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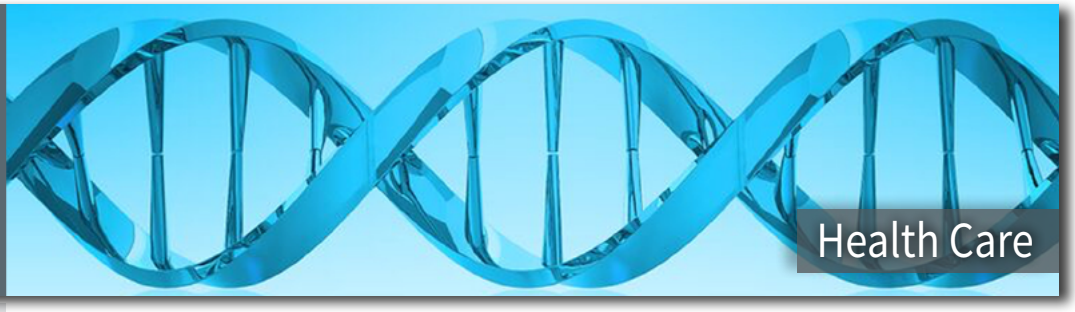

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MACRA: Proposed Changes to the Merit-Based Incentive Payment System Track

by Stephen M. Angelette, William E. Henderson, Rebecca Frigy Romine, Cybil G. Roehrenbeck, Neal D. Shah and Sidney Welch

In this Issue:

The Centers for Medicare & Medicaid Services (CMS) published a proposed rule on the Medicare Quality Payment Program (QPP) in the Federal Register[1] on June 30, 2017. This rule proposes the QPP program requirements for calendar year 2018, the second year of the QPP, per the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). These adjustments are designed to decrease the burden of the QPP on clinicians and assist them in achieving a neutral or positive reimbursement adjustment for Medicare Part B payments in 2020. Reactions to the proposed rule have varied; some stakeholders have expressed concern that changes to the QPP would dilute MACRA's goal of moving from volume-based to value-based healthcare, while others have praised the proposal as appropriately tailored to reduce regulatory burden.

Given the mixed reception to the proposed rule, CMS may make some substantial changes in the final, which is likely to be released this fall.

This article outlines CMS' proposals related to the QPP Merit-Based Incentive Program (MIPS) track, and is a companion piece to an earlier Polsinelli article which outlined the proposed 2018 requirements for the QPP Advanced Alternative Payment Model (AAPM) track.

MIPS Proposals

Under MIPS, eligible clinicians are given a score for their performance in four categories: Quality, Cost, Advancing Care Information (ACI), and Improvement Activities (IA). In 2018, based on that score, a clinician's 2020 Medicare Part B reimbursement may be

1 82 FR 30010. Accessible at https://www.federalregister.gov/documents/2017/06/30/2017-13010/medicare-program-cy-2018-updates-to-the-quality-payment-program.

adjusted upward or downward by 5 percent. CMS proposes to weight the four categories as follows:

MIPS Component	2018 Statutory Weight	2018 CMS Proposed Weight
Quality	30%	60%
Cost	30%	0%
ACI	25%	25%
IA	15%	15%

CMS proposed a number of changes to the overall scoring methodology for program year 2. This includes a number of new bonuses for patient complexity, end-to-end use of Electronic Health Record Technology certified to the 2015 standard, and small practices. In addition, CMS proposes to increase the "threshold" score from 3 to 15 points. MIPS scores below this amount will receive a penalty, while MIPS scores at or above the threshold would receive a neutral adjustment or a bonus. This proposal effectively ends the "Pick Your Pace" minimal participation track, and makes it slightly more difficult to earn a positive score under the partial participation track. **Despite these changes, CMS expects the vast majority of clinicians to receive a neutral or positive adjustment due to the other flexibilities and new bonus opportunities created by the agency.**

CMS also proposed modifications to the four MIPS categories in program year 2, as follows:

Cost

Stakeholders have consistently voiced concerns with including Cost as a category in the early years of QPP, citing issues with measuring cost and the need for a transition into the program to minimize burden on small practices. Correspondingly, CMS proposes to weight Cost at 0 percent for 2018, and to ramp up to a 30 percent Cost component in the third program year, 2019.

