Quality Payment Program

Introduction

MACRA (Medicare Access and CHIP Reauthorization Act of 2015), in addition to repealing the unpopular Sustainable Growth Rate formula, accelerated the move from fee-for service payment models to pay-for-performance models that are intended to reward more efficient and effective clinicians and limit the potential billing abuses inherent in a fee-for-service setting. In the words of CMS, the aim is to "reward clinicians for value over volume." For clinicians that are required to participate in QPP, there are two participation pathways to compliance: Merit-Based Incentive Payment System (MIPS) or an Advanced Alternative Payment Model (APM).

Alert: Due to the significant increase of the low-volume threshold in 2018, the majority of small practices no longer need to participate in the Quality Payment Program. Before making participation plans, review the "Exemptions" segment on page 2 to see if you qualify.

Note: It is crucial for providers to ensure they understand and meet all quality measure requirements to avoid negative payment adjustments in the future. The reporting period runs for the calendar year, though in some circumstances, some data only needs to be collected for 90 days. October 2nd is an important date to keep in mind. For the data that requires 90 days of reporting, this is the last day to start collecting it.

Who Participates in MACRA?

Eligible Clinicians (ECs)

The term Eligible Clinicians (ECs) replaced the term Eligible Professional (EP) used with PQRS. ECs are clinicians who bill Medicare Part B and includes the following licensed professionals and any group that includes at least one of the following professionals:

- Medicare physicians (Doctor of Medicine, Doctor of Osteopathy, Doctors of Dental Surgery/Medicine, Doctors of Optometry, Doctors of Podiatry, Doctors of Chiropractic)
- Physician Assistants (PAs)
- Nurse Practitioners (NPs)
- Clinical Nurse Specialists (CNSs)
- Certified Registered Nurse Anesthetists (CRNAs)
- Physical and Occupational Therapists (PTs, OTs)
- Speech-Language Pathologists (SLPs)
- Clinical Social Workers (CSWs)
- Clinical Psychologists (CPs)

Reminder: ECs only need to participate in ONE of the two programs (MIPS or APM), not both.

Alert: If you are NOT a MIPS Eligible Clinician (EC), you are exempt (see the "Exemptions" segment) from MIPS and do not have to report any data and you will not be subject to subsequent payment adjustments. If you ARE an eligible EC, failure to report will result in negative payment adjustments.

Exemptions

Providers are considered exempt from QPP participation and the associated payment adjustments if they:

- Are newly enrolled in Medicare (first year)
- Have less than or equal to $90,000 in Medicare covered charges OR have fewer than 200 Medicare Part B patients in one year OR provide fewer than 200 professional services as defined under the Physician Fee Schedule (PFS)
- Are not on the list of ECs
- Experienced hardship, such as those affected by natural disasters

Exempt practices may be relieved at the reduced administrative burden, but there are a few downsides to non-participation to consider. Without the potential payment incentives available through successful participation in MACRA, exemption could be viewed as a "small provider pay cut." In addition, MIPS scores are published on the Medicare Physician Compare website. Providers who are listed here with high rankings could potentially see a reputation boost, and those without a score might be perceived as lower quality providers.

Clinicians or groups who meet or exceed one or two, but not all, of the low-volume threshold criterion (see bullet point two above) can choose to opt-in to MIPS. If choosing to opt-in, the decision *cannot* be changed and the rules apply just as they would to any other EC.

Note: Those who are exempt can voluntarily report quality data to CMS. They will get feedback on quality measures which will prepare them should MIPS reporting ever be required again. There will be no payment adjustments (positive or negative). It's like auditing a class. You learn, but you don't get the grade.

Merit-Based Incentive Payment System (MIPS)

MIPS was designed to replace the individual incentive programs of Meaningful Use (MU), the Physician Quality Reporting System (PQRS), and Value-Based Payment Modifiers (VBM) with a single, streamlined program. MIPS takes the scores from four categories, listed in detail below, and creates a Composite Performance Score (CPS). Medicare then adjusts payments (for covered professional services *only*, rather than all Part B items and services) up or down (anywhere between -9 and 9%) depending on whether the CPS is above the threshold (adjusting upward), below the threshold (adjusting downward), or at the threshold (no adjustment).

The performance threshold is set at 45 points for 2020, with the exceptional performance bonus kicking in at 85 points. It should also be noted that if budget neutrality is not achieved, Medicare will make additional payment adjustments in order to achieve budget neutrality.

