What's New in 2017: The Medicare Quality Payment Program (QPP)

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Some of the most significant provisions affecting Medicare physician payment enacted under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) will first take effect in 2017. The new payment provisions, collectively referred to by the Centers for Medicare & Medicaid Services (CMS) as the "Quality Payment Program" or QPP, describes requirements for physicians to participate in the Merit-Based Incentive Payment System (MIPS) and/or qualify for the Advanced Alternative Payment Model (Advanced APM) Incentive Payment. The performance period on which physicians will initially be assessed under both programs begins in 2017 and will dictate fee-for-service payment updates or APM incentive payments for calendar year 2019.

Merit-Based Incentive Payment System (MIPS)

At the outset of the new programs, according to CMS estimates and the Academy's Performance and Quality Metrics Committee's analysis, most PM&R professionals will have payments updated under the MIPS program. In general, MIPS conducts a performance assessment under 4 distinct performance categories: Quality, Cost, Improvement Activities, and Advancing Care (more information on each category is provided below). The performance assessments under each category will be combined to give the eligible clinician or group a MIPS score that will map to a percentage payment update on all Medicare Part B claims. Again, reporting and performance in 2017 will dictate your payment updates in 2019.

What to Know for 2017:

- **Enhanced Reporting Flexibility in 2017.** Given that 2017 is the first year of the new reporting and assessment requirements, CMS is providing eligible clinicians multiple options for participation. At the very least, choosing one of these options would ensure that you do not receive a penalty in 2019.
- **Physicians can report to MIPS as individuals or through their groups.** However, physicians must elect one or the other for all MIPS categories. For those who choose group assessment, groups must be organized by their Tax Identification Numbers (TINs).
- **Not all categories are equal.** As was dictated by the MACRA legislation, not all performance categories carry the same weight. For 2017 reporting, the performance category weights are as follows:
  - » Quality: 60%
  - » Cost: 0%
  - » Advancing Care Information (ACI): 25%
  - » Improvement Activities (IA): 15%

The MIPS total composite score will translate into payment adjustments in the following manner:

Final MIPS Composite Score	Payment Adjustment
> 70 points	• Positive adjustment
	• Eligible for exceptional performance bonus—minimum of additional 0.5%
4–69 points	• Positive adjustment
	• Not eligible for exceptional performance bonus
3 points	• Neutral payment adjustment
0 points	• Negative payment adjustment of -4%

Quality Performance Category: For those who are familiar with reporting under the Physician Quality Reporting System (PQRS), you will notice similarities in reporting the quality category under the MIPS program.

- Quality measures reporting reduced from 9 to 6. Previous baseline reporting criteria under the PQRS program require reporting on 9 measures. Under MIPS, the baseline number of measures on which eligible clinicians should report in order to have access to a potential full quality score has been reduced to 6 measures. CMS also eliminated the PQRS cross-cutting measure requirement, although 1 of 6 measures needs to be either an outcome measure or if no outcome measures are available, another high priority measure.

President Obama Signs 21st Century Cures Act

The 21st Century Cures Act, a $6.3 billion landmark piece of legislation that will accelerate the discovery, development, and delivery of new cures and treatments, and provide new funding for the National Institutes of Health and Food and Drug Administration, was signed into law by President Obama on December 13, 2016. The President, in his weekly address on December 3, 2016, said "it (21st Century Cures) is an opportunity to save lives, and an opportunity we just can't miss."

AAPM&R applauds Congress for passing this legislation and proudly recognizes that the 21st Century Cures Act includes a key provision—Section 2040—enhancing the stature and visibility of medical rehabilitation research at the National Institutes of Health (NIH). The rehabilitation research provision in the House bill is virtually identical to the Senate Bill S.800 the "Enhancing the Stature and Visibility of Medical Rehabilitation Research at the NIH Act," that was approved unanimously by the Senate Health, Education, Labor, and Pensions (HELP) Committee in February 2016.

The Academy has been a leader in advocacy efforts to bring S.800 and the advancement of rehabilitation science and research at NIH to this point. Academy efforts go back as far as 2012 when NIH published the *"Blue Ribbon Panel on Medical Rehabilitation Research Report,"* which was the impetus for the original rehabilitation research legislation. The panel concluded that rehabilitation research is not thriving at NIH, in part because the NIH had not updated its research plan for the conduct and support of medical rehabilitation research since 1993. An updated medical rehabilitation research plan was recently published in September 2016.

AAPM&R President, Steve R. Geiringer, MD, stated, "This bipartisan piece of legislation is a significant step forward to advance rehabilitation science at NIH and improve the care provided to people with disabling injuries, illnesses, and conditions. We especially want to recognize our Congressional sponsors: Senator Mark Kirk (R-IL), Senator Michael Bennett (D-CO), Representative James Langevin (D-RI), and Representative Gregg Harper (R-MS)."

