



# Medicare Quality Payment Program: Deep Dive FAQs for 2017 Performance Year Hospital-Employed Physicians

This document supplements the AMA’s [MIPS Action Plan – 10 Key Steps for 2017](#) and provides additional information to answer questions from hospital-employed physicians about participation in the Quality Payment Program (QPP) created by the Medicare Access and CHIP Reauthorization Act (MACRA). For more AMA Medicare payment resources, see [ama-assn.org/medicare-payment](http://ama-assn.org/medicare-payment). NOTE: These FAQs only apply to hospital-employed physicians. It does not address issues related to hospital-affiliated physician practices.

## General

**Q. I’m planning to become a hospital employee. Do I even need to know about MACRA?**

A. Yes, for several reasons. First, because the reimbursement the hospital receives for your service will be impacted by your performance under MACRA, and your performance today will impact future payment and may impact your compensation. Second, because Medicare reimbursement for the services of physicians and other eligible clinicians in virtually all practice settings (i.e., hospital employment, private practice) will be effected by MACRA’s payment adjustments. Becoming a hospital employee doesn’t change MACRA’s potential impact on you

**Q. I’m a hospital employee. Is MACRA going to impact me?**

A. Probably. Clinicians should expect that MACRA’s positive or negative payment adjustments

will eventually impact the hospital’s financial position and the methods it uses to pay its employed physicians. MACRA’s requirements apply to all eligible clinicians, regardless of practice setting, so its requirements can’t be avoided by hospital employment alone.

**Q. How might MACRA impact the professional services collections received by my employer hospital for my professional services?**

A. MACRA will impact the amount of money received by your employer for your professional services; that amount will depend on whether you’re evaluated based on performance under MIPS or an Advanced APM, and actual performance on a number of variables. For most physicians, performance under MIPS in 2017 can result in a positive or negative adjustment of up to 4% to the reimbursement paid for services you deliver in 2019 [CMS will also distribute an additional \$500 million to MIPS “exceptional performers” who achieve a MIPS composite score significantly higher than the minimum score needed to earn points]. Likewise, if you are a qualified professional who furnishes services through an Advanced APM in 2017, a 5% APM incentive bonus that’s based on your Medicare professional services in 2018 will be paid in 2019. These and potentially other variables can impact what your employer receives for your professional services under MACRA.

**Q. Not all the physicians who are employed by the hospital take MACRA seriously. How can I protect myself from their poor performance?**

- A. Protecting yourself may be difficult if the hospital has already made participation decisions for you. However, you may be able to advocate for individual reporting under MIPS as that will permit your performance to be separated from the performance of your colleagues. Be prepared, however, to hear that the hospital wants your performance “in the pool” to improve the overall score.

A group of specialists could agree to participate in an APM model that focuses on episodes relevant to their specialty. Depending on the legal structure of your employment relationship, you might want to seek a new legal structure [i.e., you will bill through a tax identification number (TIN) that is separate from the TIN used by your lower performing colleagues] as a means to ensure you have maximum autonomy and control over your performance.

Given how difficult it can be to reverse decisions made by an employer, knowing what participation track they have chosen should be part of your pre-employment due diligence.

### Private Practice Comparisons

**Q. As a hospital employee, will MIPS be applied to me in a manner that is different from how it would be applied if I was in private practice?**

- A. No. The core rules and requirements under MIPS are the same regardless of practice setting. In most hospital employment arrangements the physicians and other eligible clinicians will have fewer choices as well as less individual say and decision-making authority regarding key MIPS related decisions. This includes selecting whether to report on an individual or group basis, what EHR technology to use, and what improvement activities will garner corporate support.

**Q. What opportunities might be offered within my hospital-employment relationship that may not be available in private practice?**

- A. Hospitals and health systems often provide significant resources to support practice migration to value-based care, including CEHRT, and have the ability to invest in new approaches to care delivery and APMs. Those resources may permit physicians and other eligible clinicians to succeed under MIPS and participate in APMs at a lower direct near-term financial cost.

