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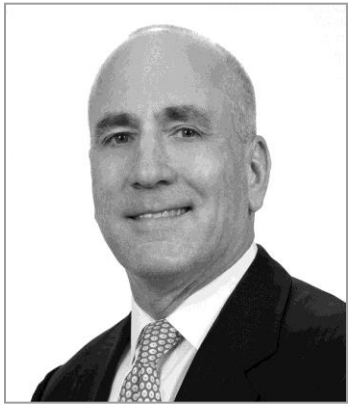
MACRA final rule: highlights and implications

Thursday, January 12, 2017

Speakers



Bernard Duco, *Of Counsel*

Bernie Duco joined Norton Rose Fulbright in 2014 after serving as Chief Legal Officer with the Memorial Hermann Health System. Bernie led the development of Memorial Hermann's Medicare certified Accountable Care Organization and was the lead legal advisor for MHMD – Memorial Hermann's clinically integrated physician group. Prior to joining Memorial Hermann, Bernie served as Senior Vice President and General Counsel for Mercy Health System in St. Louis. Having served for over 20 years as general counsel for large non-profit health systems, Bernie has broad corporate governance, transaction, and litigation management experience. Bernie received his JD from the University of Houston Law Center and his BA from Rice University. He is licensed to practice in Texas and Missouri.

Speakers

Mark Faccenda, *Partner*

Mark Faccenda is part of Norton Rose Fulbright's health care transactional group, Mark has represented health care industry clients on regulatory and transactional matters. Representative clients include pharmaceutical manufacturers, academic medical centers, health systems, physician groups, physician/hospital joint ventures, long-term care facilities and durable medical equipment suppliers.

Prior to joining, Mark worked for the Pennsylvania House of Representatives Legislative Office for Research Liaison where he conducted economic and health care regulatory research in support of prospective legislation. As part of his work for the Legislative Office for Research Liaison, Mark authored and contributed content to the University of Pittsburgh Institute of Politics' quarterly Institute of Politics Report and its annual policy briefing, the Institute of Politics Status Report.

Mark also worked for payer and provider sides of an integrated health system where he drafted corporate policies and provided legal research focusing on HIPAA, ERISA, EMTALA, same-sex benefit coverage and the Peer Review Protection Act.

Speakers

Joseph Keillor, *Associate*

Joseph Keillor is an associate, and his practice focuses on various health care matters. Joseph has experience in all phases of affiliations, mergers and acquisitions. He is experienced in assisting clients in structuring accountable care organizations (ACOs) and clinical integration and co-management arrangements. Joseph also regularly assists clients with compliance investigations, self-disclosures under the self-referral disclosure protocol (SRDP) and restructuring contractual arrangements to minimize compliance risk.

Prior to attending law school, Joseph was an officer in the United States Air Force (USAF) and served a tour of duty in Afghanistan in 2005. Joseph received his LLM from the University of Chicago and his JD from Washington University in St. Louis. He is licensed to practice in Illinois and Missouri.

Continuing education information

We have applied for 1.0 hour of California and Texas CLE credit and 1.0 hour of New York transitional CLE credit. For attendees outside of these states, we will supply a certificate of attendance which may be used to apply for CLE credit in the applicable bar or other accrediting agencies.

Norton Rose Fulbright will supply a certificate of attendance to all participants who:

