PCG Software, Inc.

"Committed to reducing the cost of healthcare"

Minimum MACRA:

The Merit Based Incentive Path in CMS's Quality Payment Program

PCG Software, Inc.
7065 W. Ann Road, # 130-549
Las Vegas, NV 89130
(877) 789-1291
www.pcgsoftware.com

January 2017

Minimum MACRA:

The Merit Based Incentive Path in CMS's Quality Payment Program

1. Background

On January 1, 2017, CMS will set into motion a complex set of regulatory rules that will change physician payments under Part B of Medicare. These regulations implement the 2015 Physician Payment "reform" legislation officially known as the Medicare Access and Child Health Program Reauthorization Act[1]. From a narrow perspective, the "MACRA" statute replaced the highly controversial Sustainable Growth Rate (SGR) process for updating the Medicare Physician Fee Schedule. However, the underlying objective of the legislation looked beyond the correction of a technical flaw in the law it replaced. The intent of MACRA was to build a framework to allow CMS to reorient Part B provider payments based on a "quality and value proposition" in contrast to the long-standing "payments made for services rendered" approach[2]. The recent election of a new Administration is likely to

---

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services 42 CFR Parts 414 and 495 [CMS-5517-FC] RIN 0938-AS69 Medicare Program; Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models: Final Rule at: https://www.federalregister.gov/documents/2016/11/04/2016-25240/medicare-program-merit-based-incentive-payment-system-mips-and-alternative-payment-model-apm.

[2] Ibid., Executive Summary, Page 4. It should be emphasized that the QPP program only applies to PART B payments made under the Medicare Physician Fee Schedule.

result in a significant amount of change in the federal government's approach to healthcare. However, for practical and political considerations, the essentials of MACRA's new approach to physician/provider payments are likely to survive this shift in the country's healthcare policies[3].

a. CMS's Quality Payment Program (QPP)

The centerpiece of the MACRA legislation is the Quality Payment Program[4]. Multifaceted in its structure, the QPP will be "phased in" over several years. The November "Final Rule" detailing its implementing regulations is over two thousand pages in length. In it, three existing CMS quality-based provider payment initiatives are terminated, although many of their measurement components are preserved and incorporated into the new QPP program.

The QPP is not, however, just a rendition of pouring "old wines into a new bottle." A distinguishing characteristic of the QPP is its flexibility. Participating providers are given alternative avenues to comply with the QPP's requirement and those paths have numerous additional options structured into them. The first QPP "track" is the Merit-Based Incentive Payment Approach (MIPS). It is a compliance path that requires providers to select and then report their performance on various quality and cost measures[5].

---

[3] See; Kaiser Health News, "A Consumer's Guide to Medicare's New Rules on Doctor Pay," November 7, 2016 at: http://khn.org/news/a-consumers-guide-to-medicares-new-rules-on-doctor-pay/.

[4] The Quality Payment Program major websites are: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html and, https://qpp.cms.gov/.

[5] MIPs physicians can report as individuals under the NPI and TIN Numbers they typically use. They may also report as "medical groups" or two or more providers using one assigned TIN. Group reporting can be done by the group or through using a qualified party data submission service such as a qualified clinical data registry. There is a deadline of June 20, 2017 for registration as a group data submitter.

The alternative program track requires providers to enroll in one of about twenty different Advanced Payment Models[6]. Some of those models (e.g., Alternative Care Organizations) are on-going programs. Others are newly designed APMs having a more "boutique" flavor. Those payment models are targeted to specialized groups of providers and the patients they treat[7].

The fundamental difference between the two approaches is that the MIPS approach is a *provider reporting program that attempts to link quality and cost performance with changes in payments*. One reports, or does not report, his or her performance on specific quality and cost measures and, subsequently, is or is not subject to various penalties or rewards prescribed in the program's rules.