### Impact on Structure and Relationships

**Q. My practice is negotiating a Professional Services Agreement (PSA) with a hospital system. Will we be subject to MIPS?**

- A. Yes, although the structure of the PSA will impact how MIPS applies. For example, if, under the PSA you furnish services on an exclusive (i.e., you cease billing through your practice TIN) basis and reassign payment for those services to the hospital or its captive medical group via the PSA, then your performance will be submitted via the MIPS reporting mechanism selected by the hospital (i.e., individual or group reporting), and you will not have separate reporting requirements under your practice's TIN.

**Q. Do I need to do anything to comply with MIPS this year since I'm considering becoming a hospital employee in 2018?**

- A. Yes. Planning to become a hospital employee in the future does not change the need to comply with MIPS this year. Your performance this year will follow you and impact what the hospital will be paid for your services two years hence. All physicians and other eligible clinicians in all practice settings should take steps to ensure at least partial compliance under MIPS in 2017.

**Q. Can a hospital change my compensation or terminate my employment based on how I do under MACRA?**

- A. Perhaps, although the answer will depend on the terms of your employment agreement. Many employment agreements impose general requirements related to compliance with value-based, quality and other efforts. Many also require physicians and other clinicians to use their “best efforts” to succeed under such programs. Physicians should anticipate that hospitals and other employers (including physician-owned practices) will seek to change the terms of employment agreements over time to more closely align continuing employment and compensation with your performance under MACRA and other value-based arrangements.

**Q. What types of compliance-related audits or concerns might come into play with my employment relationship with the hospital?**

- A. Hospitals and other provider entities will likely institute audits to assess compliance with

attestations under MIPS performance categories (e.g., quality, improvement activities etc.). Audit activities will vary depending on whether the data for performance reporting are collected and submitted by you or are extracted from the EHR or other systems. Hospitals, other employers and you will want to ensure that all information submitted in connection with MACRA participation is factually correct and appropriate.

### **MIPS Requirements**

#### **Q. What should I expect the hospital will ask me to do to succeed under MIPS?**

- A. Your employer entity (hospital or other) will likely decide whether to report MIPS measures either individually or as a group, and make decisions regarding what quality measures to report on, and the reporting method used (such as the EHR, a qualified registry or other means). The fact that you are an employee is likely to impact the amount of input you have over such decisions, but you should take advantage of whatever governance and other vehicles you have within your employment model to ensure that your participation in the QPP is as successful as possible. Although hospital employment may provide physicians with certain benefits and protections from changes in external payment and reimbursement systems, that insulation has limits, and physician input and performance – both individually and as a group – will always be important regardless of practice setting.

#### **Q. Does it matter whether my employer medical group opts for individual or group reporting?**

- A. Yes. Under individual reporting, each individual eligible clinician selects and reports on data, including quality metrics, for his/her respective practice. Individual reporting has potential benefits in that you can select and report quality measures and other variables that are aligned with your practice. Under group reporting, all eligible clinicians in your employer TIN will be evaluated as a group. As a result, your performance score will depend on the collective success (or failure) on a single shared set of measures implemented by the group as a whole. The measures reported as a group may be more or less meaningful to your practice as those you might have chosen to report as an individual.

#### **Q. Can the hospital that employs me require me to individually report under MIPS?**

- A. Probably. Most employment agreements require physicians to use their best efforts to meet quality and other value-based incentives. You should review the terms of an offer or existing employment agreement.

#### **Q. What can hospital-employed physicians do to influence how much MIPS and MACRA impact them?**

- A. Physicians are at the center of the delivery system regardless of practice setting, so exercising a leadership role in connection with MACRA is a good place to start. That can include influencing operational systems and practices in the hospital, ensuring that employed physicians have access to and use CEHRT, promoting employed physician engagement in selecting and reporting on MIPS quality and improvement activity category measures, and encouraging peers in the physician enterprise to do their part in connection with individual or group measures. Employed physicians can and should play a similar role in leading the delivery system's participation in APMs.