MIPS Participation Options

- **Individual:** Payment adjustment is made based on a single National Provider Identifier (NPI) tied to a single Tax Identification Number (TIN).
- **Group:** A group is made up of two or more ECs (with at least one being a MIPS eligible clinician)
- **Virtual Group:** A virtual group is made up of a group of solo clinicians or groups of 10 or fewer clinicians who participate in MIPS together. It is not necessary to join with providers with either the same specialty or location. All that is needed is a formal agreement and these groups are treated similarly to other groups.

Facility-Based Measurement

MIPS does not apply to hospitals or facilities; however, as of Year 3 (2019), facility reporting measures will allow for a wider range of reporting options for ECs who bill Parts A and B. Cost and Quality scores will be calculated based on the performance of the hospitals at which they work. The individual physician does not need to submit data.

An individual eligible for MIPS must furnish 75% or more of their covered professional services in an inpatient hospital (POS 21), on-campus outpatient hospital (POS 22), or an emergency room (POS 23). A group must have 75% or more ECs billing under the group TIN who would be eligible as individuals for facility-based measurement.

MIPS Performance Categories Overview

The MIPS Composite Performance Score (CPS) is based on the following categories: Quality, Advancing Care Information, Improvement Activities, and Resource Use (Cost). Any associated fee adjustments will be assessed two years after the performance year (e.g., 2017 reporting affected 2019 payments, 2018 reporting will affect 2020 payments, and so on).

Quality

The Quality category replaced the Physician Quality Reporting System (PQRS) and the Quality component of Value-Based Modifiers (VBM). Clinicians choose up to six (out of hundreds) measures to report. These six must include one cross-cutting measure (if patient-facing) and one outcome measure (if available) or another high quality measure. Alternatively, clinicians can choose to report a pre-designed specialty measure set, created with the intention of reducing the burden of finding appropriate quality measures.

To meet the needs of quality reporting, special codes have been created in the HCPCS code set to report performance measurement services and events. The intent of these codes is to facilitate the collection and reporting of evidence-based performance measures at the time of service, rather than from labor intensive retrospective chart reviews.

These codes are not a replacement for CPT Category I codes, (all numeric), nor are these codes required for all billing situations. Proper use of these codes can help to establish standards and promote evidence-based best practices. Accordingly, no RVUs or fees are associated with these information codes.

Alert: Quality measures. as discussed in this chapter, do not apply to Medicare Part C – Medicare Advantage beneficiaries. All Medicare Advantage (MA) organizations are required to have a quality improvement (QI) program which may be similar to, but is not the same as the MIPS and APM models.

Resource: See FindACode.com/topics/topic/quality-payment-program.html forcurrent information on quality measurements.

Types of Quality Measures

There are three types of quality measures that Eligible Clinicians (ECs) need to understand for reporting purposes:

1. **Quality (Performance) Measures**

   Performance measures describe a process or outcome of care, in terms of: whether, when, or how often it occurs. New performance measures are released annually in the November Federal Register.

Resource: See FindACode.com/topics/topic/quality-payment-program.html for current information regarding performance measurement codes.

2. **Cross-Cutting Measures (if patient facing)**

   In MIPS, providers with 25 or more patient-facing encounters may report a cross-cutting measure as one of their required six measures to report. It is important to note that these are not additional measures, but

rather, CMS is evaluating submitted claims to ensure that all broadly applicable measures such as BMI are reported in all appropriate situations. Cross-cutting measures were part of the PQRS system and we anticipate the evaluation process will be much the same under MIPS as it was for PQRS with one major difference, qualifying providers who do not report cross-cutting measures will simply not receive points for this category which will result in a lower quality performance score and thus a lower Composite Performance Score (CPS).

Note: Cross-cutting measures are not always required for MIPS reporting since CMS recognizes that cross-cutting measures are not always meaningful for all clinicians. However, they should be reported where applicable.

3. **Outcome or High-Priority Measures**

   If an outcome measure is not available, then the EC reports one other high priority measure (appropriate use, patient safety, efficiency, patient experience, and care coordination measures) in lieu of an outcome measure. High priority measures are not a separate list of measures, rather they are categorizations of the individual quality measures. For example, Quality Measure #1 Diabetes: Hemoglobin A1c Poor Control is categorized as a high priority measure.

Note: Measure groups were eliminated with the implementation of QPP.

Resource: See qpp.cms.gov/mips/quality-measures to be linked to the CMS Quality Measures webpage.

