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MACRA and the Quality Payment Program

How Does It Relate to Orthopaedic Nursing?

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The introduction of 2017 also brought with it the beginning of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) legislation related to the Quality Payment Program (QPP), in addition to alternative payment models and the merit-based incentive payment system. The successful implementation of the QPP within the specialty of orthopaedics will rely heavily on the active involvement of orthopaedic nurses when it comes to improving quality, lowering costs, and incorporating value. It is important for orthopaedic nurses to understand the QPP and the role it plays in determining value-based payment of orthopaedic care delivery, in addition to how the structure of the QPP correlates with nursing diagnoses and respective plans of care delivery.

The implementation of the Patient Protection and Affordable Care Act, also known as the Affordable Care Act (ACA), in 2010 introduced the beginning of many initiatives to reform the U.S. healthcare system from the standpoints of cost and quality (U.S. Department of Health and Human Services [HHS], 2015). One of the main avenues of achieving value by decreasing costs and improving quality is to integrate quality into various payment structures. The shift from a fee-for-service model to a value-based model has birthed the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), with additional offspring being the Quality Payment Program (QPP) that consists of alternative payment models (APMs) and the merit-based incentive payment system (MIPS) (Centers for Medicare & Medicaid Services [CMS], 2016a). The purpose of this article is to discuss the structure of the QPP, how it impacts payment for orthopaedic-related care, and the role orthopaedic nurses will play in the implementation of this new legislation within the specialty of orthopaedics.

The Beginning

The ACA was introduced into law on March 23, 2010, with two of the foci being increased access to high-quality healthcare and the lowering of healthcare costs for all Americans (HHS, 2016). In January 2015, the HHS publicized goals related to value-based reimbursement and APMs in Medicare to transform the U.S. healthcare system in way that promotes better care, smarter spending, and healthier people by focusing on clinician incentives, care delivery, and information sharing (CMS, 2015a). This began with the development of Medicare payment reforms that support more efficient and effective care delivery models that are innovative and patient-centered while connecting quality measures with payment to providers. Because of the desire to improve quality and lower cost, the traditional fee-for-service payment model in Medicare is being replaced by pay-for-performance or value-based payment models. Once the ACA was signed into law, the approach to improving quality and lower healthcare cost began with the introduction of meaningful use and the reporting of quality measures among clinical providers, which has now led to MACRA. Table 1 contains the meanings of acronyms that are used throughout this article.

What Is the Quality Payment Program?

The QPP is a quality payment structure for clinician that replaces Medicare fee-for-service payment with payment that is based on quality outcome measures. The MACRA legislation was passed in 2015 and repealed the Medicare Sustainable Growth Rate methodology related to the Physician Fee Schedule and replaced it with the QPP. The QPP framework rewards clinicians for providing high-quality and value-based care instead of high-volume care. It also combines the existing programs for quality reporting and value into one streamlined program. This framework that rewards clinicians for integrating quality measures into practice is known as the QPP (CMS, 2016a). The QPP has two paths that promote value-based reimbursement for services to Medicare beneficiaries, which are MIPS and APMs.

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Table 1. Acronym Meanings

MACRA: Medicare Access and CHIP Reauthorization Act of 2015
QPP: Quality Payment Program
MIPS: Merit-based incentive payment system
APM: Alternative payment model
CJR: Comprehensive Joint Replacement
EPM: Episode Payment Model
SHFFT: Surgical hip/femur fracture treatment

The goals that the HHS plans to achieve through QPP are multifaceted, with the global aim being the availability of multiple pathways for clinicians to receive reimbursement based on value with diverse levels of risk and reward. Long-term goals include the expansion of opportunities for a wide range of clinicians to take part in APMs by minimizing added burdens related to reporting, to promote clinicians' understanding of their status in regard to MIPS and/or APMs, and to support initiatives from multipayers to further encourage the development of APMs and other payer models (CMS, 2015a).