Practices will begin receiving information about the Cost category this year. However, CMS is currently working with stakeholders to refine the episode-based cost measures (which cover the costs of specific clinical episodes across multiple settings of care). **As a result, the feedback received in 2017 and 2018 may not directly translate to the actual measures applied in 2019.**

Quality

CMS proposes to maintain a 60 percent Quality component in 2018, reallocating the 30 percent Cost category to this category, and reasoning that this will allow MIPS-eligible clinicians another year to review their performance on Quality measures. CMS proposes that, in future years, both the Cost and the Quality category will be weighted at 30 percent.

CMS also made an adjustment to the data completeness standard for MIPS Quality reporting. In the 2017 performance year, CMS required MIPS-eligible clinicians to report at least 50 percent of their data (or denominator-eligible patients) to meet the data completeness criterion for each measure. And, if a MIPS-eligible clinician did not meet this standard, they could be held harmless from any penalty as long as they submitted one measure. Previously, CMS had finalized a policy to raise this data completeness standard to 60 percent in 2018; however, CMS now proposes to retain the 50 percent standard for 2018, and raise it to 60 percent in 2019. CMS also proposes to provide one point for Quality measures that do not meet the 50 percent data completeness, except for small practices of 15 or fewer who would still receive three points if they report measures but are below the 50 percent standard.[2] In combination with overall scoring changes, if finalized as proposed, this policy could mean that 2018 payment penalties may apply to practices that fall below the data completeness threshold.

Quality Measure Scoring. Under the 2017 Final Rule, MIPS eligible clinicians can earn between three and ten measure achievement points for each measure they submit, so long as the measure can be reliably scored against a benchmark by meeting the case minimum and data completeness requirements. The Proposed Rule would maintain these requirements. For the 2018 MIPS performance period, CMS is proposing to maintain the three point floor for quality measures that can be reliably scored against a benchmark.

2 Note that this change in scoring from the Proposed Rule does not apply to CMS Web Interface measures or administrative claims based measures.

- For 2018, CMS also proposes a number of additional changes to quality scoring rules. For example, CMS proposes a new bonus for performance improvement. The agency also proposes a number of new rules around "topped out" measures designed to evaluate and potentially phase out these common measures, as well as a technical fix to address ICD-10 changes in the middle of a performance year.

Methods of Quality Reporting. Eligible clinicians may report data using several means. These include claims (for individuals only); qualified registries; Qualified Clinical Data Registries (QCDRs); electronic health records (EHRs); or the CMS Web Interface (for larger groups only). Under current rules, clinicians could choose one method to report data for each MIPS component; they were not allowed to report data through multiple sources for the same component. This could cause serious issues for clinicians who practiced in multiple settings (such as a clinician who was required to use different EHR systems in the hospital and office setting). For Year 2, CMS proposes to allow clinicians to submit data using multiple sources, even in the same category. Under this approach, CMS will use data on measures reported through different sources to calculate an overall score for each component. If a clinician reports data on the same measure using different sources, CMS will use the highest score. **The most significant impact of this change is that clinicians or practices may achieve higher quality scores (as this component has the most complex reporting standards).**

However, this change would eliminate a CMS review process for practices using EHRs and QCDRs that allowed practices to achieve a high score on the quality component without submitting all six measures. Under this proposal, CMS would not allow this kind of review for some practices. Specifically, the agency will now expect practices using EHRs and QCDRs to have access to sufficient data submission systems to allow them to provide data on at least six Quality measures. As a result, they state practices using this process would no longer be able to rely on this process; if such practices submit fewer than six measures they will be scored zero points. **One important unanswered question related to this model is whether this proposal will impact practices that use specialty or sub-specialty measure groups.** For example, if a specialty/sub-specialty group has fewer than six applicable measures available for EHR reporting, it is unclear whether a practice may still fulfill Quality reporting standards simply by reporting all of these applicable EHR specialty measures (as allowed under the 2017 Rule), or whether CMS would also expect the practice to report additional measures using another method.

