Health Law Daily Wrap Up, TOP STORY—Physician reporting streamlined, less burdensome under flexible Quality Payment Program, (Apr. 28, 2016)

Click to open document in a browser

By Kathryn S. Beard, J.D.

The Medicare physician fee schedule (PFS) is in for big changes as CMS begins implementing the 2015 legislation that ended a decade of provider payment uncertainty. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114-10) ended the failed sustainable growth rate (SGR) and combined multiple value and quality programs into a single framework (see Ding dong, the SGR is dead!, April 15, 2015). In an advance release of a Proposed rule, CMS announced its plan to create the unified Quality Payment Program, which will give providers two payment paths: the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). MIPS replaces three existing programs, consolidating components of the Physician Quality Reporting System (PQRS), Physician Value-based Payment Modifier (VM), and Meaningful Use. The Proposed rule will publish in the Federal Register on May 9, 2016, and comments will be accepted through June 26, 2016.

The Proposed rule is the next step in CMS’ incremental plan toward developing standardized quality measures. MACRA, building on quality improvement measures from the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148), seeks to streamline and strengthen quality-based payments to physicians. The Proposed rule would give providers fewer measures to report on, remove redundant reporting requirements, and allow for more flexibility in delivering quality care to Medicare beneficiaries than previous physician fee schedule regulations (see, e.g., CMS updates physician payment and quality reporting for 2016, November 18, 2015). HHS Secretary Sylvia Burwell admitted that the agency has “more work to do,” but called the Proposed rule “just the first step in a complicated process” (see CMS is developing quality one measure at a time, December 22, 2015).

Merit-based Incentive Payment System. MIPS, which was created by MACRA, ties Medicare payment rates to the provision of high-value care, measured through four performance categories. Information can be submitted individually, or through a group, and will use a unified approach across all performance categories. The four performance categories are given different weights toward a MIPS composite performance score (CPS). Each participant’s CPS would be compared against a MIPS performance threshold, which would be used to determine the participant’s payment adjustment (upward, none, or downward). For exceptional performance, an additional positive adjustment factor would be available.

MIPS performance categories. The four performance categories to calculate the MIPS CPS are:

- **Quality.** CMS proposes including a minimum of six quality measures, including at least one cross-cutting measure and an outcome measurement if available. Quality would account for 50 percent of the CPS in year one.
- **Advancing care information.** CMS would assess this performance category based on advancing care information measures and objectives, which participants could customize to reflect the use of technology, focusing on interoperability and information exchange. It would account for 25 percent of the CPS in year one.
- **Clinical practice improvement activities (CPIA).** CMS would not require a minimum number of CPIAs, but would encourage participants by rewarding clinical practice improvements, particularly those that improve care coordination, beneficiary engagement, and patient safety. CPIAs would account for 15 percent of the CPS in year one.
- **Cost.** Cost, or resource use, would be based on Medicare claims, and require no additional reporting from participants. It would account for 10 percent of the CPS in year one.

MIPS participants. Participants in the MIPS program will be known as “MIPS eligible clinicians”—replacing the previous term “eligible professionals” or EPs—and include physicians, physician assistants, nurse practitioners,
clinical nurse specialists, certified registered nurse anesthetists, and groups including such clinicians. Specific Medicare-enrolled practitioners will be excluded from MIPS.

**MIPS performance period.** Under the Proposed rule, MIPS would use the calendar year (CY) for its performance period. CMS plans on CY2017 as the first performance period, which would be used to calculate the 2019 payment adjustment. This timeframe would provide enough time to allow submission and analysis of data and claims and to base adjustments on a full year of measurement.

**Additional MIPS proposals.** CMS proposes using a targeted review process, allowing individual providers to request a review of the MIPS adjustment factor calculation. Certain third parties would be able to act on behalf of MIPS eligible clinicians to submit performance data on quality, advancing care information, and CPIA (not for the cost performance category, however). CMS also proposes using the Physician Compare website to publicly report MIPS information, in an easily understandable format.

**Advanced Alternative Payment Models.** CMS hopes to increase participation in APMs that focus on better care, smarter spending, and healthier people. Participants in the Advanced APM program, known as qualifying APM participants (QPs), would receive a lump sum incentive payment instead of a MIPS adjustment. The incentive payment, beginning in 2019, would be equal to 5 percent of the prior year’s estimated aggregate expenditures under the fee schedule. In 2026, the fee schedule growth rate would be higher for QPs than for other practitioners. The Proposed rule would create two types of Advanced APMs: Advanced APMs and Other Payer Advanced APMs.

**Advanced APM requirements.** To be an Advanced APM, the Proposed rule would require an APM to:

- require participants to use certified electronic health record (EHR) technology;
- provide payment for covered professional services based on quality measures comparable to those used in the quality performance category of MIPS; and
- be either (a) a Medical Home Model expanded under sec. 1115A of the Social Security Act, or (b) bear more than a nominal amount of risk for monetary losses.

**Other Payer Advanced APM requirements.** Other Payer Advanced APMs would have similar requirements to Advanced APMs. The Proposed rule would require commercial or Medicaid APMs to:

- require participants to use certified electronic health record (EHR) technology;
- provide payment for covered professional services based on quality measures comparable to those used in the quality performance category of MIPS; and
- be either (a) a Medicaid Medical Home Model that is comparable to a Medical Home Model expanded under sec. 1115A of the Social Security Act, or (b) bear more than a nominal amount of risk for monetary losses.

**Qualifying models.** Under the Proposed rule, participants in the following models would qualify as Advanced APMs:

- Comprehensive ESRD Care Model (Large Dialysis Organization arrangement)
- Comprehensive Primary Care Plus (CPC+) (see CMS announces largest ever primary care initiative, April 11, 2016)
- Medicare Shared Savings Program (MSSP) Tracks 2 and 3
- Next Generation ACOs (see Next generation ACOs one step closer to value-based care, March 18, 2015 and Consumer advocates encourage increased beneficiary engagement in Next Generation initiative, May 21, 2015)
- Oncology Care Model Two-Sided Risk Arrangement (available in 2018)

The list would be updated annually to add new qualifying payment models.

**Physician-focused payment model Technical Advisory Committee.** MACRA encourages expansion of the APM options available to physicians, especially specialists, through physician-focused payment models (PFPMs). It required the establishment of the PFPM Technical Advisory Committee (PTAC), which will assess...
PFPM proposals and work on the process to consider PFPMs for testing and implementation. The Proposed rule includes criteria for PTAC to use in making its comments and recommendations to the HHS Secretary.