

MIPS & APMs FAQ

What will replace the SGR? What is the Merit-Based Incentive Payment System?

The Merit-Based Incentive Payment System (MIPS) is a new payment mechanism that will provide annual updates to physicians starting in 2019, based on performance in four categories: quality, resource use, clinical practice improvement activities and meaningful use of an electronic health record system.

Unlike the flawed sustainable growth rate (SGR), the new system will adjust payments based on individual performance. It does not set an arbitrary aggregate spending target, which is what has led to the need for annual patches to prevent cuts in the current system.

What happens to the PQRS, the Value-Based Modifier Program that adjusts payments based on quality and resource use; and the Meaningful Use of EHR Program?

H.R. 2 consolidates the three existing quality programs into the MIPS program, which is designed to give certainty for providers, reward those who meet performance thresholds, and improve care for seniors. The MIPS program will assess the performance of eligible professionals in four performance categories: quality, resource use, meaningful use (MU) of EHRs, and clinical practice improvement activities. The penalties associated with the current programs are sunset at the end of 2018, including the 2 percent penalty for failure to report PQRS quality measures, the 3 percent (increasing to 5 percent in 2019) penalty for failure to meet EHR MU requirements, and potential negative modifiers associated with the VBM. The money expected from these cuts would be returned to the physician fee pool, increasing the overall amount available for incentive updates.

Physiatrists with low numbers of Medicare patients and those who receive a significant portion of their revenues from eligible APMs are excluded from MIPS.

How is the MIPS program different from current law if it is using existing programs?

Beginning this year, the existing programs (Physician Quality Reporting System [PQRS], EHR MU, and the Value-Based Modifier) penalize physiatrist for non-compliance. These penalties will grow to 7 percent or more of a physiatrist's annual Medicare revenue. Under the MIPS program, the three programs will be combined and the associated penalties eliminated. They will then be used along with additional factors to determine a single composite score. Physiatrists who achieve a composite score above the performance threshold are eligible for positive incentive payments. The potential downside risk remains similar to the penalties associated with the existing quality programs (growing to 9 percent for 2022 and beyond), but with the potential for substantial updates. The highest achievers could be eligible for updates three times larger than the corresponding potential negative updates for a given year.

When does MIPS begin?

Reporting for the MIPS program will begin in 2017 and penalties for the 2017 reporting year will be realized in 2019. Physiatrists who treat few Medicare patients and professionals who receive a significant portion of their revenues from eligible APMs will be excluded from the MIPS.

How does MIPS work?

Physiatrists participating in the MIPS program will receive a composite performance score of 0-100, based on their performance in each of the four performance categories:

- Quality
- Resource use
- Clinical practice-improvement activities
- Meaningful use of EHRs

Each professional's composite score will be compared to a performance threshold that consists of the mean or median of the composite performance scores for all MIPS-eligible professionals during a period prior to the performance period. Eligible professionals whose composite performance scores fall above the threshold will receive a positive payment adjustment; those whose scores fall below the threshold will receive negative payment adjustments.

How is the threshold for the MIPS program incentive payments calculated?

The threshold is the mean or median of the composite performance scores for all MIPS-eligible professionals prior to the performance period. The threshold resets each year, so a physiatrist's composite score in one year does not affect their composite score the next year. However, credit can be given for improvement from one year to the next, as well as for achievement.

How will my update be calculated?

Positive Adjustments

A physiatrist whose composite performance scores are above the threshold will receive positive payment adjustments. These adjustments can be up to 4 percent in 2019 and grow over time to a maximum of 9 percent in 2022 and beyond. If the number of physicians attaining high composite scores is low, these incentives can be increased by a factor of up to 3. If it is higher than those receiving lower scores, these incentives can be scaled down to ensure budget neutrality. A special Additional Incentive Payment funded with \$500 million per year is applied for the top 75 percent of physicians above the performance threshold, ensuring that even if all physicians meet the MIPS threshold, there will still be funds for positive updates.

