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Liability Risks under MACRA and Value-Based Contracts

INSIGHTSARTICLE

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Physician services are reimbursed under Medicare Part B based upon a fee schedule that includes more than 7,000 separate services for office visits, surgical procedures, diagnostic tests and therapeutic procedures.

Until recently, physician fees were updated annually pursuant to a formula set forth in Section 1848 of the Social Security Act known as the sustainable growth rate (SGR). Each year, from 2003 through 2015, Congress acted to override rate reductions (the “doc fix”) as a result of decreased reimbursement and the threat of large payment cuts.

In order to replace the fee for service paradigm with a value-based system, MACRA (the Medicare Access and CHIP Reauthorization Act) was enacted in 2015. MACRA repealed the SGR formula and replaced it with a new value-based reimbursement system that creates two tracks for rate adjustment based upon physician performance and quality: MIPS (the Merit-Based Incentive Payment System), which assesses performance based on a variety of categories that measure quality, advancing care information, improvement in health activities and cost, and APM's (Advanced Alternative Payment Models), which provide bonus payments to physicians for the use of certified EHR technology, quality measurement, and level of financial risk.

Payment adjustments will take effect in 2019, based on data reported in 2017, and will be phased in over time. Participating physicians will choose six applicable measures relevant to their practices from among 271 separate quality measures. Quality accounts for 60% of the physician's final score; advancing care information constitutes 25% of the score; and improvement activities constitute 15% of the overall score. Physicians and other groups are also required to report four improvement activities (groups with fewer than 15 participants only need to complete two).

Cost will be a reported measure beginning in 2018, but will not be factored into payment adjustments until 2020. The cost measure will include all Medicare Part A and B claims, beginning three days prior to hospital admissions and continuing through thirty days post discharge, and will be benchmarked against a risk-adjusted expected Medicare Spending Per Beneficiary Cost.

Physicians will receive a combined score that is weighted, based upon category of measured activity, and then combined into a Composite Score that will determine whether a payment adjustment will be made. Failure to participate in MIPS will result in a 4% reduction in reimbursement in 2019.

The administrative burdens of participation in MIPS are substantial, particularly for the small to medium sized practice, and solo practitioners, who are already struggling to upgrade existing EHR technology. Moreover, the value-based payment methodology has the potential to create new and additional risks for physician providers, including Fraud and Abuse, False Claims, HIPAA/HITECH violations and medical liability.

The OIG recently released a study of potential liability issues regarding MIPS implementation, highlighting concerns about: 1) whether IT systems necessary to support data submission would be completed on time; and 2) whether clinicians have sufficient information to ensure their ability to meet reporting requirements. OIG also reviewed whether CMS had developed and implemented a comprehensive integrity plan for the quality payment program, noting continuing concern about whether the system is vulnerable to the submission of inaccurate data.

It is unclear whether potential errors in the submission of multiple new quality measures will be viewed by the government as improperly submitted claims. Moreover, the quality payment program may require modifications to the Stark and Anti-Kickback statutes, which were designed to prevent overutilization in a fee for service environment, the risk of which is largely mitigated in alternative payment models that reward value and outcomes.

From a medical professional liability standpoint, there is a risk that quality payment program guidelines may be relied upon in litigation to either: 1) demonstrate compliance, or failure to comply, with quality assessments in an underlying incident; or 2) demonstrate whether the standard of care has been met.

Pennsylvania courts have already had occasion to rule on whether general practice guidelines are relevant and admissible. In 1992, the Pennsylvania Supreme Court affirmed a trial court ruling admitting two medical guidelines

in *Levine v. Rosen,* 616 A.2d 623, 628 (Pa. 1992). If relevant and authenticated by an expert, they are likely to be admitted in a malpractice case.

Anticipating the use of quality program guidelines in malpractice litigation, MACRA provides, in pertinent part, that "the development, recognition or implementation of any guidelines or other standard under any Federal health care provision shall not be construed to establish the standard of duty of care owed by a health care provider to a patient in any medical malpractice or medical product liability action or claim." MACRA, Section 106(d)(1). This provision, however, does not prohibit quality program standards from being offered as evidence in establishing the standard of care. Conversely, compliance with quality program standards cannot confer immunity from medical liability. Physicians should expect to see quality program standards being offered as evidence of the standard of care.

Importantly, physicians should take care to document situations where their treatment deviates from quality program guidelines, in order to prevent the failure to follow guidelines from being used to establish a deviation from the standard of care. Clinicians should be familiar with the Clinical Recommendation Statements that accompany Quality Payment Program Measures that they have selected in their practice.

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