shm | POLICY & ADVOCACY

MACRA and the Quality Payment Program

Frequently Asked Questions

2018 Edition

Contents

Overview

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 It permanently repealed Medicare's Sustainable Growth Rate (SGR) formula, restructured Medicare provider pay-for-performance programs, and created an incentive for the adoption of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 towards payment that rewards 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)**, which combines past programs such as the Physician Quality Reporting System (PQRS), value based payment modifier, and Meaningful Use into one streamlined pay-for-performance program, and **Alternative Payment Models (APMs)**, which incentivizes 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 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.

What is at risk under the QPP?

The QPP has both financial risks and rewards for participants, depending on the pathway. The program operates on a two-year time lag. For the MIPS, performance on measures in 2018 will determine payments in 2020. For APMs, performance in 2018 will determine eligibility for an incentive payment in 2020.

The MIPS operates in a budget neutral manner. That is, money collected as penalties form the pool of money available for reward payments.

Payment Adjustment Year					
	2019	**2020**	**2021**	**2022**	**2023 >**
MIPS Reward	+4.0%*	+5.0%*	+7.0%*	+9.0%*	+9.0%*
MIPS Penalty	-4.0%	-5.0%	-7.0%	-9.0%	-9.0%
APM Incentive	+5.0%	+5.0%	+5.0%	+5.0%	+5.0%
APM Risk	Downside risk as part of the alternative payment model rules				
**MIPS reward payments can be up to 3x these percentages, depending on the funds available.*					

Who participates, and who is excluded?

All physicians, PAs, NPs, CNS, CRNAs who bill Medicare more than $90,000 per year and see more than 200 Medicare patients per year must participate in the QPP or face a 5% 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 $90,000 or see fewer than 200 Medicare patients per year are exempt.

How do I know if I'm eligible?

If you are unsure if you are eligible to participate in the Quality Payment Program, go to qpp.cms.gov. Enter your National Provider Identifier (NPI) and CMS will automatically check your participation status.

Where do hospitalists fall?

SHM estimates that most hospitalists will be subject to MIPS reporting in 2018. Although many hospitalists are participating in risk-based alternative payment models, such as Bundled Payment for Care Improvement (BPCI) or ACOs, they may not meet the APM incentive thresholds and will still be participating in the MIPS.

