to avoid the negative payment adjustments in 2019, but it is unclear whether CMS will provide additional transition periods after 2017. Already, however, CMS stated that it expects to require longer performance periods and higher performance thresholds after 2017 in order to avoid negative MIPS payment adjustments in 2020 and beyond.

CMS also made a number of other significant changes in the Final Rule, which we will detail in future alerts and blog posts. The following is a brief summary of some of the major items that MIPS-eligible clinicians should note in the Final Rule:

1. **Reduced Reporting Obligations During The "Transition Year"**. During the 2017 transition year, a provider's MIPS score will only be based on the Quality, Advancing Care Information and the Improvement Activities performance categories. The Final Rule makes the following changes to the required reporting measures under each performance category during 2017:
    - Quality: For full participation, MIPS-eligible clinicians or groups must report on all applicable measures (up to six measures), including at least one outcome measure if available for a minimum of a continuous 90-day performance period. Alternatively, for a minimum of a continuous 90-day period, the MIPS-eligible clinician or group can report one specialty-specific measure set, or the measure set defined at the subspecialty level, if applicable. If the measure set does not include any available outcome measures, MIPS-eligible clinicians must instead report on another high priority measure (appropriate use, patient safety, efficiency, patient experience, and care coordination measures). More measures are required for groups who submit measures using the CMS Web Interface, however.
    - Improvement Activities: The Final Rule reduces the number of improvement activities required to achieve full credit under MIPS from six medium-weighted (or three high-weighted) activities to four medium-weighted (or two high-weighted) activities. There are also additional reductions in reporting requirements for small practices, rural practices, or practices located in geographic health professional shortage areas (HPSAs), and non-patient facing MIPS-eligible clinicians.

- Advancing Care Information: The Final Rule reduces the number of required measures in this performance category from 11 to five, and makes all of the other measures optional for reporting purposes.
- Cost: The Final Rule assigns a weight of 0 percent to scores in the Cost performance category for the 2017 transition year.

2. **Incorporating Non-Advanced APMs in MIPS Reporting**. For the transition year, CMS has designated certain one-sided risk value-based payment models that do not qualify as "Advanced APMs" – such as the Medicare Shared Savings Program Track 1 Model – as "MIPS APMs." Clinicians participating in such MIPS APMs will be scored using the APM scoring standard instead of the MIPS framework, and will not have additional reporting requirements under MIPS for the Quality and Improvement Activities performance categories other than those already taken care of through the APM entities. This should make it easier for MIPS-eligible clinicians already engaged in APMs to gradually transition to the Advanced APM track of QPP without duplicating their reporting obligations.

3. **Payment Incentives for Advanced APMs**. For CMS, APMs represent an important step forward to move our healthcare system from volume-based to value-based care. CMS reiterated its intention for payment incentives for APM participants to drive delivery of better health outcomes and smarter spending. The provisions of the notice of proposed rulemaking were largely finalized, with changes that provide more possible options for qualifying as an Advanced APM, which are a subset of APMs that let practices earn increased bonus payments for taking on additional shared risk. For example:
   - To broaden opportunities for clinicians to participate in Advanced APMs, the Final Rule eases the risk criteria for Advanced APMs and permits flexible uptake and a broader range of future models.
   - The Comprehensive ESRD Care Model Non-Large Dialysis Organization arrangement was added to the six Advanced APM models named in the notice of proposed rulemaking (the Comprehensive Primary Care Plus (CPC+); the Medicare Shared Savings Program (Accountable Care Organizations (ACOs)), Tracks 2 and 3; the Next Generation ACO Model; the Oncology Care Model Two-Sided Risk Arrangement; and the Comprehensive ESRD Care Model (Large Dialysis Organization arrangement)).
   - CMS is considering the inclusion of a new ACO Track 1+ Model as an eligible Advanced APM beginning in 2018, with lower risk-sharing requirements than currently available to Medicare ACOs.

   MIPS-eligible clinicians and groups in Advanced APMs may earn up to five percent in additional Medicare incentive payments during 2019 through 2024 and would be exempt from MIPS reporting requirements and payment adjustments. CMS expects the number of qualified clinicians participating in Advanced APMs to increase significantly during 2017 and 2018.

If the submission of over 4,000 comments from over 100,000 stakeholders to CMS in response to the notice of proposed rulemaking is any indication, there will be intense scrutiny of, and reaction to, the CMS Final Rule based on how responsive the agency is perceived to be to stakeholder comments. CMS has sought additional comments on specific aspects of the rule, which will be due 60 days after the Final Rule is published in the Federal Register (which should occur later this week).

Crowell & Moring's attorneys are continuing to review the Final Rule in detail and will publish additional alerts on the most important changes to the QPP's provisions and potential areas of further comment for health care stakeholders. In the

meantime, for a refresher, readers can review our previous summaries of the MIPS program and APM-related proposals in response to the notice of proposed rulemaking.

For more information, please contact the professional(s) listed below, or your regular Crowell & Moring contact.

Jodi G. Daniel
Partner – Washington, D.C.
Phone: +1 202.624.2908
Email: jdaniel@crowell.com

Troy A. Barsky
Partner – Washington, D.C.
Phone: +1 202.624.2890
Email: tbarsky@crowell.com

Stephanie D. Willis
Counsel – Washington, D.C.
Phone: +1 202.624.2721
Email: swillis@crowell.com

Joe Records
Counsel – Washington, D.C.
Phone: +1 202.624.2709
Email: jrecords@crowell.com