FROM THE PRESIDENT'S DESK

Payment Readine$$, Part III: Quality Reporting/Improvement & Resource Use

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QUALITY PAYMENT PROGRAM (QPP)

Centers for Medicare and Medicaid Services (CMS) released its 2017 Final Rule on the new Quality Payment Program (QPP) on October 14, 2016. With the final rule, CMS eased some of the requirements for Quality Reporting and Resource Use.[1] This was in response to many organizations, including ACOFP, insisting that solo and small practices would be disadvantaged by the original proposed rule.

If you do not meet the threshold for Medicare patients,* you are exempt from the CMS Quality Payment Program. If you are not in a CMS certified Advance Payment Model (APM) *(see #4, right)* you will be in the CMS Merit-Based Incentive Payment System (MIPS). The remainder of this article will be about the requirements for the MIPS program for calendar year 2017.

In 2017, Quality will account for 60% of an Eligible Professional's/Group's Composite Performance Score (CPS). Resource Use will account for 0% of the CPS (for 2017 only). Resource use will still be reported to CMS via normally administered claims. No additional steps are required. The data from EP will be analyzed and used as a "benchmark" for 2018 Resource Use comparison. Review the four CMS categories in Table 1 below, which will comprise the 2017 Composite Performance Score.

PICK YOUR PACE

For the calendar year of 2017, CMS is using a "Pick Your Pace" approach to Quality Reporting. There are four ways you can avoid a non-reporting penalty, and potentially gain incentives of plus 4%.

1. **Report quality on at least one individual** or PCP measure for any period of time. This documents to CMS that you have the ability to correctly report quality for your practice or group. By doing this, you will avoid a non-reporting penalty, but will not be eligible for an incentive payment.
2. **Report quality for a continuous 90-day period** starting January 1, 2017 to October 1, 2017. Report on a minimum of one quality measure. You may receive a small incentive payment.
3. **Report quality for the entire calendar year.** Report on a minimum of one quality measure. You may receive a modest incentive payment.
4. **If you are in an Advanced Alternative Payment Model (APM),** you automatically qualify for a 5% incentive payment for 2017. These risk-sharing models include: Medicare Shared Savings Program (MSSP) Tracks 1 and 2; CPC+ Model (this is a demonstration project by CMS, and will reopen to new participants soon), Next Gen ACO, Pioneer ACO, Chronic Kidney Care Model, and Oncology Care Model. The PCMH model is not currently qualified by CMS this year, but a new model will be launched by NCQA in March 2017.[3] This model should meet CMS requirements for an APM.

If you choose not to report at all, you will receive a maximum penalty of negative 4% which will be deducted from your Medicare Part B payments.[4]

TABLE 1:

The Four CMS Categories Used to Determine an EP's Composite Performance Score[2]

Measurements	2017 - Percentage of CMS Composite Performance Score	Possible Point Score[1]
Quality Reporting	60%	70 points
Resource Use	0% for 2017 - Benchmark Year	No points for 2017
Advancing Care Information (ACI) *Previously Meaningful Use*	25%	100 points
Clinical Practice Improvement Activities	15%	40 points

From the American College of Osteopathic Family Physicians.

REPORTING & AVOIDING PENALTIES

The first step to reporting your quality is to select at least one individual or Primary Care measure to report on. You can make your selection within your EMR system (contact your EMR vendor to learn how). If you do not have an EMR system, you still can report using your Medicare claims. Record the Quality Data Codes (QDC) for reimbursement on the Medicare Claim Forms. Follow the guidance in the *2016 Physician Quality Reporting System (PQRS): Claims-Based Coding and Reporting Principles*. Contact Debbie Sarason† for a copy of the document.

In closing, a number of members have contacted me with news that they received a letter from CMS at the close of 2016. The letter stated that they were subject to a negative 2% payment penalty on Medicare Part B payments for 2017, which was due to not reporting to CMS in 2015. This will be an annual occurrence, with increasing penalties, if you choose not to follow the these guidelines.

Leverage the *2017 Payment Ready Toolkit* and the information that is provided in the weekly President's Newsletter to avoid the penalty for 2017 (impact seen in 2019). Subscribe to ACOFP Quality Markers 7.0™ to fine tune your ability to identify and intervene in the treatment of those patients who are pulling your quality score down. Seamlessly report your measures through Quality Markers' CMS approved QCDR registry to insure your measures reach CMS in the right format and on time. The reporting fee is included in the annual subscription price. Go to acofpqualitymarkers.org for more information and a subscription form.

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REFERENCES:

1. McLaughlin, Jennifer JD. "Under the MACRAscope." MGMA webinar. November 2016.
2. www.cms.gov. Accessed on October 27 and November 27, 2016
3. www.cms.gov. Accessed October 27, 2016
4. www.ncqa.gov Accessed November 22, 2016
5. Quality Payment Program. www.cms.gov. October 14, 2016

*For those EP's who see less than 100 Medicare Part B patients, or receive less than $30,000.00 in revenue from these patients, these EP's are exempt due to "low volume threshold" from the CMS Quality Payment Program requirements.

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RESOURCES

If you need assistance in selecting an EMR system which is best suited for your practice, helpful advice is available at no charge from Software Advice, www.softwareadvice.com. (See category "Electronic Medical Records). They can help you select an EMR from over 300 vendors in 10-15 minutes. Ph. (844) 686-5616.

More information is located at www.acofp.org under "Practice Enhancement." View the *2017 Payment Ready Toolkit* at www.acofp.org/PaymentReadyToolkit to find out more information and instructions on all CMS payment requirements.