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Health Policy and Clinical Practice in the New Era of Quality

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ABSTRACT

April 27th, 2016 executive notice by the US Department of Health and Human Services issued key provisions to the Medicare Access and Summary CHIP Reauthorization Act of 2015, (MACRA). MACRA replaced the 1997 Sustainable Growth Rate formula for determining Medicare reimbursement. MACRA provides a new approach in Medicare reimbursement based on value and quality care. MACRA legislation is guided by the Quality Payment Program, directing two paths for Medicare reimbursement: The Merit-based Incentive Payment System (MIPS), or the Advanced Alternative Payment Model (APM). Nurse Practitioners, require knowledge and information to prepare for MIPS and APM to begin January 1, 2017.

Keywords: Affordable Care Act, Alternative Advanced Payment Models, Health Policy, Merit-Based Incentive System, Nurse Practitioner

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The 2010 passage of the largest and most complex legislation in United States health care history has prompted massive changes. These innovative changes are directly linked to a new system that provides incentives for quality patient-centered outcomes that adhere to the 3-part tenets of the Affordable Care Act, better health and better care that is cost-effective. This new era of clinical transparency and quality metrics requires the application and implementation of evidence-based practice. The purpose of this article is to provide the nurse practitioner (NP) with an update on the newly proposed legislation that will influence the care, practice, and reimbursement of Medicare patients.

In January 2015, President Obama created the Health Care Planning and Learning Action Network used to direct reimbursement changes in the US, and Secretary Burwell announced the new and evolving health care system of value versus volume and the commitment from the administration to create a transparent delivery of primary and specialty health care based on value and quality.[1,2]

These announcements led to the rapid escalation and development of the April 27th, 2016 US Department of Health and Human Services Notice of Proposed Rulemaking to implement key provisions to the Medicare Access and Summary Chip Reauthorization Act of 2015 (MACRA) legislation. This is the long-awaited bipartisan direction that the US has been waiting for after the 1997 sustainable growth repeal by Congress in 2015. The MACRA legislation has identified 2 specific tracks for Medicare reimbursement.

MACRA LEGISLATION

The implementation of these reimbursement and practice changes are led by a unified framework called the Quality Payment Program.[3] The 2 paths of care include the Merit-Based Incentive System (MIPPS) and Advanced Payment Models (APMs). Each of these reimbursement tracks provide incentives when providers, practices, organizations, or health systems demonstrate and meet or exceed the quality and value metrics uniquely determined by type of practice and patient care population served. The MACRA changes the manner in which Medicare will reward providers for value over volume. It provides incentive payment for providers through MIPS and bonus payment for provider participation in eligible APMs.[4]

MIPS

MIPPS will replace the current Medicare measures used to determine quality and value. The Physicians Quality Reporting System, the Value Modifier (VM) program, and the Medicare Electronic Health Record (EHR) Incentive Program's or Meaningful Use

will be grouped together under MIPPS.[3] Congress streamlined and improved on these individualized programs into 1 merit-based incentive payment. The Centers for Medicare & Medicaid Services (CMS) suggests most Medicare providers (physicians, NPs, physician assistants, and certified registered nurse anesthetists) will participate in the quality payment program through MIPPS.[3]

Before this new incentive approach, providers have been required to embed a minimum of 9 quality measures into a CMS-certified meaningful use EHR. MIPPS requires 6 measures and allows providers flexibility by choosing measures and activities that are appropriated by the care they provide. Providers will continue to use the core measures from the National Quality Forum (NQF) by selecting from over 300 NQF-endorsed measures.[5]

The NQF offers a portfolio of performance measures that provide the measures used to quantify health care processes and patient-centered outcomes and evaluate patient satisfaction and organizational systems responsible for high-quality care.[5] The NQF endorses consensus standards for measuring and reporting quality and value and is currently used by hospitals, health care systems, and government agencies such as the CMS when publicly reporting quality metrics. The NQF-endorsed consensus standards are considered the *gold standard* for the measurement of quality health care in the US.[5]

MIPPS is used to ensure that Medicare providers are incentivized for high-quality and efficient care through the demonstration of the following 4 performance categories:

1. Quality performance: this category replaces the Physicians Quality Reporting System and VM and is responsible for 50% of weight in the first year. Emphasis is on outcome measurements (6 measures in the certified CMS meaningful use EHR).
2. Advancing care information: this category supports the use of patient engagement, medication safety, patient access to her, and so on and accounts for 25% of the weight in the first year. The weight of this category may decrease as more providers and practices adopt EHR use.[3]
3. Clinical practice improvement: providers can select from over 90 proposed activities such as self-management, shared decision making, care coordination, patient safety checklists, and so on. This category accounts for 15% of the weight in the first year.
4. Resource use: CMS calculates the weight of this category based on claims data and accounts for 10% in the first year. This category replaces the VM.[3]

A composite total of MIPS performance categories is aligned to a performance period of 1 full calendar year beginning the first of 2017. The composite MIPS score will be used from individual providers and practices to determine the 2019 payment year.[3] MIPS data will identify if the provider or practice meets the national threshold and, if above or below, will determine penalty or incentive payment in 2019.[3]

Advanced APM

Under MACRA legislation, APMs are a way other than MIPS for Medicare to pay for quality and value. APMs primarily include innovation care models funded and awarded by the CMS Innovation Center (CMMI), Medicare Shared Savings Program, and/or any demonstration under the Health Care Quality Demonstration Program or federally funded demonstrations.[3,6]

Under MACRA legislation, the following are required of providers and participants by APM:

1. Use a certified EHR (minimum requirement of 50% use of EHR between providers).
2. Payment is based on quality measures similar to the MIPS quality performance category. There is no set number of measures; however, APMs are required to report at least 1 outcome measure.
3. Identify the ability to take on financial risk for monetary losses if not meeting quality measures or be identified as a Medical Home Model defined by CMMI.[3,6]
4. Medical home models that have not expanded by CMMI criteria will be responsible for alternate financial and risk benefit ratios.[3]

The current legislation by MACRA has determined the following APMs: 1) Shared Savings Program, 2) Accountable Care Organization Next Generation Model, 3) Comprehensive End Stage Renal Disease Care, 4) Comprehensive Primary Care, and 5) Oncology Care Model. The CMS has agreed to annually evaluate and partner with innovative APMs that meet criteria and undergo evaluation by the US

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