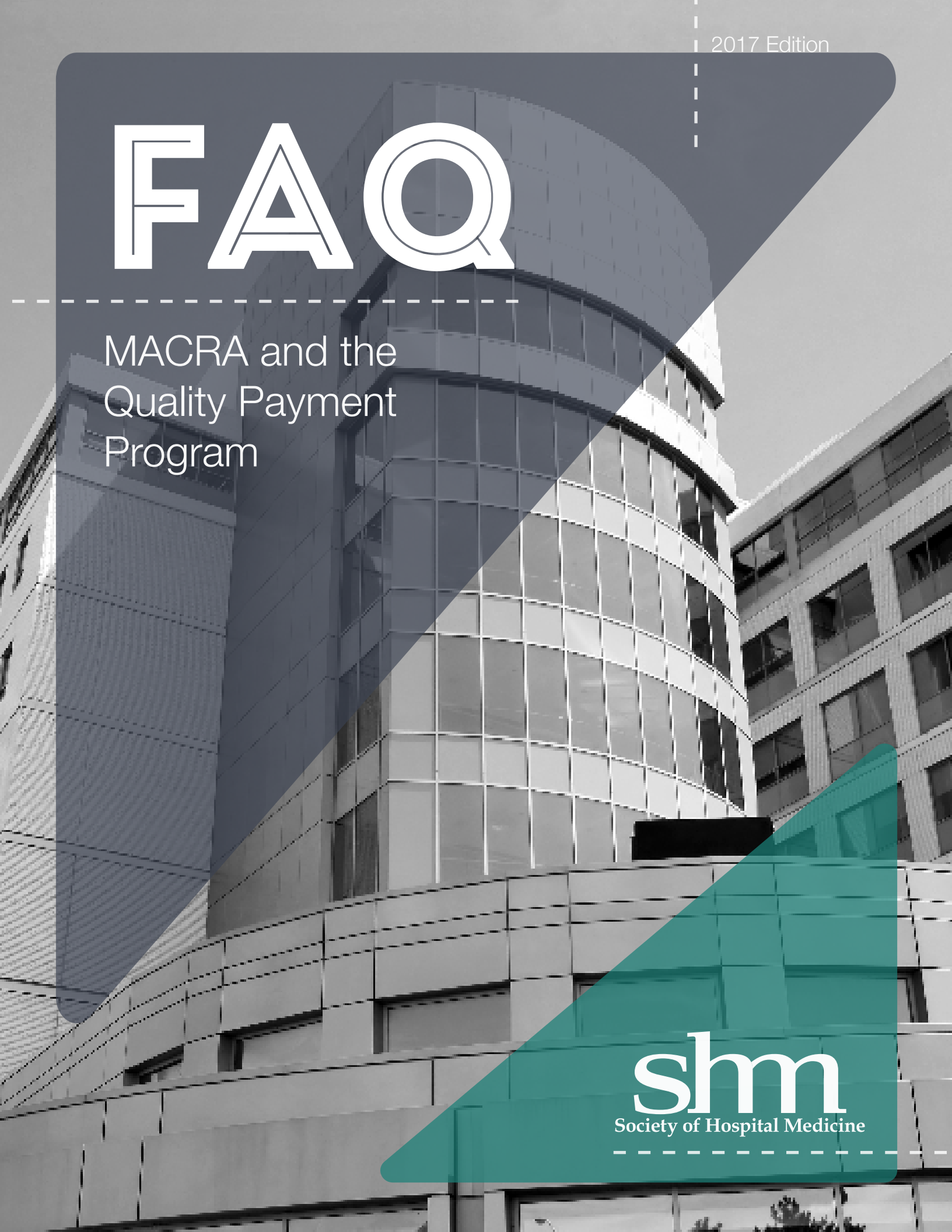
2017 Edition

FAQ

MACRA and the Quality Payment Program



shm
Society of Hospital Medicine

WHAT IS MACRA?