- Participate in the web seminar by phone and via the web
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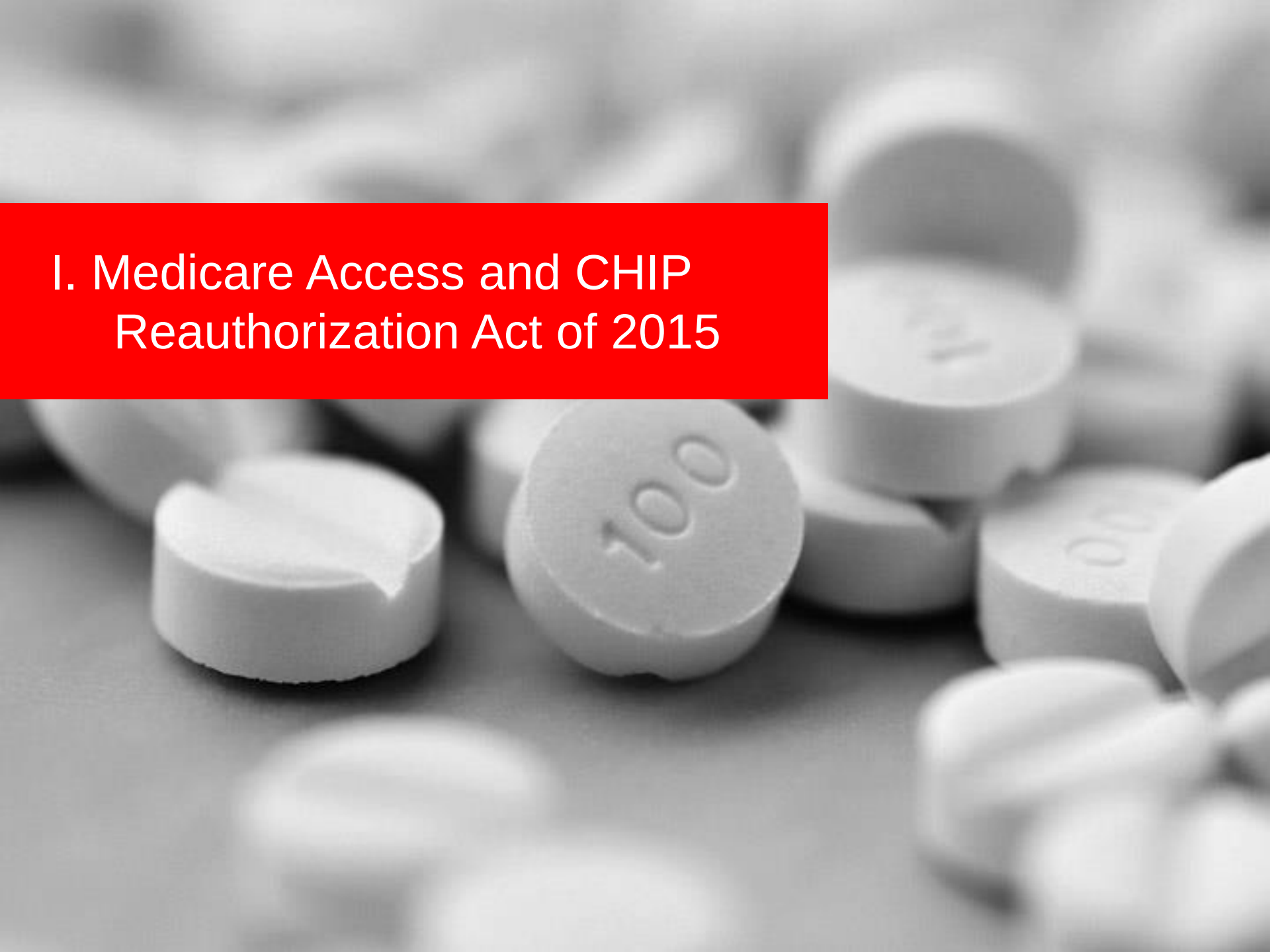
- Everything we say today is opinion. We are not dispensing legal advice, and listening does not establish an attorney-client relationship. This discussion is off the record. You may not quote the speakers without our express written permission. If the press is listening, you may contact us, and we may be able to speak on the record.



I. Medicare Access and CHIP Reauthorization Act of 2015

Historical Payment for Physician Services

- Resource-based relative value scale (RBRVS)
- Three components of relative value:
  - physician work (52%) – reflects “time and intensity of service”
  - practice expense (44%) – reflects overhead costs
- malpractice costs (4%)
- Multiplied by indices to reflect geographic variations in cost
- Multiplied by conversion factor
- Medicare paid 80% of this amount, with the remainder paid by the patient

Attempts to Limit Increase in Physician Reimbursement

- 1998 – implementation of Sustainable Growth Rate (SGR), which uses the MEI to achieve a desired aggregate expenditure on physician fees.
- Cost-based reimbursement and initial physician fee schedule reimbursement led to increases in payment beyond anticipated or desired.
- Cost-based reimbursement potentially threatened the Medicare trust due to depletion of funds.
- SGR was implemented in an attempt to achieve “sustainable” expenditure increases over the long term.

Attempts to Limit Increase in Physician Reimbursement

- SGR allows for growth in expenditures resulting from:
  - inflation in Medicare payment rates
  - population growth of Medicare beneficiaries (excluding Medicare Advantage beneficiaries)
  - regulatory changes
  - growth in gross domestic product (GDP)
- CMS used these factors to set a target for acceptable growth in aggregate Medicare expenditures.
- Used a ten-year GDP rolling average.

