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The Quality Payment Program in 2017

With the Quality Payment Program set to begin on January 1, 2017, CMS decided to share its plan for the timing of reporting for the first year of this program. Due to the wide diversity of physician practices, the Quality Payment Program intends to allow physicians to pick their pace of participation for this first performance period. Physicians and other clinicians will have multiple options for participation in 2017.

- **First Option**: Providers will avoid a negative payment adjustment if they submit some data to the QPP. This option is to ensure your system is working and you are prepared for broader participation in 2018 and 2019.

- **Second Option**: Providers may choose to submit QPP information for a reduced number of days. With this option, providers could begin later than January 1, 2017 and still qualify for a small positive payment adjustment.

- **Third Option**: Providers who are ready to go on January 1, 2017 may choose to submit QPP information for a full calendar year and qualify for a modest positive payment adjustment.

- **Fourth Option**: Instead of reporting quality data, providers will be allowed to participate in QPP by joining the Advanced Alternative Payment Model. If providers receive enough Medicare payments or see enough Medicare patients through the Advanced Alternative Payment Model in 2017, they could qualify for a 5% incentive in 2019.

For more information on QPP and how to prepare, please visit our website at http://www.mbuinc.com/ or call Angie at 915-774-5506.

1. MGMA, Week of September 9, 2016, *MGMA Washington Connection - Special Alert*
2. CMS.gov
3. texmed.org
4. Osmon Bahr, Penny, 2016, August, *"MACRA: Moving Volume to Value",* AAPC Healthcare Business Monthly

Preparation

Do not wait until the final ruling on November 1, 2016 to prepare for MIPS. To ease the transition, providers should do the following to begin preparing for MIPS:

- Continue to focus on Meaningful Use, PQRS and Value Based Modifier as they will equal 85% of your MIPS Composite Performance Score.
- It is important for providers to identify the potentially highest performing quality measures appropriate for their practice and develop a plan to maximize efficiency and performance levels.
- Examine the viability of your EHR system: Is it certified? Can you connect and communicate with other EHR systems? Connectivity will be a big element for MIPS.
- Find the PQRS reporting vehicle that best fits the needs of your practice.
- APMs are the new reality. Providers with the best Composite Performance Scores will have the best financial opportunities.
- Monitor your quality report card dash boards to identify deficiencies, fix them and move on to the next performance level.

MIPS is a large change from previous reporting systems. MIPS is more flexible, encompasses more measures, and will apply to more providers than PQRS, Meaningful Use, and Value Based Modifier. However, it is also similar to the earlier CMS programs and will benefit providers who are familiar with these types of reporting. Overall, MACRA represents an improvement over what the physicians faced with the old system - payment uncertainty and a confusing and overlapping penalty based programs.

MACRA is near: Quality not Quantity

Under the direction of MACRA, CMS is charged with implementing the Quality Payment Program (QPP). The QPP terminates the Sustainable Growth Rate (SGR) formula, rewards healthcare providers for giving better care and combines our existing quality reporting programs (PQRS, Value Based Modifier and Meaningful Use) into one new system. CMS proposed two new payment systems starting in 2017: Merit-based Incentive Payment System (MIPS) or Advanced Alternative Payment Models (APMs). Here is a brief overview of both payment systems.

MIPS (Merit-based Incentive Payment System):

MIPS is comprised of 4 performance categories that have components of our existing programs. These performance categories will be valued on a scale of 0-100. These scores will contribute to a composite performance score that will be compared to a performance threshold that CMS will calculate based on available reported data in 2017. These scores will determine 2019 payment adjustments.

MIPS reporting of these four performance categories can be achieved at the individual level or as a group. MIPS will apply to eligible clinicians and not to hospitals or other facility types. Also excluded from MIPS are eligible clinicians in their first year of Medicare Part B participation. Eligible clinicians defined as having a low volume threshold or annual billed Medicare charges of less than $10,000 and 100 Medicare patients or less are excluded as well.

MIPS scores are required to be budget neutral. Clinicians' MIPS scores will be used to compute a positive, negative or neutral Medicare payment adjustment. In the first year, negative payment adjustments will be no more than 4% and positive payment adjustments will generally be up to 4%. Additional bonuses will be made for the highest performers.