Data Completeness

The data completeness means that providers must report data on a specific percentage of patients. For 2020, the threshold is 70% (up 10% from 2019) for submission mechanisms (e.g., claims, registry, EHR) except for the CMS Web Interface and CAHPS. Subsequent years may see increases to the threshold percentage. If a measure does not reach this threshold, zero points will be earned. Small practices will receive three points even if data completeness requirements are not met.

Topped-Out Measures

Topped-out measures are those where performance is so high that any meaningful distinction between different levels of quality cannot be made, leaving the measure useless for data gathering purposes. These measures are phased out in subsequent years if they are determined to have this status. For example, Quality Measure #52 Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy was on the topped out list for 2018. You may still report a topped out measure that has not been phased out, but even if you report perfectly, you can only earn 7 out of 10 possible points for that measure.

Measures Impacted by Clinical Guideline Changes

In response to evolving clinical guidelines or other changes which negate or reduce the importance of a quality measure, those impacted measures will be given a score of 0 and the Quality performance category scoring will be accordingly adjusted. If this situation occurs, the clinician would be required to submit data for one less measure (e.g., 5 measures instead of 6).

Specialty-Specific Measure Sets

A common complaint about PQRS was that Eligible Providers were asked to review close to 300 measures to find applicable measures for their practice. To address this issue, specialty-specific measure sets were created. ECs may continue to select individual MIPS measures or choose a specialty-specific measure set.

If an individual or group is utilizing a specialty-specific list that does not include any outcome measures, they must also report on a measure categorized as a high-priority measure as explained in the "Outcome or High Priority Measure" segment.

Bonus Points

Bonus points may be added to the Quality Score for reporting more than one high-priority measure (2 points for outcome or patient experience high priority measures, 1 point for other high priority measures), for small practices of 15 or fewer clinicians (3 points), and for end-to-end electronic reporting (1 point).

Resource Use (Cost)

The Resource Use category replaces the Cost component of Value-Based Modifiers. Scores are calculated based on the information obtained from submitted claims, so there are no additional reporting requirements on the part of the clinician. Essentially, delivering more efficient and higher quality care will earn more points. More specifically, the cost is calculated via two measures: Total Per Capita Cost and Medicare Spending Per Beneficiary (MSBP).

Promoting Interoperability (PI)

The Promoting Interoperability (formerly Advancing Care Information) category replaced the Meaningful Use incentive program for Electronic Health Record use. Clinicians report on a chosen customizable set of measures that reflects how EHR technology is used in day-to-day processes in their practice. There is a particular emphasis on interoperability and information exchange.

Prior years provided a bonus for using 2015 CEHRT, rather than 2014. As of Year 3, 2015 CEHRT is now required, with no bonus scoring, but performance-based scoring will still occur at the individual-level measure.

Certain MIPS-eligible clinicians will have this category reweighted to 0%, with the other categories adjusted to compensate in the following situations:

- Significant hardship or extreme and uncontrollable circumstances
- Provider is a nurse practitioner, physician assistant, clinical nurse specialist, certified registered nurse anesthetist, clinical psychologist, physical therapist, occupational therapist, or clinical social worker
- 50% or more of patient encounters occurred in practice locations where there was no control over the availability of CEHRT
- Non-patient facing provider (e.g., radiologist) or hospital or Ambulatory Surgical Center-based provider

If any of the providers in the circumstances above DO report PI measures, the reweighting will not take place and they will be scored like any other MIPS-eligible clinician.

The measures that will be reported fall into one of four objectives based on 2015 Edition CEHRT: e-Prescribing, Health Information Exchange, Provider to Patient Exchange, and Clinical Data Exchange.

Scoring Change for Year 3

Along with the name changes comes a new scoring mechanism for this category. Rather than having a base score, performance score, and bonus score, scoring will be done at the individual-measure level. In a sense, it will be scored more like Quality Measures.

Improvement Activities

The Improvement Activities category was new with the implementation of MIPS. This category is designed to promote positive change in the way providers and practices operate, with annually updated activities in the following categories:

- Expanded practice access
- Beneficiary engagement
- Achieving health equity

- Population management
- Patient safety and practice assessment
- Emergency preparedness and response
- Care coordination
- Participation in an APM, including a medical home model
- Integrated behavioral and mental health

ECs receive double points if they are any of the following: a small practice, non-patient facing providers, in a rural location, or in a health professional shortage area. Clinicians who are not patient-facing (e.g., pathologists, radiologists) need only report one activity. Participation in a patient-centered medical home will earn full credit for this category when they attest during the submission period. Improvement Activities marked as "CEHRT-Eligible" qualify for a 10% bonus points award.