---

[6] There is a unique category of providers enrolled in *less advanced* APM models (e.g., so called "MIPS/APMS") have a special subset of MIPS reporting requirements applied to them. The providers in these MIPS/APM models also have a special scoring system applied to them to be used in calculating the 2019 payment adjustments. The applicable details of MIPS/APMs is not considered in this review. The constituent providers in MIPS/APMs are designed as "non-QP" providers by CMS.

[7] The list CMS QPP *approved* Advanced Practice Models (APMs) was, as of 11/1/2016. Accountable Health Communities (AHC), Bundled Payment for Care Improvement Model 2, (BPCI) Bundled Payment for Care Improvement Model 3, (BPCI) Bundled Payment for Care Improvement Model 4, (BPCI) Comprehensive Care for Joint Replacement (non-CEHRT), Comprehensive ESRD Care (CEC) Model (LDO arrangement), Comprehensive ESRD Care (CEC) Model (non-LDO two-sided risk arrangement), Comprehensive Primary Care Plus (CPC +) Model, Financial Alignment Initiative, Frontier Community Health Integration Program (FCHIP), Graduate Nurse Education Demonstration, Health Plan Innovation (HPI), Part D Enhanced Medication Therapy Management Model, Home Health Value Based Purchasing Model (HH-VBP), Independence at Home Demonstration (IAH), Intravenous Immune Globulin (IVIG) Demonstration, Maryland All-Payer Hospital Model (MM), Medicare Advantage Value-Based Insurance Design, Medicare Care Choices Model (MCCM), Medicare Shared Savings Program—Track 1 (MSSP,) Medicare Shared Savings Program—Track 2, (MSSP) Medicare Shared Savings Program—Track 3, (MSSP) Million Hearts: Cardiovascular Disease Risk Reduction Model (MH CVDRR), Next Generation ACO Model, Oncology Care Model (OCM) (one-sided risk arrangement), Oncology Care Model (OCM) (two-sided risk arrangement), Prior Authorization: Repetitive Scheduled Non-Emergent Ambulance Transport, Prior Authorization: Non-Emergent Hyperbaric Oxygen Therapy Model, Initiative to Reduce Preventable Hospitalization among Nursing Home Residents: Phase 2, State Innovation Models Round 2, (SIM 2), Strong Start for Mothers and Newborns, Transforming Clinical Practice Initiative (TCPI).

Under the QPP, providers who do not take the MIPS path are required to become *participants in a provider organization that entails the assumption of some degree of shared financial risk*. Since there are a number of specific models in the overall APM umbrella, there are different organizational and financial relationships in each. However, provider compliance with the requirements in the APM approach is based on enrollment in the organization and not just following the requirements of a payment system based on the measurement of quality and cost monitored by the periodic submission of reports and enforced through an algorithm of rewards and penalties.

Relative to the two paths, QPP compliance CMS makes it clear that the program's objective *over the long-term* is to gradually re-structure the QPP's program incentives and disincentives, in such a way to channel all, or most all, providers, into the organizational shared risk framework upon which the Alternative Payment Model is based[8]. How quickly and successfully that goal is achieved remains problematic.

b. Program Exemptions

Generally speaking, the vast majority of Part B providers are affected by the QPP requirements. There are, however, certain types of providers who are, initially at least, shielded from required participation. Any one of the following conditions exempts a provider from the QPP Program. In 2017, however, you are exempt from QPP compliance if:

[8] This is evidenced by the more lucrative incentives that CMS has incorporated into the APM path, the significant retrofitting of current APMs and the creation of additional APM models. See discussion in: "Doctors Raise Concerns for Small Practices in Medicare New Payment System," Kaiser Health News, August 25, 2016.

- **You do not participate in Medicare Part B**
- **You are not an eligible QPP Provider Type[9]**
- **Your practice does not meet the financial and patient volume thresholds for QPP eligibility**
- **You deliver twenty five or less "patient facing" services within QPP reporting period**
- **You do not deliver <u>any</u> Part B outpatient services**
- **You are a newly enrolled (e.g., a 2017 first year) Medicare Part B participating provider**

2. The Merit Based Incentive System: A Thumbnail Sketch

The reader is advised that, from this point forward, the narrative has a "one track mind." Our discussion will be confined to the Quality Payment Program as it applies to just those providers who have elected to follow the Merit-Based Incentive Payment Approach (MIPS). Why are we limiting our scope to only one compliance track? There are several reasons.

