

IMPLEMENTATION OF NEW MEDICARE QUALITY PAYMENT PROGRAM IN 2019: WHAT IT WILL MEAN TO YOU IN 2017

CMS has released its final rule implementing the Merit-Based Incentive Payment System (MIPS) and the Alternative Payment Models (APMs). These new payment systems, now being referred to by CMS as the “Quality Payment Program,” are required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the same law that repealed the sustainable growth rate (SGR) methodology. The final rule is almost 2400 pages, but there is a shorter summary available on the CMS website.

The CMS summary of the rule includes extremely useful information, and excellent summaries have been prepared by the American Medical Association and other groups. It is another thing altogether to thoroughly understand what this new—and extraordinarily complex—program actually means for you and your practice. That is the focus of this article.

First the basics: The MACRA rule implements two paths to Medicare payment, beginning in 2019: The Merit-based Incentive Payment System (**MIPS**) and the Advanced Alternative Payment Models (**AAPMs**). Since the AAPM pathway is extremely limited and CMS itself anticipates that only an estimated 495 cardiologists will qualify, this article focuses on MIPS.

Under MIPS, Medicare Physician Fee Schedule payment for physicians and certain other clinicians¹ will be adjusted up or down based on how they perform with respect to four performance categories: Quality (currently PQRS), Advancing Care Information (ACI)(currently Meaningful Use of Certified Electronic Health Records (CEHRT)), Clinical Practice Improvement Activities (CPIA) (new), and Cost (currently Value-Based Modifier). CMS expects between 592,000 and 642,000 eligible clinicians will be paid under MIPS in 2019, based on 2017 performance.

In response to adverse reaction to the onerous requirements that would have been imposed by the proposed rule issued earlier this year, CMS has implemented new transition rules for the first year of MIPS which will virtually assure that any physician that even attempts to participate will not incur a payment reduction. Under the MIPS transition rules,

- If MIPS eligible clinicians choose to not report even one measure or activity, they will receive the full negative 4 percent adjustment.
- Clinicians can choose to report one measure in the quality performance category OR one activity in the improvement activities performance category; OR report the required measures of the advancing care information performance category and avoid a negative MIPS payment adjustment.
- Clinicians can choose to report to MIPS for a period of time less than the full year performance period 2017 but for a full 90-day period at a minimum and report more than one quality measure, more than one improvement activity, or more than the required measures in the advancing care information performance category in order to avoid a negative MIPS payment adjustment and to possibly receive a positive MIPS payment adjustment.

¹ MIPS impacts certain non-physician clinicians. This article generally uses the term physicians and MIPS eligible clinicians interchangeably.

- Clinicians can choose to report to MIPS for a full 90-day period or, ideally, the full year, and maximize the MIPS eligible clinician's chances to qualify for a positive adjustment. In addition, MIPS eligible clinicians who are exceptional performers in MIPS, as shown by the practice information that they submit, are eligible for an additional positive adjustment for each year of the first 6 years of the program.

In addition, CMS substantially reduced the requirements necessary for a physician to be exempt from MIPS altogether. The proposed rule issued earlier this year would have had a significant negative impact on solo and small practices, but the final rule adopts exemption criteria (including a low volume threshold under which those with \$30,000 in Medicare allowed claims OR fewer than 100 Medicare patients for the year are eligible for exemption) that, combined with other exceptions, are anticipated to result in the exemption of 40% of otherwise eligible clinicians.

MIPS incentives and penalties are required by law to be budget neutral, with the exception of \$500 million available outside of budget neutrality rules for "exceptional performers." This means that positive adjustments are funded by penalties for under performers, which inevitably makes this a system of winners and losers. Even with only an estimated 5% of eligible physicians likely to incur negative adjustments in 2019, CMS anticipates having enough in savings from these adjustments to distribute approximately \$199 million in incentive payments in 2019 and an estimated \$249 million in 2020 (not counting exceptional performer bonuses). And for those years after the transition is complete when requirements will increase and more negative adjustments are likely to be made, the amounts available for distribution to those who perform well could increase substantially. Theoretically, positive adjustments could reach up to three times the maximum (-9%) negative adjustment –up to a 27% positive adjustment -- when MIPS is fully phased in. While positive adjustments of this magnitude may prove unlikely, in light of the substantial potential for up-side adjustments, it is well worthwhile for practices with relatively high Medicare utilization to take MIPS seriously.