MACRA stands for the Medicare Access and CHIP Reauthorization Act. It is legislation that was signed into law on April 16, 2015. It permanently repealed Medicare's Sustainable Growth Rate (SGR) formula, restructured Medicare provider pay-for-performance programs and created an incentive for the adoption of alternative payment models.

WHAT IS THE QUALITY PAYMENT PROGRAM?

The Quality Payment Program (QPP) is the program that the Centers for Medicare & Medicaid Services (CMS) created to implement MACRA. In other words, the QPP is MACRA. It is the new payment system for providers who care for Medicare beneficiaries. The intent of the QPP is to begin moving Medicare away from straight fee-for-service payments toward payments that reward quality and value.

HOW DO PAYMENTS WORK UNDER THE QPP?

The QPP is broken down into two pathways. The **Merit-based Incentive Payment System (MIPS)** combines past programs such as the Physician Quality Reporting System (PQRS), Physician Value-Based Modifier and Meaningful Use into one streamlined pay-for-performance program, and **Alternative Payment Models (APMs)** incentivize the adoption of payment models that move away from a fee-for-service system.

The MIPS pays providers on a modified fee-for-service system. Providers will receive payment adjustments based on performance across a range of measures and activities.

APMs pay providers based on the rules associated with the model itself. Some examples of APMs include Accountable Care Organizations (ACOs) or patient-centered medical homes. Providers in APMs receive their APM payments and are potentially eligible for an additional 5% payment increase to their Medicare Part B billing if they and the APM in which they are participating meet the APM pathway requirements.

WHO PARTICIPATES, AND **WHO IS EXCLUDED?**

All physicians, PAs, NPs, CNSs and CRNAs who bill Medicare more than $30,000 per year and see more than 100 Medicare patients per year must participate in the QPP or face a 4% penalty under the MIPS. MIPS is the default program for all providers who bill Medicare Part B.

- Clinicians in their first year of participating in Medicare are exempt.
- Clinicians who bill Medicare less than $30,000 or see fewer than 100 Medicare patients per year are exempt.

WHERE DO **HOSPITALISTS FALL?**

The Society of Hospital Medicine (SHM) estimates that most hospitalists will be subject to MIPS reporting in 2017, the first year of reporting for the QPP. Although many hospitalists are participating in risk-based alternative payment models, such as Bundled Payment for Care Improvement (BPCI), these models are not considered Advanced APMs due to the criteria set forth in the MACRA law. CMS has stated it intends to make changes to the APM pathway in future years of the program.

WHAT IS AT RISK UNDER THE QPP?

The QPP operates on a two-year time lag. For the MIPS, performance on measures in 2017 will be used to determine payment in 2019. For APMs, performance in 2017 will determine eligibility for incentive payments in 2019.

	2019	2020	2021	2022
MIPS Reward	+4.0%	+5.0%	+7.0%	+9.0%
MIPS Penalty	-4.00%	-5.00%	-7.00%	+9.0%
APM Incentive	+5.0%	+5.0%	+5.0%	+5.0%
APM Risk	Downside risk as part of accepting an alternative payment model +			

HOW IS THE FIRST YEAR DIFFERENT THAN OTHERS?

CMS has decided that the first year of the QPP will be more flexible to give providers time to transition into the program. To avoid a negative payment adjustment, providers need only submit something — anything — to CMS. It could be as small as reporting on one measure or improvement activity on one patient, or a full year of reporting. The first year was deemed "Pick Your Pace" by CMS, which provides four options for providers.

- **Submit Anything** – just one measure or one activity will avoid the penalty
- **Partial or Full MIPS Participation** – avoid a downward adjustment and be eligible for potential positive payment adjustments
- **Submit Nothing** – will receive the penalty (negative 4% adjustment)
- **Participate in an Advanced APM** – exempt from MIPS, eligible for 5% bonus payment

MERIT BASED INCENTIVE PAYMENT SYSTEM

The MIPS combines performance across four categories to create a total score per provider or group. That total score will then determine whether the providers get a positive, neutral or negative payment adjustment to their Medicare Part B billing. Providers will need to report on measures and activities across the following four categories to receive a MIPS score and be eligible for a positive payment adjustment:

Quality

which replaces the Physician Quality Reporting System, requires the reporting of quality measures.