Zero Adjustments

A physiatrist whose composite performance score is at the threshold will not receive a MIPS payment adjustment.

Negative Adjustments

A physiatrist whose composite performance score falls between 0 and ¼ of the threshold (for example, if the performance threshold is 60, then scores between 0 and 15) will receive the maximum possible negative payment adjustment for the year. Professionals with composite performance scores closer to the threshold will receive proportionally smaller negative payment adjustments. Negative adjustments will be capped at 4 percent in 2019, 5 percent in 2020, 7 percent in 2021, and 9 percent in 2022 and beyond.

How will the MIPS program quality component be calculated?

The quality measures will consist of those currently used in the existing quality performance programs (PQRS, VBM, EHR) with additional measures solicited by the Secretary for the U.S. Department of

Health and Human Services from professional organizations and others in the health care community. Measures used by qualified clinical data registries (QCDR) may also be used.

To the extent practicable, quality measures selected for inclusion on the final list will address all five of the following quality domains: clinical care, safety; care coordination; patient and caregiver experience; and population health and prevention.

How do I know which measures to choose for the MIPS quality component?

Each year, the secretary of HHS will publish a list of quality measures to be used in the forthcoming MIPS performance period through the normal rulemaking process. This will include a public comment period. Updates and modifications to the list of quality measures will also occur through this process. Eligible professionals will select which measures on the final list to report and be assessed on them.

How will the MIPS program resource-use component be calculated?

The resource-use assessment will include measures used in the current VBM program with an enhanced methodology through public input.

Physiatrist will be allowed to report their specific role in treating the patient and the type of treatment used. This provision seeks to allay concerns that algorithms and patient-attribution rules fail to accurately link the cost of services to a specific professional. In addition, the legislation seeks additional research and recommendations on how to improve risk-adjustment methodologies so physiatrist are not penalized for providing care to sicker or more costly patients.

How will the MIPS program EHR Meaningful-Use component be calculated?

Current EHR Meaningful-Use requirements will continue to apply to the MIPS assessment and composite score. AAPM&R continues to advocate for changes to the Meaningful-Use program that make it easier for physiatrist to comply with its requirements.

What does the legislation do about EHR interoperability?

The legislation requires that EHRs be interoperable by 2018 and prohibits providers from deliberately blocking information sharing with other vendor products. In addition, the legislation seeks to broaden the use of EHR technology by requiring the Government Accountability Office to report on barriers to expanded use of telemedicine and remote patient monitoring.

What are Clinical Practice Improvement Activities (CPIA) and how will they impact my MIPS composite score?

The CPIA assesses physiatrist according to their effort to engage in clinical practice-improvement activities. Professionals will be given credit for working to improve their practices and facilitate future participation in APMs. The menu of recognized activities will be established in collaboration with professionals, and must be applicable to all specialties and be attainable for small practices and professionals in rural and underserved areas.

If I work in a small or rural practice, how do I meet the MIPS program requirements and have the ability to achieve a composite score above the threshold?

Two provisions in the bill are specifically designed to assist these providers in the MIPS program. First, an individual EP or a group practice with up to 10 EPs may form with other such individual EPs and/or group practices a "virtual group" defined by the combination of the tax IDs of the participating EPs and/or group practices. The virtual group's performance is then measured as the combined performance of all the EPs in the virtual group. For example, this mechanism may allow a struggling individual EP to benefit from the MIPS score of the entire virtual group of which that EP is a part. CMS will define any additional requirements for virtual groups in the final rule. Second, \$20M per year will be allocated to provide technical assistance via entities such as quality improvement organizations or regional extension centers to practices that have 15 or fewer EPs, particularly in rural and underserved areas.

Finally, with respect to defining what constitutes Clinical Practice Improvement activities to earn points in that MIPS category, "the Secretary shall give consideration to the circumstances of small practices (consisting of 15 or fewer professionals) and practices located in rural areas and in health professional shortage areas".