Sustainable Growth Rate

- SGR methodology was intended to achieve a desired aggregate expenditure on physician fees.
- Attempts to implement SGR payment methodology were politically problematic; Congress passed more than a dozen legislative attempts to postpone implementation.
- Repeated delays of SGR implementation led to threatened 20 and 25% payment reductions to physician reimbursement.

Medicare Access and CHIP Reauthorization Act of 2015

- Adopted April 16, 2015
- Repeals the SGR payment methodology
- Includes scheduled updates to the physician fee schedule payment rate
- Includes Merit-Based Incentive Payment System (MIPS) for physicians not participating in an alternative payment model (APM)
- Combines elements of existing quality reporting and incentive programs into MIPS payment methodology
- Includes incentives for physicians participating in APMs

Medicare Access and CHIP Reauthorization Act of 2015

- MACRA “represents the most sweeping set of changes to Medicare's physician payment methodology since the current system was put in place 25 years ago.”
- MACRA averted the planned 21% across-the-board cut in Medicare's provider payments. “Perhaps more importantly, it represents for Medicare a dramatic step away from traditional fee-for-service (FFS) reimbursement and toward value-based payments for physician services.”
- Also described as a more significant change to healthcare payment reform than the Affordable Care Act, due to the number of individuals / entities involved, the culture of compliance of those impacted, and the significance of value-based reimbursed in the physician sector.

M. Corry, B. Durie, D. Wofford &L. Barrera, Making Way for MACRA: Positioning Your Organization for Payment Reform, Bloomberg BNA (Sept. 3,2015)

Medicare Access and CHIP Reauthorization Act of 2015

- MACRA provides physicians with 2 alternatives:
  - Physicians can participate in the MIPS program, with relatively flat reimbursement rates as compared to present payment methodology, with upward or downward payment adjustments based on compliance with MIPS quality and cost reporting requirements.
  - Physicians participating in an APM may be excluded from MIPS reporting and payment, and will be eligible for a 5% incentive payment for the year.

Medicare Access and CHIP Reauthorization Act of 2015

- MIPS consolidates elements of the following programs:
  - Physician Quality Reporting System (PQRS)
  - Value-Based Payment Modifier (VM)
  - Medicare Electronic Health Records (EHR) Incentive Program, (i.e., Meaningful Use program)
- MIPS payment begins in 2019

Medicare Access and CHIP Reauthorization Act of 2015

- Physicians electing the MIPS side will potentially receive payment adjustments (upward or downward) of 4% in 2019, which increases to 9% in 2022
- Physician fee schedule updates according to the following schedule:
  - 0.5% update 2015 through 2019
  - 0% update 2020 through 2023
  - Payment updates resume after 2023, with differential updates for MIPS and APM participants

Medicare Access and CHIP Reauthorization Act of 2015

- Performance will be based on 4 categories:
- Clinical quality
- Resource utilization
- Meaningful use of EHR Technology
- Clinical practice improvement
- Physician performance in each of these categories will contribute towards a composite score, and each physician will be ranked on a scale of 0 to 100
- Composite scores will differentiate between the best and worst performers with respect to these metrics
- Payment under MIPS will be zero-sum, so the expectation is that incentives will be offset by penalties

Medicare Access and CHIP Reauthorization Act of 2015

- Instead of participating and reporting under the MIPS program, physicians can participate in an alternative payment model (APM).
- The 5% APM incentive will be offered from 2019 to 2024.
- Beginning in 2026, the APM incentive will take the form of a 0.75% fee schedule update, whereas MIPS program participants will receive a 0.25% fee schedule update in comparison.

Medicare Access and CHIP Reauthorization Act of 2015

- MIPS and APMs generally:
- CMS goal to “tie 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018.”
- CMS goal for “30 percent of traditional Medicare payments [to] be tied to APMs by the end of 2016, and 50 percent of such payments would be tied to these models by the end of 2018.”
- Each approach represents a departure from past payment models, where physician reimbursement was tied to:
  - Physician traditional charges
  - Physician costs in delivering care
  - Neither providing incentive to provide the right kind of care (e.g., quality, appropriate utilization)

II. Merit-based Incentive Payment System (MIPS)

Merit-based Incentive Payment System

- What is the MIPS program?
- “MIPS promotes better care, healthier people, and smarter spending by evaluating [eligible physicians (EPs)] using a Composite Performance Score that incorporates EP performance on quality, resource use, clinical practice improvement activities, and meaningful use of certified electronic health records. Based on the Composite Performance Score, EPs may receive an upward payment adjustment, a downward payment adjustment, or no payment adjustment.”
- Applies to physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists.