Cost

which replaces the cost evaluation of the Physician Value-Based Modifier, has CMS-calculated cost measures.

Advancing Care Information

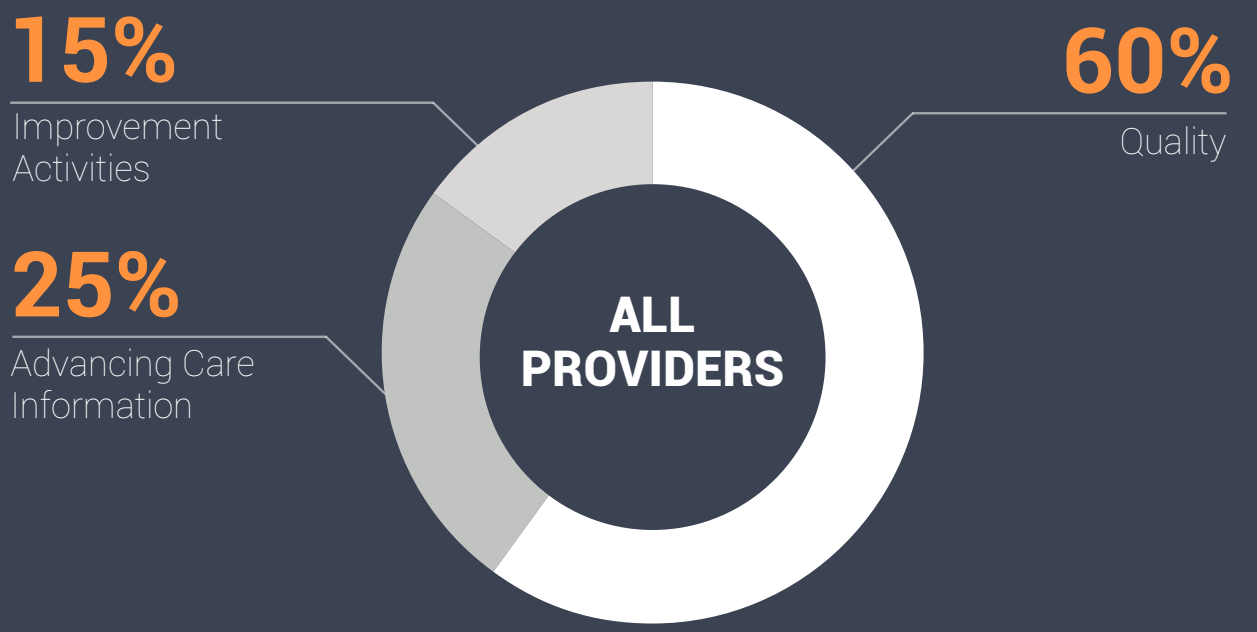
which replaces the Medicare eligible provider Meaningful Use program, requires use of Certified Electronic Health Record Technology.

Improvement Activities

is a new category that has an inventory list of activities in which providers must partake to get credit.

HOW IS THE MIPS SCORE CALCULATED?

Each of the four MIPS categories is weighted a proportion of the overall MIPS score. Hospitalists have different category weightings due to being exempted from the Advancing Care Information category, and that category weight being shifted to Quality. In 2017, CMS has also zeroed out the weighting for the Cost category for all providers. This category will be weighted in future years.



WHY DOES QUALITY COUNT FOR SO MUCH?

CMS decided that the Cost category would be weighted at 0% for the first year of the program, and hospitalists are exempt from the Advancing Care Information category, which would normally count for 25%, shifting the weight to the Quality category.

HOW CAN I PARTICIPATE IN THE MIPS?

You can participate in the MIPS by reporting at either the group or individual levels. Individual reporting can be done through claims, registry, qualified clinical data registry (QCDR), or Electronic Health Record (EHR) reporting. Group reporting can be submitted through the CMS web interface, EHR, registry or QCDR. SHM cautions that not every reporting option may be available to hospitalists, depending on how their practice is structured. Also, note that you need to report at a consistent level (group or individual) across the MIPS categories.