First, the best estimates are that about three-quarters of the total number of eligible providers and/or groups will, initially at least, select

[9] 2017 provider types subject to the QPP are: physicians (M.D. and D.O.), chiropractors, podiatrists, doctors of optometry, dental surgery, and dental medicine hospitalist physicians, physician and D.O. assistants, clinical nurse specialists, and certified registered nurse anesthetists. Beginning in 2019 the list will expand to include: therapists (e.g., PTs, OTs, STs), CSWs, audiologists, nurse midwives, psychologists, dietitians and nutritionists. Physicians who are hospitalists are also included.

this compliance path[10]. Second; the MIPS alternative represents the minimal path to compliance with the QPP requirements. As such, it is the path of less provider risk and less provider cost[11]. Third, CMS in the MACRA/QPP Final Rule significantly liberalized the MIPS's original requirements to make that path more attractive to providers[12]. Finally, earlier comments notwithstanding; there remains a degree of uncertainty about the finality of the regulatory rules given the multi-year time frame over which the QPP Program's implementation is structured.

While the passage of the MACRA legislation was based on bipartisan political support, the complexity of its implementing regulations and the extended time frame over which it will be introduced as well as CMS's statement that further regulatory guidance will be forthcoming suggests that providers will adopt a cautious path to it. They are likely to adopt a "wait and see" approach and follow the more "conservative" MIPS compliance path.

The requirements that make up MIPS's route within the QPP consist of six basic elements: (a) Program Structure, (b) Time Frame, (c) Program Process, (d) Performance Measures, (e) Measurement Scoring, and (f) Provider Scores and Program Payment.

---

[10] For an overview of the changes see: Executive Summary, Department of Health and Human Services, Centers for Medicare & Medicaid Services, 42 CFR Parts 414 and 495 [CMS-5517-FC] RIN 0938-AS69, pp.9-10.

[11] See: "Few Doc's Ready For Risk under MACRA", Modern Healthcare, August 13, 2016 and Sara MacDonald's "10 Things You Need to Know About MACRA", at Https://www.rachethealth.com/10-thingsneed-to-know-macra/ By Sarah MacDonald Posted August 18, 2016.

[12] CMS estimates that about 70,000-120,000 of the 600,000 QPP eligible providers will chose the APM path in the initial two years. This is about one-quarter of all QPP eligible providers. About 700,000 providers are excluded from the QPP because they are not provider-type eligible or they fail to meet volume and threshold requirements, See: Reed Smith Client Alert, "Pick a Lane: CMS Finalizes Two Track System to Implement Significant Changes in Medicare Payment Policies under MACRA", November 1, 2016 and, Centers for Medicare & Medicaid Services, CMS Fact Sheet "Quality Payment Program Page 6, October 14, 2016.

a. The MIPS Structure: The Four Categories

The Merit Based Performance system adjusts providers' professional payments based on a comparative assessment of the content of the periodic performance reports that the provider submits. Providers are required to report data to CMS across four performance categories: (1) Quality, (2) Clinical Practice Improvement Actions, (3) The use of Electronic Health Records, and (4) Practice Resource Expenditures. Metrics for the fourth assessment category remain as a "work in progress." In the 2017 performance year CMS announced that it will delay the reporting requirements for the practice resource use metric[13].

b. Time Frame: A Long March

CMS has established an extended time schedule for the implementation of the QPP program. The introductory phase extends over a three-year period. Any direct effects of the "key" component, the performance-based penalties or rewards that adjust Part B provider payments are not triggered until the program's third year. However, the measurement data collected in the first two years of the program collectively establishes a performance threshold against which all providers are assessed and determines the relative standing of each individual provider. Therefore, an awareness of "what happens when," as the QPP program unfolds, is extremely important.