New Quality Bonuses. CMS proposes to add a new set of bonuses to the clinician or group's quality score:[3]

Performance Improvement: CMS proposes a new bonus reflecting improvement of a clinician's performance in this component. This would be based on the overall Quality category, and would not depend on the specific measures reported. A clinician or group could earn a Performance Improvement Bonus of up to 10 points to their Quality component score. This score would be determined by dividing the difference between the 2018 and 2017 Quality score by the 2018 Quality score, and multiplying by 10.

A clinician will only be eligible for this bonus if he or she reports at least six measures in 2018 (and otherwise full performs under the Quality category). In order to prevent a windfall for clinicians who did not participate in 2017, CMS will apply a "floor" of 30 points for 2017 performance, reflecting the minimum score for a clinician that reported on six measures. The Performance Improvement Bonus will apply to the same TIN/NPI combination if possible. If not (for example, if a clinician reported through a Group in 2017, but individually in 2018) CMS will apply a set of "hierarchy" rules to determine the score that should apply. Finally, CMS solicits comments on alternative ways to measure improvement, including using a series of "bands" reflecting ranges of improvement, and the use of the ACO improvement bonus.

Topped Out Measures. CMS is not proposing to remove topped out measures for the 2018 performance period because it recognized that there are currently a large number of topped out measures, and that removing them may impact the ability of some MIPS eligible clinicians to submit six measures and unfairly impact some specialties more than others. CMS did, however, propose to cap the score of a select set of six topped

3 Note that CMS also proposes a small practice bonus that would apply to the overall MIPS score (discussed infra).

out measures at six measure achievement points and propose a timeline for removing those topped out measures in future years. The six topped out measures will be measured for three years. If the measures continue to be identified as topped out, they will be removed from the 2020 performance period and no longer be available for reporting.

The six proposed measures are listed in the following table:

Measure name	Measure ID	Measure type	Topped out for all submission mechanisms	Specialty set
Perioperative Care: Selection of Prophylactic Antibiotic—First OR Second Generation Cephalosporin	21	Process	Yes	General Surgery, Orthopedic Surgery, Otolaryngology, Thoracic Surgery, Plastic Surgery
Melanoma: Overutilization of Imaging Studies in Melanoma	224	Process	Yes	Dermatology.
Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)	23	Process	Yes	General Surgery, Orthopedic Surgery, Otolaryngology, Thoracic Surgery, Plastic Surgery.
Image Confirmation of Successful Excision of Image—Localized Breast Lesion	262	Process	Yes	n/a.
Optimizing Patient Exposure to Ionizing Radiation: Utilization of a Standardized Nomenclature for Computerized Tomography (CT) Imaging Description	359	Process	Yes	Diagnostic Radiology.
Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy	52	Process	Yes	n/a.

Notably, because the Medicare Shared Savings Program incorporates a methodology for measures with high performance into the benchmark, CMS does not believe that capping benchmarks from the CMS Web Interface for the Quality Payment Program would be appropriate at this time.

ICD-10 Exceptions. CMS proposes to create a set of exceptions for scoring against measures in which 10% or more of the diagnosis codes cited in a measure change in the middle of a year. CMS states it would publish a list of these measures in advance. For measures using these codes, CMS would only look at data from January to September (reflecting the agency's understanding of the timing of ICD-10 changes).

Advancing Care Information. On the Advancing Care Information (ACI) front, CMS proposes to retain the existing base score methodology. However, the Proposed Rule creates several new avenues for reporting flexibility, and new options to address practical barriers to participating in this category. For example, the Proposed Rule would expand the current opportunity to earn bonus points by reporting data to an Immunization Registry. Under this proposal, one could earn points by reporting to any Public Health or Clinical Data Registry. This would allow groups or individuals to earn bonus points even if Immunization Registry reporting is not a clinically relevant aspect of their practice. However, a group or individual could only receive bonus points for reporting to one registry. The Proposed Rule also adds new options for

certain IA measures (including newly proposed IA measures) to count towards the ACI category as well, so long as they are reported using CEHRT.