WHAT IS THE QUALITY CATEGORY?

Hospitalists can report through either the hospitalist-specialty measure set or the **broader list of measures**. To give hospitalists more clarity on what measures are available for hospitalists, SHM worked with CMS to establish a hospitalist specialty measure set. If the measures do not all apply to your practice, you can choose only to report on those that do.

NOTE: There is a six-measure requirement for the quality category including one outcome measure. If the specialty list does not have six applicable measures for you, a "clinical validation test" will be performed by CMS to ensure there were no other measures to report. Most hospitalists will not have six or more measures to report and will therefore be subject to the validation process. SHM is working to ensure that hospitalists who report within the measure set and report fewer than six measures will not be penalized.

WHAT IS THE ACI CATEGORY?

The **Advancing Care Information (ACI)** category is a reboot of the Meaningful Use program. Providers must be using Certified Electronic Health Record Technology (CEHRT) and report on several EHR-based activities and metrics to be successful in this category. Most hospitalists should be exempt from this category, due to what is known as "the hospital-based exemption." **Hospital-based Exemption** from ACI: Hospitalists are exempt from this category if they provide 75% or more of their services in POS 21 (Inpatient), 22 (Outpatient) or 23 (ER). The hospital-based exemption is calculated at the individual level. If providers do not reach the 75% threshold, such as if they practice in skilled nursing facilities or other post-acute settings, they can apply for a hardship exception.

WHAT IS THE COST CATEGORY?

The Cost category comprises cost and efficiency measures such as the Total Per Capita Cost and Medicare Spending Per Beneficiary measures from the current Physician Value-Based Modifier program. CMS collects information via claims for this category and provides feedback to groups based on their performance.

NOTE: For the first year of the QPP, cost will not be weighted as part of the MIPS final score. However, CMS will provide information surrounding cost measures for physicians based on their performance – to be utilized as a baseline for future years.Cost measures will be included in the MIPS final score in year two and beyond.

WHAT IS THE IMPROVEMENT ACTIVITIES CATEGORY?

This is a new category that CMS has created. The inventory list of activities is both lengthy and vague. The good news is that these activities are usually things that hospitalists are already doing (i.e. systems improvement, quality improvement). Providers must attest two to four activities to receive full credit.

WHEN WILL CMS PROVIDE INFORMATION ABOUT OUR **PERFORMANCE IN THE MIPS?**

CMS will produce and disseminate feedback reports in the year between the performance and payment adjustment years. These reports are expected to show your performance across all of the four MIPS categories (Quality, Cost, Advancing Care Information, and Improvement Activities) and some more detailed information about the performance scoring. For the first year of the MIPS, there will be a feedback report issued in 2018 based on performance from 2017. Performance reported in these feedback reports will be used to determine payment adjustments in 2019.

HOW ARE THE MIPS PAYMENT **ADJUSTMENTS APPLIED?**

After the MIPS total score is calculated, CMS will apply an adjustment to Medicare Part B payments. Payment adjustments occur two years after the performance year; performance in 2017 will determine payments in 2019. These payment adjustments (positive or negative) are applied at the individual Tax Identification Number/National Provider Identifier (TIN/NPI) level. We note, however, the payment adjustment would be carried forward even if you are practicing under a different TIN; an individual provider who moves and changes TINs would still receive the payment adjustment based on performance at their former practice.

ALTERNATIVE PAYMENT MODELS (APMS)

The APM pathway is meant to incentivize the adoption of payment models that move farther away from traditional fee-for-service Medicare. Participating in an APM that qualifies as an Advanced APM will exempt participants from reporting under MIPS and will give them a 5% bonus yearly, in addition to any potential gainsharing or incentives associated with the selected model.

To be an Advanced APM, the APM must meet the following criteria:

1. Utilizes the use of Certified Electronic Health Record Technology.
2. Has quality measures comparable to the MIPS.
3. Has more than nominal financial risk or is an expanded Medical Home Model.

