

Transitioning from Volume to Value: Medicare's New Physician Payment Program

October 26, 2016 – *Dorsey Health Law*
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The Centers for Medicare & Medicaid Services (CMS) released an advanced copy of the final rule implementing the agency's new dual-track Quality Payment Program created by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The final rule made several significant changes to the proposed rule that was released earlier this year and offers eligible clinicians considerable flexibility for participation in 2017.

By way of background, MACRA, which passed with broad bipartisan support, replaced Medicare's much-maligned "Sustainable Growth Rate" formula with the new Quality Payment Program. The new Quality Payment Program continues CMS's transition from paying for volume to paying for value and represents the most comprehensive Medicare payment reform since the creation of the hospital prospective payment systems. Under MACRA, eligible clinicians, including physicians, physician assistants, nurse practitioners, clinical nurse specialists and certified nurse anesthetists, can participate in the Quality Payment Program through one of two tracks: the Merit-Based Incentive Payment System (MIPS) or Advanced Alternative Payment Models (Advanced APMs).

CMS received over 4,000 comments in response to its proposed rule released on April 27, 2016. In a call with reporters following the release of the final rule, acting CMS Administrator Andy Slavitt said many of the comments could be summed up as a request from providers to make the transition as simple and flexible as possible. At least initially, responses from providers and provider associations have been positive, particularly in response to CMS's decision to treat 2017 as a transition year.

Some of the key changes in the final rule include the following:

- Adoption of the pick your pace concept to allow clinicians to avoid negative payment adjustments. CMS established a number of policies for calendar year 2017, which CMS refers to as a transition year, in an effort to make the initial transition into the Quality Payment Program more flexible. The most significant of these policies was the formal adoption of the "pick your pace" concept that was originally announced as a possibility in September. Under the pick your pace concept, clinicians participating

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in the MIPS track (which CMS estimates will initially be over 90% of eligible clinicians) can choose from three levels of participation during the first performance year. By submitting only a minimum amount of data, eligible clinicians can avoid a downward payment adjustment in 2019 based on first year (2017) performance. Eligible clinicians may earn positive adjustments through higher levels of participation.

- Reduced year one goals to help alleviate reporting burden. CMS also reduced a number of the objectives required for participation in each of the four MIPS performance categories in 2017. For example, the final rule reduces the number of activities required to achieve full credit in the improvement activity performance category from six medium-weighted or three high-weighted activities to four medium-weighted or two high-weighted activities.
- New category weighting to address provider concerns about first year reporting. The final rule includes adjusted MIPS performance category weighting. Specifically, the quality performance category weight was increased from fifty percent to sixty percent for year one while the resource use performance category weighting was reduced from ten percent to zero for year one. The weighting will change in future performance years, with resource use eventually being worth thirty percent of the total composite performance score.
- Including more clinicians in the “low volume” exclusion; Support for small and independent practices. The final rule includes a number of revisions designed to make it easier for practices with 15 or fewer clinicians to participate in MIPS. In addition, the final rule modified the low volume threshold to exempt more clinicians from participation. Under the final rule, MIPS will not apply to practices with less than \$30,000 in Medicare charges or fewer than 100 unique Medicare patients per year. The threshold was originally set at \$10,000 in the proposed rule.
- New website. CMS launched a new website on the same day it released the final rule. The website (available [here](#)) includes a number of resources designed to help clinicians identify how best to participate in the Quality Payment Program based on practice size, specialty, location and patient population.

The advanced copy of the final rule is available [here](#). An executive summary of the final rule prepared by CMS is available [here](#). The official version of the final rule is scheduled for publication in the Federal Register on November 4, 2016.