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Management Alert

The Brave New World of Physician Medicare Payment: MACRA Makes Sweeping Changes

By William B. Eck

On November 14, 2016, CMS published its final rule implementing the physician payment provisions of the Medicare Access and CHIP Reauthorization Act ("MACRA"). The rule became effective January 1, 2017. Data collection from physicians begins with 2017 data, and the payment impact will begin in 2019 based on the 2017 data.

MACRA and the final rule make the most dramatic changes in Medicare payment for physician and other clinician services in decades. Clinicians have been paid by Medicare under a fee schedule, with inflation-related annual updates, referred to as the sustainable growth rate ("SGR"). MACRA replaces the SGR with the Quality Payment Program ("QPP"). The QPP is intended to shift the emphasis in clinician payment from quantity to quality.

The QPP establishes two payment tracks. With the exception of practices that have very low Medicare volume, clinicians will be paid on one of these two tracks. Low Medicare volume is defined as billing Medicare less than $30,000 per year or providing care to 100 or fewer Medicare patients per year. The first track is called the merit based incentive payment system ("MIPS"). MIPS is the default track, and most clinicians will be paid under MIPS.

The second payment track is called the advanced alternative payment model track ("advanced APM"). Advanced APMs may, for example, pay clinicians on capitation or in part on an outcome related basis, and they may focus on certain procedures, disease states or specialties. In general, clinicians who participate in advanced APMs will be paid by Medicare on the advanced APM track. Each of these tracks is discussed below.

MIPS

As noted, MIPS is the default payment track of the QPP, and most clinicians will be paid by Medicare under MIPS. It subjects clinicians to adjustments to the fee schedule payment amounts based on three, then four, categories of measures, as follows: (i) quality measures (to be published annually); (ii) clinical practice improvement; (iii) advancement of care information (implementation of IT); and, beginning in 2018, (iv) cost. Clinicians subject to MIPS include not only physicians, but also other health care providers such as dentists, physician assistants, nurse practitioners and certified registered nurse anesthetists. Clinicians will submit these data to CMS contractors for 2017 in a format to be prescribed by March 31, 2018. The final rule provides detail on the content of each of these measures.

The data will be weighted and scored, and begin affecting payment in calendar year 2019. For 2019, clinicians will be subject to payment adjustments based on 2017 data as follows: (i) a clinician who reports nothing will be subject to a four (4) percent decrease in payment; (ii) a clinician can choose to report one measure for a 90-day period (other than cost) and avoid a negative adjustment, but not be eligible for a positive adjustment; (iii) a clinician can report for less than a full year

performance period (but at least 90 days) more than one quality measure, more than one improvement activity, or more than the required measures in the advancing care information category to possibly achieve a positive adjustment; and (iv) a clinician can choose to report all measures for more than a 90-day period, or ideally the full year, and maximize the opportunity for a positive adjustment.

CMS encourages clinicians to report in all three categories: quality, improvement, and advancing care information. For full participation in the quality performance category, clinicians will report information in 6 measure sets, or one specialty-specific or subspecialty-specific measure set. For full participation in the improvement activities performance category, clinicians can engage in up to 4 activities. Full participation in the advancing care information category requires reporting on 5 required measures. The details and weightings of these measures are set forth in the final regulations and their appendices.

Once clinicians submit the data in each of the categories, CMS will score the data based on criteria articulated or determined in accordance with the final regulations. The scored data will then be weighted, and the scored and weighted data will be used to calculate the MIPS adjustments to the fee schedule.

The MIPS adjustments are required to be budget neutral. Therefore, there will be winners and losers under MIPS. As noted, the greatest negative adjustment in 2019 under MIPS is 4 percent. The greatest possible positive adjustment in the 2019 payment year is 4 percent, but CMS estimates that more realistically the greatest positive adjustment will be approximately 2 percent. There is a $500 million pool for positive adjustments in the 2019 payment year, which must be shared by those receiving positive adjustments. Adjustments gradually increase until 2022, and subsequent years, when the greatest positive or negative adjustment will be 9 percent. Thus, as implementation of MIPS and the QPP proceeds, the effect of these adjustments becomes quite substantial.

Advanced APMs

Clinicians who qualify and participate in advanced APMs, Qualifying APM Participants or "QPs," may thereby avoid MIPS. To be a QP, a clinician must be part of an APM entity (a network or other entity that includes clinicians) that provides: (1) at least twenty-five (25) percent of its total Medicare professional covered services through an advanced APM; or (ii) services to at least twenty (20) percent of its total Medicare patients through an advanced APM. These thresholds increase in years after 2018, as discussed below. CMS estimates that 70,000 to 120,000 clinicians will initially be eligible to be QPs. Clinicians who do not satisfy these thresholds may be able to satisfy somewhat lower thresholds and be Partial QPs.

QPs in 2017 will receive a five (5) percent positive incentive bonus payment adjustment in 2019. This will apply to future years as well. Partial QPs will not receive this adjustment but will be entitled to opt out of MIPS.

In the 2017 and 2018 performance years (2019 and 2020 payment years), only participation in Medicare advanced APMs will count towards whether a clinician has satisfied the threshold to be a QP or a Partial QP. Thereafter, participation in all payer advanced APMs will also count towards these thresholds, but the final rule establishes different thresholds for the all payer advanced APM than for the Medicare only advanced APM. As in the case of the Medicare only advanced APMs, these thresholds increase over time. MACRA and the final regulations also establish criteria for the less frequently used Medicaid advanced APM and medical home models.

Medicare and other advanced APMs must: (i) use electronic health records; (ii) pay for professional services using quality measures similar to MIPS; and (iii) require that APM entities (which, as noted, include clinicians), bear risk of more than a nominal amount related to poor performance or monetary losses. This last factor diminishes the benefit of the 5 percent positive payment adjustment.

