shm | POLICY & ADVOCACY

MACRA and the Quality Payment Program

Frequently Asked Questions

2019 Edition

Contents

What is New to Consider in 2019?

The Quality Payment Program is a complicated, ever-changing program. From year to year, the Centers for Medicare and Medicaid Services (CMS) makes changes to the program. SHM consistently listens to your experiences, monitors upcoming policy changes and works to address issues in the program on behalf of hospitalists.

Major relevant changes to the program in 2019 include:

- **Facility-based Measurement Option.** Beginning in 2019, hospitalists and hospitalist groups will have scores in the Quality and Cost categories of the MIPS automatically calculated for them. CMS will give facility-based providers a score in those categories based on their hospital's hospital value-based purchasing (HVBP) score. For providers or groups that also elect to report on measures independent of this option, CMS will use the higher of the scores for the total MIPS score.

- **Elimination of claims-based reporting of quality measures for groups.** Groups of more than 15 MIPS eligible clinicians will not be able to report on quality measures through Medicare Part B claims. This means those providers will need to report by registry, Qualified Clinical Data Registry (QCDR), GPRO web-interface or direct electronic health record (EHR) submission.

Hospitalists should also keep in mind how the **Promoting Interoperability category** may affect their MIPS score. SHM has been apprised that some groups that report as a group have been held accountable in the PI category due to individual providers in the group (including providers who practice in post-acute settings, locum tenens providers and moonlighting providers) not meeting the hospital-based exemption criteria. SHM is actively working to address this issue, but we encourage groups in the meantime to keep this in mind and be sure to apply for hardship exceptions for providers who may not qualify for an exemption from the Promoting Interoperability category.

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 It permanently repealed Medicare's Sustainable Growth Rate (SGR) formula, restructured Medicare provider pay-for-performance programs, and created an incentive for the adoption of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. 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 2019 will determine payments in 2021. For APMs, performance in 2019 will determine eligibility for an incentive payment in 2021.

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				

• Payment adjustment years correspond to the performance year two years prior. E.g., 2021 payment adjustments are based on 2019 performance.
** MIPS reward payments can be up to 3x these percentages, depending on the funds available.*

Who participates, and who is excluded?

Providers may participate in the Quality Payment Program in either the MIPS or in an Advanced APM. MIPS is the default program for all providers who bill Medicare Part B. These include physicians, physician assistants, nurse practitioners, certified nurse specialists, and certified registered nurse anesthetists. Providers may be exempt from the MIPS if:

- They do not exceed one or more of the low volume thresholds, which are:
  - Billing $90,000 or less in Medicare Part B allowed charges for covered professional services; or
  - Provide covered professional services for 200 or fewer Part B-enrolled individuals; or
  - Provide 200 or fewer covered professional services to Part B-enrolled individuals.
- They are in their first year of participating in the Medicare program.
- They are participating in a qualifying Advanced Alternative Payment Model and meet the thresholds for participation.

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?

Most hospitalists will be subject to MIPS reporting in 2019. Although many hospitalists are participating in risk-based alternative payment models, such as Bundled Payment for Care Improvement – Advanced (BPCI-A) or ACOs, they may not meet the APM incentive threshold and still be required to participate 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 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.

Promoting Interoperability

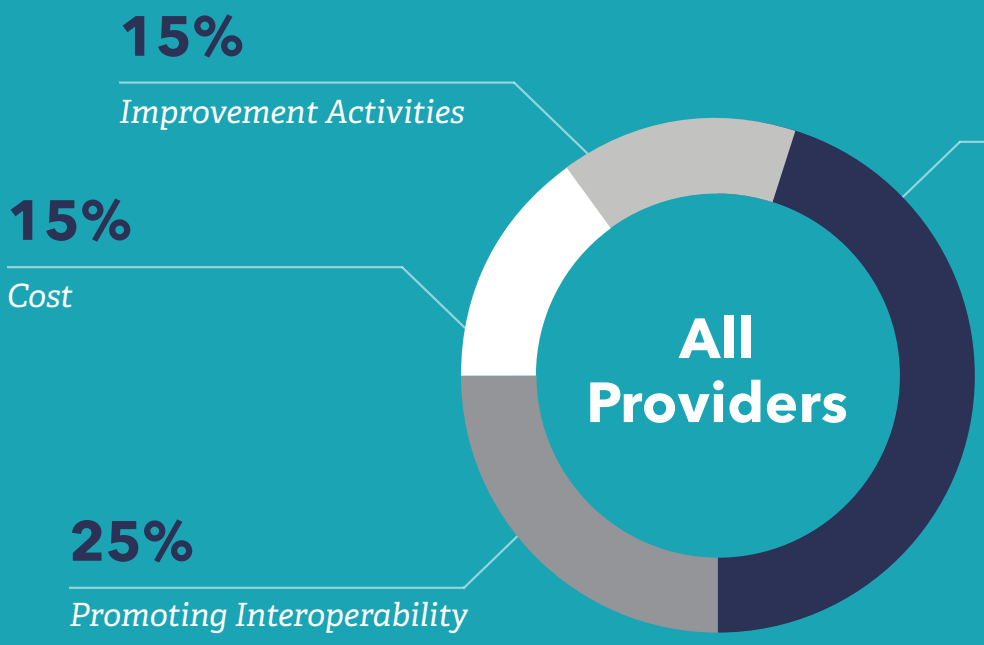
(formerly, Advancing Care Information) which replaces the Medicare eligible provider Meaningful Use program, requires use of Certified Electronic Health Record Technology.