#### **Q. Since my hospital-owned medical group is part of a health system-sponsored ACO do we need to worry about MIPS?**

- A. Most likely yes. Certain ACO arrangements (i.e., MSSP Track 1+, 2 and 3 and Next Generation ACOs) qualify as Advanced APMs under MACRA. The most common Medicare ACO arrangements (MSSP Track 1) do not. However, there's no guarantee that a particular ACO entity will meet applicable Advanced APM patient or payment thresholds, so taking steps to succeed under MIPS through the ACO arrangement is important. In general, that can be accomplished by promoting success under the ACO arrangement itself. MACRA also provides for special scoring under MIPS for ACOs.

### **Compensation-Related Implications**

#### **Q. What types of performance-based changes might the hospital propose to my compensation?**

- A. The exact changes, if any, will likely depend on how you're currently compensated under your employment relationship. Many employers (hospitals, physician groups and

others) will seek to ensure physicians are individually accountable for their performance by requiring individual reporting under MIPS, and by coupling that with adjustments to the physician's employment compensation. For example, in compensation models based on individual production measured by work RVUs, the employer might make the dollar amount that you are paid per RVU contingent upon MIPS or other performance variables. The hospital may propose other changes to the underlying compensation structure as federal and other payment programs evolve.

**Q. How do I know whether a hospital's proposed change to my compensation is fair to me?**

- A. At a minimum, you should understand how your compensation is currently determined, and have confidence that the data used and the methodology applied are accurate and can be validated. This means, for example, that any adjustments to your compensation linked to MIPS should be able to be tracked and understood by you. You should receive meaningful reports and feedback that help you understand your performance on important variables including those that may impact compensation. It's in your own best interest (and the best interest of the hospital as your employer) to ensure that you are able to optimize your performance under MIPS and any APM in which you participate.

**Q. If I do well under MIPS will I get the full amount of the positive MIPS adjustment as additional compensation under my employment relationship with the hospital?**

- A. Maybe, but it depends on the terms of your employment and compensation agreement. To the extent that you're paid a flat dollar amount per RVU, through a base salary or similar arrangement, there may be no direct correlation between a positive or negative MIPS payment adjustment and your compensation. Conversely, to the extent that your compensation agreement takes into account the revenue collected for your professional services (e.g., percentage of collections methods, revenue minus expense or "virtual private practice" methods), then MIPS payment adjustments will likely have a more direct impact on your compensation.

**Q. How might MACRA impact the amount I'm paid per work RVU for my professional services?**

- A. A typical work RVU-based compensation plan does not directly relate to or correlate with the amount of money generated by the practice from Medicare and other payers. That's of considerable immediate benefit to hospital employed physicians as each physician gets paid for the work he/she performs, without regard to the amount that's collected for those services. While this may be beneficial today, it's likely that hospitals and other physician employers using such models will seek to modify the arrangements over time as the financial implications of MACRA, MIPS and APM performance take effect.

**Q. What does it mean when a hospital says it is limiting my compensation for professional services to an amount that's fair market value?**

- A. Hospital-physician employment relationships are subject to fair market value limitations due to legal and compliance requirements. The level of compensation that is (or is not) considered fair market value for your services is likely to evolve over time as value-based reimbursement becomes more common in Medicare and commercial payor arrangements. MACRA encourages the migration to APMs that involve at-risk arrangements, and certain "at-risk" payment arrangements can be structured to avoid application of fair market value limitations in some circumstances.

**Q. Do I have to be at risk of a cut in my dollar amount per RVU that's equal to the MIPS negative adjustment in a particular year?**

- A. No. There is no legal requirement, for example, that if the reimbursement received by your hospital (or other) employer decreases by 4% that your dollar amount per RVU or other payment under your employment arrangement must also decrease by 4%. In most instances, the answer will depend on whether your compensation for your services is consistent with fair market value. Different employers will likely adopt different approaches to MIPS payment adjustments – and there's no one "correct" answer or approach that must be applied in all settings. It's important to know the approach your hospital employer plans to take.