Under the Proposed Rule, clinicians could continue to use either 2014 or 2015 Edition CEHRT into the 2018 performance year. However, clinicians who use the 2015 Edition CEHRT will be eligible for a bonus. Because of this extension, MIPS eligible clinicians may also report on the ACI transition objectives and measures in performance period CY2018, as modified and described below.

CMS also proposes new exclusions/exceptions, to allow certain clinicians to avoid reporting obligations under the ACI category. First, CMS proposes that a clinician who writes fewer than 100 prescriptions in a performance period is not required to report on the e-prescribing objective and measures. Second, CMS would create an exclusion for Health Information Exchange measures for any MIPS eligible clinician who either transfers a patient to another setting or refers a patient fewer than 100 times during the performance period.

Measure Specifications

For the Patient Electronic Access Measure, a MIPS eligible clinician must provide the patient with "timely" access to view online, download, and transmit or download his or her health information. Pursuant to the proposed regulations "timely" would be defined to mean within 4 business days of the information being available to the MIPS eligible clinician. This clarification would begin with the CY2018 performance period.

CMS also created a number of technical changes for specific ACI measures. These are further detailed below.

Related to the Immunization Registry Reporting Measure, CMS clarified that the MIPS eligible clinician must have the ability to *receive* immunization forecasts and histories from the public health immunization information system, not just merely submit immunization data. Such functionality is required to be part of 2015 Edition CEHRT.

For the Medication Reconciliation Measure in the 2017 transition objectives and measures, CMS has proposed to remove medication list, medication allergy list, and current problem list from the numerator.

CMS also proposed a clarification to its current policy for the E-Prescribing Measure of having a MIPS eligible clinician report a "null" value if he or she writes fewer than 100 permissible prescriptions in a performance. Under the proposed regulation, any such MIPS eligible clinician who wishes to claim the e-prescribing exclusion must both select yes to the exclusion and submit a null value for the measure.

New Exemptions

In the 2017 Final Rule, CMS created a limited number of exclusions and hardship exemptions for certain eligible clinicians who faced difficulties reporting on ACI measures. If an exemption applied, the ACI category would be weighted to 0% of the MIPS overall score and the quality category would be reweighted to 85%. This year, CMS proposed a number of new hardship exemptions.

Small Practices. The Proposed Rule would establish a new hardship exception for eligible clinicians in small practices of fifteen or fewer professionals. Clinicians would need to submit an application by December 31 of the performance period or a later date defined by CMS, demonstrating overwhelming barriers that prevent the clinician from complying with the requirements of the ACI performance category.

ASC-Based MIPS Eligible Clinicians may have their ACI performance category reweighted to zero percent of the MIPS final score. An "ASC-based MIPS eligible clinician" will mean a MIPS eligible clinician who furnishes 75% or more of his or her covered professional services in sites of service identified by POS 24 [i.e., Ambulatory Surgical Center] based on claims for a specified period of time. CMS is requesting comments as to whether or not additional POS codes should be included in this definition or whether an alternative method for determining ASC-based status should be used. Status as an "ASC-based MIPS eligible clinician" will be based on claims with a date of service between September 1 of the calendar year 2 years preceding the performance period, unless not feasible, then a 12-month period as close to practicable to this time period would be used. **This would allow MIPS eligible clinicians who qualify for ASC-based status to be notified**

prior to the start of the relevant performance period. ASC-based determinations will be made separate and apart from hospital-based determinations. Similar to hospital-based MIPS eligible physicians, an ASC-based MIPS eligible clinician may voluntarily choose to report on ACI measures; however, if he or she makes such a choice, then he or she will be scored accordingly like all other MIPS eligible clinicians. ASC-based MIPS eligible clinician status would apply beginning with the CY2017 performance period and the exemption would be available until 3 years after the date on which the Secretary determines that CEHRT applicable to ambulatory surgical centers is available.