Merit-based Incentive Payment System

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Merit-based Incentive Payment System

- Physicians electing the MIPS side will potentially receive payment adjustments (upward or downward) of 4% in 2019, which increases to 9% in 2022
- Physician fee schedule updates according to the following schedule:
  - 0.5% update 2015 through 2019
  - 0% update 2020 through 2023
  - Payment updates resume after 2023, with differential updates for MIPS and APM participants
- The final rule creates an exceptional performance bonus
  - $500M / year available to participants in the 25th percentile above the normal performance threshold (70 points in 2017)
  - available for the next 6 years

Merit-based Incentive Payment System

- Payments under this part of the MIPS program works the same as under the current system – physicians are paid under the fee schedule, with RBRVS payments made for each service performed.
- Same criteria are used in determining this aspect of payment (i.e., work component, cost component, malpractice component, geographic index, and conversion factor).
- The conversion factor will be adjusted based on the rate changes addressed on the previous slide.

Merit-based Incentive Payment System

- Performance will be based on 4 categories:
  - Clinical quality (60% (2019) – 25% (2022))
  - Resource utilization (10% (2020) – 25% (2022))
  - Advancing Care Information (25%)
  - Clinical practice improvement (15%)
- Physician performance in each of these categories will contribute towards a composite score, and each physician will be ranked on a scale of 0 to 100.
- Composite scores will differentiate between the best and worst performers with respect to these metrics.
- Payment under MIPS will be zero-sum, so the expectation is that incentives will be offset by penalties.

Merit-based Incentive Payment System

- It is clear that not all physicians, nor even a majority, will be able to realize significant payment increases under the new system.
- Incorporation / replacement of the current PQRS, EHR and VM reporting /compliance structures is intended to (i) provide consistency in transitioning from the current structure and (ii) avoid duplication of reporting / compliance obligations.

Merit-based Incentive Payment System

- **Clinical Quality**
- Performance will be assessed using the following criteria:
  - clinical care
  - safety
  - care coordination
  - patient and caregiver experience
  - population health and prevention
- Intended to replicate, at least in part, the current reporting obligations under PQRS
- Reporting requirement – 6 quality measures (down from 9 in proposed rule), including 1 outcomes measure or all available measures in a specialty set

Merit-based Incentive Payment System

- **Resource Utilization**
- Intended to reflect the cost parameters under the current physician Value-Based Modifier created under Social Security Act section 1848(p)
- Will include consideration of socioeconomic, demographic, and other risk factors
- Criteria Considered:
  - Per capita costs for all attributed beneficiaries
  - Per capita costs for beneficiaries with specific conditions
- No reporting required under this criterion, per se - CMS analyzes Medicare claims data

Merit-based Incentive Payment System

- **Advancing Care Information**
- Compliance with this criterion replaces reporting under the Medicare EHR Incentive Program.
- As with the transition away from the PQRS and VM programs, compliance with ACI criteria will no longer result in discrete incentive payments or penalties.
- Rather, reporting ACI measures will count towards each physician's composite score, which will then be translated into one increase or decrease in payment per year.
- Physicians reporting compliance with the various MIPS criteria through EHR technology will be deemed to be compliant with the requirements for this component.

Merit-based Incentive Payment System

- **Advancing Care Information**
- Reporting requirements include base criteria (50 points):
  - Security risk analysis
  - E-prescribing
  - Patient access to data
  - Ability to send summaries of care through a health information exchange
  - Ability to request and accept summaries of care through an HIE
- Plus optional performance criteria (90 points)
  - Secure messaging
  - Medication reconciliation
  - Patient education
  - Public health reporting
- Bonus registry reporting / accomplishment of CPIA activities through EHR (15 points)
- Goal – to obtain 100 points in order to receive the 25% towards MIPS composite score

Merit-based Incentive Payment System

- **Clinical Practice Improvement**
- Final rule requires reporting on 4 measures (6 under the proposed rule) or 2 high-weighted measures
- This criterion will reward or penalize physicians for clinical practice improvement activities
  - Activities selected for consideration towards the composite MIPS score must be applicable to all specialties
  - Compliance must be attainable for small practices
  - Compliance must be possible in rural and underserved areas
- Criteria are published in final rule Table 8, and categories include expansion of practice access, population management, care coordination, beneficiary engagement, safety and practice assessment, and enhancements to EHR data capture