---

[13] The submission of practice cost information will not begin until the second reporting year of the program (e.g., 2018) and will not impact the initial 2019 payment year. CMS stated "To address public comments on the cost performance category the weighting of the cost performance category has been lower, to 0 percent for the transition year", See: Executive Summary, Department of Health and Human Services, Centers for Medicare & Medicaid Services 42 CFR Parts 414 and 495 [CMS-5517-FC] RIN 0938-AS69, page 8.

In Phase One (2017), designated as the initial QPP "performance year," all eligible providers must select which compliance path they intend to follow. As was noted above, it is assumed that all have elected the MIPS path. This path allows the provider to choose the "participatory pace" they wish to follow[14]. These choices will be discussed in the Section that follows. Next, following certain rules, they must select how many measures they wish to report on and designate the specific measures they chose from the QPP's three designated measurement categories as each contains many measures within it[15]. Finally, MIPS providers must initiate within the practice (or the group) the process of gathering the data to report their performance on the numbers and types of measures selected.

In Phase Two (2018), MIPS track providers continue to collect the required data. The deadline for data submission for the first payment year is in this second performance year. CMS requires that by the end of the *first quarter of the second year* (e.g., March 31, 2018), all measure-specific data must be submitted to CMS. Once that data is submitted, any issues that may arise are to be ironed out between CMS and the provider through feedback reports. CMS then begins the process of calculating the provider's scores that will adjust provider Part B payments for the forthcoming QPP Program's 2019 payment year.

---

[14] CMS indicates that providers are not required to prospectively declare their MIPS participation level. That will be determined retrospectively by CMS based on the scope of the data they submit in the performance period.

[15] The requirements for the ACI and CPI measures have various technical qualifications. Three of the more important ones are: (a) For the ACI measures the number of measures that must be reported (e.g., 4 or 5) depends on which of two EHR Systems the provider uses, (b) For the CPI measure "small practice groups" (e.g., those with less than 15 physicians) and rural practices, including geographic HPSA located providers may report a smaller number of quality measures, and (c) The requirement that data applicable to the selected MIPs category measures must have been gathered by the submitting provider over a 90 day time span is a limiting requirement and not an absolute requirement. By not meeting the requirement, a providers' maximum point score for that measure is capped by the QPP scoring system at 3 points out of possible of a maximum of 10 points on that measure.

In Phase Three (2019), the first QPP "payment year" is reached. This year represents the ***initial application*** of the new QPP payment mechanics to adjust upward or downward the Part B payments to providers or groups. Adjustments to provider payment will be based on, or affected by, the pace of their participation (e.g., none, minimal, moderate, or maximum) and the provider's level of performance as calculated by a scoring system and compared to a collective baseline score. Let's begin by looking at the participatory levels available to providers following the MIPS path and the initial 2017 requirements established for those levels.

c. MIPS Process: Picking Your Pace of Participation

As was noted above, a hallmark of the Quality Payment Program is its flexibility, which is especially evident for MIPS providers as that path uses a "menu approach." In it, three "portion controlled" entrées are featured:

1) Minimal MIPS Participation - Providers electing to take this "minimalist" approach to QPP compliance must do the following:

   Data Submission Requirements: Submit for a minimum 90-day period, or less in special circumstances:

   - Practice Data on ***one*** Quality Measure ***or***
   - Practice Data on ***one*** Clinical Improvement Activity Measure ***or***
   - Practice data ***on any four (or five)*** of the eleven Advancing Care Information (ACI) Measures

   A practice's data collection must start no later than 10/1/17, and must be submitted no later than 3/31/2018.

   Result: The first payment year's financial negative adjustment of -4% will ***not be applied*** when the first (i.e., the 2019) payment adjustment period comes into effect. There

are no other positive financial incentives (e.g., bonuses) available.

