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Proposed Rule to Implement the Quality Payment Program

OVERVIEW

On April 27th, the Department of Health and Human Services (HHS) issued a proposed rule that would implement provisions of the Medicare Access and CHIP Reauthorization Act (MACRA). Under the proposed rule, the Medicare sustainable growth rate (SGR) methodology for updates to the physician fee schedule would be replaced with the two-tracked Quality Payment Program (QPP). The proposed rule would only apply to Medicare payments to physician offices and not hospitals or other Medicare providers.

HHS will accept comments on the proposed rule until June 26th. The proposed rule is available here.

QUALITY PAYMENT PROGRAM (QPP)

Medicare providers currently participate in a variety of payment models, such as: accountable care organizations; the Comprehensive Primary Care Initiative; the Physician Quality Reporting System; the Value Modifier Program; and the Electronic Health Record (EHR) Incentive Program, commonly referred to as "Meaningful Use." In an effort to consolidate these programs and support the transition to value-based payments, the proposed rule would establish the QPP. The QPP would include two tracks: the Merit-based Incentive Payment System (MIPS) and the Advanced Alternative Payment Models (APMs).

Merit-Based Incentive Payment System (MIPS)

Most Medicare providers will begin participating in the QPP through MIPS, which is intended to reduce the reporting burden for providers and offer some flexibility for providers to choose which measures and activities to report on. Under MIPS, providers would have their payments adjusted according to their composite score in the following performance categories:

1. *Quality* (50%) – Providers would choose to report a minimum of six measures that are relevant to their specialty. Quality measures would be selected annually from a list of measures that will be published by November 1st each year. Providers would be required to choose at least one cross-cutting measure and one outcome measure. If a specialty-specific outcome measure is not available, the provider may choose to report on a high priority measure, such as: patient safety, appropriate use, or care coordination.
2. *Advancing Care Information* (25%) – Providers would report 11 customizable measures that reflect how they use technology and exchange information. Compared to Meaningful Use, this would decrease the number of measures that are reported on; remove "all-or-nothing" EHR measurements and quality reporting requirements; and allow providers to report as a group.
3. *Clinical Practice Improvement Activities (CPIAs)* (10%) – Providers would select CPIAs from a list of over 90 options that include efforts to improve care coordination, beneficiary engagement,

and patient safety. Under the proposed rule, there is no minimum number of CPIAs that a provider must implement.

4. *Cost* (10%) – There are no reporting requirements for this category. Providers would be scored according to 40 episode-specific measures based on their Medicare claims.

The rule proposes that the first performance period would begin on January 1, 2017. Upward and downward payment adjustments would begin in 2019 and would be based on the 2017 performance period. The payment adjustment would start at four percent in 2019 and would incrementally increase to nine percent in 2022.

Advanced Alternative Payment Models (APMs)

Under the proposed rule, providers who participate in Advanced APMs would be exempt from MIPS reporting requirements. Advanced APMs include the Comprehensive Primary Care Plus model, the Next Generation ACO model, and other APMs that:

- Require participants to use certified EHR technology;
- Provide payment based on quality performance measures that are similar to those in MIPS; and
- Bear a significant amount of risk for monetary losses.

Many clinicians who participate to some extent in Alternative Payment Models may not meet the law's requirements for sufficient participation in the most advanced models, but HHS expects the number of providers participating in Advanced APMs would increase over time.

For years 2019 through 2024, a clinician who meets the law's standards for Advanced APM participation is excluded from MIPS adjustments and receives a five percent Medicare Part B incentive payment. For years 2026 and later, a clinician who meets these standards is excluded from MIPS adjustments and receives a higher fee schedule update than those clinicians who do not significantly participate in an Advanced APM.