Merit-based Incentive Payment System

- **2017 Reporting Requirements**
- MIPS participants can report on a 90-day performance period or up to the full year
- If reporting all MIPS measures and for the full year, the MIPS participant may be eligible for an exceptional performance adjustment
- Otherwise, if the participant reports on more than 1 quality measure, more than 1 improvement activity or more than the required EHR measures, the participant may be eligible for the 4% payment increase
- If the participant reports on 1 quality, 1 improvement or the required EHR measures, the participant may avoid the 4% payment reduction

Merit-based Incentive Payment System

- Individual physicians and small group practices may elect to form a “virtual group” with other like physicians / groups in order to report on MIPS criteria
  - May do so on an annual basis
  - Virtual group performance may be tied together on those issues ordinarily reported as a group
- Exceptions to 2017 reporting:
  - Physicians below $30,000 in annual Medicare Part B charges
  - Physicians below 100 annual Medicare patients
- The final rule also provides funding for training assistance for small groups (15 or fewer physicians)

Merit-based Incentive Payment System

- Ways in which a physician may report compliance with MIPS requirements:
  - claims-based reporting
  - qualified registry reporting
  - qualified clinical data registry (QCDR) reporting
  - direct EHR products
  - EHR data submission vendor products
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS)
  - CMS web interface (groups of 25 or more)

III. Advanced Alternative Payment Model Participation

Advanced Alternative Payment Model (Advanced APM) Overview

- Advanced APM's are an alternative pathway under the Quality Payment Program, in which clinicians may be excluded from MIPS reporting (and associated bonuses/penalties) by participating in a payment model that is sufficiently-risk-based and satisfies certain other requirements
- Participating clinicians receive enhanced fee schedule payments
- Pathway is consistent with pre-MACRA CMS objectives of nudging providers to participate in risk-based payment models

Advanced APM Payment Model Incentives

- For years 2019 through 2024, Qualifying APM Participants (QP's) receive a lump-sum incentive payment of 5% of prior year's Part B covered professional services
  - A "time-limited incentive intended to encourage movement into the most challenging and potentially most rewarding alternative payment models"
  - Tied to a QP Performance Period two years prior to the payment year (e.g., 2019 payment dependent on 2017 Advanced APM participation)
- Beginning in 2026, QP's receive a higher Physician Fee Schedule update (0.75% versus 0.25%)
- Beyond participation thresholds discussed herein, the preceding payments are not tied to a clinician's performance within an Advanced APM, or even the performance of an Advanced APM as a whole; for example, a primary care physician within an MSSP Track 2 ACO could still receive the Advanced APM incentives even if (i) the physician individually performed with poor quality/efficiency or (ii) the ACO as a whole performed with poor quality/efficiency
- Exclusion from MIPS reporting requirements and payment adjustments

Advanced APM Requirements

- MACRA Final Rule's implementation of statutory requirements of Advanced APM's:
  - I. Must require participants to use certified EHR technology
    - The Advanced APM must require >50% of eligible clinicians to use CEHRT
    - Special criterion exclusively for MSSP ACO's deems this element satisfied through one quality measure that assesses meaningful use of EHR technology (which affects the ACO's shared savings/losses)
  - II. Provides for payment based on quality measures comparable to those in MIPS
    - CMS liberally interpreted this requirement, permitting non-MIPS measures such as those "endorsed by a consensus-based entity" or even "any other quality measures that CMS determines to have an evidence-based focus and be reliable and valid"
    - At least one outcome measure is generally required
  - III. Entails "more than nominal" financial risk for monetary losses, or is a medical home model
    - For 2017/2018, the following minimum amounts must be at risk by the APM Entity:
      - Revenue-based standard: 8% of the average estimated total Medicare A/B revenues, OR
      - Benchmark-based standard: 3% of the expected expenditures for which the APM Entity is responsible
- Determined on a track/option basis

2017 Advanced APM's

- Comprehensive ESRD Care (CEC) – Two-Sided Risk
- Comprehensive Primary Care Plus (CPC+)
- Next Generation ACO Model
- Shared Savings Program – Track 2
- Shared Savings Program – Track 3
- Oncology Care Model – Two-Sided Risk
- Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1 – CEHRT)
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)

