

# Medicare Quality Payment Program: Deep Dive FAQs for 2018 Performance Year Hospital-Employed Physicians

This document supplements the AMA's [MIPS Action Plan – 10 Key Steps for 2018](#) 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).

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 – are likely to be important regardless of practice setting. For more AMA Medicare payment resources, see [www.ama-assn.org/medicare-payment](http://www.ama-assn.org/medicare-payment).

NOTE: These FAQs only apply to hospital-employed physicians. For issues specifically related to hospital-affiliated physician practices, please see the [AMA's Value-Based Care Models Deep Dive FAQs: Hospital-Affiliated Physicians](#).

## General

**Q. I just became a hospital employee. Do I even need to know about MACRA and the QPP?**

A. Yes, you do. The reimbursement your employer, the hospital, receives in the future for professional services you deliver will be adjusted based on your performance under the QPP. As such, it is reasonable to anticipate that this will impact your compensation. Therefore, you should not assume that becoming a hospital employee will not change the QPP's

potential to impact your employment agreement and compensation.

**Q. What is the QPP, and what are the participation options for clinicians employed by hospitals?**

A. As detailed in the [AMA's Medicare payment resources](#), the QPP is a Medicare payment program for clinician services that provides for positive and negative payment adjustments based on a certain eligible clinician's or group's score on certain measures across certain metrics. In general, there are two tracks for participation in the QPP: the Advanced Alternative Payment Model (APM) track; or (2) the Merit-based Incentive Payment System (MIPS) track. Clinicians who elect to participate in one or more Advanced APMs approved by the Centers for Medicare & Medicaid Services (CMS) are exempted from participation in MIPS, and clinicians not participating in an Advanced APM are required to participate in MIPS. Under MIPS, a clinician can receive positive or negative adjustments to Medicare reimbursement based on their performance in four performance categories: quality, use of electronic health information technology (promoting interoperability, formerly called advancing care information), improvement activities and cost.

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

A. The QPP may 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 clinicians, performance under MIPS in 2018 can result in a positive or negative adjustment of up to 5% to the reimbursement paid for services you deliver in 2020. Likewise, a clinician furnishing services through an Advanced APM in 2018 may earn a 5% incentive for achieving threshold levels of payments or patients through Advanced APMs in 2020 based on services delivered in 2018. These and potentially other variables can impact what your employer receives for your professional services under the QPP.

**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, MIPS allows clinicians to report individually or as a member of a group or facility, and you may be able to advocate for individual reporting under MIPS as that will permit your performance to be measured separately from that 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 Advanced 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 taxpayer identification number (TIN) that is separate from the TIN used by your lower performing colleagues] as a means to have some autonomy and control over your performance.

Given how difficult it can be to reverse decisions made by an employer, knowing what participation track it has 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 were in private practice?**

- A. Generally, 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. For this reason, the measure of the MIPS score associated with EHR reporting may be weighted differently for clinicians employed by a hospital. However, the other components of the MIPS score are applied uniformly to clinicians regardless of employment status.

**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 (Certified Electronic Health Record Technology), 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 basis (i.e., you cease billing through your practice TIN) 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 2019?**

- 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 participate to some extent in MIPS in 2018.

**Q. Can a hospital change my compensation or terminate my employment based on my performance in MIPS or an Advanced APM?**

- 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 performance under the QPP 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 reporting and attestations under the MIPS performance categories. Audit activities will vary depending on whether the data for performance reporting are collected and submitted by you, are extracted from the EHR, or other methods. Hospitals, other employers and you will want to ensure that all information submitted in connection with QPP participation is factually correct and appropriate.

**Q. How do I know if I qualify as a hospital-based clinician under MIPS? What if I work at an off-campus outpatient hospital?**

- A. The QPP defines a hospital-based clinician as an individual who furnishes at least 75 percent of his/her professional services at a location identified by Place of Service (POS) codes as an off-campus outpatient hospital (POS 19), inpatient hospital (POS 21), on-campus outpatient hospital (POS 22), or emergency room (POS 23). Clinicians who furnish at least 75 percent of their services at one or more of these sites of service are designated “hospital-based,” meaning that certain elements of the MIPS score are calculated differently.

### MIPS Requirements

**Q. As an employee, what should I expect the hospital will ask me to do to succeed under MIPS?**

- A. Your employer (hospital or other entity) will likely decide whether to report MIPS measures either individually or as a group, and make decisions

regarding what measures to report on, and the reporting method used (such as the EHR, a clinical data 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 – are likely to 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 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 measures and other variables that are aligned with your patient population and specialty. 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. Potential advantages of group reporting are that your group may need to implement fewer practice changes (thereby lowering the administrative burden to the group and each individual clinician) and be able to share results within the practice to drive improvement. A potential tradeoff is that measures reported as a group may be more or less meaningful to your individual practice of medicine 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, as the QPP rules do not prohibit hospitals from doing so. Most employment agreements require physicians to use their best efforts to earn 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 the QPP impacts them?**

- A. Physicians are at the center of the delivery system regardless of practice setting, so exercising a leadership

role in connection with your hospital’s participation in MIPS or an Advanced APM is a good place to start. That can include influencing operational systems and practices in the hospital, ensuring that physicians have access to and use CEHRT, promoting physician engagement in selecting and reporting on MIPS quality and improvement activity category measures, and encouraging peers to do their part in connection with individual or group measures. 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 accountable care organization (ACO) do we need to worry about MIPS?**

- A. Most likely yes. Certain ACO arrangements (i.e., Medicare Shared Savings Program (MSSP) Track 1+, 2 and 3 and Next Generation ACOs) qualify as Advanced APMs under the QPP. 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. The QPP 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 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 you should be able to track and understand any adjustments to your compensation linked to MIPS. 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. 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., methods such as percentage of collections, revenue minus expense or “virtual private practice” methods), then MIPS payment adjustments may have a more direct impact on your compensation.

**Q. How might the QPP 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 QPP 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 5% that your dollar amount per RVU or other payment under your employment arrangement must also decrease by 5%. 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 continued changes to the MIPS and Advanced APM tracks.

- Q. Must my employment compensation from the hospital be put “at risk” since my hospital-owned ACO is moving to an “at risk” Advanced APM model next year?**
- A. No. An Advanced APM requires the 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 of addressing 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 distribute that risk across physician and hospital participants. The MSSP and other ACO models provide considerable flexibility on how an Advanced APM can meet its financial risk requirements.

### Effect on Electronic Health Records (EHRs) and Usage

- Q. Should I become employed by a hospital to access its CEHRT to meet the requirements of the QPP?**
- A. Not necessarily. Having access to CEHRT is likely to increase in importance as the QPP 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 CEHRT, but it’s by no means the only option. Other organizations, including physician-owned medical practices, independent practice associations, and other entities 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), provisions that hold the physician harmless from decreases in production due to EHR transition may be included in a compensation plan. Likewise, for physicians on a base salary compensation model, inevitable decreases 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 APMs. CMS imposes specific rules under each APM 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.

#### **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 is the entity 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 Oncology Care Model, and also participate in a MSSP ACO. The Advanced APM track within the QPP has special rules for dual participation, but overall it is possible for some clinicians to participate in more than one Advanced APM at a time.

#### **Q. Is there a barrier to a hospital-employed physician taking on a leadership role in an ACO or other type of 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 may 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 health maintenance organizations (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 likely represents a compliance issue with program rules of the ACO, as well as potential exposure to liability under federal or state fraud and abuse laws. 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, low cost, and with whom you have effective communication regarding clinical matters). The MSSP does not permit participating providers to prohibit the use of non-ACO providers.

#### **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 it 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