MIPS Eligible Clinicians Using Decertified EHR Technology may apply for an exemption (and a reweight of the ACI performance category to zero), if the MIPS eligible clinician's CEHRT is decertified either during the performance period or during the calendar year preceding the performance period. As part of the application process, it is proposed that the MIPS eligible clinician must demonstrate that he or she made a good faith effort to adopt and implement another CEHRT in advance of the performance period. Applications for the proposed exception would be due by December 31st of the performance period (and on an annual basis thereafter) and the exemption may only be granted for up to 5 years. The exemption would be available beginning with the CY 2018 performance period.

In addition to the foregoing additional exemptions, CMS has also proposed to modify the definition of "hospital-based MIPS eligible clinician" for purposes of the existing hardship exemption for such clinicians. Currently, a "hospital-based MIPS eligible clinician" is defined as: a MIPS eligible clinician who furnishes 75% or more of his or her covered professional services in sites of service identified by the Place of Service codes POS 21 (inpatient hospital), POS 22 (on-campus outpatient hospital), and POS 23 (emergency room setting) based on claims for a specified period. Under CMS's proposal, professional services furnished at POS 19 (off-campus outpatient hospital) would also count towards "hospital-based eligible clinician" status. **The rationale for this proposal is that these clinicians do not generally have control over the development and maintenance of the EHR systems they use.**

Nurse Practitioners, Physician Assistants, Clinical Nurse Specialists, and Certified Registered Nurse Anesthetists will continue to be assigned a weight of zero for ACI in performance period CY2018, unless they (or their groups) voluntarily submit ACI measure data. Because CMS does not yet have data related to whether there are measures applicable to these types of mid-level providers, CMS has proposed to extend its current policy of automatically reweighting the ACI performance category percent to zero for these types of clinicians, unless ACI measure data is submitted, in which case, the clinician will scored as any other MIPS eligible clinician would be.

Improvement Activities. This category continues to represent 15% of the MIPS total score. It remains largely unchanged. CMS proposed a number of new IAs, as well as the following limited modifications:

- Greater overlap between the ACI and IA categories, with new opportunities to earn points in both categories by reporting on the same set of measures.
- Proposed IA measures that would give practices credit for complying with Appropriate Use Criteria for diagnostic imaging.
- Inclusion of the CPC+ model in the definition of a "patient centered medical home" (PCMH), giving participants in this model an automatic high score in this category.
- A modification to the PCMH rules, providing that favorable treatment under the IA rules will only apply if at least 50% of a TIN's practice sites are PCMHs.

Methodological Changes to MIPS

MIPS Final Score. CMS proposes a number of changes to MIPS scoring methodology. Under current rules, a clinician could earn a bonus of up to 5% of the prior year's Medicare Part B reimbursement. The actual amount of any bonus or penalty is determined using a MIPS final score that will range from 0-100 points.

Modifications to the Performance Threshold: CMS determines the reimbursement implications of a MIPS final

score by comparing this score to a "threshold" amount set by the Agency. Scores below the threshold receive a penalty, scores equal to the threshold receive no adjustment, and scores above the threshold may receive a bonus. For 2017, the threshold is 3 points (meaning that a clinician could avoid a penalty by submitting minimal data on a single Quality measure, or data on one other component). CMS proposes to raise this threshold to 15 points. This increase will make it more difficult to achieve a positive score, but CMS observes a clinician could meet this threshold by reporting on only one component, so long as its substantive performance on that component is strong. Even with this change, CMS estimates that over 90% of clinicians will receive a positive or neutral adjustment for the 2018 performance year.

Small Practice Bonus: Under the Proposed Rule, a small practice (with 15 or fewer clinicians) is eligible for an additional scoring bonus. This five-point bonus would be added directly to the final score. The bonus would not depend on performance on Quality measures or other reporting requirements; it would automatically apply to small practices. The bonus would cover groups, virtual groups, or APM Entity groups, so long as they had no more than 15 eligible clinicians. It is unclear whether clinicians reporting individually will be treated as a "small practice." Note that CMS does not propose to apply this bonus to 2017 scores; instead, it would only apply starting in the 2018 year.

