Briefings on APCs

Preparing clinicians for MIPS reporting in 2017

The 2017 calendar year marks the beginning of a new approach to physician payment through the Quality Payment Program (QPP), an initiative created by the Medicare Access and CHIP Reauthorization Act to revise the physician payment system previously updated through the Sustainable Growth Rate.

Clinicians in hospitals and provider-based clinics can choose from two pathways of participation in this program: an Advanced Alternative Payment Model (APM) or the Merit-based Incentive Payment System (MIPS). This new system will replace three previous Medicare reporting programs: Medicare meaningful use [MU], the Physician Quality Reporting System [PQRS], and the Value-Based Payment Modifier.

Most providers will participate in the QPP through the MIPS track, according to CMS, which will apply a positive or negative payment adjustment to the traditional standard fee paid according to the Medicare Physician Fee Schedule. This payment adjustment will be based on the clinicians' total MIPS performance score, which is calculated from the following four categories:

- Advancing Care Information (ACI)
- Cost
- Improvement Activities
- Quality

Some of these categories bear a resemblance to programs previously used by Medicare. ACI, for example, replaces the MU program. The Cost category replaces the Value-Based Payment Modifier, and Quality replaces PQRS.

CMS assigned each of the four new categories a weight toward the total MIPS score. In 2017, points earned in the Quality category will form 60% of the total MIPS score. ACI will be worth 25%, and Improvement activities will make up the other 15%. The Cost category will not count toward the final MIPS score in 2017, but data will still be collected from adjudicated claims, and CMS will offer feedback to providers based on this data, the agency said on its website. These weights will change in future years.

MIPS entered its first reporting period on January 1 of this year, and the data from 2017 will be used for the 2019 pay period.

Eligibility requirements for individuals and groups

In 2017, clinicians are eligible for MIPS if they bill Medicare more than $30,000 in Part B charges per year and provide care for more than 1,000 Medicare patients in the year. A clinician also must be a physician, physician assistant, nurse practitioner, clinical nurse specialist (CNS), or certified registered nurse anesthetist (CRNA) to be eligible for MIPS in 2017. Clinicians reporting to Medicare for the first time in 2017 are not eligible for MIPS.

Eligible clinicians can report their data either as an individual (which is defined by CMS as a single National Provider Identifier tied to a single Tax Identification Number) or as a group (defined as a set of clinicians sharing a common Tax Identification Number). If clinicians report as a group, data must reflect the work done on a group level and cannot be a selection of an individual clinician's best numbers.

Individuals can submit data via an EHR, a registry, or a qualified clinical data registry. Groups can submit data via those same methods, or they may choose to submit via a CMS web interface. If groups choose that option, they must register as a group by June 30, 2017.

Participation in an APM will be an alternative to participating in MIPS for clinicians who meet the requirements of a qualified participant per CMS guidelines. These include either:

- Receiving 25% of Medicare Part B payments through the APM
- Seeing at least 20% of Medicare patients through an APM

Clinicians also must be on an APM Participation List on at least one of the dates set by CMS: March 31, June 30, or August 31. CMS designated seven eligible APMs for the 2017 reporting year. These include:

- Comprehensive ESRD Care Model (LDO)
- Comprehensive ESRD Care Model (non-LDO)

- Comprehensive Primary Care Plus
- Medicare Shared Savings Program ACOs— Track 2
- Medicare Shared Savings Program ACOs—Track 3
- Next Generation ACO Model
- Oncology Care Model OCM (two-sided risk)

Clinicians participating in the APM path of the QPP will receive a 5% incentive payment for the 2019 payment year.

Low threshold in 2017

In order to help clinicians adjust to the QPP system, CMS created the “Pick Your Pace” program for the 2017 reporting year. This system will allow clinicians to participate in MIPS at a very minimal level in 2017 without receiving a negative adjustment. Clinicians who participate at a higher level will have the chance to receive a greater positive payment adjustment.

