PUBLICATION

Proposed 2016 Physician Fee Schedule Would Impact Medicare Shared Savings Program [Ober|Kaler]

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The proposed Physician Fee Schedule for 2016 [PDF] contains several provisions that are likely to have an impact on the Medicare Shared Savings Program (MSSP). These provisions focus in large part on quality measures and the beneficiary assignment process. In addition, however, CMS seeks comment on the need for and scope of a potential new Stark exception for alternative payment models.

Quality Measures

New 34th Quality Measure

To date, there are 33 quality performance measures that Accountable Care Organizations (ACOs) must meet to be eligible to share in any MSSP savings generated. CMS is now proposing to add a 34th quality measure: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease.

According to CMS, the measure is "intended to support the prevention and treatment of cardiovascular diseases." Specifically, the measure will report the percentage of certain beneficiaries who were prescribed, or were already on, statin medication therapy during the measurement year.

New Policy to Address Out-of-date Quality Measures

Citing to the frequency with which scientific evidence and clinical practice changes, CMS is proposing to adopt a new approach for addressing quality measures that no longer align with clinical guidelines, high quality care, or may cause patient harm. If a measure owner determines the measure no longer aligns with updated clinical practice or causes patient harm, the measure owner will inform CMS, who will either: (1) maintain the measure as pay-for reporting or (2) revert the measure from pay-for-performance to pay-for reporting. This proposed change will allow CMS to respond quickly outside the PFS rulemaking cycle.

Any necessary change to the measure would subsequently be made in the next PFS rulemaking cycle, by either retiring the measure or maintaining it as pay-for reporting.

Use of Health Information Technology

CMS believes continued expansion of the use of health IT systems greatly enhances ACOs' ability to coordinate care for beneficiaries and manage the cost of such care. CMS currently requires all ACO participants to report on the percentage of primary care physicians who successfully meet meaningful use requirements (MU Measure). While CMS is not proposing any changes to this measure, the agency seeks comments on how this measure may best evolve over time, such that it continues to incentivize providers to adopt advanced health information technology (HIT).

Specifically, CMS is interested in comments regarding the following: (1) whether the MU Measure should be expanded in the future to include all eligible professionals, including specialists; (2) how the current MU Measure could be updated to reward providers who achieve "higher levels of health IT adoption"; (3) whether there is another metric, other than meaningful use, that focuses on the use of HIT and could replace the

current MU Measure; and (iv) what other measures of IT-enabled processes would be most relevant to participants within ACOs.

PQRS Reporting

ACOs must submit quality measures on behalf of their "ACO provider/suppliers who are eligible professionals," for purposes of the PQRS payment adjustment under the MSSP. 42 C.F.R. § 425.504(a). In the proposed rule, CMS suggests clarifying that an ACO's PQRS reporting obligations for its eligible professionals extend only to those eligible professionals who bill under the taxpayer identification number (TIN) of the ACO.

Beneficiary Assignment

An ACO participant's TIN must be exclusive to a single ACO when the ACO participant TIN submits claims for primary care services considered in the assignment process. With respect to this process, CMS is now proposing to amend the definition of *primary care services* to (1) exclude certain claims submitted by skilled nursing facilities and (2) add certain claims submitted by Electing Teaching Amendment hospitals

Stark Exception: Alternative Payment Models

CMS recognizes that outside of the MSSP or certain CMS Innovation Center-sponsored care delivery and payment models, many providers are pursuing alternative payment models and are struggling to comply with the Stark law. As a result, CMS is soliciting comments regarding the "impact of the physician self-referral law on health care delivery and payment reform."

CMS has outlined a number of specific areas where they are seeking comments, including:

- Whether the physician self-referral law generally and, in particular, the "volume or value" and "other business generated" standards pose barriers to or limitations on achieving clinical and financial integration.
- Whether there is a need for new exceptions to the physician self-referral law to support alternative payment models, shared savings and/or gainsharing arrangements. CMS is also interested in comments related to the specific financial relationships that should be accepted and what conditions should be placed on such relationships to protect against program or patient abuse.
- What aspects of alternative payment models are particularly vulnerable to fraudulent activity.
- Have litigation or judicial rulings created a need for additional guidance from CMS?
- Whether existing exceptions, such as the exception at 42 C.F.R. § 411.357(n) for risk-sharing arrangements, should be expanded to protect certain physician compensation, for example, compensation paid to a physician who participates in an alternative care delivery and payment model sponsored by a non-federal payor.
- Is there a need for revision to or clarification of the definition of indirect compensation arrangements or the exception for such arrangements at 42 C.F.R. § 411.357(p)?

Though any resulting changes will not directly impact participants in the MSSP, CMS's request for comments provides some indication of the agency's movement with respect to shared saving models outside of the MSSP. Moreover, those MSSP participants that are currently (or considering) pursuing a shared savings model with commercial payors may wish to consider responding to CMSs' request for comments.

Ober|Kaler's Comments

The proposed changes to the MSSP are largely technical in nature, and focus on an evolving clinical and health information technology landscape. However, the proposed rule also reveals a growing commitment by CMS to alternative payment models, and the potential for many of the MSSP program goals to be replicated and realized outside the four corners of the MSSP program, as evidenced in part by the solicitation of comments for new self-referral exceptions related to such programs.

This article is part of Ober|Kaler's client alert "CMS Drives Change in Quality, Physician Payment, and Stark in Proposed 2016 Physician Fee Schedule." View other installments of the alert at these links:

- Changes Are Afoot for Quality Measures and Physician Payment Provisions
- Stark Regulations: Proposed Physician Recruitment Provisions
- Stark Regulations: Proposed Physician-owned Hospitals Provisions
- Stark Regulations: Technical Revisions
- Proposed 2016 Physician Fee Schedule Would Impact Medicare Shared Savings Program