CMSIssuesProposedRuleIntroducingQPP
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On April 27, the Centers for Medicare & Medicaid Services (CMS) released the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Proposed Rule introducing the Quality Payment Program (QPP). The proposed rule is a first step in implementing MACRA, a key piece of legislation that was the result of bipartisan efforts aimed at ending more than a decade of last-minute fixes and potential payment cliffs for Medicare physicians and other clinicians.¹ The goal of these measures is to offer physicians more flexibility to treat patients in accordance with their own professional judgment and what is in the patient’s best interests, while also creating a mechanism to reward physicians for the quality of care they offer, instead of the current system, which rewards the quantity of services they provide.

If finalized, this proposed rule will replace the current patchwork of programs² aimed at measuring value and quality with a uniform framework that includes two payment paths that physicians and other clinicians can choose: (1) the Merit-Based Incentive Payment System (MIPS); or (2) the Advanced Alternative Payment Models (APMs).

Path 1: MIPS

MIPS applies to Medicare Part B (Part B) clinicians, including physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists. Under this option, these clinicians have the opportunity to be paid more based on the quality of care provided. In order to determine whether clinicians met the requirements for the Advanced APM track, all clinicians will report through MIPS in the first year. There is flexibility in the rule to allow clinicians to move between components of the MIPS path
and the APM path.

The rule proposes four categories upon which the MIPS score is calculated (the following details to some extent what elements of prior programs are incorporated/replaced by these categories, and how they are designed to offer more flexibility than prior programs):

- **Quality:**
  - **Incorporates/Replaces:** Nine measures currently required under the Physician Quality Reporting System.
  - **Flexibility:** Clinicians choose six measures (from more than 200 to pick from, at least 80 specifically tailored to specialists) to report to CMS that best reflect their practice. One of these measures must be an outcome measure or a high-quality measure, and one must be a crosscutting measure. Clinicians also can choose to report a specialty measure set. For individual clinicians and small groups (2-9), MIPS calculates two population measures based on claims data, meaning there are no additional reporting requirements for clinicians for population measures.

- **Advancing Care Information:** Clinicians will report key measures of interoperability and information exchange.
  - **Incorporates/Replaces:** Replaces Meaningful Use (Medicare Electronic Health Record Incentive Program). No longer requires reporting on the Clinical Decision Support and the Computerized Provider Order Entry objectives for the base score. New criteria are customizable, flexible, and aligned with other Medicare reporting programs.
  - **Flexibility:** Clinicians are rewarded for their performance on measures that matter most to them. Six objectives proposed for the base score are:
    1. Protect Patient Information;
    2. Electronic Prescribing;
    3. Patient Electronic Access;
    4. Coordination of Care through Patient Engagement;
    5. Health Information Exchange; and

- **Clinical Practice Improvement Activities:** Clinicians are rewarded for clinical practice improvement activities.
  - **Incorporates/Replaces:** Creates new opportunities to document and be paid for implementing quality measures. Examples include care coordination, shared decision making, safety checklists, and expanding practice access.
  - **Flexibility:** Clinicians can choose the activities best suited for their practice; the rule proposes over 90 activities from which to choose. Credit can be obtained for participation in APMs and Patient Centered Medical Homes.

- **Cost (Resource Use):**
Incorporates/Replaces: Replaces the cost component of the Value Modifier Program.

Flexibility: CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything.

Access this CMS presentation on the QPP for more information on how the MIPS score will be calculated.

**Path 2: APMs**

Advanced APMs are the CMS Innovation Center models, Shared Savings Program tracks, or statutorily required demonstrations where clinicians accept both risk and reward for providing coordinated, high-quality, and efficient care. Clinicians who participate will be exempt from MIPS payment adjustments and would qualify for a 5% Part B incentive payment. Under this option, clinicians can decide to be a part of new organizations that get paid primarily for keeping people healthy. Included among the list of models that would qualify under the terms of the proposed rule as Advanced APMs are:

- Comprehensive End-Stage Renal Disease Care Model (Large Dialysis Organization Arrangement) Medicare Shared Savings Program—Track 3;
- Next Generation ACO Model;
- Comprehensive Primary Care Plus (CPC+);
- Oncology Care Model Two-Sided Risk Arrangement; and
- Medicare Shared Savings Program—Track 2 (available in 2018).

Under the proposed rule, CMS would update this list annually to add new payment models that qualify. When they get better health results and reduce costs for the care of their patients, they receive a portion of the savings.

CMS is accepting public comments on the proposed rule, which must be submitted on or before June 27.

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2 MIPS replaces the Physician Quality Reporting System, the Value Modifier Program, and the Medicare Electronic Health Record (EHR) Incentive Program.

Member benefit educational opportunity: Attend the Accountable Care Organization Task Force luncheon, entitled "Navigating Corporate Practice of Medicine Laws in a Value-Based Payment Environment: ACOs and Interaction with State Laws, Waivers, and Regulations" (May 17), taking place at the Health Care Transactions program (May 17-18, Nashville, TN).