Merit-Based Incentive Payment System

The MIPS path applies to clinicians who bill Medicare Part B and does not apply to hospitals or facilities. It combines sections of the Physician Quality Reporting System, Value-Based Payment Modifier, and the Medicare electronic health record (EHR) incentive program into one program where providers will be measured on the basis of four performance components: quality, use of resources or costs, improvement in clinical practice, and advancing care information, also known as meaningful use of an EHR. Quality will focus on the reporting of quality measures, whereas improvement will focus on the attestation of quality improvement activities (CMS, 2015b). Table 2 displays the four performance components of MIPS.

The MIPS composite performance score across these four components of performance will determine whether a clinician receives positive, negative, or neutral adjustments up to certain percentages based on the current Medicare Part B Physician Fee Schedule payments. In 2019, the percentages will range from 4% to −4%, followed by 5% to −5% in 2020, 7% to −7% in 2021, and 9% to −9% in 2022 onward (CMS, 2015a). These MIPS adjustments are budget neutral in nature, which means if the number of clinicians obtaining high composite scores is lower, then incentives can be increased and if the number of clinicians obtaining lower composite scores is high, the incentives will be decreased.

Table 2. Performance Focus Areas of the MACRA Quality Payment Program MIPS

Quality
Improvement activities
Advancing care information
Cost

Note. MACRA = Medicare Access and CHIP Reauthorization Act of 2015; MIPS = merit-based incentive payment system.

Clinicians who will be exempt from MIPS are those in their first year of participating in Medicare, those participating in eligible APMs that qualify for bonus payments, and those below the low-volume threshold (CMS 2015a). A low-volume threshold is considered as having less than or equal to Medicare Part B allowable charges of $30,000 or 100 patients who are Medicare Part B beneficiaries. At the time this article was being published, CMS released a final ruling for year two beginning in 2018 of the QPP in which the low-volume threshold will be less than or equal to $90,000 of Medicare Part B allowable charges or less than or equal to 200 patients who are Medicare Part B beneficiaries (CMS, 2017a).

Alternative Payment Models

The APMs are described as new approaches to paying clinicians for care delivered to Medicare patients that incentivizes value and quality (CMS, 2015a). Examples of APMs include the CMS Innovation Center models, Medicare Shared Savings Program, demonstrations under the Health Care Quality Demonstration Program, or other innovation demonstrations where clinicians provide efficiently coordinated, high-quality care where there is shared risk and reward such as a medical home model or accountable care organization. There are newly developed APMs that focus on the specialty of orthopaedics such as the Comprehensive Joint Replacement (CJR) model and the Surgical Hip/Femur Fracture Treatment Episode Payment Model (SHFFT EPM), which are discussed later in this article.

Within the APMs path, bonus payments are provided to clinicians who actively participate in eligible Advanced APMs. An eligible Advanced APM is considered as containing the following according to MACRA: (1) reimbursement is based on quality measures that are comparable with the quality measures included in MIPS; (2) required use of a certified EHR; and (3) bear more than nominal financial risk for monetary losses or be a medical home model that has been expanded under the Center for Medicare and Medicaid Innovation authority (CMS, 2015a).

Most clinicians who participate in Advanced APMs will be subject to the MIPS quality reporting measures and will receive scoring under the MIPS category of clinical practice improvement activities to determine the type of payment adjustment. However, clinicians who participate in Advanced APMs may be designated as qualifying participants (QPs). Clinicians designated as QPs are not subject to MIPS; they receive lump sum bonus payments of 5% for years 2019–2024; and they also receive a higher Physician Fee Schedule update beginning the year 2026 forward (CMS, 2015a).

Orthopaedic-Related Quality Measures and Improvement Activities

There are a plethora of MIPS quality measures and improvement activities that are closely related to the

specialty practice of orthopaedics. In the clinical setting, orthopaedic nurses and other ancillary clinical office staff members will be responsible for documenting the quality measures and conducting improvement activities. Examples of specific quality measures topics that are applicable to orthopaedics include fall risk assessment, functional outcome assessment, functional status changes related to various anatomical musculoskeletal locations such as the hand, foot, knee, or hip, pain assessment and follow-up, opioid therapy follow-up, patient-centered surgical risk assessment, surgical site infection, perioperative measures related to venous thromboembolism prophylaxis, selection of prophylactic antibiotic, and temperature management, in addition to measures related to rheumatoid arthritis and total joint replacement.