2) Moderate MIPS Participation - Providers electing to take a "moderate" approach to compliance with the QPP must do the following:

   Data Submission Requirements: Submit for a minimum 90-day period:

   - Practice Data on *more than one* Quality Measure *or*
   - Practice Data on *more than one* Clinical Improvement Activity Measure *or*
   - Practice data on *more than five* of the eleven Advancing Care Information (ACI) Measures

   Result: The first payment year's financial negative adjustment of -4% will *not be applied* when the first payment adjustment period comes into effect. Depending on the levels of performance on the submitted compared to the performance year threshold, a small bonus may be earned.

3) Maximum MIPS Participation - Providers electing to "maximize" compliance with the QPP must:

   Data Submission Requirements: Submit for a minimum 90-day period or up to a full-year period:

   - Practice Data on *six* Quality Measures *or* one specialty/sub-specialty specific measure set, *and*
   - Practice Data on *four* Clinical Improvement Activity Measures *and*
   - Practice data on *more than five* of the eleven electronic records Advancing Care Information (ACI) Measures

Result: **The -4% negative adjustment will *not be applied* to the practice when the penalty period comes into effect. In addition, depending on the length of the time period over which the data is submitted and the performance level of the practice compared to the CMS designated threshold, a *bonus payment may be available*. The practice will also become bonus eligible for later payment periods if the level of their performance continues to be exceptional.**

No MIPS Participation **- The Provider elects not to participate in the MIPS program[16].**

Result: **The -4% *negative adjustment* is applied in the 2019 payment year.**

d. MIPS Performance Measures

Performance measurement is the touchstone of the QPP program. The measures used in MIPS are familiar to many Part B providers. That is because the initial triad of measures in the MIPS path; Quality, Practice Improvement, and Use of Electronic Medical Information are culled from three existing, though soon to be "legacy," CMS quality programs. These are the Value Based Modifier Program, the Electronic Health Record Program, and the Physician Quality Reporting System. Let's briefly take a look at the measures in each category[17]. Then, in the next Section, we will look at the general structure of the MIP Scoring System; how measures in each performance category are scored, and how a provider's overall score is calculated from the component scores.

---

[16] This assumes, of course, that the non-MIPS provider does not participate in an APM model. If he or she does participate in the AMP path his/her payments adjustments are based on the rules applicable to that OPP track.

[17] The full set of measures can be found and downloaded at the Merit Based Performance Initiative Program Section at the CMS website: https://qpp.cms.gov/education.

The number of measures in the Quality Measurement category is very large. There are about 300 individual Quality Measures grouped in various "Sets" or "Domains." (Some are designated as low priority measures). The remainder are high priority measures. An example of a high priority Quality Measure in the Communication and Care Coordination Domain is: *"Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred*." Another Quality Measure, taken from Clinical Care domain, is: "*Percentage of patients aged 18-85 years of age with a diagnosis of hypertension whose blood pressure improved during the measurement period*."

The second MIPS measurement category, Clinical Practice Activity Category (CIPA), consists of eight sub-categories of individual measures. Examples include: care coordination, shared decision-making, and safety checklists. The individual measures in each subcategory are designated as a medium-weight or a high-weight activity. An example of a medium-weight activity is in the Care Transition Documentation domain. The measure requires: *Implementation of practices/processes for care transition that include documentation of how a MIPS eligible clinician or group carried out a patient-centered action plan for first 30 days following a discharge (e.g., staff involved, phone calls conducted in support of transition, accompaniments, navigation actions, home visits, patient information access, etc.).*

Fifteen measures make up the Advancing Care Clinical Information category. An example is a measure for *Information Reconciliation*. This measure requires: *for at least one transition of care or referral received or patient encounter in which the MIPS eligible clinician has never before encountered the patient, the MIPS eligible clinician performs clinical information reconciliation. The MIPS-eligible clinician must implement clinical information reconciliation for the following three clinical information sets: (1) Medication: Review of the patient's medication, including the name, dosage, frequency, and route of each medication, (2) Medication allergy:*

Review of the patient's known medication allergies, and (3) Current Problem list: Review of the patient's current and active diagnoses.

e. Scoring the Measures[18]

Measures in all the three of the initial 2019 performance categories have maximum point scores assigned to them. However, measure scoring in each of the three categories varies. For the 2019 payment year, where only three categories apply, Quality is weighted 60%, Practice Improvement Activities 25%, and Advancing Clinical Information activities 15%. The maximum possible point score an individual provider can achieve in a performance year is 100 points. Providers, with various qualifications, can select the specific measurers they wish to report on across the three categories.