Advanced APMs must be approved by CMS. The final regulations establish the Physician Focused Payment Model Technical Advisory Committee ("PTAC") to streamline consideration of APM applications and make recommendations to CMS. For 2017, the advanced APMs are: (i) Comprehensive Primary Care Plus, a national model under the Affordable Care Act; (ii) next generation ACOs; (iii) Medicare shared savings programs, tracks 2 and 3; (iv) certain oncology models with two-sided risk; and (v) comprehensive ESRD care. CMS has indicated that cardiology and joint replacement are also likely candidates to be advanced APMs in the future.

QPs and Partial QPs

As noted, the final regulations establish thresholds for clinicians to be QPs or Partial QPs. Other than clinicians with low Medicare volume practices, only clinicians who are QPs or Partial QPs are exempt from or may opt out of MIPS. CMS will evaluate whether advanced APM entities meet the thresholds for their clinician members to be QPs or Partial QPs using a combination of two methods -- the payment amount method and the patient count method. Each of these is intended to establish that a specified threshold of the APM entity's total services are advanced APM services, and are described below.

The payment amount method determines the aggregate of payments for covered Part B services provided to beneficiaries attributed to the APM entity divided by the aggregate of payments for covered Part B services furnished by the APM entity to all attribution-eligible beneficiaries.

The patient count method determines the number of beneficiaries attributed to the APM entity for whom the APM entity's clinicians provided covered Part B services divided by the total number of attribution eligible beneficiaries for whom the advanced APM entity clinicians provided covered Part B services.

"Attribution eligible" beneficiaries are Medicare primary fee for service beneficiaries enrolled in both Part A and Part B who are at least 18, reside in the U.S., and have a minimum of at least one claim for evaluation and management services by an eligible clinician or group of clinicians during the performance period. Thus, in each case, in general, the method divides the volume (either dollars or patients) of the advanced APM entity's clinicians' advanced APM Medicare Part B services by their total Medicare Part B services.

The thresholds for QP status for 2017 and 2018 are noted above. The complete set of thresholds for QP and Partial QP status established in the final regulations are as follows:

QPs

Payment Year	Medicare Advanced APM	All Payer Advanced APM
2019 – 2020		
Payment Amount Method	25%	N/A
Patient Count Method	20%	N/A
2021 – 2022		
Payment Amount Method	50%	Medicare – 25%, All – 50%
Patient Count Method	35%	Medicare – 20%, All – 35%
2023 and Subsequent		
Payment Amount Method	75%	Medicare – 25%, All – 75%
Patient Count Method	50%	Medicare – 20%, All – 50%

Partial QPs

Payment Year	Medicare Advanced APM	All Payer Advanced APM
2019 – 2020		
Payment Amount Method	20%	N/A
Patient Count Method	10%	N/A
2021 – 2022		
Payment Amount Method	40%	Medicare – 20%, Total – 40%
Patient Count Method	25%	Medicare – 10%, Total – 25%
2023 and Subsequent		
Payment Amount Method	50%	Medicare – 20%, Total – 50%
Patient Count Method	35%	Medicare – 10%, Total – 35%

CMS desires a significant percentage of clinicians to become QPs, and it desires wide adoption of advanced APMs. In view of the high thresholds for QP status, it is not clear that this will occur, at least not so rapidly as CMS desires.

Some Likely Consequences

MACRA and the final regulations are likely to increase practice costs. Investment in information technology will be required, and an IT infrastructure for tracking, aggregation, analysis and reporting of data. Support systems will be necessary to identify and assist in implementing changes in practice patterns. This will have a potentially significant impact on the economics of clinician service delivery, and it may lead to consolidation of practices, particularly in specialties with high Medicare utilization.

It is likely that MACRA and the final regulations will enhance the drive to integration and the implementation of alternative payment models. MACRA increases the incentives toward the adoption of these models, and can be expected to increase clinician support and buy-in for such models.

Contract and Compliance Issues

Especially in practice areas with high Medicare utilization, the wRVU compensation model should be re-examined. These practice areas include nephrology, cardiology, orthopedics and gerontology. Methods of compensation of clinicians should be aligned with methods of payment for the services of the clinicians for both business and regulatory reasons. Otherwise, the compensation method may give rise to a misalignment of business incentives, or what could potentially be worse, a risk that the compensation payments could be characterized as not being fair market value or commercially reasonable. Guarantees and fixed or volume-based compensation should also be reviewed. Particularly where a clinician is employed or engaged by a hospital or other health care facility, or hospital or facility affiliate, the employment or independent contractor agreement should be reviewed in light of MACRA, both for business and for regulatory compliance reasons.

MACRA also impacts valuation of clinician practices. Here, there are a couple of critical issues. First, valuations tend to rely on historical data. Under MACRA, valuation advisors and counselors will need to consider whether and how the changes wrought by MACRA should be factored into assessments of value. Second, valuations have tended to take into account wRVU or other productivity metrics. Valuation advisors and counselors will need to consider the extent to which new and different metrics need to be considered under MACRA.

Summary

MACRA and the final regulations promulgated by CMS make substantial changes to payment of physicians and other clinicians under Medicare. These changes are important to all who employ or engage clinicians as independent contractors, as well as to clinicians. MACRA and the regulations establish two tracks for payment. The default track, MIPS, adjusts the fee schedule payment based on various quality, technology, and soon, cost factors. The default track is budget neutral and therefore involves winners and losers. The other track, advanced APM, exempts clinicians from MIPS but requires exposure to payment risk. MACRA is expected to enhance the drive to integration and the adoption of alternative payment models. Finally, those who employ or engage clinicians are well-advised to review contracts in light of MACRA and those who value practices or advise on practice valuation will need to take account of MACRA.

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