PUBLICATION

Physician Payment: CMS Proposes Quality Payment Program, Advanced APMs, and Merit-Based Incentive Payment System [Ober|Kaler]

2016

CMS published its 426 page proposed rule [PDF] on the Quality Payment Program (QPP) – the successor to oft-maligned Sustainable Growth Rate adjustment – on May 9, 2016. The QPP will adjust physician and mid-level provider reimbursement based on their quality of care and combine existing quality reporting programs into one system.

As we have explained previously, physicians, mid-level providers, and their practice groups will need to understand QPP and its two tracks, the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs), because they will impact the reimbursement for professional medical services. **Comments are due by June 27, 2016.**

Under MIPS, CMS will consolidate a variety of reporting systems, including the Physician Quality Reporting System, the Value-Based Payment Modifier, and the Medicare Electronic Health Record incentive program. MIPS will apply only to Eligible Professionals (EPs) comprised of:

- Physicians,
- Physician Assistants,
- Certified Registered Nurse Anesthetists,
- Nurse Practitioners,
- Clinical Nurse Specialists, and
- Groups that include such professionals

CMS will evaluate EPs based on four performance categories: quality, resource use, clinical practice improvement, and meaningful use of certified electronic health records technology (CEHRT). CMS proposes different weights to each performance category and CMS can also change these weights over time. EPs can elect to be measured as a group practice across all performance categories or on an individual, EP-by-EP, basis. The MIPS score also includes EPs' overall care delivery, which means their MIPS reporting includes all patients instead of solely Medicare beneficiaries.

CMS proposes to begin collecting MIPS scores on January 1, 2017, and will use MIPS scores to provide payment adjustments to EPs' Medicare payments beginning in 2019. CMS also proposes to provide payment increases and decreases of up to 4% in 2019. That maximum percentage is proposed to increase annually until it reaches 9% in 2022.

Under Advanced APMs, CMS will create a second track intended to provide incentives to clinicians who are participating in already-established APMs. Physicians who participate in an Advanced APM, which would require the physicians to take on financial risk for their patients, would qualify for incentive payments and do not need to meet the MIPS criteria. Incentive payments will take the form of a 5% increase in Medicare reimbursement and are in addition to the incentives built-in to the alternative payment model. CMS proposed the following Advanced APMs:

- Comprehensive Primary Care Plus (CPC+),

- Medicare Shared Savings Program – Tracks 2 and 3,
- Next Generation ACO Model,
- Comprehensive ESRD Care Model (accountable care model for large dialysis organizations), and
- Oncology Care Model Two-Sided Risk Arrangement (beginning in 2018)

CMS proposes to update the list of Advanced APMs on an annual basis.

Ober|Kaler's Comments

The proposed rule for QPP aligns Medicare reimbursement for professional medical services with quality and value incentives. CMS proposes to begin collecting data January 1, 2017, and making payment adjustments in 2019.

On the balance, EPs are now faced with a 4% adjustment in 2019 (and eventually a 9% adjustment in 2022) to their Medicare reimbursement depending on meeting, or failing to meet, the MIPS criteria. However, beginning in 2016 and through the end of 2019, there is a .5% increase to the physician fee schedule. This is a significant difference from the perennial threat of the former -20% SGR adjustment for physician reimbursement. Mid-level providers, like physician assistants and certified registered nurse practitioners, will be under the same MIPS standard. Similar to many of these new payment programs, the QPP is a zero sum game – the positive and negative adjustments are required to be budget neutral.

For those EPs willing to take on financial risk for their patients, which is traditionally the role of health insurance, voluntarily entering an Advanced APM and the 5% reimbursement incentive should be considered.

At the same time, physicians involved in MIPS or an Advanced APM are entering into an era where billing, collecting, and understanding the payments for their services is increasingly more complex. In the future, CMS would also like third-party payors to continue to adopt similar models. Perhaps long gone are the days of paying cash on the barrelhead for physician services and physicians should take note that traditional fee for service payments will continue to shrink as CMS and the CMS Innovation Center fund new payment programs that affect how physicians are paid for their services.