Merit-based Incentive **Payment System (MIPS)**

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

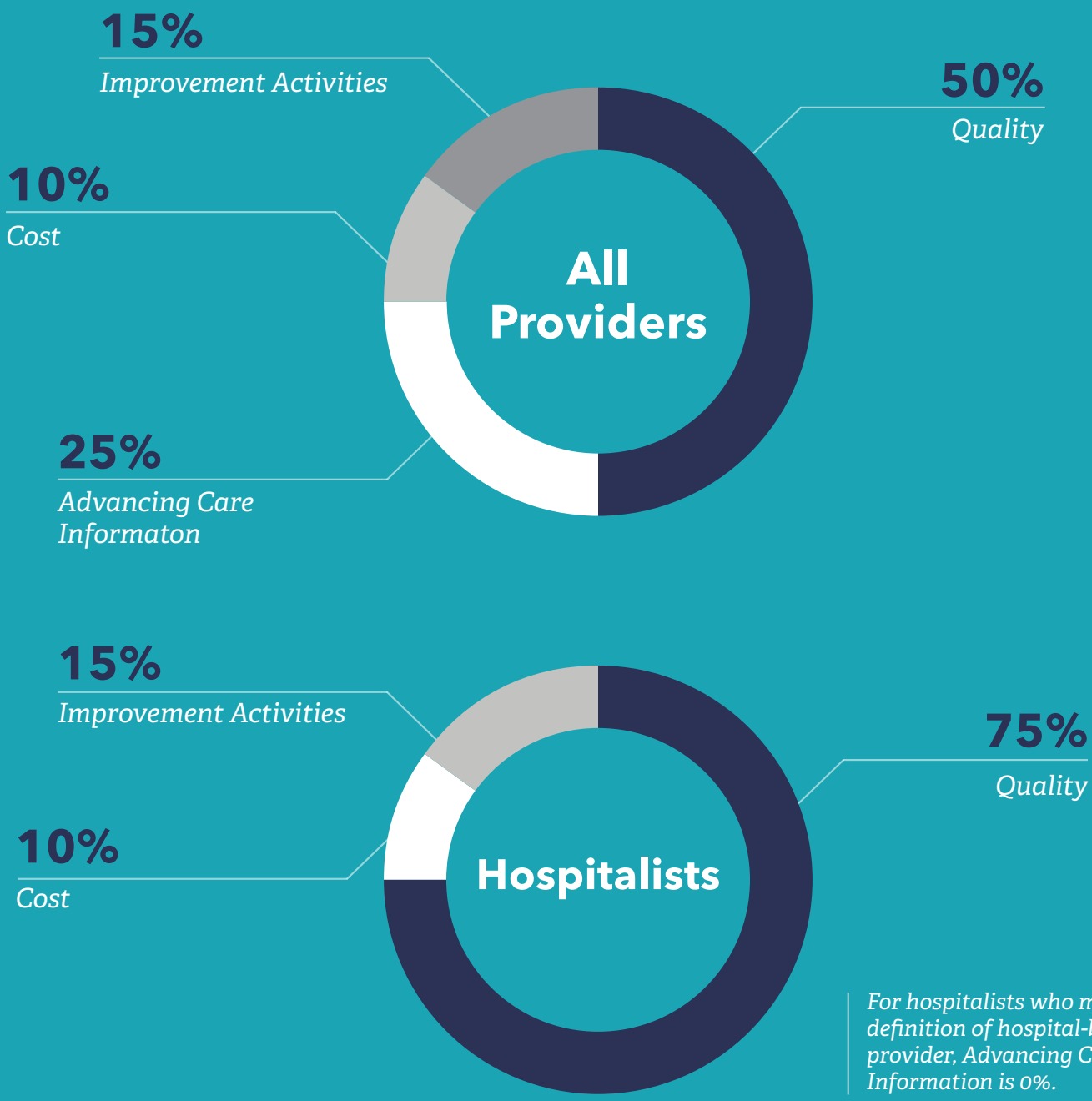
which replaces the Medicare eligible provider Meaningful Use program, requires use of Certified Electronic Health Record Technology.

Improvement Activities

is a new category that requires providers to select and complete activities from an inventory to get credit.

How is the MIPS Score Calculated?

Each of the four MIPS categories are weighted a proportion of the overall MIPS score. Most hospitalists have different category weightings due to an exemption from the Advancing Care Information category, and that category weight being shifted to Quality.



For hospitalists who meet the definition of hospital-based provider, Advancing Care Information is 0%.

Merit-based Incentive Payment System (MIPS)

How can I participate in the MIPS?

You can participate in the MIPS by reporting at either the group or individual level. 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, which are available at https://qpp.cms.gov/mips/quality-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. CMS has also finalized a 60% data completeness threshold for quality measures submitted using QCDRs, qualified registries, EHR, and Medicare Part B Claims.

Note: There is a 6-measure requirement for the quality category including one outcome measure. If the specialty list does not have 6 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 6 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 6 measures will not be penalized.

Applicable Quality Measures for Hospitalists

SHM worked with CMS to ensure that the "Hospitalist Specialty Measure Set" only contained measures that are applicable for hospitalists. Although some will remain low volume measures for some providers, as long as providers report as many measures as apply to their practice, they should avoid a penalty.

QUALITY #5

Heart Failure: ACE/ARB for LVSD

Reporting Method: Registry, EHR

QUALITY #8

Heart Failure: Beta-blocker for LVSD

Reporting Method: Registry, EHR

QUALITY #47

Advanced Care Plan

Reporting Method: Claims, Registry

QUALITY #76

Prevention of CRBSI: CVC Insertion Protocol

Reporting Method: Claims, Registry

QUALITY #130

Documentation of Current Medications

Reporting Method: Claims, Registry

QUALITY #407

Appropriate Treatment of MSSA Bacteremia

Reporting Method: Claims, Registry

Why is the Quality category worth more for hospitalists?

Hospitalists should be exempt from the Advancing Care Information category, which would normally count for 25%, shifting the weight to the Quality category.