CMS will set a score threshold each year. Those scoring below the threshold will receive a negative adjustment, and anyone scoring above the threshold will receive an increase in pay proportionate to how that clinician performed in comparison to his or her peers.

The threshold for 2017 is very low, as clinicians only need to score 3 out of 100 to avoid a payment penalty in 2019. Clinicians can achieve that score simply by sending in one quality measure, four or five of the ACI measures, or one improvement activity on one Medicare patient, CMS said on its website.

Jeanne J. Chamberlin, MA, FACMPE, a practice management consultant for MSOC Health in Chapel Hill, North Carolina, elaborated on the reasoning behind setting a low score threshold during a DecisionHealth webinar, “Maximize MIPS Incentives: Put a Plan in Place to Gain Max Payment Bonuses.”

“CMS received over 4,000 comments to their proposed rule, and the most common comment was that people just could not prepare fast enough for this program,” Chamberlin said.

Because the law said the program would start paying in 2019, clinicians would have to start reporting in 2017 since anyone reporting for the entire calendar year would not be able to submit the data until early 2018. Then CMS would need time to process the data and calculate payments before issuing payment in 2019.

“The earliest time frame it makes sense for it to start is January 1 of the following calendar year,” Chamberlin said. “So as a result, CMS chose a threshold for the first year of operation of 3 essentially as a way of delaying the program—as a way of letting everybody get their feet wet."

In 2017, the program will be flexible in terms of offering a positive payment adjustment. Participation for all 12 months of the year is optional, but clinicians who report for at least a 90-day period across all MIPS categories will likely receive a higher payment adjustment and be more prepared for the years to come, when clinicians will be required to report a complete set of data in all categories for a 12-month period. Other clinicians who report for at least a 90-day period but only report a few measures in each category (or from only one or two categories instead of all three) will still receive a positive payment adjustment, but they will not be as prepared for the higher level of reporting required in the coming years, according to Chamberlin.

Performance categories

CMS will ease clinicians into MIPS by allowing varying levels of participation when it comes to reporting for these categories in 2017. Clinicians can avoid a negative payment adjustment for the 2019 pay period simply by submitting one piece of data from any of these categories for the 2017 reporting year. Those aiming for a positive payment adjustment, however, should report more complete data for at least a 90-day period in 2017.

The Quality category

In the Quality category, clinicians who wish to participate fully should select six measures to report, and at least one measure must be an outcome measure or a high-priority measure. The options to select from are abundant, as CMS has a list of nearly 300 quality measures available for this category. Unlike with PQRS, there are no measure groups, but clinicians can narrow down the list of measures by determining which reporting approach to take, as some measures are only available for some reporting approaches. For example, the Care Plan measure is a quality measure that can only be submitted via claims or a registry, while the High Blood Pressure Control measure can be submitted via claims,

CMS’ web interface, EHRs, or a registry.

Another way to narrow down the list of measures is by choosing to report from a specialty-specific measure set. Clinicians are not required to use this set, but it might help clinicians find measures that are applicable to their practice in a faster and simpler way.

If clinicians are reporting as a group and that group has more than 15 providers and a minimum of 200 cases, CMS will calculate a seventh measure, which will be a readmission measure based on claims data.

Each measure is worth a total of 10 points based on how clinicians perform in that measure relative to a CMS-determined benchmark, and clinicians will earn a minimum of 3 points for each measure in 2017 simply by reporting data. If a clinician reports six measures, the total number of base points he or she can earn in the Quality category is 60 points. If the clinician is part of a group that qualifies for the readmission measure, the clinician can earn a possible 70 points in the Quality category because the group will be reporting seven measures.

Points for specific measures in the Quality category will range from 3.0 to 10, with the numbers before the decimal point representing the decile the data falls into and the subsequent digits representing where in the decile the data falls rounded to the nearest tenth. CMS released a list of these benchmarks and deciles for the 2017 reporting year here.

Editor's Note: *The above is an excerpt from JustCoding's Briefings on APCs. Read more on this topic here.*