Based on cardiology participation in existing quality and other programs, such as PQRS, CMS anticipates that cardiologists and cardiology practices will be eligible for substantial positive payment adjustments and payments for exceptional performance in 2019, based on 2017 performance. While an estimated 26.7% of cardiologists will be exempt from MIPS (generally because they meet the low volume threshold) and 5% will experience negative adjustments in 2019, it is anticipated that 95% of cardiologists will have neutral or positive payment adjustments under MIPS in the first year of the program. In the aggregate CMS anticipates distributing \$15 million in positive adjustments to cardiologists under MIPS (not counting amounts distributed to exceptional performers), plus \$40 million in "exceptional performance" payments.

So the question for many cardiology practices in the coming year will be how to maximize 2019 payment, and how to use 2017 as a year to put in place the systems and processes necessary to maximize performance in future years. Set forth below are a number of considerations that ASE members and their practices may wish to take into account:

Individual vs. Group Reporting.

Under the final regulations, performance may be evaluated on an individual, group, or ACO basis. For the purposes of simplicity, this article does not address reporting through an ACO: ASE members who are identified as ACO participants in ACO documents submitted to CMS will be receiving information and instruction on the relationship between the ACO and MIPS reporting requirements from their ACOs.

Please note that if your practice participates in PQRS, it has already elected whether to submit quality data

on an individual clinician or group basis. While CMS assumes that physicians will not change their elections in this regard, there is nothing in the final regulation that precludes a practice from reconsidering this issue either for the 2017 performance year or subsequently. A number of considerations may be relevant in making this decision:

A practice that elects to have its performance assessed as a group will be assessed as a group across all four MIPS performance categories, and physicians within a practice must aggregate their performance data across the group in order for their performance to be assessed as a group. Unfortunately, the regulation is not entirely clear about how this aggregation is to be done for some of the components of MIPS. For example, while the final rule suggests that a group's score for the CPIA component of MIPS will be an average of individual clinician's scores, it is not entirely clear how that average will be calculated, since different CPIA scoring may apply to different members of a group (e.g. non-patient facing physicians have lower CPIA requirements.) While these details are not entirely clear, what is clear is that if your practice chooses group reporting, you should be prepared to be evaluated based on the performance of all of the physicians who bill through the group for all components of MIPS.

It is also important to note that certain exemptions may be available for one form of reporting but not another. For example, if a group includes physicians who meet the low volume threshold for a MIPS exemption, individual reporting should be used, since the low volume exemption likely will be lost if group reporting is used. Likewise, it is not entirely clear whether or how a practice that includes hospital-based physicians or physicians entitled to hardship exemptions from the ACI (CEHRT) component of MIPS can preserve their exemptions if their practice submits its data under the group reporting option. (See discussion below).

Since quality is the primary determinant of scoring during the first several years of MIPS implementation, it is important to consider the selection of group vs. individual reporting from the quality scoring standpoint. In this regard, it is important to note a critical difference between the quality component of MIPS and PQRS: While PQRS requirements may be met if a physician (individually or through a group) successfully reports quality measures, a physician's score on the quality component of MIPS will depend on performance (as compared with a measure-specific benchmark). The quality component of MIPS takes into account performance on six measures, whether reporting is on an individual or group basis, and measures are self-selected in either case. Large and multi-specialty practices are likely to engage in a deliberative process to determine which measures to submit in order to maximize performance scores, and may well choose measures having nothing to do with your specialty. Reporting on an individual basis allows reporting of quality data that is more relevant to a physician's practice but, on the other hand, does not allow individual physicians whose quality scores may be suboptimal to "fly below the radar" to the same extent as group reporting.

In determining whether to report as individual clinicians or as a group, practices should also consider which mechanism it wishes to use to submit quality data, since some mechanisms are only available for individual reporting and some are only available for group reporting. For example, claims-based quality reporting is allowed only if a clinician uses individual reporting, while only groups of 25 or more eligible clinicians may choose to report using the CMS Web Interface. This may be particularly important since certain measures may be available only using certain reporting mechanisms. For example, many measures are available for registry and EHR but not claims reporting submission mechanisms. The CAHPS survey, which counts for "extra credit" under the MIPS scoring system, may be used only by those that submit quality data based on group reporting.

Please note that, for MIPS purposes, a group is defined as single Tax Identification Number (TIN) with two or more eligible clinicians (including at least one MIPS eligible clinician), as identified by their individual NPI, who have reassigned their billing rights to the TIN. So if you work for more than one practice, each of which uses group reporting, your performance will be evaluated separately for each practice that bills for your services. This may occur, for example, if you perform echocardiograms for an independent practice, which bills for them under its own TIN.