What is the quality measure validation process?

If a provider reports on fewer than 6 measures, the Eligible Measure Applicability (EMA) process will be triggered to see if there were any other measures that could have been reported by that provider. The EMA has a two-step process:

1) A clinical relation test sees if there are more clinically related quality measures based on the one to five quality measures you submitted OR if none of the six or more measures included an outcomes measure – the clinical relation and outcome/high priority tests to see if there were any that could have applied.

2) A minimum threshold test looks at the Medicare claims that you submitted to see if there are at least 20 denominator eligible instances for any extra measures found in step 1.

For more information regarding this process see https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Resource-library.html.

What is the Advancing Care Information Category (ACI)?

The 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 a hospital-based provider 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 a provider does 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 is comprised of cost and efficiency measures such as the Total Per Capita Cost and Medicare Spending Per Beneficiary measures from the current value-based-payment-modifier program. CMS collects information via claims for this category and provides feedback to groups based on their performance.

What is the Improvement Activities Category?

Improvement Activities is a new category that encompasses activities that focus on care coordination, beneficiary engagement, and patient safety. 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 2-4 activities to receive full credit.

Examples include:

- Implementation of regular care coordination training
- Implementation of antibiotic stewardship program
- Use decision support and standardized treatment protocols to manage workflow
- Participation in Maintenance of Certification Part IV

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 four of the MIPS categories (Quality, Cost, Advancing Care Information, and Improvement Activities) and more detailed information about the performance scoring. For 2018 reporting, there will be a feedback report issued in 2019 based on performance from 2018. Performance reported in these feedback reports will be used to determine payment adjustments in 2020.

How is the MIPS final score calculated?

CMS will create a score in each of the categories, based on your performance. Those scores will then be given the category weight and added together to give you your total MIPS score. That score will be on a scale of 1 to 100 points.

In 2018, CMS has set a performance threshold of 15 points in the MIPS. Providers who are able to attain at least 15 points will avoid a penalty in 2020 from the MIPS, and providers who score higher may be eligible for incentive payments.

How are 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 2018 will determine payments in 2020. 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 yearly 5% bonus.

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

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

The only models that meet Advanced APM criteria in 2018 are:

- Bundled Payments for Care Improvement Advanced
- Comprehensive Care for Joint Replacement Model (Track 1)
- Comprehensive ESRD Care Model
- Comprehensive Primary Care Plus (CPC+) Model
- Medicare Shared Savings Program ACO Tracks 1+, 2, and 3
- Next Generation ACO Model
- Oncology Care Model
- Vermont All-Payer ACO

Be sure to check the most up-to-date list of Advanced APMs at **https://qpp.cms.gov**.

How can hospitalists participate in the APM Pathway and get the bonus payment?

First you must participate in a designated Advanced APM. Second, you must be considered a Qualifying Participant (QP), by having a participation agreement within 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) advanced model?

CMS recently announced a new Bundled Payments for Care Improvement (BPCI) Advanced model. This model qualifies as an Advanced APM. However, we caution it may still be difficult for providers to meet the threshold of patients or payments to be considered a Qualifying Participant (QP) and be eligible for the 5% incentive payment.

Can a hospitalist group, such as one employed by the hospital, be counted in an APM their 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 take 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 MIPS in the last year, or if you reported quality measures for the Physician Quality Reporting System (PQRS) in the past.
- Make sure your group has a plan for reporting under the QPP and that you're ready to start in the new year.
- Share with your colleagues and continue to educate yourself about the MIPS and APMs and opportunities for hospitalists.

More Resources

- **CMS Quality Payment Program Website:** https://qpp.cms.gov
- **CMS QPP Resource Library:** https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Resource-library.html
- **SHM MACRA Resources Website:** www.macraforhm.org

Questions?

Contact us anytime at **advocacy@hospitalmedicine.org.**

Help us help hospitalists: Let us know what worked and didn't work when reporting in the QPP last year. If there are other quality measures or improvement activities that you feel are appropriate for hospitalists to report, let us know at **advocacy@hospitalmedicine.org**.

Empowering hospitalists. Transforming patient care.