All Quality measures have a maximum of ten points. A provider's performance on each measure is translated into his/her individual Quality points. A provider's performance on the measure is then compared to his/her peer's performance. Based on that score, the provider's performance score is mapped to a percentile range derived from the performance of all providers on that measure. The percentile ranges for a measure corresponds to the measure's point spread. For example, when the measure's point spread is from 0 Points to 10 Points, a provider whose score falls in the 50th to 60th percentile receives a possible 5.0 - 5.9 points for that measure. This process is repeated for the remaining Quality measures. The provider's Quality Point scores are summed and then weighted, based on the Quality Category's weight (e.g., 60%). This determines the number of points his or her quality based performance is compared to all providers.

---

[18] A good overview of the scoring process for MIPS measures can be found on pages 9-13 in, "10FAQs About the Merit Based Incentive Program (MIPA) at http://www.saignite.com/resources/faq-about-merit-based-incentive-payment-mips.

Measurement and scoring for the Advancing Care Information category is more complex. It has three components. First there is a Base Score with a possible 50 points total. Measures in it requiring "Yes," -"No" or "0 - 1" responses use the "legacy" Meaningful Use EHR metrics. Next, there is a Performance Score with a possible 90 points total. It has eight performance measures. Those are scored using the same method as the Quality Measures discussed above. Finally, there is the opportunity to earn 15 "bonus" points added in this category. These are earned if the provider enrolls in a designated clinical registry. Total points in the ACI Category are downwardly scaled if they exceed 100 points. A provider's total points are then adjusted by the 25% weighting that applies to this category.

The third Clinical Practice Activity Category (CIPA) is made up of eight categories of measures. Examples include: care coordination, shared decision-making, and various safety checklists. The individual measures in each subcategory are designated as a medium-weight or a high-weight activity. The former have a point value of 10 points, while high-weighted CIPA measures are valued at 20 points. A provider who selected the "maximum MIPS participation level" must report on four of these measures. The provider's performance is scored using the same method as the Quality Measures discussed above. Point scores are then summed and weighted based on the CIPA category weight (e.g., 15%) to determine the number of point's improvement activities performance contributes to the provider's final performance score.

f. Scoring Providers: Linking Performance to Payment

A MIPS participating ***provider's score*** determines the adjustment made to his/her Part B reimbursement in each payment year. That final score also may determine his/her eligibility for a possible

performance-based bonus payment if he/she so qualifies. The score is a composite number derived from the provider's individual scores across the three performance categories measured in the initial 2017 performance year.

The scoring formulae, in the simplest case of an individual provider participating in the MIPS track, are:

Total Quality Points Earned x Quality Point Weighting (60%) +

Total Advancing Care Information Points Earned x

ACI Point Weighting (25%) +

Total Clinical Practice Improvement Points Earned x

CIPA Point Weighting (15%) =

Total Points Earned In QPP Performance Year

The ***size*** and ***extent*** of the (upwards or downwards) score-based adjustment that providers receive in a payment adjustment year will be largely determined based on a "point threshold" that is calculated in that year by CMS. Thresholds are calculated based on provider's collective performance with adjustments that incorporate a small annual inflation factor.[17] The threshold number represents ***the score that generates a neutral pay adjustment*** in that payment year. A provider scoring at ***the*** payment year threshold experiences no payment adjustment. Each serial number point increase or decrease above or below the threshold translates into a proportional (%) upwards or downwards percentage increase or decrease in the provider's score-based payment. Since in any payment year there is only one threshold number, there will be a high probability that most providers will not hit the payment year's threshold score. Therefore, most providers

will have **their payments positively or negatively impacted in the payment year[19].**

For the initial payment year of 2019, CMS has, by design, minimized the impact of any penalties. The MIPS performance threshold number for a neutral pay adjustment score was artificially set at a mere 3.0 points. To reach that score, a MIPS provider needs only to submit one quality measure to avoid the penalty. In the 2019 payment year the maximum penalty percentage has been "capped" at -4%.