Additional Advanced APM Options Likely

- CMS considering new Medicare Shared Savings Program Track 1+ Model starting for the 2018 performance year
  - Track 1+'s payment model would "incorporat[e] more limited downside risk than is current present in Tracks 2 or 3 of the Shared Savings Program"
  - Could be open to:
    - Initial applicants
    - Track 1 ACO's within their current agreement period
    - Track 1 ACO's renewing their agreement
  - Potentially significant development given relatively modest number of MSSP Track 2/Track 3 (or Next Generation) ACO's
- MACRA Final Rule more broadly foreshadowed the future development of new Advanced APM's, including those that may be proposed through the newly-created Physician-Focused Payment Model Technical Advisory Committee (PTAC)

Advanced APM Participation Thresholds

- Intent is for Advanced APM incentives to only be available to entities/individuals “who are clearly and significantly engaged in delivering value-based care through participation” in Advanced APM’s
- Must achieve:
  - A statutory Payment Amount Threshold; or
  - A rule-based Patient Count Threshold
- With limited exceptions, QP determinations are a single determination for all eligible clinicians within an Advanced APM entity
- Based on the first 8 months of a QP Performance Period
- Thresholds focus on Medicare payments/patients respectively, except that beginning in performance year 2019 (i.e., payment year 2021), clinicians can satisfy threshold criteria based on combined payments from Medicare and other payers, with reduced Medicare floors
  - Assumes the existence of private payor ACO or other models with the key features of Advanced APM’s (Other Payor Advanced APM’s)

Advanced APM Participation Thresholds

	Payment Year 2019, 2020	Payment Year 2021, 2022	Payment Year 2023 and later
QP Thresholds	25% Medicare Payments OR 20% Medicare Patients	50% Medicare Payments* OR 35% Medicare Patients**	75% Medicare Payments* OR 50% Medicare Patients**
Partial QP Thresholds	20% Medicare Payments OR 10% Medicare Patients	40% Medicare Payments*** OR 25% Medicare Patients****	50% Medicare Payments*** OR 35% Medicare Patients****

* If threshold achieved via All-Payer Total, Medicare threshold reduced to 25%
** If threshold achieved via All-Payer Total, Medicare threshold reduced to 20%
*** If threshold achieved via All-Payer Total, Medicare threshold reduced to 20%
**** If threshold achieved via All-Payer Total, Medicare threshold reduced to 10%

Partial QP MIPS Election

- Partial QP's do not receive the 5% incentive payment (or the increased physician fee schedule update that begins in 2026)
- Partial QP's are still exempt from MIPS reporting (and associated payment modifications), but may elect to participate in MIPS
  - Election generally must occur at the APM Entity level
  - However, where the QP determination is made at the individual clinician level, the clinician will make the MIPS election
- Partial QP's would presumably only elect to participate in MIPS to the extent that they anticipate a positive payment adjustment

IV. MACRA Implications

Macra Integration Implications

- MACRA embodies the fundamental goal of CMS to shift Medicare reimbursement from fee for service to performance-based.
- MACRA, through MIPS and Advanced APM, has created significant incentives for physicians to align with Health Systems, large Clinics, or well-capitalized MSO organizations.

- This alignment is essential because only through it can physicians reasonably gain access to the clinical and financial structures necessary to report, perform and, it is hoped, thrive under the MIPS or Advanced APM requirements.
- Potential Physician Alignment Models:
  - Employment
  - Leased or Contracted Services
  - MSO
  - ACO or CIN membership

- The alignment model selected will raise issues about the extent of support provided and the financial terms under which it is provided.
  - Employment (Stark, AKS)
  - Leased or Contracted Services (Stark, AKS)
  - MSSP ACO membership (Waivers)
  - MSO (Stark, AKS)

MACRA Implications for ACO and CIN Development

- The financial benefits accruing to physicians from participating in a successful MIPS or Advanced APM program create an important additional incentive to join an ACO or CIN.
- These benefits would be in addition to the other less certain financial benefits offered by ACO and CIN participation.
  - Sharing in MSSP Awards (if a MSSP ACO and if awarded)
  - Sharing in improved private payor reimbursement through better contracts (sometimes slow to develop)
  - Health System's quality and performance program payments (can vary based on System engagement)

Macra Implications For Health Systems

Like success under the MSSP ACO Program, success under MACRA in the form of higher reimbursement to physicians will likely be at the cost of FFS in-patient revenue that would have accrued to the Health System. As Health Systems change their strategy from relying on FFS as their leading revenue driver to relying on performance-based revenues, careful management and development of MACRA-based programs will be necessary.


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