MIPS Scoring

The performance threshold, or the point at which a provider would not have either a positive or negative adjustment, is set at 45 points for 2020, up 15 points from 2019. The "exceptional performance" threshold is set at 85 points, up 5 points from last year. The baseline payment adjustment is +/- up to 9%, with exceptional performers receiving adjustments up to 27%.

The composite score is based on the following category weights for 2020 (barring any category reweighting that may occur in certain specific circumstances):

- Quality – 40% (down 5% from 2019)
- Cost – 20% (up 5% from 2019)
- Promoting Interoperability – 25% (same as 2019)
- Improvement Activities – 15% (same as 2019)

Based on your score in the performance year, payment will be adjusted either up or down by (up to) 9% two years later. If a MIPS-eligible clinician is scored on fewer than two performance categories, a final score equal to the performance threshold will be assigned and the EC will receive a payment adjustment of 0%.

Note: In the first year of QPP, 93% of participants received a positive payment adjustment. In subsequent years, as standards have become more strict, it is likely more participants will see negative payment adjustments.

MIPS Reporting

How to Report

CMS realized that there was considerable confusion around data submission, so they proposed new terminology aimed at clarifying this process:

- **Collection type:** A set of quality measures with comparable specifications and data completeness criteria including, as applicable: electronic clinical quality measures (eCQMs); MIPS Clinical Quality Measures (MIPS CQMs); Qualified Clinical Data Registry (QCDR) measures; Medicare Part B claims measures; CMS Web Interface measures; the CAHPS for MIPS survey; and administrative claims measures.
- **Submission type:** The mechanism by which a submitter type submits data to CMS, including, as applicable: direct, log in and upload, log in and attest, Medicare Part B claims, and the CMS Web Interface.
- **Submitter type:** The MIPS eligible clinician, group (including APM Entities and virtual groups), or third party intermediary acting on behalf of a MIPS eligible clinician or group, as applicable, that submits data on measures and activities.

The following table summarizes reporting options based on whether you are reporting individually or as a group.

MIPS DATA SUBMISSION METHODS		
INDIVIDUALLY AS TIN/NPI		
Performance Category	**Submission Type**	**Collection Type**
Quality	• Direct • Log-in and Upload • Medicare Part B Claims (small practices only)	• eCQMs • MIPS CQMs • QCDR Measures • Part B Claims Measures (small practices) • Medicare Part B Claims (small practices only)
Promoting Interoperability and Improvement Activities	• Direct • Log-in and Upload • Log-in and Attest	
Cost	• Administrative Claims (no submission required)	
GROUPS		
Performance Category	**Submission Type**	**Collection Type**
Quality	• Direct • Log-in and Upload • CMS Web Interface (groups of 25+ ECs) • Medicare Part B Claims (small practices only)	• eCQMs • MIPS CQMs • QCDR Measures • CMS Web Interface Measures • CMS Approved Survey Vendor Measure • Administrative Claims Measures • Medicare Part B Claims (small practices only)
Promoting Interoperability and Improvement Activities	• Direct • Log-in and Upload • Log-in and Attest	
Cost	• Administrative Claims (no submission required)	

Alert: Not all reporting options are available for all quality measures. When reviewing performance measures, always check the reporting mechanisms to ensure that you may be able to report the measure. For example, not all measures may be reported via claims.

Validation Process

Under the old PQRS program, clusters of clinically related measures were used to determine relationships between measures. That validation process was called Measure Applicability Validation (MAV). Some of the same processes will be used to validate data submission in MIPS. There is a validation process for quality measures that are collected through claims and/or qualified registries if you didn't have six applicable quality measures. CMS may request data and documentation to support MIPS performance reporting for up to six years. CMS says the following about this process:

> By definition, data validation is the process of ensuring that a program operates on accurate and useful data. MIPS requires all-payer data for all data submission mechanisms with the exception of claims and the CMS Web Interface. The data from payers other than Medicare will be used for informational purposes to improve future validation efforts and will not be the only source of data used to make final determinations on whether you pass or fail an audit from the 2017 transition year.

How Much to Report

For 2020, scores for both the quality and cost performance categories will be calculated based on information reported for the entire year (January 1, 2020 through December 31, 2020). However, scores for improvement activities and advancing care information performance categories will be based on the reporting of these measures for any continuous 90-day period of their choosing instead of an entire year.