Upside incentive payment levels generated by the scoring system are also subject to a ceiling. In the 2019 payment year, they are capped at a percentage amount not to exceed 3.0 (the 2019 threshold score) times the maximum incentive percentage of +4% set for that year. Therefore, in principle, a provider could receive a 12% incentive payment. In addition, a further 10% bonus is available to exceptional performers whose scores in the 2017 performance period were equal to 70 points. That score could only be attained by MIPS providers who had elected *Maximum Participation* and whose performance scores were *significantly above* their peers in that performance year.

---

[19] It is important to note that various "macro" budgetary, statutory, and programmatic factors will impact the pool of dollars available for provider payment adjustments. Examples are: (a) The small statutory required inflation factor update of .05 for the period 2017-2019, (b) The programmatic requirement that the QPP program's impact must, overall, be "budget neutral" and (c) How providers in various aspects of the QPP program distribute themselves across program metrics. For example, relative to the "bonus" features structured into the QPP program, if a disproportionate number of providers perform "exceptionally" based on the metrics, the size of each individual provider's bonus payment will decrease.

3. Conclusion: An Assessment of MIPS

Under the current regulatory rules and time frames, the performance-based re-distribution of payments to providers under the QPP could be potentially significant. One estimate suggests that a payment spread of -9% downside to = +37% upside in five years; that is by the payment year of 2022. In addition, since it is CMS's intention to make the QPP performance data available to the public, the possible effects from the disclosure of this information on beneficiaries, the general public and other payers cannot be discounted.

For the majority of providers who are expected to follow the Merit-Based Incentive Program as their participatory path there is one important caveat as the Quality Performance Program unfolds. If, going forward, the current design of the planned changes to QPP incentives and disincentives remains in place, the payment incentives built into the Advanced Payment Model are projected, on a per unit of service basis, to surpass the incentives built into the MIPS performance path. This is, of course, an intentional bias as it is CMS's stated plan to move as many providers as possible into collective provider organizations that both share financial risk and, hopefully, provide more "valuated" care.

Initially, the Quality Payment Program applies to Part B beneficiaries only. Its parameters, for now at least, are the compass for payment changes under the Medicare Physician Fee Schedule. CMS has hinted that its application to Medicaid Providers and the Medicare Part C Advantage Programs is under consideration. Then too, there is the possibility that the program's structure augments or supplants various initiatives that commercial payers have launched to better relate provider performance to provider payments using a system of quality/cost "value" metrics. Will the Quality Payment Program stand as the payment system that, over time, provides a workable and acceptable framework of incentives for Part B providers of professional service? Will it, as its proponents hope, be able to deliver demonstratively higher quality services and also stabilize a medical cost curve whose malleability has proven stubbornly one directional? Stay tuned!

BULLET POINT SYNOPSIS

- On January 1, 2017, CMS will set into motion a complex set of regulatory rules that change physician payments under Part B of Medicare. The regulations implement the 2015 Physician Payment "reform" legislation officially known as the Medicare Access and Child Health Program Reauthorization Act or MACRA.

- The centerpiece of the MACRA is the Quality Payment Program (QPP).

- The QPP gives participating providers alternative avenues to comply and those compliance paths have many options structured into them.

- One QPP "track" is the Merit Based Incentive Payment System (MIPS). This path allows providers to select and then report their performance on various quality and cost measures.

- The MIPS approach links quality and cost performance with changes in provider payments.

- Providers who do not take the MIPS path are required to participate in one of several alternative Advanced Payment Models. These provider organizations require the assumption of some degree of shared financial risk.

- Certain types of providers are, initially at least, exempted from QPP participation.

- The content of this article is confined to the Quality Payment Program applied to those providers who elect to follow the Merit-Based Incentive Payment System.