Improvement Activities

is a 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 Promoting Interoperability (formerly, Advancing Care Information), and that category weight being shifted to Quality.



For hospitalists who meet the definition of hospital-based provider, Promoting Interoperability 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.

Groups of 16 or more eligible clinicians that choose to report at the group level should be aware that claims-based reporting of quality measures is no longer available. Groups should also be mindful of potential issues with the hospital-based exemption in the Promoting Interoperability category and ensure that 100 percent of their eligible clinicians are exempt or granted exceptions from the category (see FAQ questions on Promoting Interoperability and the Hospital-based Exemption for more information).

What is the Quality Category?

The largest category of the MIPS is the Quality category. In 2019, hospitalists will generally see a Quality category weight of 70% of the total MIPS score (if they are exempt from Promoting Interoperability). CMS requires the reporting of at least 6 measures, including one outcome measure, and that those measures have at least 20 cases and meet a 60% data completeness threshold. Performance on each measure will be scored individually and rolled up into the Quality category score.

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**. Many hospitalists may not have 6 relevant measures to report or have enough cases in each measure to meet the case-minimum. In the event of reporting on fewer than 6 measures, CMS will apply a clinical validation test to ensure there were no other additional measures to report.
Beginning in 2019, hospitalists will also have scores in the Quality category associated with

their facility and may not need to report on quality measures. The facility-based measurement option would give eligible providers an automatically-calculated score in their Quality and Cost categories based on their hospital's Hospital Value-Based Purchasing Score. For more information, see the question on facility-based measurement.

Note: Beginning in 2019, CMS no longer allows groups of 16 or more eligible clinicians to use Medicare Part B claims to report quality measures. Individuals and small groups may continue to utilize claims-based reporting but note that CMS has indicated an interest in moving away from claims-based reporting entirely in the future.

Why is the Quality category worth more for hospitalists?

Hospitalists are generally exempt from the Promoting Interoperability category. In the case that an individual or group are exempt from Promoting Interoperability, the 25% category weight for Promoting Interoperablity shifts to the Quality category. So for 2019, the Quality category is generally worth 70% of the total MIPS score for hospitalists.

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 Cost Category?

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

The Cost category is made up of CMS-calculated cost measures that are applied to the group or individual. In 2019, the category has a weight of 15%. Measures in the category include Total Per Capita Costs, Medicare Spending Per Beneficiary and eight episode-based cost measures. Potential episode-measures relevant to hospitalists include simple pneumonia with hospitalization, intracranial hemorrhage or cerebral infarction, and ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI). Since cost measures are automatically calculated by CMS, providers will only receive scores on measures that have cases attributed and meet case minimums.

Beginning in 2019, hospitalists will also have scores in the Cost category associated with their facility and may not be scored on the MIPS cost measures. The facility-based measurement option would give eligible providers an automatically-calculated score in their Quality and Cost categories based on their hospital's Hospital Value-Based Purchasing Score. For more information, see the question on facility-based measurement.

What is facility-based measurement?

Beginning in 2019, CMS will automatically calculate a score in the Quality and Cost categories for facility-based providers. SHM actively advocated for hospitalists to receive credit for the work they are already doing for their hospitals' quality reporting and pay for performance requirements. We believe this option significantly reduces administrative burden and enables hospitalists to focus on clinical care and local system quality improvement efforts.

This scoring takes the percentile of hospital performance in the Hospital Value-Based Purchasing (HVBP) program and gives the provider the score associated with the same performance percentile in the Quality and Cost categories of the MIPS. Individuals and groups may also report measures in the Quality and Cost category through traditional MIPS reporting and CMS will use the highest score for MIPS payment adjustments. Either way, providers will still need to report Improvement Activities and Promoting Interoperability (unless exempt). In addition, providers using facility-based measurement will have a minimum score floor of 30% in the Quality category—regardless of their hospital's HVBP performance.

