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Compliance Today - March 2019
Quality Payment Program: A new compliance frontier

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With the passage of the Medicare Access to Care and CHIP Reauthorization Act of 2015 (MACRA), Congress set out to transform the US clinician compensation structure from a system that rewards providers for the volume of patients treated to a system that is "outcome-focused, patient-centered, and resource-effective."[1]

For many, the passage of MACRA signaled the arrival of the forthcoming shift in US healthcare to an emphasis on value. Beginning in 2017, qualifying providers were required to participate in either an Advanced Alternative Payment Model (APM) or in the Merit-Based Incentive Payment System (MIPS). Both programs involve the submission of data relating to value-based treatment activities in return for incentive payments. Starting in 2019, CMS will begin to make the incentive payments resulting from providers' year 2017 submissions. Now that providers will begin receiving payment from CMS related to these programs, it is as good a time as ever to consider the compliance risk associated. This article will provide an overview of the Quality Payment Program, explore the prospect of regulatory enforcement relating to the program, and consider best practices to help ensure compliance.

What is the Quality Payment Program (QPP)

MACRA requires qualifying providers to participate in either an Advanced APM or the MIPS program. These two tracks are what constitute the Quality Payment Program (QPP). An Advanced APM is a payment model developed by CMS in partnership with the clinical community whereby providers can enroll and receive incentives for delivering high-quality care that is cost efficient.[2] Advanced APMs may be designed to address specific clinical conditions, care episodes, or populations. Examples of APMs include the Shared Savings Program, patient-centered medical home models, the Oncology Care Model, and the Comprehensive Care for Joint Replacement Model. As of 2017, providers who participate in an Advanced APM and meet certain thresholds are eligible to receive a 5% bonus payment every year.

Meanwhile, qualifying providers who choose not to participate in an APM must participate in MIPS, which combined elements of three already-existing programs: the Physician Quality Reporting System (PQRS), the Physician Value-based Payment Modifier (VM) and the Medicare Electronic Health Record (EHR) Incentive Program for Eligible Professionals (also known as Meaningful Use). Specifically, providers submit data for four separate program categories: Quality, Promoting Interoperability, MIPS Improvement Activities, and cost.[3]

From the various performance measures, providers have the option to choose among Quality measures on which to submit data, and beginning in 2019, the Quality measures will account for 45% of the total MIPS score. Examples of Quality measures include screening for influenza immunization, breast cancer screening, colorectal cancer screening, body mass index (BMI) screening and follow-up, and falls risk assessment.

The second category, Promoting Interoperability (formerly operating as Meaningful Use), accounts for 25% of

the total score and incentivizes use of the EHR to allow patients to access their own data and empower clinicians to share patient information with one another.

The third category, MIPS Improvement Activities, accounts for 15% of the total MIPS score and includes measures that assess improvement of care processes, increase patient participation in care, encourage patient and clinician collaboration, and promote increased patient access. Examples of Improvement Activities include care transition documentation practice improvements, advance care planning, and annual registration in the Prescription Drug Monitoring Program.

The final category is cost, which unlike the other three categories, does not require providers to submit any additional data. Each provider's cost score is calculated by CMS entirely using that providers' claims data and will be increased to account for 15% of the total MIPS score in 2019, up from just 10% the year before. Through the cost measure, CMS rewards those clinicians who provide care efficiently. Starting in 2019, qualifying providers not participating in an Advanced APM will be eligible to gain or lose 7% of their Medicare reimbursement based upon their performance in MIPS, up from 5% in 2018 and 4% in 2017.