Quality

Quality is by far the most important MIPS component for the 2017 and 2018 performance years, accounting for at least 60% of physicians' final score for 2017 performance (and 50% in the 2018 performance year). And for many ASE members who may not have scores in for the ACI component, the quality component may be weighted even more heavily. (See discussion below).

The quality component of MIPS is based on the PQRS framework, and the final rule indicates that the PQRS participation rate for 2015 was almost 83%. Therefore, for a good many physicians seeking to avoid the -4% adjustment in 2019 by reporting a quality measure, quality reporting is not a new experience. The exception may be for practices with less than 10 clinicians, which participated in PQRS at a rate of 58.2% in 2015. By contrast, PQRS participation rates for larger practices for that year were near universal (92.6% for practices with 25-99 physicians and 98.5% for practices with 100+ physicians).

The rule projects that, based on 2015 PQRS data, during the first year of MIPS 332,729 clinicians will submit quality data as individuals through claims submission mechanisms; 258,993 clinicians will submit as individuals or groups through qualified registry or QCDR submission mechanisms; 105,987 clinicians will submit as individuals or groups through EHR submission mechanisms; and 107,884 clinicians will submit as groups through CMS Web Interface. Thus, quality reporting through claims submissions is currently the single most popular form of submission. It appears likely that those new to quality reporting (primarily practices with fewer than 25 physicians) will view claims based reporting as the simplest way to avoid the 4% adjustment in 2019.

Despite its popularity, it is unclear whether reliance on claims submission to meet quality reporting requirements is the most efficient long term strategy. While in order to meet CMS' data submission requirements using claims reporting will only require a physician to submit data on 50% of applicable Part B beneficiaries in 2017, the data submission requirement will increase in future years (e.g. 60% of Part B beneficiaries in performance year 2018 with the potential for a higher threshold in future years). In addition, many quality measures cannot be reported via claims. Thus meeting MIPS quality reporting requirements using the claims submission mechanism ultimately may be extremely cumbersome. In addition, using other submission mechanisms may help increase a physician or group's overall quality and other scores. For example, physicians and groups are provided with "extra credit" for submitting quality information using electronic submission mechanisms that do not involve any manual processing; are provided with extra credit in the CPIA category for using CEHRT for CPIAs; and a number of CPIAs provide credit for using Qualified Clinical Data Registries and other registries. Finally, in response to comments, CMS makes it clear that it does not favor claims submission for quality performance measurement, and physicians and groups choosing this method to submit quality data in 2017 may be well advised to make plans to transition to registry, QCDR or CEHRT submission in future years.

The performance threshold for the quality component of MIPS consists of six measures including one outcome (or, if not available, one high priority) measure. As indicated above, unlike PQRS, which requires only reporting, the quality component of MIPS grades performance for the measures that are reported, with

individual benchmarks determined for each measure that meets a specified threshold of utilization. Since measures that are not utilized enough are not scored, there is an incentive to use measures that are reported relatively commonly, rather than using more obscure measures. Bonus points are provided for additional high priority and outcome measures (beyond the one that is required) and for measures reported entirely using electronic means.

Regardless of whether quality data is submitted on a group or individual clinician basis, the measures are self-selected. Since MIPS scores reflect performance rather than just reporting, there is an obvious incentive to choose measures on which you (or your practice) are likely to score well. While scores will be determined based on six measures, a physician or practice may submit data on more than six, and the top six scores will be counted. While submission on fewer than 6 measures is allowed if fewer than six are applicable, it is highly unlikely that this will apply to ASE members who are members of cardiology practices, since there are many cardiology measures that are on the approved list of quality measures, and the rule includes a “core cardiology measure set” that makes it simpler to identify measures of interest to cardiology practices. A list of cardiology and echo-related measures is separately transmitted.

Clinical Practice Improvement Activities (CPIAs)

The CPIA component of MIPS will account for 15% of a clinician’s final score in 2019 (2017 performance year) and for subsequent years. To get full credit for the CPIA component of MIPS, physicians generally must perform either two highly weighted CPIAs or four medium weighted CPIAs. Since the highly weighted CPIAs generally relate to aspects of primary care, most echocardiographers likely will need to perform four CPIAs, each for 90 consecutive days, to get full credit for this component of MIPS. CPIAs are reported on an individual basis (by answering “yes” to activities performed for a minimum 90 day continuous period) on the “improvement activities inventory.” While physicians technically may use CEHRT, registries and QCDRs to meet CPIA requirements, it is unclear whether or not these mechanisms will be in place in time for CPIA reporting in 2017, and physicians are most likely to need to attest to their performance of CPIAs in order to get credit for the first MIPS year.

