ROPES & GRAY

ALERT

Health Care

July 20, 2015

CMS Proposes Reporting and Payment Changes in Proposed 2016 Physician Fee Schedule Rule

On July 15, 2015, the Centers for Medicare and Medicaid Services ("CMS") published its Calendar Year ("CY") 2016 Physician Fee Schedule ("PFS") Proposed Rule in the Federal Register. The rule proposes new physician payment and quality monitoring policies; begins implementation of the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA"), in which Congress scrapped the historic Sustainable Growth Rate (or "SGR") formula and, separately, authorized CMS to implement the Merit-Based Based Incentive Payment System ("MIPS"); and proposes to finalize changes to the Physician Quality Reporting System ("PQRS"), the Physician Value-Based Payment Modifier ("Value Modifier"), and the Medicare Electronic Health Record ("EHR") Incentive Program. Notably, the to-be-developed MIPS program will replace the PQRS and Value Modifier programs in 2019; the first MIPS performance measurement period could begin as early as CY 2017.

Although the proposed rule keeps the existing physician value-based purchasing programs largely in place for the time being, it reinforces the need for physicians to stay abreast of evolving reporting structures and requirements for quality and outcomes-based measures, especially as MIPS rolls out, lest they face significant reductions, or miss out on meaningful increases, in Medicare payment. As one example, under the existing PQRS and Value Modifier programs, Medicare groups of ten or more physicians could face as high as a 6% percentage reduction in their Medicare rates of payment in CY 2017. Moreover, under MIPS, the potential Medicare payment rate percentage adjustments, positive and negative, will increase from 4% in 2019 to 9% in 2022 and subsequent years. Further, physicians should note CMS's intention to increase the volume of their reported quality data that is publicly available to consumers for comparison.

These proposals, as well as certain other proposed changes, are summarized below. Also, see *CMS Proposes New Stark Exceptions and Clarifications in Proposed 2016 Physician Fee Schedule Rule*, published here, for a description of the proposed rule's changes to physician self-referral regulations. Comments on the proposed rule are due by September 8, 2015.

Select Topics Covered in the 2016 PFS Proposed Rule

- Physician Quality Reporting System. CY 2016 will be used as the reporting period for the CY 2018 PQRS reductions. Consistent with the 2017 PQRS reduction (to be taken based upon 2015 reported measures), CMS proposes a 2% payment reduction in 2018 for individual eligible providers or group practices that do not satisfactorily report data on PQRS quality measures or, in lieu of reporting, participate in a qualified clinical data registry ("QCDR") in 2016. The 2018 reduction will be the last under PQRS; adjustments thereafter will be governed by MIPS. CMS further proposes the addition and elimination of certain measures, yielding a grand total of 300 measures in the PQRS set for 2016 if all proposals are finalized.

- Reported Measures and Benchmarks Publicly Available. CMS continues to increase public reporting of individual and group-level PQRS reported measures on the Physician Compare website and proposes to do the same with QCDR measures. In addition, CMS proposes public reporting of benchmarks using the Achievable Benchmark of Care methodology, which is annually calculated based on PQRS performance rates. CMS believes that such benchmarks, to be displayed as a five-star rating, will enable consumers to compare both physician groups and individual physicians.

ATTORNEY ADVERTISING

- Physician Value-Based Payment Modifier. As in years past, the CY 2018 Value Modifier will be applied based on PQRS participation by group practices and individual providers. CMS will continue to use its quality-tiering methodology for upward, neutral and downward adjustments for all groups and practitioners that successfully report PQRS measures during CY 2016. Beginning with CY 2018, Value Modifiers will be applied to non-physician eligible provider groups (PAs, NPs, CNSs, CRNAs) and solo practitioners; however, such providers will not be subject to downward adjustments. Further, CMS proposes to waive application of the Value Modifier if groups and providers participated in the Pioneer ACO Model, CPCI or another applicable model beginning with the CY 2017 adjustment period. Finally, consistent with CY 2017, the maximum upward and downward adjustment factors remain at 4.0% for groups of 10 or more eligible providers and 2.0% for groups of fewer than ten as well as solo providers (both physicians and non-physicians). The Value Modifier Program will end in CY 2018 and be replaced with MIPS beginning in CY 2019.
- Medicare EHR Incentive Program. CMS proposes to revise the definition of certified EHR technology such that in order to electronically submit clinical quality measures, EHR technology must be certified according to applicable submission standards issued by the Office of the National Coordinator for Health Information Technology.
- Medicare Shared Savings Program. CMS proposes to modify specific sections of the Shared Savings Program regulations. Most importantly, CMS allows measure owners to eliminate measures if such owners determine that such measures no longer align with current clinical practice or cause patient harm. Further, CMS clarifies how PQRS-eligible providers participating in ACOs can meet their PQRS reporting requirements when ACOs report quality measures. Finally, CMS proposes to amend the definition of "primary care services" to exclude claims submitted by skilled nursing facilities and to include claims by Electing Teaching Amendment hospitals.
- Request for Input on MACRA Implementation. CMS seeks input on the implementation of MACRA, including how to structure the physician-focused payment model (MIPS). CMS indicates that it will send out a subsequent Request for Information requesting comments on a broader range of MACRA implementation issues.
- Other Proposed Rule Changes. CMS proposes other changes to physician reporting and payment mechanisms, including: (i) modifying billing codes for biosimilars; (ii) implementing methodologies to reduce the payment of misvalued CPT codes and phasing in certain RVU reductions, both in accordance with the Protecting Access to Medicare Act of 2014; (iii) tightening up the requirement that, for certain "incident to" services furnished by auxiliary personnel, the billing practitioner must also be the individual who supervises the personnel; and (iv) changing physician opt-out procedures to accord with new statutory requirements enacted by Congress in MACRA.

Should you have questions regarding this alert, please contact your usual Ropes & Gray advisor.

This alert should not be construed as legal advice or a legal opinion on any specific facts or circumstances. This alert is not intended to create, and receipt of it does not constitute, a lawyer-client relationship. The contents are intended for general informational purposes only, and you are urged to consult your attorney concerning any particular situation and any specific legal question you may have. © 2015 Ropes & Gray LLP

ATTORNEY ADVERTISING