The following is a brief description of the 4 performance categories:

1. Quality
    a) Replaces PQRS and the quality component of the Value Based Modifier Program
    b) 50% of total MIPS score in year 1.
    c) The number of reported measures is reduced from 9 to 6 measures.
    d) 1 cross cutting measure (any measure that is broadly applicable across multiple clinical setting and eligible professionals within a variety of specialties) is required.
    e) 1 outcome (i.e. clinical or patient reported) measure is required.
    f) In absence of an applicable outcome measure, a high priority measure may be substituted. This type of measure focuses on patient experience, patient safety, care coordination, efficiency or appropriate use.

2. Resource Use
    a) Replaces the cost component of the Value Based Modifier Program.
    b) 10% of total MIPS score in year 1.
    c) Score would be based on Medicare claims.
    d) Does not require separate data submission.
    e) Will use more than 40 episode-specific measures to account for differences among specialties.

3. Advancing Care Information
    a) Replaces the Medicare EHR Incentive Program or Meaningful Use.
    b) 25% of total MIPS score in year 1.
    c) Clinicians will choose to report customizable measures that reflect how they use EHR technology.
    d) Emphasizes interoperability and information exchange.
    e) Will not require an "all or nothing" EHR measurement or quarterly reporting.

APMs (Advanced Alternative Payment Models)

Clinicians who take a step further towards care transformation would be exempt from MIPS payment adjustments and would qualify for a 5% Medicare Part B incentive payment. To qualify for the incentive payment, clinicians would have to receive enough of their payments or see enough of their patients through Advanced APMs. These APMs must also meet criteria for payment based on quality measurement and for the use of EHRs.

Under the new law, the Advanced APMs are:

1. CMS Innovation Center Models - New payment and service delivery models in accordance with Section1115A of the Social Security Act. It is organized into 7 categories:

    a) Accountable Care - Accountable Care Organizations and similar care models are designed to incentivize health care providers to become accountable for a patient population and to invest in infrastructure and redesigned care processes that provide for coordinated care, high quality and efficient service delivery.

    b) Episode based Payment Initiatives - Under these models, health care providers are held accountable for the cost and quality of care beneficiaries receive during an episode of care, which usually begins with a triggering healthcare event (i.e. hospitalization or chemotherapy administration) and extends for a limited period of time thereafter.

    c) Primary Care Transformation - Primary care providers are a key point of contact for patients' healthcare needs. Strengthening and increasing access to primary care is critical to promoting health and reducing overall health care costs. Advanced primary care practices (medical homes) utilize a team based approach, while emphasizing prevention, health information technology, care coordination and shared decision making among patients and their providers.

d) **Initiatives Focused on the Medicaid and CHIP Population** - Medicaid and CHIP are administered by the states but are jointly funded by the federal government and states. Initiatives in this category are administered by the participating states.

e) **Initiatives Focused on the Medicare-Medicaid Enrollees** - The Medicare and Medicaid programs were designed with distinct purposes. Individuals enrolled in both programs account for a disproportionate share of the programs' expenditures. A full integrated, person-centered system of care that ensures all their needs are met could better serve this population in a high quality and cost effective manner.

f) **Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models** - Many innovations necessary to improve the health care system will come from local communities and healthcare leaders from across the entire country.

g) **Initiatives to Speed the Adoption of Best Practices** - The Innovation Center is partnering with healthcare providers, federal agencies, professional societies and other experts to test new models for disseminating evidence based best practices and increase the speed of adoption.

2. The Medicare Shared Savings Program helps coordination and cooperation among healthcare providers to improve the quality of care for Medicare fee-for-service beneficiaries. Eligible providers and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO.) The Shared Savings Program rewards ACOs that lower their rate of growth in health care costs while meeting quality performance standards.

3. Statutorily required demonstrations where clinicians accept both risk and reward for providing coordinated, high quality, and efficient care.

   CMS would annually update and add new payment models that qualify to be an Advanced APM. It will also continue to modify models in coming years to help them qualify as Advanced APMs. In addition to this, starting in 2019, clinicians could qualify for incentive payments based on participation of Advanced APMs developed by non-Medicare payers (commercial insurances) or state Medicaid programs.

   In order to determine whether clinicians met the requirements for the Advanced APM, all clinicians will report through MIPS for the first performance year. The QPP rule provides flexibility for participating in MIPS. This flexibility will make it easy to move between the components of the QPP.