What is the Alternative Payment Model (APM) program?

While the details of the APMs are not clear, the alternative payment would generally involve enhancing or replacing some of the current fee-for-service payments with a patient-level payment amount not related to volume or intensity.

Professionals who receive a significant share of their revenue from an APM will receive a 5 percent bonus each year from 2019-2024. Participants must receive at least 25 percent of their Medicare revenue through an APM in 2019-2020. This threshold will increase to 50 percent in 2021-2022, and 75 percent beginning in 2023. The policy also incentivizes participation in private-payer APMs.

If I meet the APM requirements, do I have to meet the MIPS requirements?

No. Physiatrist who meet the APM requirements will be excluded from the MIPS assessment and most EHR Meaningful Use requirements.

What if there are limited Medicare APM options where I practice?

There will be two tracks available for professionals to qualify for the APM program and incentive payments. The first will be based on receiving a significant percent of Medicare revenue through an APM, and the second will be based on receiving a significant percent of APM revenue combined from Medicare and other payers. The second option makes it possible for professionals to qualify for the bonus even if there are limited Medicare APM options available in their area.

Why is there an additional bonus payment for physiatrist participating in qualified APMs?

Policymakers see APMs as a way to realign incentives in the Medicare program and are relying on bonus payments (and differentiated conversion factors starting in 2026) to incentivize participation in an APM, as well as to encourage development and testing of new models. Congress also recognizes the need for practice changes to facilitate such participation. Bonus payments promote the alignment of incentives across payers.

What are the legislation's requirements for public reporting?

The secretary of HHS will be required to publish utilization and payment data for professionals, including psychiatrist, on the Centers for Medicare & Medicaid Services (CMS) Physician Compare website. This data will be available on the services most commonly furnished by health care providers, and will include the number of services and the submitted charges and payments for the services. The information will be searchable by the professional's name, provider type, specialty, location, and services furnished.

What are Qualified Entities and why have they been granted access to Medicare claims data?

The legislation expands the current activities of Qualified Entities (QEs), consistent with applicable privacy and security laws. QEs will be permitted to provide or to sell non-public analyses and claims data to physicians, other professionals, providers, medical societies, and hospital associations to assist them with their quality improvement activities, or to develop new APMs. QEs will also be permitted to provide or to sell non-public analyses to health insurers (who provide claims data to the QE) and self-insured employers, but only for the purposes of providing health insurance to their employees or retirees.

Provisions to ensure the privacy, security, and appropriate use of Medicare claims information are included in the legislation. QEs must have a data-use agreement with providers and entities to which they provide data; they must be subject to an assessment for breach of such agreement. Further, providers and entities receiving data and analyses are prohibited from re-disclosing them or using them for marketing purposes.

QEs that provide or sell data or analyses are required to submit an annual report to the secretary of HHS who provides an accounting of: the analyses provided or sold, including the number of analyses and purchasers; the amount of fees received, and the topics and purposes of the analyses; and a list of entities that were provided or sold data, the uses of the data; and the fees received by the QE for such data. Claims data made available to QEs will also include Medicaid and Children's Health Insurance Plan data.

Identified health providers will have the opportunity to review and provide any needed corrections before the QE provides or sells the analysis to another entity.

Can physicians use the Medicare claims data to their benefit?

Yes, the secretary of HHS will be required to make data available for a fee that covers the costs of preparing the data, to requesting QCDRs to support quality improvement and patient safety activities, consistent with applicable privacy and security laws.

Health care providers identified in public reports will have the opportunity to review and correct any errors found in the information before it is made publicly available.

What about medical liability protections?

The bill includes language mirroring the Standard of Care Protection Act. This provision clarifies that the development, recognition, or implementation of any guideline or other standard under any federal health care provision, including Medicare, cannot be construed as to establish the standard or duty of care owed by a psychiatrist to a patient in any medical liability or medical product liability action or claim.