**Q. What changes to employed physician compensation would be useful as our hospital-owned medical practice migrates from volume to value?**

- A. There's no perfect compensation plan. In general, compensation arrangements that provide a reasonably stable compensation structure can be beneficial during the migration from volume to value. While salaried employees may have the most stability, a value-based compensation structure might include a base salary or "draw" on compensation to provide income stability, coupled with appropriate rewards and/or incentives for providing services that align with quality, productivity and other variables in the external payment environment. Practices in predominantly fee-for-service markets will likely retain a heavy productivity focus (i.e., RVUs, charges, collections or otherwise), while those in a heavily at-risk and/or capitated environment are more likely to use a base salary plus incentive compensation model.

**Q. Does MACRA require hospitals and other organizations to change the compensation methodology or the amount of compensation I receive as a matter of law?**

- A. No. Changes are not required by MACRA, although it's likely that hospitals and other employers will change compensation methodologies over time as payment becomes increasingly "value-based" (i.e., with a focus on quality and cost), including in connection with the on-going roll-out of MACRA's MIPS and APM alternative tracks.

**Q. Must my employment compensation from the hospital be put "at risk" since my hospital-owned ACO is moving to an "at risk" APM model next year?**

- A. No. An Advanced APM requires the advanced payment arrangement between the APM entity and CMS to have certain "at-risk" components – meaning that the ACO entity has agreed to go "at-risk" in its relationship with CMS. However, the at-risk agreement is between the ACO and CMS and not necessarily between the ACO and its participating physicians and practices. An ACO can certainly decide to require individual providers to also assume financial risk, but there are other means to address the ACO's financial risk requirements. For example, in many ACOs involving institutional providers (i.e., hospitals/health systems), those institutional providers

bear the risk. However, arrangements can also be crafted to share or allocate that risk across physician and hospital participants. The MSSP and other models provide considerable flexibility on how an Advanced APM can meet its financial risk requirements.

**Effect on Electronic Health Records and Usage**

**Q. Does it make sense to become employed by a hospital to access its Certified Electronic Health Record Technology (CEHRT) to meet the requirements of the QPP?**

- A. Not necessarily. Having access to CEHRT is likely to increase in importance as MACRA is implemented over time. Whether you gain access for your practice through employment or another relationship is a personal and professional decision. Becoming an employee of a hospital may provide access to a CEHRT, but it's by no means the only option. Other organizations, including physician-owned medical practices, independent practice associations, and others may also serve as potential partners, allowing you to maintain an independent practice while gaining access to CEHRT.

**Q. How can I protect my compensation if the hospital changes EHRs due to MACRA or for other reasons?**

- A. Migration from one EHR to another can be disruptive to a physician or other eligible clinician's practice, and may impact personal production, compensation, and satisfaction with the practice of medicine. Hospitals and health systems commonly provide supplemental support in the form of additional personnel, additional compensation or other types of transitional assistance to support physicians as they transition from one electronic record system to another. For physicians on a production-based compensation plan (i.e., dollars per RVU), the physician can be held harmless from decreases in production due to medical record transition as part of the compensation plan. Likewise, for physicians on a base salary compensation model, the inevitable dip in production due to medical record transition can be addressed (and excluded) from any evaluation of productivity in setting and/or adjusting the base salary. Because these are decisions that are made by the employer, you should seek hold harmless provisions when negotiating your contract.

## APM Participation (including ACOs)

### Q. Must the hospital-owned ACO that employs me let independent practices participate in the ACO?

- A. No. There is considerable discretion regarding what practices and/or eligible clinicians participate in ACOs and other APM models. CMS imposes specific rules under each APM model regarding the types of entities or individuals that can or must participate in the APM, but beyond that, which physicians or groups participate is subject to local decision-making. This means that hospital-affiliated ACOs or other APMs are not required to offer participation to independent physicians or practices, just as independent practice driven ACOs and APMs are not required to offer participation to hospital-affiliated practices. Experience to date with ACOs has found considerable year-to-year changes in ACO participant lists.