Fewer CPIAs --only two medium weighted CPIAs or one high weighted CPIA--are required to get full credit if you are a “non-patient-facing physician” and this relaxed scoring is also available if you are a physician in a small practice or rural area. Half credit for the CPIA category is provided for physicians who are on the “participation list” submitted to CMS by an Alternative Payment Model (APM), and this provision may be relevant to some cardiologists participating in ACOs (regardless of Track) and other demonstration projects. While full credit is available for those participating in certain patient-centered medical homes, this scoring boost is less likely to be available for cardiologists than for primary care physicians. By contrast, it is possible that cardiologists ultimately may be able to benefit from a provision that allows full credit for a “comparable specialty practice that has received the NCQA Patient-Centered Specialty Recognition” and the regulation leaves the door open for other organizations to be approved to provide practices with full credit in this category.

Unfortunately, the regulations do not make it clear how this category is to be scored for those practices that use group reporting. However, it appears that CMS intends to derive a group score by averaging the scores of the physicians whose services are billed through the group, with a cap of 40 points, which is the highest score obtainable for this category.

Advancing Care Information (ACI)

The ACI component of MIPS is weighted at 25% of the final score for the 2017 performance year. Please note, however, that this component of MIPS is not counted for hospital-based physicians, and it is anticipated that at least some ASE members may meet the definition of hospital-based for MIPS purposes. If at least 75% of services are provided in inpatient, emergency room and on-campus hospital outpatient settings, you may qualify as hospital-based for MIPS purposes. In addition, some ASE members who work in off-campus hospital outpatient departments may qualify for a hardship exemption with respect to the ACI component of MIPS, if 50% of their services are provided in settings where they have no control over decisions regarding CEHRT (e.g. an off-campus hospital outpatient department where the hospital is in charge of IT decisions.) When the score for this category is zero, either because the physician is hospital based or because s/he qualifies for an exception, the weight that would otherwise be accorded to this component is shifted to the quality component. Thus, for many hospital-based ASE members, the quality score will comprise 75%-85% of the overall score for the first two years and more than half of the score thereafter.

Under the final rule, a physician's score is comprised of a "base score" plus a "performance score" for additional measures specified by CMS, plus bonus points for certain registry reporting and for performing a CPIA using CEHRT. Scoring for the ACI category continues to reflect a bit of all-or-nothing thinking: While CMS reduced the number of "base" measures that must be reported in order for a physician to avoid a "zero" score, failure to report the required base measures will still leave a physician with no "points" in this category. For the 2017 performance year, the ACI component of MIPS allows the use of EHR technology certified under the ONC Health IT Certification Program that meets the 2014 Edition Base EHR definition, provided certain certification requirements are met. However, for the 2018 performance year and subsequent years, the CEHRT must meet the 2015 Edition Base EHR definition, so practices that have not yet updated their CEHRT may wish to focus on this task in preparation for the 2018 performance year.

Compared to the reporting requirements in the 2015 Medicare EHR Incentive Program Final Rule, two objectives and their associated measures (Clinical Decision Support and Computerized Provider Order Entry) will no longer be required for submission purposes. Those in the best position to score well in this category are those that have already made the efforts necessary to become Meaningful Users of EHR under the existing program.

The final rule does provide a group reporting option for the ACI component of MIPS. Under the MIPS, groups will have the ability to attest or submit their advancing care information data through a qualified registry, QCDR, EHR, attestation, or CMS Web Interface as a group, rather than submitting separate attestations for each physician.

Cost

CMS will not weight the cost component of MIPS for 2017 and it will only count for only 10% of a physician's score for performance year 2018; however, this component of MIPS ultimately will count for 30% of a physician's overall score. Therefore, it is worth paying attention to your score on this component of MIPS in 2017 even though it won't "count."

In the final rule, CMS decided to limit the cost measures finalized for the CY 2017 performance period to those that have been included in the Value Modifier or the 2014 sQRUR and that are reliable for both individual and group reporting. However, CMS cautions that because of differences in attribution and scoring methodologies, past performance on the Value Modifier and sQRUR measures may not be accurate predictors of performance on the cost component of MIPS, and for that reason, CMS indicates that

performance reports issued next year will reflect the scoring and attribution for the cost component of MIPS.

Conclusion

CMS' changes in the final rule address many of the concerns raised by the physician community. In general, it is anticipated that larger groups and those that have already made significant investments in IT and related infrastructure likely will do well under the new system. While it is likely that initial implementation of the new system will be accompanied by glitches and growing pains for all involved, the new system may carry with it the potential for significant upside potential for those willing to wade through the regulatory morass.