

Understanding Medicare's Quality Payment Program

NOVEMBER 2016

The Medicare Access and CHIP Reauthorization Act (MACRA) is intended to accelerate the transition to a health care system that rewards quality and value, rather than volume, and help ensure that patients experience better care and improved health outcomes. Under MACRA, the new Quality Payment Program (QPP) will bring the biggest change in Medicare reimbursement in decades. It offers a critical opportunity to drive health system transformation that results in authentic patient- and family-centered care.

The Quality Payment Program changes the way Medicare providers are paid to better reward quality and value.

MACRA immediately replaces the Sustainable Growth Rate (SGR) methodology for Medicare payments, providing stability through short-term annual payment updates to providers. Beginning in 2019, health care providers will be paid through one of two pathways that will link payments to the quality of care provided: the **Merit-Based Incentive Payment System** (MIPS) or **Alternative Payment Models** (APMs). Together, the MIPS and APM tracks make up the QPP.

Providers will begin reporting performance data for the QPP in 2017, with payment adjustments beginning in 2019. The lag between when performance data is reported and when payment adjustments begin is designed to provide adequate time for submission and feedback. The first reporting year will be considered a transition year, during which providers can choose how much data to report.¹

The implementing rules for the QPP provide guidance on how the two payment systems will reimburse Medicare providers.² As the Centers for Medicare & Medicaid Services (CMS) works with various stakeholders to implement and evaluate the new rules, the requirements for providers will change and evolve.

The Merit-Based Incentive Payment System

MIPS builds on the traditional fee-for-service architecture in Medicare but is structured so that payment rewards providers for delivering high-quality care and achieving better health outcomes. While most Medicare providers will be in MIPS when the program starts, the law intends for providers to transition into APMs.

Providers in MIPS will earn a composite score between 1 and 100 based on performance in four categories during the reporting period. Payment to providers (bonuses or penalties) will be adjusted up or down by as much as:

- ▶ Four percent in 2019;
- ▶ Five percent in 2020;
- ▶ Seven percent in 2021; and
- ▶ Nine percent in 2022.

However, in 2017 – the transitional year for reporting data – providers are permitted to “pick their pace” for reporting. This means they will have several options for participation in MIPS in the first year. If providers do not submit any data, they will face a negative adjustment. Providers who opt to submit performance data in 2017 can choose to 1) submit minimal data to avoid a negative payment adjustment; 2) submit data for a partial year and be eligible for a neutral or positive payment adjustment; or 3) submit a full year of data and be eligible for a positive payment adjustment.³

MIPS uses the following four performance categories to evaluate providers:

- ▶ **Quality** will be assessed by consolidating existing Medicare quality reporting programs (including the Physician Quality Reporting System). Most providers will choose from more than 200 measures to report on up to six quality measures, including one outcome measure, for a minimum of 90 days. Over time, additional evidence-based measures will be defined and further developed for MIPS through the traditional rulemaking process, with emphasis on outcomes-based measures.

Providers can receive a bonus point for reporting on a patient experience measure by choosing to participate in Consumer Assessment of Healthcare Providers and System (CAHPS) for MIPS.

- ▶ **Cost** will incorporate Medicare’s existing Value-Based Payment Modifier, which provides for differential payment based on the quality of care provided compared to the cost of care. All cost measures are based on claims data; providers will not have to report any additional data to CMS in order to calculate scores.

The cost category will be calculated in 2017, but will not be used to determine payment adjustments for the first year. In 2018, CMS will start using the cost category to determine payment adjustments for 2020.

- ▶ **Advancing care information (ACI)** replaces the “Meaningful Use” Electronic Health Record (EHR) Incentive Program for eligible Medicare professionals and rewards providers for specific uses of technology that improve patient care. The overall ACI score combines a *base score*, a score for participation and reporting, and a *performance score* to reward exceptional performance on high-priority measures. The reporting period for 2017 is 90 days.

To receive a full base score, providers are required to report on five measures: 1) protecting patient health information; 2) electronic prescribing; 3) providing patient access to health information; 4) sending a summary of care document; and 5) requesting/accepting a summary of care document.