Patient Complexity Bonus: CMS proposes a Patient Complexity bonus that would use Hierarchical Condition Categories ("HCCs") to calculate a bonus reflecting the clinical complexity of the patients seen by a clinician.[4] CMS would analyze the average HCC scores of patients seen by a clinician from September 1, 2017 to August 31, 2018 (the same 12-month period used to determine non-patient-facing and low-volume status). Clinicians could receive a bonus of up to 3 points to their overall score. A clinician must submit at least one measure in any component (i.e., not only Quality) to receive this bonus.

HCCs are currently used in a number of CMS programs, including risk adjustment for Medicare Advantage and Health Insurance Exchange plans. The VM program provided a bonus for clinicians who saw the highest-complexity patients based on HCCs. However, this is the first time HCCs would be used to evaluate a wide cross-section of physicians in the Medicare Physician Fee Schedule. While HCCs provide a useful method to measure the relative complexity of patient health needs, this model has been criticized for potentially incentivizing upcoding.

CMS also solicits comment on applying an adjustment for other risk factors, including a variety of "social risk factors." Its most developed proposal concerns a bonus for clinicians who treat a large proportion of dual eligible enrollees.

"Low Volume" Exclusion. MIPS is the "baseline" set of rules for payments made to clinicians under the Medicare Physician Fee Schedule. In general, MIPS will apply unless: 1) an individual or practice is part of an alternative payment model; or 2) a MIPS exclusion applies. One major MIPS exclusion is the "low-volume" exclusion, which shields practices with limited Medicare volume.

Under the 2017 Final Rule, CMS exempted from MIPS individuals or groups that saw 100 or fewer patients or received $30,000 or less in Medicare Part B reimbursement. The Proposed Rule would increase this threshold to 200 or fewer Medicare beneficiaries or $90,000 or less in Medicare Part B reimbursement. If incorporated into the final rule, this change would exempt almost half (nearly 600,000/1.2M) of the otherwise MIPS-eligible clinicians). This also has implications for the availability of certain Quality measures, since a measure will not be scored unless CMS can create a benchmark based on data from at least 20 MIPS eligible clinicians. CMS seeks comments on this expansion, particularly noting that without change to its benchmark policy, one consequence of this exemption's expansion is that it may cause many quality measures to fall below the benchmark threshold. CMS requests comments on whether, and if so how, it should modify its benchmark policy to address this issue.

Methods of Reporting. The 2017 Final Rule established three participation options for MIPS – individual, group, or APM reporting. The Proposed Rule includes new participation options: partial reporting and virtual groups, and facility-

4 Used in other CMS programs, HCCs have been useful in measuring relative complexity of patient health needs; however, HCCs have also been criticized for potentially incentivizing upcoding.

based measurement. CMS also finalized a new, distinct set of rules for clinicians that primarily practice in hospitals. Each of these is discussed in more detail below.

Partial Group Reporting: In general, MIPS requires an entity that is reporting as a group to report on behalf of all eligible clinicians who bill through its TIN. However, CMS notes that certain APMs allow portions of a TIN to participate in an APM (for example, a single location of a multi-location group may be a participant in certain kinds of APMs). CMS proposed partial group reporting where portions of a tax payer identification number (TIN) participate in an APM (such as a single location of a multi-location group). Under this proposed option, the non-APM clinicians may collectively report as a group (even though the TIN would therefore be split between two reporting methods).

Virtual Group Reporting: There are generally three ways to participate in MIPS: (1) as an individual; (2) as a group; and (3) as a virtual group. Virtual groups were not available for the 2017 performance year but are proposed for introduction in 2019. Virtual groups may choose their participants, but must include at least two entities (or an entity and an individual). A group may only join a "virtual group" if it contains 10 or fewer clinicians. A list of participants must be provided to CMS no later than December 1 of the year before the performance year (i.e., for 2017, such a list must be submitted no later than December 2, 2017). Participants in a virtual group cannot change this election during the performance year.

