Understanding the Medicare Quality Payment Program

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The Medicare Access and CHIP Reauthorization Act (MACRA) legislation introduced a new value-based reimbursement system that will affect Medicare reimbursement amounts beginning in 2019. The strategic goals of this program include improving beneficiary outcomes, maximizing participation, enhancing clinician experience, increasing adoption of advanced Alternative Payment Models (APMs), improving data and information sharing, and ensuring operational excellence in program implementation.

This new system, called the Quality Payment Program (QPP), repeals the sustainable growth rate (SGR) formula and is made up of 2 participation tracks—the Merit-Based Incentive Payment System (MIPS) and APMs. According to the Centers for Medicare & Medicaid Services (CMS), only about 10% of clinicians will qualify in 2017 under the advanced APM. By 2018, that number is expected to increase to 25%.

For clinicians who bill services under the Medicare Physician Fee Schedule (Part B), understanding the requirements and payment changes under MACRA are very important since payment adjustments that occur in 2019 will be based on action and performance starting January 1, 2017.

MIPS is a Medicare value-based payment system combining 3 Medicare programs (Physician Quality Reporting System [PQRS], Value-based Modifier [VM] and the Medicare Electronic Health Records Incentive Program) that were sunset at the end of 2016. The new system will evaluate the performance of all MIPS-eligible clinicians (ECs) or eligible groups across 4 performance categories to determine payment adjustments that will be applied in future years: Quality, Cost, Advancing Care Information, and Improvement Activities.

The first MIPS performance year is January 1, 2017 through December 31, 2017, and payment adjustments accrued from that performance year will be applied to Medicare Part B reimbursements beginning on January 1, 2019. In response to feedback from stakeholders and health care providers, CMS has designated the 2017 performance year as a transition year, with reduced requirements that are hoped will encourage broad successful participation by MIPS ECs.

For 2017, clinicians are eligible to participate in MIPS if they bill more than $30,000 to Medicare and provide care to more than 100 Medicare patients per year, and are one of the following provider types:

- Physician
- Physician Assistant
- Nurse Practitioner
- Clinical Nurse Specialist
- Certified Registered Nurse Anesthetist

In 2017, there are 3 exemptions from MIPS for clinicians who otherwise meet the eligibility requirements:

- First-year Medicare Part B participants
- Clinicians billing Medicare Part B less than $30,000 in allowed charges and/or providing care for fewer than 100 Part B patients in 1 year
- Providers sufficiently participating in an advanced APM

Excluded from MIPS payment adjustments are payments from Medicare Part A, Medicare Advantage Part C, Medicare Part D, Federally Qualified Health Center (FQHC), or Rural Health Clinic facility payments billed under all-inclusive payment methodologies, and Critical Access Hospital (CAH) Method I facility payments.

The other path available to clinicians to engage in the QPP is to participate in an advanced APM. An APM is a payment approach that provides added incentive payments for high-quality and cost-efficient care. The primary purpose of APMs is to move clinicians away from fee-for-service payment mechanisms to pay-for-value/value-based payment programs. Value, driven by the quality of care in relation to its cost, is measured and rewarded in APMs implementing value-based payment principles. APMs can apply to a specific clinical condition, a care episode, or a population. Advanced APMs are a subset of APMs and let practices earn more for taking on some risk related to their patients' outcomes. Clinicians may earn a 5% incentive payment by going further in improving patient care and taking on risk through an advanced APM.

CMS will provide a list of care models each year that qualify for advanced APM incentive payments. In 2017, the following models are advanced APMs:

- Comprehensive ESRD [End Stage Renal

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Disease] Care (CEC) – Two-Sided Risk
- Comprehensive Primary Care Plus (CPC+)
- Next Generation Accountable Care Organizations (ACO) Model
- Shared Savings Program – Track 2
- Shared Savings Program – Track 3
- Oncology Care Model (OCM) – Two-Sided Risk
- Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1- CEHRT)
- Vermont Medicare Accountable Care Organization (ACO) Initiative (as part of the Vermont All-Payer ACO Model)

Technical assistance for the QPP is available to practices with 16 or more ECs through the Lake Superior Quality Innovation Network (Lake Superior QIN), which includes Michigan and Minnesota in addition to Wisconsin. MetaStar represents Wisconsin in the Lake Superior QIN and provides technical assistance for clinicians in Wisconsin.

For practices with 15 or fewer ECs, assistance is available through the QPP Resource Center. For direct assistance with the QPP Resource Center, Wisconsin ECs should contact MetaStar. The QPP Resource Center, funded by CMS, is collaborating among 10 key partners across Michigan, Ohio, Indiana, Illinois, Kentucky, Wisconsin, and Minnesota.

The QPP Resource Center is tasked with helping more than 35,000 clinicians prepare for and participate in the QPP. If you have a small practice (15 or fewer clinicians), are in a rural area, a Health Professional Shortage Area (HPSA), or a medically underserved area, the QPP Resource Center is authorized to provide assistance to you.

If you are interested in exploring assistance with the QPP, regardless of practice size, e-mail MetaStar at qpp@metastar.com. As part of the Lake Superior QIN and the QPP Resource Center, MetaStar provides a one-stop-shop approach for questions about the QPP.

More information about the program can also be found at https://qpp.cms.gov/. For resources and assistance visit www.lsqin.org/qpp or https://qppresourcecenter.com.

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