The improvement activities focus on coordination of care, patient safety, and engagement of beneficiaries. Some of the QPP improvement activities related to orthopaedics include registration in the prescription drug monitoring program, anticoagulant management improvements, care coordination agreements that promote improvements in patient tracking across settings, care transition documentation practice improvements and standard operational improvements, engagement of patients, family, and caregivers in developing a plan of care, and implementation of episodic care management practice improvements. Each quality improvement activity will be classified into one of the following subcategories: expanded practice access, patient safety and practice assessment, care coordination, beneficiary engagement, behavioral and mental health, population management, achieving health equity, and emergency response and preparedness (CMS, 2017b).

Value-Driven Orthopaedic Care Models

The push for value-driven outcomes serves to promote payment that is quality-based rather than quantity-based. Orthopaedic-related care has traditionally been a large percentage of costs for the CMS, and in the recent years, there has been a push for the development of value-driven orthopaedic care models to create sustainable value that is shared between the orthopaedic surgeon and the health system. Value-driven orthopaedic care models involve the delivery of patient-centered, cost-effective care where safety, efficiency, and productivity are maximized (Lansky, Nwachukwu, & Bozic, 2012). Examples of APM-designated value-driven orthopaedic care models that will involve collaborative efforts of the orthopaedic surgeon, orthopaedic nurses, specialty clinicians, other members of the interdisciplinary team, and healthcare organizations include the CJR model and the SHFFT EPM that were mentioned previously in this article.

Comprehensive Joint Replacement Model

The CJR model began April 1, 2016, in 67 metropolitan statistical areas of the United States, with the overall goal of the CJR model was to promote improvement in the value, quality, and efficiency of care delivery related to joint replacements of the hip and knee among Medicare beneficiaries (CMS, 2016b). Metropolitan statistical areas are defined as counties that have an association with a core urban area consisting of a population of 50,0000 people or greater (CMS, 2016b). The CJR model falls under the category of an episode-based payment initiative and encourages collaboration among hospitals, clinicians, and providers of post-acute care by testing bundled payments and quality measurements of the episode of care related to joint replacement of the hip and the knee with respect being given to the rate of complications such as infections and joint replacement implant failures. Orthopaedic nurses practice in all of the focus areas of the CJR model, which means they will play a key role in achieving the overall goals of the CJR model by using evidence-based practice to guide clinical decisions, promoting continuity in care coordination across the transitions of care, and encouraging patient-centered case management practices throughout the episode of care.

On December 1, 2017, a final rule was released by CMS that says the CJR model will now be automatically terminated by February 1, 2018 for 33 of the 67 participating hospitals in metropolitan statistical areas that are considered low volume and rural hospitals (CMS, 2017c). These hospitals can elect to remain in the CJR model program if they notify CMS of their desire to election to continue participating in the CJR model.

SHFFT EPM

The SHFFT EPM is part of the Post-Acute Care Center for Research (PACCR) Advancing Care Coordination proposed rule that focuses on the three new CMS EPMs, with SHFFT EPM being one of the three (PACCR, 2016). The other two EPMs address acute myocardial infarction and coronary artery bypass graft. The definition of episode for these three payment models is 90 days post-discharge. The SHFFT EPM has been proposed as being an expansion of the CJR model beginning July 1, 2017. These three new mandatory EPMs address payment from the standpoints of risk-bearing, benchmarking, quality, in addition to overall financial arrangements, patterns of care, and opportunities for savings. The SHFFT EPM recommends the use of home visits and telehealth during the first 90 days following hospital discharge resulting from a hip fracture (PACCR, 2016).

The CJR model has gain sharing and risk sharing where the SHFFT EPM involves hospitals sharing reconciliation payments and repayment risk with collaborators such as skilled nursing facilities, long-term acute care facilities, home health agencies, physicians, nurse practitioners, physician assistants, accountable care organizations, and providers of outpatient therapy services (PACCR, 2016). This structure is an excellent example of how an interdisciplinary team approaches to care coordination that is collaborative and patient-centered. It is within all of these environments and professions that the orthopaedic nurse will have a key role in the delivery and success of value-driven orthopaedic care models.

At the time this article was being published, CMS released a final ruling on November 30, 2017, stating the

Table 3. Correlations of Nursing Diagnoses to MIPS Quality Measures and Improvement Activities Related to Orthopaedic Value-Based Models of Care Delivery

MIPS Components	Applicable Nursing Diagnoses
Quality measures	
Fall risk assessment	Risk for falls
Functional outcome assessment	Risk for injury
Functional status changes related to various anatomical musculoskeletal locations such as the hand, foot, knee or hip	Risk for disuse syndrome
Pain assessment and follow-up	Impaired physical mobility
Opioid therapy follow-up	Impaired comfort
Patient-centered surgical risk assessment	Acute pain
Surgical site infection	Chronic pain
Perioperative measures related to venous thromboembolism prophylaxis	Imbalanced nutrition: less than body requirements
Selection of prophylactic antibiotic	Risk for pressure ulcer
Temperature management	Risk for impaired skin integrity
Measures related to rheumatoid arthritis and total joint replacement	Impaired skin integrity
	Risk for infection
	Risk for delayed surgical recovery
	Risk for perioperative hypothermia
	Risk for bleeding
	Acute confusion
	Risk for acute confusion
Improvement activities	
Anticoagulant management improvements	Risk for bleeding
Care coordination agreements that promote improvements in patient tracking across settings	Frail elderly syndrome
Care transition documentation practice improvements and standard operational improvements	Risk for frail elderly syndrome
Engagement of patients, family, and caregivers in developing a plan of care	Deficient community
Implementation of episodic care management practice improvements	Ineffective protection
	Ineffective health maintenance
	Ineffective health management
	Risk for deficient fluid volume
	Deficient fluid volume
	Risk for deficient fluid volume
	Impaired physical mobility
	Impaired standing
	Impaired transfer ability
	Impaired wheelchair mobility
	Fatigue
	Activity intolerance
	Impaired home maintenance
	Self-care deficit related to bathing, dressing, feeding, toileting
	Acute confusion
	Risk for acute confusion
	Chronic confusion
	Impaired memory

(*continues*)

Table 3. Correlations of Nursing Diagnoses to MIPS Quality Measures and Improvement Activities Related to Orthopaedic Value-Based Models of Care Delivery (*Continued*)

	Hopelessness
	Caregiver role strain
	Dysfunctional family processes
	Interrupted family processes
	Impaired social interaction
	Relocation stress syndrome
	Ineffective activity planning
	Risk for ineffective activity planning
	Compromised family coping
	Disabled family coping
	Fear
	Grieving
	Powerlessness
	Risk for powerlessness
	Impaired resilience
	Risk for impaired resilience
	Stress overload
	Decisional conflict
	Decision making

Note. MIPS = merit-based incentive payment system.

SHFFT EPM that were due to begin January 1, 2018 will be canceled (CMS, 2017c). Cancellation of the SHFFT EMP and restructuring of the CJR model shows that CMS is taking into account feedback from stakeholders and further consideration of voluntary participation instead of mandated regulatory approach to episodic payment models (Siljander & Gross, 2017).

Role of Orthopaedic Nursing

Orthopaedic nurses will be a valuable asset in the collaborative coordination and care management as it relates to the role of the CJR model and SHFFT EPM in the MACRA QPP because they practice in all areas of care delivery that are impacted by these value-driven models. The various roles of orthopaedic nurses may include remote or on-site case management, care coordination, monitoring of rehabilitation progress, and maintaining communication of patient's health status among all members of the interdisciplinary team. Maintaining interdisciplinary communication is vital for patients receiving post-hip fracture or joint replacement rehabilitation in a skilled nursing facility where there are multiple disciplines such as physical therapy, occupational therapy, pharmacy, and dietetics. These various disciplines will provide a wealth of findings related to the patient's rehabilitative progress, which can be put together to create a comprehensive view of patient's overall health status and functionality and can serve to guide continued rehabilitative efforts. The orthopaedic nurse is able to pull these findings together in way that can guide the patient's plan of care to support continued progress, address existing barriers, and provide interdisciplinary clinicians and family members with a detailed update of the patient's rehabilitative status and prognosis.