To receive points toward a performance score, providers can choose from nine high-priority measures in the areas of patient engagement, care coordination and health information exchange. These include measures such as view/download/transmit health information, secure email messaging with patients or applicable caregivers, and patient generated health data. Providers are also eligible for bonus points if they report on

certain public health measures and/or complete specified improvement activities using certified electronic health record technology (CEHRT).

- ▶ **Improvement activities** is a new performance category that includes a broad swath of activities designed to reward clinicians for care focused on beneficiary engagement, care coordination and patient safety. Providers will choose from a list of nearly 95 activities; each activity is either “medium-weighted” or “high-weighted.” Most providers in MIPS will have to participate in two to four activities, depending on their weighting, for at least 90 continuous days.

There are several activities likely to bring progress on patient- and family-centered care and improve health outcomes, for example: 1) use of evidence-based decision aids to support shared decision-making; 2) engagement of patients and families to guide improvement in the system of care; and 3) access to an enhanced patient portal that includes interactive features.

Providers participating in a certified patient-centered medical home (PCMH) will receive the highest possible score for clinical improvement activities. Providers participating in an APM (that is not a PCMH) will automatically receive half the points toward full credit in this category; some providers in APMs may be eligible for full credit.⁴

Alternative Payment Models

Providers can choose to participate in an eligible Advanced APM and be excluded from the MIPS payment adjustments. APMs move away from traditional fee-for-service and toward value-based arrangements that tie payment for health care services to quality performance, health outcomes and value for a specific population.

Providers in an Advanced APM will receive an automatic five percent annual bonus, in addition to any financial bonuses or penalties they receive through the APM itself, such as shared savings or losses in a Medicare Accountable Care Organization (ACO).

Under the QPP, an Advanced APM must:

- ▶ Tie payment to quality performance, including at least one outcome measure in the set;
- ▶ Use CEHRT; and
- ▶ Bear financial risk.

Additionally, Medical Home Models and Medicaid Medical Home Models are given special consideration; to be an Advanced APM, those models have to meet a less stringent test for bearing financial risk.

Based on the above criteria, CMS determined the following are qualifying Advanced APMs:⁵

- ▶ Comprehensive End-Stage Renal Disease (ESRD) Care (CEC) with two-sided risk;
- ▶ Comprehensive Primary Care Plus (CPC+);
- ▶ Oncology Care Model (OCM) with two-sided risk;
- ▶ Next Generation ACO Model; and
- ▶ Shared Savings Program Tracks 2 and 3.

CMS announced a pipeline for additional alternative payment models that will qualify for the Advanced APM bonus.

The Quality Payment Program should lead to better care and better outcomes for patients.

If implemented with a patient- and family-centered approach, the QPP – and APMs in particular – has the potential to move us toward more comprehensive, coordinated, patient- and family-centered care while driving down costs.

As the program evolves, it will be essential that providers demonstrate sustained high performance on patient- and family-centered measures including patient and family experience of care and patient-reported outcomes, as well as continuous practice improvement. Focusing on payment reforms alone will not lead to the system-wide changes needed to make the health care system more responsive to the diverse populations and patients it serves and improve health outcomes and the quality of care for all.

The payment reforms in QPP are directed toward Medicare providers, but are likely to lead to system-wide changes across the public and private sectors as providers gain more experience with value-based payment and the adoption of APMs becomes more widespread. Ensuring the program yields improved health outcomes and high-quality care will be critical for the success of health care transformation occurring across sectors.

¹ More information on the “pick your pace” policy is available at <https://qpp.cms.gov/>.

² 42 CFR Part 414 – Payment for Part B Medical and Other Health Services.

³ See note 1.

⁴ Some providers may be in APMs but will not qualify for the Advanced APM bonus.

⁵ List is current as of October 2016. The list of eligible Advanced APMs may change; more information is available at <https://qpp.cms.gov/learn/apms>.

The National Partnership for Women & Families is a nonprofit, nonpartisan advocacy group dedicated to promoting fairness in the workplace, access to quality health care and policies that help women and men meet the dual demands of work and family. More information is available at NationalPartnership.org.

© 2017 National Partnership for Women & Families. All rights reserved.