MEDICARE QUALITY PAYMENT PROGRAM:
WHAT PRACTICE LEADERS NEED TO KNOW FOR 2017

The Centers for Medicare & Medicaid Services (CMS) recently finalized the Medicare Quality Payment Program (QPP) created by MACRA, which establishes two tracks for physician payment—the Merit-Based Incentive Payment System (MIPS) and alternative payment models (APMs). As a direct result of MGMA advocacy, the final QPP rule significantly mitigates the administrative burden for group practices in MIPS and continues to increase opportunities to move away from MIPS into APMs. That said, the rule is more than 2,000 pages long and is very complex. MGMA Government Affairs created this guide to prepare physician practice leaders for the transition to the QPP in 2017.

QPP Fast Facts:
• The majority of physician practices will participate in MIPS in 2017 – the first performance year of the QPP. CMS estimates 25% of clinicians will participate in Advanced APMs by 2018.
• Beginning in 2019, Medicare physician payments will be increased or decreased based on MIPS performance data from 2017.
• 2017 is a transition year from the current federal quality reporting programs (e.g., PQRS, Meaningful Use) to MIPS. The only physician practices that will experience a 4% penalty in 2019 are those who choose not to report any performance data.

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

What is MIPS?
The MIPS program combines existing quality reporting programs—PQRS, the Value-Based Payment Modifier, and Meaningful Use—and rolls them into a single program. The single program contains four performance categories: quality, advancing care information (ACI), improvement activities, and cost. A clinician’s or group practice’s performance in these four categories will determine their performance score and their payment rate.

The MIPS performance threshold in 2017 will be three out of a possible 100 points. Eligible clinicians and groups will only need a performance score of three points to avoid a payment penalty in 2019. CMS estimates more than 90% of MIPS-eligible clinicians will receive a bonus or avoid a penalty in the transition year. Eligible clinicians who achieve a final performance score of 70 or higher will be eligible for a portion of the “exceptional performance adjustment,” funded from a separate incentive pool of $500 million.

Are there exclusions from MIPS?
Physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists who bill under the Medicare Part B physician fee schedule and groups consisting of these professionals will participate in MIPS. However, as many as 55% of these clinicians will be
excluded from a MIPS-related payment adjustment. Clinicians are excluded if they fall into one of three buckets:
1. They are new to Medicare. In other words, they are newly-enrolled clinicians who have never billed Medicare previously.
2. They bill less than $30,000 in Medicare allowed charges or furnish services to fewer than 100 Medicare beneficiaries.
3. They are significantly participating in an Advanced APM.

CMS indicates it will provide notice to clinicians and groups that fall into one of these three exceptions either in advance of 2017 or during 2017. We expect more details about the notification process in future guidance.

**How will CMS determine a practice’s MIPS score?**

In 2017, physician practices will be evaluated on three performance categories – quality, ACI, and improvement activities. Each category will be weighted differently with quality accounting for the majority of the score. Specifically, quality will account for 60% of a group’s MIPS score while ACI will account for 25% and improvement activities will account for the final 15%. In response to MGMA’s concerns that patient attribution and risk adjustment methodologies are not sound, CMS will not count cost measures in the 2017 MIPS score.

**What must a physician practice do in 2017 to avoid a MIPS penalty in 2019?**

Because the MIPS performance threshold is set at three points out of 100 total possible points, physician practices that submit a minimal amount of data in 2017 will avoid a penalty in 2019. Specifically, practices may report one of the following options to avoid a MIPS penalty:
1. One quality measure, or
2. One improvement activity, or
3. The ACI base measures

MGMA strongly recommends group practices report or attest to more than one measure as an insurance policy in case the group experiences any data submission issues or inaccuracies. Failure to report even one measure or activity in 2017 will result in a 4% penalty to Medicare payments in 2019.

**What must a physician practice do in 2017 to earn a MIPS bonus in 2019?**

MIPS scores greater than three points will qualify clinicians and group practices to earn a small bonus in 2019. Because the program is budget neutral and very few groups are expected to receive a penalty in the first year, the upside potential will be very limited. CMS anticipates the bonuses will not exceed
MGMA encourages medical practice leaders to evaluate the cost of participation against the minimal upside. However, the opportunity to learn how to effectively participate in the program in a relatively risk-free environment should significantly factor into any decision to participate in 2017.

To maximize the MIPS score and potentially earn a bonus, practices should take the following actions:

- **Quality** – Capture and report performance data spanning at least 90 consecutive days on up to six quality measures. Performance on each measure is compared to a national benchmark, and groups may earn up to 10 points per measure. Measures with a low performance rate or that do not satisfy benchmarking or data completeness will still receive a score of three.

- **ACI** – Report or attest to meeting four base measures. These measures are “all-or-nothing” and worth 12.5 points toward the 2017 MIPS score. Groups can also report performance on nine additional measures and earn up to an additional 12.5 points.

- **Improvement activities** – Report or attest to completing up to four improvement activities for at least 90 consecutive days. Groups in certain patient-centered medical homes and APMs may qualify automatically for full credit in this category or 15 points towards the 2017 MIPS score.

Group practices may also earn bonus credit for submitting quality measure information using end-to-end electronic reporting, reporting outcomes or high-priority quality measure data, and completing EHR-related improvement activities. All categories require at least 90 days of reporting; however, the 90-day period does not need to be the same across the three categories.

**Is group-level reporting an option in 2017?**

Yes, group practices may participate in MIPS collectively. A group is defined as two or more clinicians who reassign their billing rights to the group’s tax identification number (TIN), no matter the specialty or practice site. Groups will submit group-level data for each of the MIPS categories. Each clinician in the group will receive the same MIPS score and applicable payment adjustment based on the group’s performance. If your practice chooses to report as a group, it must do so for each MIPS category. Group-level reporting is generally less burdensome than reporting on an individual basis, as clinicians in the practice are able to meet the program requirements together. For example, if one clinician in a group can attest to completing an improvement activity, the entire group gets credit toward the 2017 MIPS score.

**What measures are available in 2017?**

Although the measures are set for ACI, there are nearly 300 different quality measures and almost 100 improvement activities available to medical group practices. To identify the most clinically applicable measures, group practice leaders may sort measures based on their reporting mechanism of choice or specialty using CMS’ interactive measure lists. Printable lists are also available at MGMA’s MACRA Resource Center.

**What reporting mechanisms are available in 2017?**

Clinicians and groups have many options for reporting MIPS data to CMS. Groups may utilize different reporting mechanisms to submit data in the different MIPS categories. For instance, a group may submit quality measure information via claims and attest to ACI and improvement activities. However, CMS will not count data submitted via different mechanisms within a category. Rather, the agency would use the most complete information set submitted using one mechanism. For instance, if
a group submits four quality measures via EHR and two via claims, the agency would use the quality measure information submitted via EHR.

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In general, 2017 performance data will be submitted during the first quarter of 2018. For claims submissions, the quality data code must be added to the CMS-1500 form or electronic equivalent.

**When will CMS provide MIPS feedback and payment information?**

CMS will notify clinicians and groups of their MIPS performance, MIPS score, and any respective penalty or bonus by July 1, 2018. Practices will have 60 days to contest any errors, such as data inaccuracies. Payments will then be adjusted beginning Jan. 1, 2019.

**ALTERNATIVE PAYMENT MODELS (APMs)**

**What are APMs?**

APMs are a broad category encompassing many innovative, value-based approaches to paying for Medicare services, such as episode-based bundle payments and accountable care organizations (ACOs). To support practices as they move from fee-for-service to value-based payment, MACRA created new opportunities and incentives for physician practices to develop and participate in APMs. In addition to the inherent risk and reward of an APM, participating practices in Advanced APMs may qualify for exclusion from MIPS and a 5% annual, lump-sum bonus payment from 2019 through 2024. Additionally, beginning in 2026, these participants will be eligible for a higher conversion factor on their fee-for-service billing.

**What is the difference between an APM and an Advanced APM?**

Advanced APMs are a subset of APMs that qualify certain participants for exclusion from MIPS, a 5% bonus payment, and higher fee schedule updates beginning in 2026. Advanced APMs must meet the following three criteria:

1. Require 50% of participants to use certified EHR technology to document and communicate care;
2. Provide payment based on quality measures comparable to those used in MIPS; and
3. Either: (1) be a Medical Home Model expanded under CMS Innovation Center authority; or (2) bear more than a nominal amount of financial risk for monetary losses.
In 2017, the following models are designated Advanced APMs:

- Comprehensive ESRD Care Model (Large Dialysis Organization (LDO) and non-LDO arrangements)
- Comprehensive Primary Care Plus (CPC+) Model
- Medicare Shared Savings Program ACOs – Tracks 2 and 3
- Next Generation ACO Model
- Oncology Care Model (two-sided risk arrangement)

The application cycles for participation in these models have closed, but in response to MGMA’s direct advocacy, CMS intends to expand the list of Advanced APMs in 2018 and will also re-open the application cycles for CPC+ and the Next Generation ACO model for 2018 participation.

**Which Advanced APM participants qualify for the bonus payment?**

Only qualified APM participants (QPs) in Advanced APMs will be excluded from MIPS in 2017 and receive a 5% lump sum bonus in 2019. In order to be considered a QP, clinicians must have at least 25% of their Medicare Part B payments or 20% of their Medicare patient population flow through the Advanced APM. CMS will make QP designations three times during 2017 – March 31, June 30, and August 31. If an Advanced APM entity (such as an ACO) is designated a QP at any one of those times, all groups and clinicians in the entity will become QPs.

Additionally, certain Advanced APM participants who fall below the QP thresholds may be designated as “Partial QPs.” These participants will have at least 20% of their Medicare Part B payments or 10% of their Medicare patient population flow through the Advanced APM. Partial QPs will have the option to forego participation in MIPS, but will not be eligible for the 5% lump sum bonus payment.

**So then, how will groups in non-Advanced APMs and groups not designated as QPs or Partial QPs participate in the QPP?**

Good question! Because not all APMs are Advanced APMs and not all participants in Advanced APMs will become QPs or Partial QPs, there will be a number of groups who participate in MIPS and an APM simultaneously. While MGMA continues to express concerns to CMS about the conflicting aims of these programs – MIPS largely builds on fee-for-service reimbursement while APMs increase financial accountability of groups – we were encouraged to see the QPP Final Rule minimizes the MIPS burden for APM participants. More specifically, clinicians and groups that participate in APMs receive preferential scoring in MIPS in recognition of the inherent cost-reduction and quality-improvement design of APMs. In 2017, these clinicians and groups will receive full credit in the improvement activities category of MIPS automatically. If applicable, they will report quality measures through the APM and be evaluated on ACI performance collectively, as well.
NEXT STEPS TO CONSIDER

MGMA encourages practice leaders to consider a long-term strategy for the move from fee-for-service to value-based reimbursement by taking steps that not only make sense within the MIPS and APM framework, but that also have an independent benefit for the practice, such as collecting and using patient satisfaction information or extending office hours to generate additional revenue. Keep in mind, 2017 is a transition year, and MGMA strongly encourages physician practices to report some MIPS information to protect your practice against a 4% penalty in 2019 and to prepare for future years with increased reporting requirements and greater penalty risk. Here are some steps that your practice can take now to aid in this preparation:

1. **Assess performance under current programs**

   Although different, performance in PQRS, Meaningful Use, and the VBPM will provide insight into performance under MIPS. Physician practices should access the CMS Enterprise Portal (portal.cms.gov) and download your PQRS Feedback Report and Quality and Resource Use Report. These reports contain quality reporting metrics and cost performance data and may help you identify areas where improvement may be made.

2. **Consider which QPP track is best suited for your practice**

   QPs in Advanced APMs during 2017 will receive an annual 5% lump sum bonus in 2019 and exclusion from MIPS. Confirm whether you are a participant in one of the designated 2017 Advanced APMs. If not, continue to explore opportunities to join risk-bearing arrangements to qualify for the Advanced APM incentives in future years.

3. **Evaluate EHR and other vendor readiness and costs**

   CMS is continuing the movement, established by the Meaningful Use EHR Incentive Program, of putting a premium on practice adoption and use of health information technology (HIT). As practices begin to transition to the QPP, identifying a cost-effective pathway forward to appropriate HIT will be important to ensure success not just in the reporting program but, more critically, for overall practice performance. Practice leaders may also consider researching qualified clinical data registries and traditional registries, which may help streamline reporting, particularly of specialty-specific measures.

4. **Explore applicable measures and improvement activities**

   New in MIPS, practices will be given credit for improvement activities. MGMA encourages practice leaders to review the list of activities to determine which activities your practice is already engaged in. Examples include providing transitional care management and consulting prescription drug monitoring programs prior to prescribing certain amounts of controlled substances.

5. **Take advantage of MGMA resources**

   To help members anticipate and prepare for changes as Medicare transitions from fee-for-service to value-based reimbursement, MGMA created a number of practical resources that you can access today at MGMA.com/MACRA. We also encourage members to join the conversation on MGMA’s interactive e-group, “MIPS/APMs Medicare Value-Based Payment Reform.”