Another point that supports the vital role of orthopaedic nurses in maintaining interdisciplinary communication is the increased incidence of multiple chronic medical conditions in the hip and joint replacement population. The presence of multiple chronic medical conditions among patients undergoing hip or knee replacement surgery can serve to increase the incidence of intra- or postoperative complications and exacerbations of chronic illnesses, which further justifies the need for ongoing communication with various medical specialties such as cardiology, pulmonology, nephrology, endocrinology, and psychiatry. When orthopaedic nurses highlight and address underlying chronic medical conditions during the preoperative, intraoperative, and postoperative phases of joint replacement surgery, complications may be avoided and patient outcomes improved (National Guideline Clearinghouse, 2014).

The orthopaedic nurse can facilitate regular communication from all disciplines involved in the patient's plan of care in a way that serves to support a continued patient-centered, comprehensive, and appropriate approach to rehabilitative care that is based upon the patient's current level of functionality from all body organ systems (Mears & Kates, 2015). A plan of postoperative rehabilitative care that is not adequate, is too challenging, and does not address the patient's individual and unique status of various organ systems may impede the

patient's continued progress and result in a rehabilitative decline following joint replacement or femur fracture surgery (Mears & Kates, 2015). These points serve to further highlight the vital role of the orthopaedic nurses during the 90-day rehabilitative phase following joint replacement and surgical femur fracture treatment.

Orthopaedic nurses may also play a vital role in the success of MIPS from the standpoint of quality measures and improvement activities. Quality can be promoted by focusing on potentially high-risk areas of concern for patients recovering from joint replacement when it comes to immobility, poor nutritional status, compromised skin integrity, and increased risk for infection. The orthopaedic nurse can further correlate these high-risk areas with the NANDA International (NANDA-I) list of established nursing diagnoses from the domains of health promotion, nutrition, elimination and exchange, activity and rest, perception and cognition, self-perception, role relationships, sexuality, coping and stress intolerance, life principles, safety/protection, and comfort can be used to guide the development of a nursing plan of care to decrease the incidence of complications and support improved patient outcomes (Herdman & Kamitsuru, 2014). Examples of applicable NANDA-I nursing diagnoses that correlate with the previously high-risk areas of concern include risk for disuse syndrome, impaired physical mobility, imbalanced nutrition: less than body requirements, risk for imbalanced fluid volume, risk for pressure ulcer, impaired skin integrity and risk for impaired skin integrity, and risk for infection (NANDA International, 2017). Nursing care plans may also include various points of critical thinking that support many of the improvement activities included in MIPS. Table 3 contains the correlation of nursing diagnoses with MIPS.

Orthopaedic nurses may also use the online National Database of Nursing Quality Indicators for the purposes of benchmarking and comparing nurse quality measures with Magnet hospitals of similarity on state, regional, and national levels (Press Ganey, 2016). Orthopaedic nurses can compare data within their facility with data from similar facilities and regions, which will assist with determining the level of current performance and whether gaps exist in the use of best practices. This information can also be used by orthopaedic nurses to establish target goals for their facility.

Conclusion

With the introduction of MACRA QPP in 2017, orthopaedic nurses will play a vital role in the implementation and continued success of various value-based orthopaedic models of payment for care delivery and will be major players in focus of collaboratively interprofessional care. The more knowledgeable orthopaedic nurses are of the interworking components of MACRA QPP and how the components apply to the role of the orthopaedic nurse, the more likely it is that Medicare beneficiaries will benefit from the quality, value, and efficiency that are being promoted through healthcare reform. The use the nursing diagnoses to guide high-quality care that meets the needs of the orthopaedic patients at the point of care, as well as during transitions of care, will serve to meet quality measures and improvement activities associated with the QPP.

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