The only models that meet Advanced APM criteria in 2017 are:

- Comprehensive ESRD Care
- Comprehensive Primary Care Plus
- Next Generation ACO Model
- Shared Savings Program Tracks 2 and 3
- Oncology Care Model
- Comprehensive Care for Joint Replacement Model Track 1-CEHRT

WHAT IS AT RISK UNDER MIPS?

First, a hospitalist must participate in an Advanced APM (listed above).

A hospitalist must be considered a Qualifying Participant (QP), by having a participation agreement with the model and meeting a threshold for payments or patients associated with the model.

Threshold Options Required for Advanced APM Participation, by Incentive Payment Year					
YEAR	2019	2020	2021	2022	2023 ->
Medicare payments only	≥ 25%	≥ 25%	≥ 50%	≥ 50%	≥ 75%
All-payer payments	Not available	Not available	≥ 50% (with 25% Medicare)	≥ 50% (with 25% Medicare)	≥ 75% (with 25% Medicare)
Patient Count	≥ 20%	≥ 20%	≥ 35%	≥ 35%	≥ 50%

WHAT ABOUT THE BUNDLED PAYMENTS FOR CARE IMPROVEMENT (BPCI) MODEL?

BPCI does not meet the criteria to qualify as an Advanced APM. It meets the "more than nominal financial risk" requirement, but does not currently require use of CEHRT and does not require reporting of quality measures. CMS has indicated it intends to develop a new, voluntary bundled payment model soon that will meet the criteria for Advanced APM.

SHM cautions that, even if a new bundled payments model is created, it will still be difficult for hospitalists to meet the threshold of patients and payments to be considered a Qualifying Participant (QP) and be eligible for the 5% incentive payment.

CAN A HOSPITALIST GROUP BE COUNTED IN AN APM **THE HOSPITAL IS IN?**

Hospitalists groups may be able to be counted as participants in an APM led by their hospital, if the hospital has the hospitalist group included in their APM participant list.

WHAT CAN HOSPITALISTS **DO NOW?**

Hospitalists should take the time to educate themselves about the program and check in with their practice administrators and leadership to see if there is a plan set in place to be successful under the QPP. SHM strongly recommends that all hospitalists execute the following three action items to get started and be ready for the QPP.

- Check in with a practice manager, administrator or group leader to see if you have been reporting quality measures in the past for the Physician Quality Reporting System (PQRS) or if you have received any PQRS penalties.
- Make sure your group has a plan for reporting under the QPP and that you're ready to start in the new year. Remember, in 2017, all a group or individual needs to do is report one measure or one activity under the MIPS to be protected from penalties.
- Share with your colleagues and continue to educate yourself about the MIPS and APMs and opportunities for hospitalists.

PICK YOUR PACE: WHAT DO PROVIDERS NEED TO DO FOR 2017?

CMS has decided that 2017, the first year of reporting for the QPP, will be more flexible to give providers time to transition into the program. So, for 2017, providers can "Pick Your Pace" as to how much they engage with the QPP. The only way providers will receive a penalty in 2019 is if they did not participate at all.

To avoid any penalty, providers need only submit something to CMS. It could be as small as one measure or improvement activity on one patient, up to a full year of reporting.

- **Submit Anything** – just one measure or one activity will avoid the penalty
- **Partial or Full MIPS Participation** – avoid a downward adjustment and be eligible for potential positive payment adjustments adjustments. SHM recommends taking this pathway as a way to become more familiar with the program for future years since there is no risk of penalties.
- **Submit Nothing** – will receive the penalty (negative 4% adjustment)
- **Participate in an Advanced APM** – exempt from MIPS, eligible for 5% bonus payment

MORE RESOURCES

+ CMS Quality Payment Program Website: https://qpp.cms.gov
+ For more information on MACRA for Hospitalists, visit **www.macraforhm.org.**

QUESTIONS?

Contact us anytime at advocacy@hospitalmedicine.org