Verification of Reporting Status

This payment system, with its complicated calculations, needs to provide timely feedback to allow providers to assess their participation levels and look for ways to improve their performance before the reporting period has concluded. According to the law, CMS must:

- Make timely (e.g., quarterly) confidential feedback reports available to each EC
- Provide information about items and services furnished to the EC's patients by other providers and suppliers for which payment is made under Medicare to each MIPS EC

Claims Based Reporting Example

Measures which are reported via submitted claims need to use the required CPT code and its applicable "G-code." For MIPS quality reporting, ECs must report six quality measures most applicable to their practice. To receive full credit/points for this category, you must report on at least half of your eligible Medicare patients meeting the quality reporting criteria.

Reminder: Measures and their associated G-codes are updated every year.

For example, for Quality Measure #134—Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan, the following G-codes were associated, although not all of them are appropriate for all types of healthcare providers to report:

- G0101 "Cervical or vaginal cancer screening; pelvic and clinical breast examination"
- G0402 "Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of medicare enrollment"
- G0438 "Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit"
- G0439 "Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit"
- G0444 "Annual depression screening, 15 minutes"
- G8431 "Screening for clinical depression is documented as being positive and a follow-up plan is documented"
- G8432 "Clinical depression screening not documented, reason not given"
- G8433 "Screening for clinical depression not documented, documentation stating the patient is not eligible"
- G8510 "Screening for clinical depression is documented as negative, a follow-up plan is not required"
- G8511 "Screening for clinical depression documented as positive, follow up plan not documented, reason not given"
- G9717 "Documentation stating the patient has an active diagnosis of depression or has a diagnosed bipolar disorder, therefore screening or follow-up not required"

The appropriate G-code is to be included on Item Number 24 in a paper *1500 Claim Form*, and on Service Line 24 on an electronic *1500 Claim Form*. When reporting performance codes, use a charge of either $0.00 or $0.01, depending on payer and/or billing software requirements. CMS strongly encourages providers to use $0.01 instead of $0.00.

D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES
99201			72 00
G8510			00 01

Note: Providers should review Quality Measure guidelines and applicable reporting codes to ensure appropriate and correct code selection.

Advanced Alternative Payment Models (APMs)

The other route for a provider or practice to take is participation in a qualified APM as a "Qualifying APM Participant (QP)." Once qualified, participation in a qualified APM means exemption from MIPS. An Advanced Alternative Payment Model is essentially a way of approaching better care through innovative payment and/or delivery methods that qualifies under MACRA rules, including Comprehensive Primary Care (CPC+) and Next Generation ACO Models.

Advanced Alternative Payment Models are not very different from a regular APM; they still aim to provide better care in innovative ways, but they take on additional financial risk by opening themselves up to additional financial losses (e.g., reduction in payment rates, withholding of payments, etc.) should actual expenditures exceed expected expenditures. Participation in the APM track means that they are exempt from MIPS payment adjustments. When an APM does not qualify as an Advanced APM, ECs will participate in MIPS and will, in fact, benefit on scoring by virtue of being in an APM. Besides taking on additional financial risk, other rules apply, including basing payment on quality measures (MIPS quality measures or a measure otherwise determined by CMS or a consensus-based entity to be valid) and using Certified EHR Technology (CEHRT) by at least 75% of ECs in the APM. In addition, a certain percentage of Medicare revenue OR a certain percentage of patients seen must be through APMs. See the table below for further detail. Starting in 2019, The "All-Payer Combination Option" gives ECs the option to either participate in just Medicare Advanced APMs OR a combination of both Medicare and other payer advanced APMs in order to meet the volume requirement.

Rather than the payment adjustments in MIPS, QPs will be paid a 5% incentive payment based on the previous year's Part B payments, as well as a higher conversion factor starting in 2026. However, if the thresholds noted below are not met, the clinician will be scored, and payment adjusted, based on MIPS standards adopted for APM use (APM scoring standard).

MACRA established the creation of the Physician-Focused Payment Technical Advisory Committee (PTAC) to evaluate submitted proposals for additional payment models that would qualify as an Advanced APM. Therefore, the opportunities for participation in an Advanced APM are expected to increase in coming years.

Payment Year	2020	2021	2022	2023	2024 and beyond
Required percentage of payments through an Advanced APM	25%	50%	50%	75%	75%
Required percentage of patients through an Advanced APM	20%	35%	35%	50%	50%

Notes: