

## **Patient-Facing versus Non-Patient Facing Definitions and Thresholds**

**MACRA** recognizes clinician practice diversity and allows for flexibility to address different practices, particularly calling for flexibility in the application of measures and activities required by “non-patient facing” clinicians such as radiologists, pathologists and anesthesiologists. In the MACRA proposed rule, CMS proposed some exemptions and options for non-patient-facing clinicians. The proposed rule suggested a threshold of 25 patient-facing encounters, which the ACR considered too low and that definition would result in many diagnostic radiologists and groups being considered patient facing. This threshold would have included approximately 30% of all radiologists as patient-facing. In the final rule, **CMS acknowledged these concerns and will “define a non-patient facing MIPS eligible clinician as an individual MIPS eligible clinician who bills 100 or fewer patient-facing encounters (including Medicare telehealth services defined in section 1834(m) of the Act) during the non-patient facing determination period, and a group provided that more than 75% of the NPIs billing under the group’s TIN meet the definition of a non-patient facing individual MIPS eligible clinician.”**

The exact codes for determination of patient-facing interactions that determine what interactions are patient-facing have not yet been published, however the final rule mentions that CMS agrees with the commenters that a non-patient facing MIPS eligible clinician should be identified based on the evaluation and management services. CMS noted that the “denominators” used for determining the non-patient facing status of MIPS eligible clinicians are the same as the denominators of the cross-cutting measures in PQRS. Further clarification of these codes that establish patient-facing interactions will impact how many radiologists are evaluated under MIPS.

Additionally, the ACR responded that the terminology “non-patient facing”, while helpful for describing procedure types, does not accurately represent the patient-centric role of the radiologist and the diversity of activities performed including patient interaction, coordination of care and consultation with other physicians. **In recognition of concerns about the inappropriateness of the term “non-patient facing” clinician for this purpose, CMS also seeks additional comment on alternatives to the current terminology for future consideration.**

This represents an important consideration for diagnostic radiologists not frequently involved in patient-facing interactions such as office visits, who will not be subject to the same extent of requirements for patient-facing MIPS reporting (as outlined in the reporting requirements).

### **Group versus Individual Participation**

Initially, the proposed MACRA rule made no provisions to account for the Group Practice Reporting Option (GPRO) with regard to thresholds for certain reporting requirements under the patient-facing eligible clinician definition. The final rule from CMS makes a key provision for **group practices to be treated as non-patient-facing as long as “more than 75 percent of the NPIs billing under the group’s TIN meet the definition of a non-patient facing individual MIPS eligible clinician.”**

Moreover, MIPS categories may be reported on a group basis to CMS directly or through third-party data submission services including qualified clinical data registries.

### **Low-Volume Threshold Exclusion from MIPS**

Similar to considerations regarding non-patient-facing MIPS reporting criteria, the ACR expressed concern over relatively low thresholds for exclusion from MIPS on the basis of lower billing charges and small volume of Medicare beneficiaries. **CMS increased the allowable charge threshold for MIPS exclusion for both individual and group reporting from \$10,000 in the proposed rule to \$30,000 and maintained the volume exclusion of less than OR equal to 100 Medicare patients.** With this final rule, CMS also adjusted their proposal so that both the billing volume and patient threshold are not required to be met in order to be MIPS-exempt. These clinicians may elect to participate in MIPS but are not subject to MIPS payment adjustments. While these adjustments do not change group thresholds for low volume, CMS advises that practices have the option to report individually.

### **Performance Period**

The final rule stipulates that the new Quality Payment Program (QPP) and its constituent MIPS and APMs will be effective January 1<sup>st</sup>, 2017. The ACR had proposed a delayed and abbreviated initial reporting period to begin in July 2017 to allow clinicians sufficient time to prepare for these substantial changes and facilitate collection of performance benchmarks for MIPS-related data. Instead of delaying implementation of the reporting period, CMS acknowledged the concerns of the ACR and others, and first introduced in September 2016 the concept that allows clinicians to select a pace of participation and determined that **the first reporting year (2017 performance year, 2019 MIPS payment year) will be treated as a transition year with reduced performance thresholds.** Providers will be expected to submit data about the care provided and how their practices used technology in 2017 to MIPS by the deadline of March 31, 2018.

### **Pick Your Pace**

In the final rule, four options were provided for physicians to participate in to allow physicians to avoid negative payment adjustments in 2019 while adapting to the new reporting requirements under QPP:

1. **Test the QPP.** Clinicians submitting partial data including data from after January 1, 2017 will avoid a negative payment adjustment. CMS allows clinicians to choose to report one measure from the quality, improvement performance or advancing care information performance categories. *CMS also notes that MIPS eligible clinicians that choose not to report even one measure or activity will receive the full 4 percent negative adjustment.*
2. **Participate for part of the calendar year.** Data for the QPP may be submitted for part of the year (minimum of a continuous 90-day period) and allows clinicians to delay reporting within the reporting period. Clinicians may potentially qualify for a small positive payment adjustment.
3. **Participate for the full calendar year.** Practices that are able to begin reporting QPP information beginning January 1, 2017 may qualify for positive payment adjustment.
4. **Participate in an Advanced Alternative Payment Model.** Under this plan, in lieu of reporting quality data and other information clinicians receive 5% positive payment adjustment in 2019 if enough Medicare patients or payments are performed in an advanced APM.

### **Composite Performance Score Categories**

CMS reweighted the quality performance program criteria for patient-facing MIPS eligible clinicians as follows:

- Quality: 60% for the 2019 payment year, 50% for the 2020 payment year.
- Cost: 0% for the 2019 payment year, gradually increasing to 30% by 2021.
- Advance Care Information: 25% for the 2019 payment year

- Improvement Activities: 15% for the 2019 payment year

### **Reporting Criteria**

In its initial proposed rule, CMS had a reporting threshold of 90%, which was reduced following input from the ACR and other clinicians. CMS “will finalize a 50 percent data completeness threshold for claims, registry, QCDR, and EHR submission mechanisms” for 2017, with an increase to 60% in 2018 and potentially with additional increases in subsequent years. **This reduction in reporting threshold represents a significant improvement from the proposed rule and is consistent with the ACR’s comments on the proposed rule.**

### *Quality*

Within the new performance categories, MACRA reduced the reporting threshold for quality measures from nine to six from prior programs. Importantly, CMS sets forth an important consideration for clinicians unable to report enough quality measures, as stated in the final rule, “section 1848(q)(5)(F) of the Act allows the Secretary to re-weight MIPS performance categories if there are not sufficient measures and activities applicable and available to each type of MIPS eligible clinician.” Clinicians can report specialty-specific measure sets, which may not include all six measures but they must report all data within the set if less than six. Patient-facing MIPS eligible clinicians are still required to report at least one outcome measure or another high priority measure if not outcome measure exists in the set. The removal of the cross-cutting measure reporting requirement from the proposed rule represents an important change.

### *Improvement activities*

Improvement activities were reduced by CMS in the final rule to ease reporting requirements further. In it, the number of activities required to achieve full credit was decreased from six medium-weighted or three high-weighted activities to four medium-weighted or two high-weighted activities to receive full credit in this performance category. Small, rural and health professional shortage area practices as well as, **importantly, non-patient facing MIPS clinicians will be expected to report only one high-weighted or two medium-weighted activities.**

### *Advancing care information*

**The majority of ACR members would be reweighted to zero for the ACI category.** Non-patient-facing eligible clinicians and hospital-based eligible clinicians will be automatically reweighted. **Other eligible clinicians can apply to be reweighted to zero (as originally proposed) if they: 1) have insufficient Internet access; 2) face extreme and uncontrollable circumstances; or, 3) lack influence over CEHRT availability.**

The “hospital-based” determination was changed in the final rule to include those who provide 75 percent or more covered professional services in the inpatient hospital (POS 21), on campus outpatient hospital (POS 22), or emergency room (POS 23) settings. This is significantly different from the proposed “hospital-based” definition (which was first implemented in Meaningful Use) in that it lowers the threshold from 90 percent to 75 percent, and now includes POS Code 22 as a hospital setting instead of limiting the “hospital-based” determination to only inpatient and emergency room settings. Thus, the finalized definition will encompass more of ACR’s membership.

For eligible clinicians who are unable to qualify for reweighting their score for this category to zero, CMS reduced the total number of measures used in establishing ACI’s base score from eleven to five in its final rule, with 90 percent performance score available from reporting nine

measures, 5 percent bonus score available from registry participation measures, and up to 10 percent bonus score from CPIA activities using CEHRT. While the overall scoring methodology is more flexible, the individual measures are more arduous for radiologists than the meaningful use counterparts. **CMS decided that if a clinician is reweighted to zero for ACI, these points would be reassigned to the quality category.**

#### *Cost*

**CMS reweighted the cost category to zero thereby exempting the category from the performance criteria for the first performance year. CMS will calculate cost measures** with the intent of providing clinicians with feedback regarding their cost performance during the first year. However, “the final score will gradually increase from 0 to the 30 percent level required by MACRA by the third MIPS payment year of 2021.”

#### **Alternative Payment Models (APMs) and Advanced APMs**

While the number of clinicians participating in advanced APMs rather than MIPS is a minority of all clinicians, participation in an advanced APM has important implications for clinicians in providing a 5% incentive for appropriate levels of participation and excluding them from MIPS. CMS recognized the need for additional guidance concerning what advanced APMs qualify and plans on “completing an initial set of Advanced APM determinations” that will be released by January 1, 2017.

**While CMS has not yet finalized details of additional advanced APMs, CMS is actively working to develop new models including a new Medicare Accountable Care Organization (ACO) Track 1+ model to begin in 2018, and other models. In addition, CMS is working on modifying current APMs, such as the Maryland All-Payer Model and Comprehensive Care for Joint Replacement (CJR) model to qualify as advanced APMs.**

#### **Additional Information**

Below are links to the CMS MACRA MIPS/APM fact sheet and the Department of Health and Human Services (HHS) press release regarding the MACRA MIPS/APM final rule. In addition, a new Quality Payment Program website was created to explain the details of the new program. (<https://qpp.cms.gov/>)

MACRA MIPS/APM Final Rule link: <https://qpp.cms.gov/docs/CMS-5517-FC.pdf>

MACRA MIPS/APM Final Rule Press Release

link: <http://www.hhs.gov/about/news/2016/10/14/hhs-finalizes-streamlined-medicare-payment-system-rewards-clinicians-quality-patient-care.html>

MACRA MIPS/APM Final Rule Fact Sheet

link: [https://qpp.cms.gov/docs/Quality\\_Payment\\_Program\\_Overview\\_Fact\\_Sheet.pdf](https://qpp.cms.gov/docs/Quality_Payment_Program_Overview_Fact_Sheet.pdf)

MACRA Quality Payment Program Executive Summary

link: [https://qpp.cms.gov/docs/QPP\\_Executive\\_Summary\\_of\\_Final\\_Rule.pdf](https://qpp.cms.gov/docs/QPP_Executive_Summary_of_Final_Rule.pdf)