AAPM&R, along with our members, stand with the millions of Americans with disabilities, illnesses, and chronic conditions that require medical rehabilitation to restore, maintain or prevent deterioration of function. ❖

- Consumer Assessment of Health Providers and Systems (CAHPS) for MIPS is voluntary. Groups with 2 or more MIPS-eligible clinicians can voluntarily elect to participate in the CAHPS for MIPS patient experience of care survey (which can be relied on for credit under the Quality and Improvement Activities categories).
- Encourages the use of Qualified Clinical Data Registries (QCDR), electronic sources, and reporting of high priority measures through preferential scoring.
- For 2017 reporting, CMS is implementing a global floor of 3 points for all submitted quality measures. In future years, quality measures may be scored between 0 and 10 points based on performance. However, in the initial year, reporting any data on a measure will guarantee a 3-point minimum (enough to avoid a 2019 payment penalty). In order to exceed the 3-point minimum and be scored on your performance of the measure, CMS requires that you report on at least 50% of the patients eligible for that measure for at least a 90-day period. If reporting via claims, the reporting must be on at least 50% of your Medicare Part B patients during the performance period in which you choose to report. If you are reporting via electronic health record (EHR), registry or QCDR, the reporting must be on at least 50% of all patients (regardless of payer) during the performance period in which you choose to report.
- Specialty Measure Sets. In addition, clinicians may select their 6 measures from a specialty measure set (although all quality measure reporting must be done under a single reporting option). The finalized specialty measure set for physical medicine is listed in the following table and shows under which reporting options the measures are available for reporting.

PHYSICAL MEDICINE SPECIALTY MEASURE SET
(voluntary; no requirement to report on all measures in the set)

Measure #	Measure Name	Reporting Options		
		Claims	EHR	Registry
47	Care Plan	✔		✔
109	Osteoarthritis (OA): Function and Pain Assessment	✔		✔
128	BMI Screening and Follow-Up Plan	✔	✔	✔
130	Documentation of Current Medications in the Medical Record	✔	✔	✔
131	Pain Assessment and Follow-Up	✔		✔
182	Functional Outcome Assessment	✔		✔
226	Tobacco Use: Screening and Cessation Intervention	✔	✔	✔
312	Use of Imaging Studies for Low Back Pain		✔	
317	Screening for High Blood Pressure and Follow-Up Documented	✔	✔	✔
374	Closing the Referral Loop: Receipt of Specialist Report		✔	
402	Tobacco Use and Help with Quitting Among Adolescents			✔
408	Opioid Therapy Follow-up Evaluation			✔
412	Documentation of Signed Opioid Treatment Agreement			✔
414	Evaluation or Interview for Risk of Opioid Misuse			✔
431	Unhealthy Alcohol Use: Screening and Brief Counseling			✔

Cost Category: As previously mentioned, CMS assigned a weight of 0 for 2017 performance. So in the first year, the cost category will not impact MIPS scores or 2019 payment. However:

- CMS will continue to calculate scores based on the Medicare spending per beneficiary and total per capita cost measures and provide feedback to physicians.
- CMS will also continue to develop and refine more specific episode-based cost measures, which it hopes to start using for 2018 performance assessment.
- As part of an effort to improve cost measurement, CMS is also working on patient condition and patient relationship codes to improve future cost attribution.

Improvement Activities (IA): The IA category takes into account eligible clinicians' participation in activities designed to increase care coordination, beneficiary engagement, and patient safety. IAs are categorized as medium- or high-weight with increased point value for high-weighted activities.

- 2017 scoring requires 90-day reporting.
- The number of points needed to achieve a maximum score in this category is 40 points, which translates to participating in 2–4 activities depending on their weight of each activity. CMS also provided scoring flexibility for small and rural practices that could result in the ability to report on fewer IAs.
- Use of a QCDR not only helps to report quality measures under the quality performance category, but also helps eligible clinicians meet their requirements under the IA category.

Advancing Care Information (ACI): As previously mentioned, the ACI category is based on the previous clinician EHR Meaningful Use (MU) Program.

- Similar measure set to EHR MU, but 2017 thresholds are drastically reduced.
- CMS also reduced to 90-day reporting for 2017 as well as 2018.

Advanced APMs

For those eligible clinicians who deliver enough care in the context of an Advanced APM (APMs that meet a set of statutory and regulatory requirements), these Advanced APMs require the APM entities to take downside risk (i.e., it cannot just be a gainsharing arrangement). In addition, the Advanced APM incentive payment will only be available for eligible clinicians that deliver a certain percentage of care in the context of the Advanced APM (at least 25% of Part B payments or at least 20% of Medicare Part B patients). Because of these requirements, CMS estimates that, at most, 8% of eligible clinicians will qualify for the incentive payment, and for physical medicine and rehabilitation, CMS places the estimate even lower at 0.8%. Because of these, most PM&R professionals will find themselves subject to MIPS. However, MACRA also created the physician-focused Payment Model Technical Advisory Committee (PTAC) to assist physician groups who are creating APMs, vet proposals, and offer technical assistance on model development. The PTAC has already commenced its review of proposals, and as more go through the process and as the Center for Medicare & Medicaid Innovation develops additional models, the potential Advanced APM participation opportunities could expand in 2018. ❖

To assist you in navigating the new 2017 reporting rules and requirements, your Academy will continue to provide guidance and updates. For more information, visit **www.aapmr.org/quality-practice**.