Dynamic Chiropractic


SENIOR HEALTH

# Getting Paid by Medicare Is Getting a Major Adjustment

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The 2015 Medicare Access and CHIP Reauthorization Act (MACRA) was signed into law to implement a new approach to clinician payments and replace the Sustainable Growth Rate formula. The overarching intent of this program is to reward providers for delivering care that is high in quality, value-based and cost-effective.

This year, the program is set to undergo a significant makeover by way of the Quality Payment Program (QPP). On April 27, 2016, the Department of Health and Human Services issued this new QPP proposal to reduce the reporting burden across four quality categories and add the flexibility necessary to accommodate physicians from all specialties. The proposed changes also focus on fortifying the provider care and reimbursement framework, and driving provider rewards away from volume and toward value.

The Sunsetting of Existing Medicare Programs and the Recombining of Initiatives

The most notable changes that come packaged in this recent proposal will be the sunsetting of some of the more familiar Medicare programs, to be replaced with two new evaluation and payment tracks. These tracks are the Merit-based Incentive Payment System (MIPS) and the Advanced Alternative Payment Models (APMs) Program.

Both programs are housed under the larger umbrella: the Quality Payment Program (QPP). In 2018, these programs are scheduled to replace the three more familiar programs: the Value Modifier Program, the Physician Quality Reporting System, and the EHR Incentive Program.


Penalties associated with old programs also will sunset at the end of 2018, including the 2 percent and 3 percent penalties for PQRS and EHR, respectively.

The Sunrise of New Medicare Programs: MIPS & Advanced APMs

*MIPS:* The aim of the Merit-based Incentive Payment System is to improve upon Medicare's current value and quality-based payment structure by allowing clinicians the flexibility to choose the measures and activities that are best suited to the specific form of care they provide, and by consolidating today's overly complex reporting structure. Participating in MIPS is how most Medicare providers will begin their participation in the new Quality Payment Program.

*Advanced APMs:* As an alternative to MIPS, which focuses on fee-for-service reimbursements, some primary care providers are eligible to forgo MIPS payments in favor of a 5 percent lump-sum incentive payment. Providers who participate sufficiently (by receiving enough payments or seeing enough patients through Advanced APMs) would be exempt from MIPS payment adjustments, and instead would qualify for a 5 percent Medicare Part B incentive payment.

Standards are aligned between the MIPS and APMs programs to make switching between programs easier. If providers participating in Advanced APMs fall short, they can choose whether to receive a payment adjustment through MIPS instead. To determine which providers meet requirements to participate in the advanced APMs track of the quality program, all providers will report through MIPS in the first year.

Evaluation of a Composite Performance Score

New payments and penalties are now based on a composite performance score. Providers participating in MIPS will receive a composite score between zero and 100 for each annual reporting period. This score will be compared against a median or mean of all provider composite performance scores recorded during the prior evaluation period, and payments and penalties will

be issued accordingly.

This score is based on a provider's success in providing quality care, and is measured through their performance in the following four areas:

*1. Clinical Practice Improvement Activities* – A provider's score here is based on practice improvement activities that focus on beneficiary engagement, patient safety and care coordination. Providers have some flexibility to choose activities to report on (from a list of 90 options) that match their goals for their practice.

*Clinical Practice Improvement Activities are equal to 15 percent of a provider's composite score in year one.*

*2. Cost* – A provider's score here is based on Medicare claims and does not require the provider to submit reporting in order to receive a score. To account for differences among specialties, this category uses more than 40 episode-specific measures.

*Cost is equal to 10 percent of a provider's composite score in year one. It replaces the cost component of the Value Modifier Program (Resource Use). This portion of the program is not being implemented in the first year; it will be a part of 2018 reporting instead.*

*3. Quality* – A provider's score here is based on six chosen measures (a reduction from the nine previously required under PQRS). It allows providers to tailor reporting options to their unique form of care.

*Quality is equal to 50 percent of a provider's composite score in year one. It replaces the PQRS and quality component of the Value Modifier Program. (In 2017, quality is 60 percent because the cost portion is essentially absorbed into the scoring under this category.)*

*4. Advancing Care Information* – A provider's score here is based on measures that reflect how they use EHR technology within their practice. Dovetailing into the final initiatives of EHR Incentive Stage III, there is an emphasis on interoperability and information exchange, but without the stringent reporting requirements of the EHR Incentive Program.

*Advancing Care Information is equal to 25 percent of a provider's composite score in year one. It replaces the EHR Incentive Program for physicians.*

MIPS Medicare Payment Adjustments

Because MIPS must be budget neutral, provider scores are used to render a positive, negative or neutral adjustment to their Medicare payments, and providers are measured against each other. These adjustments are limited to no more than 4 percent in the negative and up to 4 percent in the positive in year one of the program, with bonuses for the highest performers. Maximum negative adjustments for each year are as follows:

- 4 percent in 2019
- 5 percent in 2020
- 7 percent in 2021
- 9 percent in 2022 and after

The first payment year for MIPS will be in 2019, based on a provider's 2017 performance results. All Medicare Part B providers are expected to report through MIPS during the 2017 calendar year. Providers may be exempted from the MIPS program if they:

- Are newly enrolled in Medicare
- Have $10,000 or less in Medicare charges, or 100 or fewer Medicare patients ($30,000 or less in the first year)
- Are significantly participating in an Advanced Alternative Payment Model (APM)
- The Reputational Impact of MIPS

The determination to increase public transparency is also evident in this new Quality Payment Program. A Physician Compare website available to patients will include the names of clinicians in Advanced APMs / MIPS programs and their associated scores, to help patients make informed personal health-care choices. These scores will include each performance category. Providers will be allowed a 30-day preview period in advance of publication to submit corrections to their posted information.

The risks of this new transparency lie in the challenge of reversing a provider's low performance scores. Penalties are enforced through 2026, and online public scores can sway consumers who have access to a standard assessment of their provider's quality of care and can compare them to their nationwide peers for the first time. Those with high performance ratings will have an undeniable advantage over competing local providers, and low historical scores will be difficult to wave away.

The Quality Payment Program is the next evolution in Medicare's plan to convert volume-based care to value- and quality-based care. This new proposal simplifies the provider reporting process and offers the provider greater flexibility in choosing the measures that cater to their specific type of care. This program also adds visibility – and therefore accountability – to a provider's overall care delivery, helping to improve the transparency and performance of the health care system at large.

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