- MIPS represent the minimal path to compliance with the QPP. It is the path that requires less provider risk and less provider cost.

- **The requirements that make up MIPS's consist of six elements: (a) Program Structure, (b) Time Frame, (c) Program Process, (d) Performance Measures, (e) Measurement scoring, and (f) Provider Scores and Payment.**

- **MIPS adjusts providers' professional payments based on a comparative assessment of the content of the periodic performance reports they submit.**

- **Providers are required to report data across four performance categories: (a) Quality, (b) Clinical Practice Improvement Actions, (c) The use of Electronic Health Records, and (d) Practice Resource Expenditures. For 2017 there is a delay in the reporting requirements that measure practice resource use.**

- **CMS has established an extended time schedule for the implementation of the QPP program. The performance-based penalties or rewards that adjust Part B provider payments are not triggered until the program's third year (2019).**

- **Data collected in the first two years of the program collectively establish the performance threshold against which all providers are measured and determine the relative standing of each individual provider.**

- **Phase One (2017), is designated as the initial QPP "performance year," where participating providers must select which compliance path they intend to follow.**

- **Phase Two (2018), MIPS track providers continue to collect the required data. The deadline for data submission for the first *payment year* (2019) is the end of the *first quarter of the second performance year (2018)*.**

- Phase Three (2019) is the first QPP "payment year" is reached. The application of the QPP payment mechanics to adjust upward or downward Part B payments begins.

- The MIPS path uses of a "menu approach." In it, three "portion controlled" entrées are offered to participating providers. They are: Minimal MIPS Participation, Moderate MIPS Participation, or Maximum, MIPS Participation.

- The performance measures used in MIPS are familiar to many Part B providers. That is because they are the measures used in CMS's "legacy" Value Based Modifier Program, the Electronic Health Record Program, and the Physician Quality Reporting System.

- With various qualifications MIPS providers can select the specific measurers they wish to report on across the three categories of measurers.

- Measures in all the three of the initial 2019 performance categories have maximum point scores assigned to them. However, measure scoring in each of the three categories varies.

- The number of measures in the Quality Measurement category is very large. There are about 300 individual Quality Measures grouped into various "Sets" or "Domains."

- The second MIPS measurement category, Clinical Practice Activity Category (CIPA) consists of eight sub-categories of individual measures.

- Fifteen measures make up the Advancing Care Clinical Information category.

- **A MIPS participating *provider's score* determines the adjustment made to his/her Part B reimbursement in each payment year. That final score also may determine his/her eligibility for a possible performance based bonus payment if he/she so qualifies.**

- **The score is a composite number derived from the provider's individual scores across the three performance categories measured in the initial 2017 performance year.**

- **The scoring formulae, in the simplest case of an individual provider participating in the MIPS track is:**

Total Quality Points Earned x

Quality Point Weighting (60%) +

Total Advancing Care Information Points Earned x

ACI Point Weighting (25%) +

Total Clinical Practice Improvement Points Earned x

CPIA Point Weighting (15%) =

Total Points Earned In QPP Performance Year

- **For the initial payment year of 2019, CMS has, by design, minimized the impact of any penalties.**

- **Upside incentive payment levels generated by the scoring system are subject to a ceiling. In the 2019 payment year, they are capped at a percentage amount not to exceed 3.0 (the 2019 threshold score) times the maximum incentive percentage of +4% set for that year. A provider could receive a 12% incentive payment and a further 10% bonus is offered for "exceptional" performers.**

- **Under the current regulatory rules and time frames, the performance-based re-distribution of payments to providers under the QPP could be potentially significant.**

- **CMS intends to make the QPP provider performance data available to the public.**
- **Going forward, the current design of the QPP incentives and disincentives remains in place built into the Advanced Payment Model are projected, on a per unit of service basis, to surpass the incentives built into the MIPS performance path.**
- **The Quality Payment Program applies to Part B beneficiaries only. However, CMS has hinted that it intends to apply it to Medicaid Providers and the Medicare Part C Advantage Programs in the future.**