### Q. The hospital-owned medical group that employs me is part of an ACO. Can I opt out of participating?

- A. No. ACO participation is determined at the level of the TIN through which you bill for your professional services. That typically means your employer entity is the participating TIN in the ACO. It may be possible for you to bill through a TIN that is different from your employer entity TIN, but doing so could require structural adjustments.

### Q. Can I participate in more than one arrangement involving an Advanced APM?

- A. Yes. Each Advanced APM arrangement has its own requirements that need to be considered and complied with, but participation in more than one Advanced APM is certainly possible. For example, oncology physicians could participate in the CMMI Oncology Care Model, and also participate in a MSSP ACO. The APM track within MACRA has special rules that CMS will follow with respect to dual participation strategies, but overall it is possible for some clinicians to participate in more than one APM at the same time.

### Q. Is there a barrier to a hospital employed physician taking on a leadership role in an ACO or APM?

- A. No. A number of ACOs are already physician-led, given the critical leadership role of physicians in the delivery system. Although participation in an APM, including an ACO, is likely to have its

own challenges, physicians who engage in and assume a leadership role in the APM will be in a better position to drive change in ways that ensure appropriate approaches to practice and patient care.

### Q. Is my hospital employer allowed to require me to only refer my patients to other physicians who participate in the hospital's ACO?

- A. No. Unlike HMOs, ACOs are not permitted to restrict the providers who furnish services to the ACO's attributed Medicare beneficiaries, nor can they restrict where patients go for care, so an outright prohibition on using or referring to non-ACO participating providers is a compliance issue. Nonetheless, the ACO delivery model is intended to promote clinical integration through the ACO, such that over time, you will have access to information regarding the quality and cost of care furnished by the ACO's participating providers. That information may, in turn, influence your referral decisions (i.e., to refer patients to other ACO providers who are high quality, and low cost and with whom you have effective communication regarding clinical matters). A strict prohibition on the use of non-ACO providers is not allowed under the MSSP.

### Q. Can a primary care medical practice that's owned by a hospital or health system participate in an APM that uses a medical home model?

- A. No, the fact that the hospital is involved is likely to prevent the medical home from qualifying as an Advanced APM under current rules. To date, the only medical home model that qualifies as an Advanced APM is CPC+ and, beginning in 2018, participants in CPC+ Round 2 that have more than 50 eligible clinicians in the entity (including its parent organization and other subsidiaries of that parent) will not be able to qualify under the Medical Home risk standard and therefore will not qualify as Advanced APM participants.

### Q. Although my employer hospital is not participating in an APM, can I participate in an APM that is sponsored by someone else?

- A. Yes, if it is permitted by your hospital or other employer and is done in accordance with the participation requirements for the APM. For example, it would be difficult to do this in an APM that requires participation by the full TIN.

## Implications for Other Arrangements

### **Q. Will MACRA impact my medical director relationship with a hospital?**

- A. Probably not directly because MACRA adjusts fee-for-service payment under the Medicare Physician Fee Schedule, which is separate from compensation received for serving in an administrative role such as medical director. However, MACRA and the overall shift to “value-based” care may impact your medical director duties and role to further enhance attention to quality and efficiency in health care services.

### **Q. How might MACRA impact my participation in a hospital service line co-management agreement?**

- A. Co-management agreements are one of the tools used by hospitals to encourage physician engagement and attention to the quality and efficiency of health care services furnished by the hospital. MACRA directly impacts reimbursement for physician and other eligible clinician services delivered to patients under Medicare Part B, so MACRA is unlikely to have a direct impact on a co-management arrangement. However, since many hospitals participate in APM arrangements with CMS, it's likely that the hospital will seek to coordinate and potentially consolidate co-management and other initiatives with APM arrangements.