Definition of facility-based:

- Individuals: Providers who bill more than 75% of their Medicare Part B services in Place of Service 21 (inpatient), 22 (hospital outpatient), and 23 (ER); bill at least 1 service in POS 21 or 23; and work in a hospital that receives a HVBP score.

- Groups: 75% or more of the individual eligible clinicians quality as facility-based.

Most hospitalists in the MIPS will qualify for this scoring and will need to decide whether to report on measures in the Quality category separately. CMS will post on their **qpp.cms.gov** website whether providers are considered hospital-based, similarly to how they report other special statuses (hospital-based, non-patient facing, etc). We encourage hospitalists to check whether they are facility-based to help decide whether to report separately on quality measures.

What is the Promoting Interoperability (PI) category?

The Promoting Interoperability category (formerly Advancing Care Information) involves the use of certified electronic health record technology (CEHRT) as part of a provider's practice. As hospitalists practice in acute care hospitals, which are governed by their own Promoting Interoperability eligible hospital requirements, there is a hospital-based exemption from this category. The exemption transfers the Promoting Interoperability category weight of 25% to the Quality category.

Hospital-based Exemption from Promoting Interoperability:

- Individuals are exempt from Promoting Interoperability if they provide 75% or more of their services in POS 19 (outpatient off-campus hospital) 21 (inpatient), 22 (hospital on campus outpatient), or 23 (ER).

- Groups are exempt from Promoting Interoperability if 100% of their providers are designated as hospital-based or otherwise exempt or granted a hardship exception from Promoting Interoperability.

Hospitalists who practice significantly (>25% of services) in settings such as SNFs or other post-acute settings will be subject to this category. Groups should also monitor their practices and ensure all their providers, including those practicing as locum tenens providers, qualify for the hospital-based exemption. SHM recommends that hardship exceptions be requested for providers who may not meet the definition of hospital-based. You can check the status of any provider at **qpp.cms.gov**. If a group or individual does not meet the exemption criteria, they will be required to participate in the Promoting Interoperability category and will receive a score for the MIPS.

SHM is actively working to address the group definition of hospital-based to better align with hospitalist practice realities. Until a policy change is made, we recommend groups monitor their providers and apply for hardship exceptions as needed. More information about hardship exceptions can be found at **qpp.cms.gov**.

What is the Improvement Activities Category?

Improvement Activities is a category that encompasses activities that focus on care coordination, beneficiary engagement, and patient safety. The inventory 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). In order to receive full credit, providers must report on at least 2 high-weighted activities, 1 high-weighted activity and 2 medium-weighted activities, or 4 medium-weighted activities. The Improvement Activities category is 15% of the total MIPS score. Visit **qpp.cms.gov** for the full list of available improvement activities.

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, Promoting Interoperability, and Improvement Activities) and more detailed information about the performance scoring. For 2019 reporting, there will be a feedback report issued in 2020. These feedback reports will indicate how your performance affects your Medicare Part B payments in 2021.

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 a score on a scale of 1 to 100 points.

In 2019, CMS has set a performance threshold of 30 points in the MIPS. Providers and groups that attain at least 30 points will avoid a penalty in 2021 Medicare Part B payments from the MIPS. Those that score higher may be eligible to receive bonus payments.

How are MIPS payment adjustments applied?

After the MIPS total score is calculated, CMS will apply an adjustment to Medicare Part B payments. Performance in 2019 will determine payments in 2021. 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 2019 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
- Maryland All-Payer Total Cost of Care (Primary Care) and Total Cost of Care (Care Redesign) Models
- 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. If a provider is a QP, they are exempt from the MIPS and would receive the 5% bonus payment.

Threshold Options Required for QP Status in Advanced APMs

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%
All-payer Patient Count	Not Applicable	Not Applicable	≥35% (with 20% Medicare)	≥35% (with 20% Medicare)	≥50% (with 20% Medicare)

Providers who do not reach and exceed the thresholds for QP status may be eligible for Partial QP status, which uses slightly lower threshold. Partial QP status exempts providers from the MIPS (allowing for voluntary MIPS participation), but does not confer any bonus payments. Providers in APMs who do not meet either the QP or Partial QP thresholds or are not participating in an Advanced APM may still be eligible for a special scoring standard in the MIPS.

What about the Bundled Payments for Care Improvement (BPCI) Advanced model?

CMS developed Bundled Payments for Care Improvement (BPCI) Advanced as an Advanced APM model. This model is very similar to prior BPCI models but meets the criteria to qualify as an Advanced APM. Providers who join the model may be eligible for QP, partial QP or APM scoring standard in the MIPS, depending on whether they meet the thresholds of payments or patients. Because of BPCI Advanced uses condition-based bundles, it may be difficult for providers to meet or exceed QP and partial QP thresholds.

Can a hospitalist group, such as one employed in a hospital, be counted in their hospital's APM?

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**.

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