MIPS: What You Need to Know Now

Summary Overview

When the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) passed into law, the era of the Sustainable Growth Rate formula—which had been confounding even highly efficient medical practices with frequent “doc fixes” and looming payment cuts since its inception in the 1990s—effectively ended. The era of the Quality Payment Program (QPP) began and is now, in 2017, in its first full year of implementation.

The QPP is mandatory for all providers who care for more than 100 Medicare patients per year and bill Medicare Part B more than $30,000 per year. However, it offers clinicians much flexibility as to how they will participate, with options based on specialty, location, practice size and other customizable factors. Moreover, while the QPP’s potential reimbursement deductions are stiff, its potential rewards are attractive: Exceptional performers stand to earn upwards of 30% in bonus payments over and above the basic Medicare fee schedule by 2021 and even more in the years beyond.

The QPP is divided into two pathways: Advanced Alternative Payment Models (APMs) and the Merit-Based Incentive Payment System (MIPS). The relatively few practices qualified to participate via advanced APMs are exempt from MIPS. All others—which is to say most groups and individual practitioners—must be active with MIPS.

MIPS allows practices to proceed at their own pace early on, but the clock is ticking. The Centers for Medicare and Medicaid Services (CMS) will need at least 90 days’ worth of performance-measure data from 2017 to make the initial QPP reimbursement adjustment in 2019. This information must be submitted to CMS, correctly and completely, by March 21, 2018.

Consolidated Categories for Comprehensible Payment Adjustments

For 2017, MIPS has three weighted performance categories*. Practices that meet the criteria for each will compile a composite performance score of 100 points and earn the maximum reward. The 2017 categories, by weight, and the previous CMS quality programs they replace and collectively consolidate are:

60%—Quality

Replaces: Physician Quality Reporting System (PQRS)

Under PQRS, clinicians had to work with nine preselected quality measures. MIPS is less onerous, allowing practices to pick the six that best suit them from a list of more than 270 measures on offer at CMS’s QPP website. The weighting for Quality will drop to 30% by 2021.

25%—Advancing Care Information

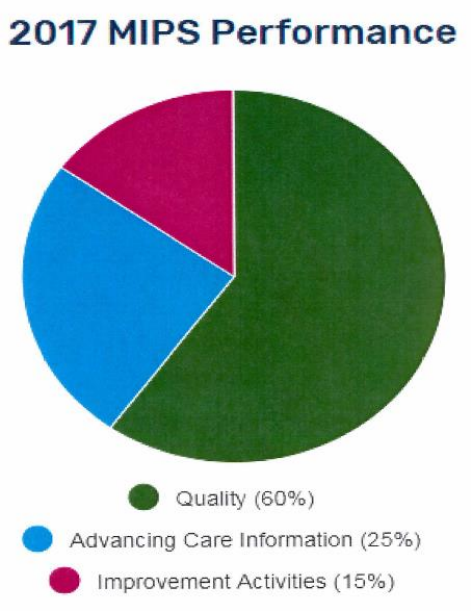
Replaces: Meaningful Use (MU)

Practices that sill lack Certified Electronic Health Record Technology (CEHRT) may apply for a hardship exception. All others must choose to report on either their objectives and measures for advancing care information or, for those working with older CEHRT, their transition to up-to-date systems.

15%—Improvement Activities (around practice management)

New category

Here CMS seeks to encourage practices to think of their work as part of the broader effort to optimize U.S. healthcare for patients while reducing the system’s per capita cost. Under this category, practices are to report on care coordination, beneficiary engagement and patient safety.



***Note:** Years subsequent to 2017 will see the addition of a fourth category, **Cost**, which will replace the Value-Based Modifier.

How to Report: Individually or as a Group?

Clinicians have a choice between reporting as individuals or, if they're part of a group, as part of that group. In most cases, while the QPP is still relatively new, most would do well to choose the group-reporting option. One clinician who thinks so is Gregory Nicola, MD, who chairs the MACRA committee of the American College of Radiology and has authored numerous journal articles on quality-performance reporting.

Group reporting for the first two years is "by far the best way to leverage data, mainly because you can consolidate measures across the group and lighten the reporting burden," Nicola said in an interview with *Radiology Business Journal*. The group approach also lets members of the group select the measures that best reflect on the group as a whole, even if the selected measures only come from the group's top-performing member or members. Group reporting thus "allows you to collect a lot more measures and then tailor the measures to how well you performed," Nicola noted.

In group-reporting situations, the group will receive one MIPS payment adjustment based on its performance as a whole as reflected in the measures chosen by the group. Reporting as an individual is, of course, the only option for clinicians in solo practice. However, it can also be sensible for individuals within groups made up of clinicians of widely varying performance. "The members who do really well would get positive income adjustments, and the one who did poorly would get a negative income adjustment—but it wouldn't hurt the whole group's income," Nicola pointed out.

Where to Report: Claims, Registry or EHR?

With MIPS, CMS welcomes reporting through several avenues. These include the routine Medicare claims process for individual reporting and, for group reporting, qualified traditional registries, qualified clinical data registries (QCDRs) and electronic health records (EHRs).

Kate Goodrich, MD, MHS, director and chief medical officer of CMS's Center for Clinical Standards and Quality, recommends reporting through a registry for many if not most cases.

“The MACRA legislation clearly emphasizes electronic reporting and registry reporting,” Goodrich says. “There are lots of registry choices out there. Some of these registries have been around for a long time, and most of them exist for the purpose of partnering with physicians to report measures for PQRS and now MIPS.” Registries do charge fees for reporting performance measures to CMS, she notes. “We have heard from a lot of clinicians that the returns are, for the most part, well worth the investment. However, some clinicians feel the fees are too high, particularly those in small practices.”

CMS maintains a list of QCDRs, and it shows that the fees to submit quality-performance data through a registry range from $400 to $1,000 per physician. Many groups opt to work with an experienced medical-billing company, which may be able to secure discounts on registry fees. For example, Affiliated Professional Services Inc. (APS), offers its clients special registry pricing—and the company handles the registration of each Eligible Clinician on behalf of the client medical practice.

When to Report: Now

Given the QPP’s tiers of escalating penalties and bonuses over the coming three to five years and beyond—and given the ease of entry in this “pick your pace” first reporting year—medical practices and practitioners have nothing to lose and much to gain by going all in with MIPS as soon as possible.

“For the first year of the program, [CMS] understood that there were a lot of folks out there who really were uncertain about what they needed to do,” says Goodrich. “They may not make a lot of extra money [for 2017], or they may get no bonus or only a small bonus, but at least they will avoid a penalty—and they’ll get some extra time to get to know the program.”

Of course, early adoption also ensures that a practice is optimally positioned to look out for the ultimate beneficiaries of systematic quality improvement: its patients.

To take the next step toward full QPP participation, visit CMS.gov and QPP.CMS.gov now.