Although there are restrictions on the specific participants in a virtual groups, CMS proposes they would otherwise enjoy significant flexibility. A virtual group is not limited to any set number of total clinicians, nor is it limited to a defined geographic area or set of specialties. However, members in a virtual group may only participate in a single virtual group. Further, a member may not participate in a virtual group if the member is excluded from MIPS (e.g., if it falls below the low-volume exclusion). Notably, CMS does not propose any changes to the application of Stark Law for participants in a virtual group, so parties should proceed carefully in structuring such arrangements.

Group participants in virtual groups need only be MIPS eligible at the group level and may include some clinicians who individually fall under one of the MIPS exclusions, though the MIPS payment adjustment may not apply to those ineligible clinicians. Once a group elects to participate in the virtual group, all clinicians under the group TIN must be included. The sole exception is that, where a single TIN contains a subset of clinicians who participate in an APM, that TIN may allow the remainder of its clinicians to be scored under the virtual group standard. (see the proposal regarding Partial Group Reporting above).

CMS would identify virtual groups using a two-step process:

- In stage one, CMS will provide virtual groups with an optional determination of their eligibility early in the year. Group participants in virtual groups need only be MIPS eligible at the group level and may include some clinicians who individually fall under one of the MIPS exclusions, though the MIPS payment adjustment would not apply to those ineligible clinicians.

- In stage two, the virtual group must identify its members to CMS and enter into a participation agreement between the members pursuant to CMS guidance. CMS has stated it will provide a "Model Agreement" establishing key terms in the future.

Entities considering election as a virtual group should consider that failure to participate in stage one of the election process could lead to a rejection in stage two without sufficient time to amend and resubmit prior to the election deadline.

Just as with group reporting, participants in a virtual group will share the same performance data and receive the same performance score. Virtual groups would also have the same options as group practices to report data (e.g., they would not be able to utilize claims reporting). CMS requests comment on these issues.

Other Key Virtual Group Points:

- If a group or solo practitioner, TIN or NPI, moves from a virtual group to an APM, CMS proposes to exercise waiver authority to utilize the applicable APM score rather than the virtual group score.

- Policies that apply to groups would generally apply to

virtual groups with the exception of the requirements for consideration as non-patient facing, small practice status, and rural and health professional shortage area designations.

- virtual group Non-Patient Facing: More than 75 percent of the virtual group NPIs meet the definition of a non-patient facing individual MIPS eligible clinician
- virtual group Small Practice Status: Fewer than 16 NPIs included in the virtual group
- virtual group Rural and Health Professional Shortage Area Designations: 75 percent or more of the TIN's practice sites designated as rural or health professional shortage area

Facility-Based Measurement: Finally, CMS proposes a scoring option for clinicians who are primarily hospital-based. Under the proposed "facility-based measurement" standard (or FBM), a clinician who furnishes at least 75% of the clinician's Medicare-covered professional services in a hospital inpatient or emergency department setting may elect to be scored using FBM. Group eligibility requires that 75 percent of group clinicians meet the eligibility requirement as individuals. Inpatient and emergency setting are to be determined by claims utilizing "place of service" codes 21 and 23, respectively. The proposed rule includes eligibility determinations that are based on the period beginning September 1 of the calendar year 2 years preceding the performance period through August 31 of the calendar year preceding the performance period, with a 30-day claims run out. If this is infeasible, a 12-month period as close as possible to the proposed determination period would be used instead.

Under this option, the hospital Total Performance Score from the facility where the clinician treats the highest number of Medicare beneficiaries during the period will be converted into a MIPS quality performance category and cost performance category score.

FBM would use the benchmarks established for the applicable facility under the VBP (Hospital Value Based Purchasing) for the applicable year to calculate a MIPS quality score for the clinicians. The benchmark would be converted to a MIPS score by relating the VBP performance percentile to an equivalent percentile rank for the MIPS quality score (as compared to non-FBM clinicians). However, clinicians using FBM would not be ranked lower than the 30th percentile. In future years, similar adjustments would apply to the cost category. Clinicians using FBM would also get the benefit of future adjustments to the hospital's Total Performance Score.

Note that participation in the FBM is voluntary. If a clinician or group participates in FBM but also submits quality data through another MIPS mechanism, CMS proposes that the higher of the two quality scores should be used along with the corresponding cost score. However, this might result in an unfair advantage for facility-based clinicians since non-facility-based clinicians would not have the opportunity to use the higher of two scores. As such, comment on the appropriateness of this proposal is requested.

Commentary has been requested on policies which relate to virtual groups.

Conclusion

Perhaps the most significant impact of the Proposed Rule is that it would significantly reduce the number of clinicians subject to MIPS. Moreover, CMS estimates the vast majority of clinicians will receive either a neutral payment or bonus, and over 70% will receive an "exceptional performer" bonus. Given the budget-neutral nature of the program, this likely means that the impact of any MIPS penalties will be concentrated among a small group of providers (each of whom receives a large penalty), while bonuses will be spread across a large pool of providers (such that many providers will receive a bonus, but the amount will be relatively small). **In some ways, 2018 should be seen as another "transition year," whose main purpose is to allow providers to continue to evaluate their performance in preparation for a wider shift to value-based payment.**

As the final rule issues this fall, Polsinelli will provide further updates.

Authors:

Stephen M. Angelette
Associate
214.661.5563
sangelette@polsinelli.com

William E. Henderson
Associate
303.256.2704
whenderson@polsinelli.com

Rebecca Frigy Romine
Shareholder
314.889.7013
rromine@polsinelli.com

Cybil G. Roehrenbeck
Counsel
202.777.8931
croehrenbeck@polsinelli.com

Neal D. Shah
Associate
312.463.6233
nshah@polsinelli.com

Sidney Welch
Shareholder | Health Care Innovation Practice Chair
404.253.6047
swelch@polsinelli.com

For More Information

For questions regarding this alert or to learn more about how it may impact your business, please contact one of the authors, a member of our **Health Care** practice, a member of our **Public Policy** practice, a member of our **Health Care Innovation** practice, or your Polsinelli attorney.

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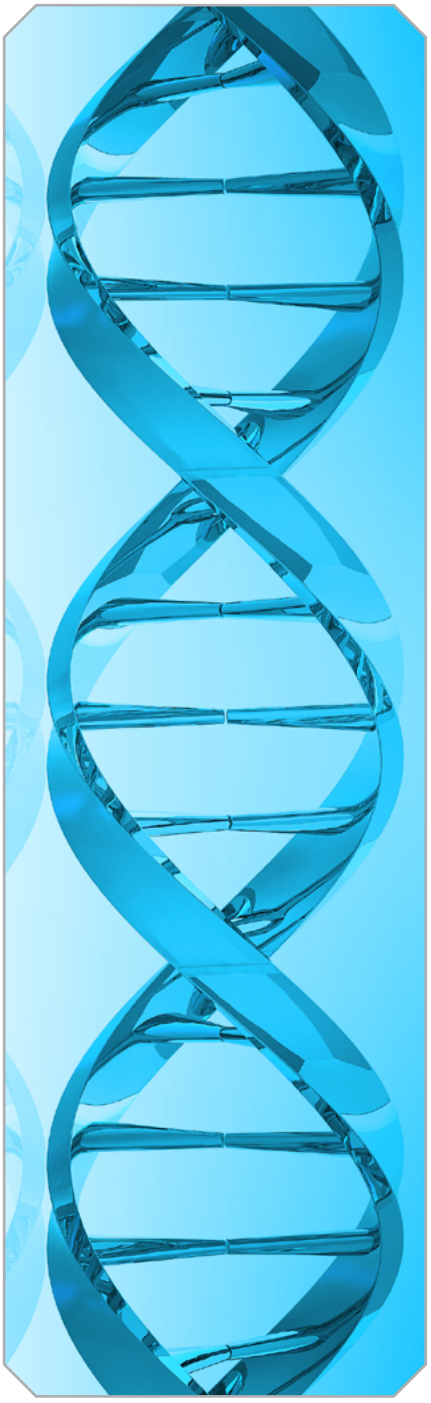

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