

Overview of Quality Payment Program



Policies for 2017 & 2018 Performance Years

The Medicare program has transformed how it reimburses psychiatrists and other clinicians for providing services, under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The Quality Payment Program (QPP) is designed to reward physicians for demonstrating a high level of quality of care or participating in new models of care that reward quality and efficiency. The Centers for Medicare and Medicaid Services (CMS) has issued annual rules and regulations for the 2017 and 2018 performance years. These programs may impact many psychiatrists, even those who do not participate in Medicare, since other payers are looking to these as a model for their own initiatives.

How Does the MACRA Stabilize Medicare Payments to Psychiatrists?

The MACRA repealed the flawed sustainable growth rate (SGR) formula that triggered deep cuts in payments for physician services, year after year. In its place, the law requires annual, across-the-board “updates” (increases) in Medicare Part B payments of: 0.5% per year from July 2015 through 2018; 0.25% for 2019; 0% (a “freeze”) from 2020 through 2025; and starting in 2026, 0.75% for “qualifying participants” in “advanced” alternative payment models (Advanced APMs), and 0.25% for all others. The Medicare Payment Advisory Commission reports to Congress each year on whether the update scheduled for the next year is sufficient. Then Congress decides whether to legislate any changes.

What are the Two Pathways Under the Quality Payment Program?

There are two pathways under the QPP for psychiatrists to earn substantial rewards. First, the Merit-Based Incentive Payment System (MIPS) replaced several Medicare quality programs and offers the first real opportunity for clinicians to receive sizable rewards for meeting quality metrics and achieving a high level of performance. Second, clinicians who participate in Advanced APMs can earn a 5% bonus for each year they meet the qualifying criteria.

THE MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

The MIPS program began with the 2017 performance year and the first payment adjustments will be in 2019. The MIPS program consolidates aspects of three Medicare quality programs: the Physician

Quality Reporting System (PQRS), Electronic Health Records Incentive Program/Meaningful Use (MU), and Value-Based Payment Modifier (VM). There are four MIPS performance categories: Quality, Advancing Care Information, Cost, and Improvement Activities. CMS has made a commitment to ease physicians' administrative burden and maintain flexibility in this program.

Who are MIPS “Eligible Clinicians”?

For MIPS performance years 2017 and 2018, “eligible clinicians” are limited to physicians, physician assistants, nurse practitioners, clinical nurse specialists, and nurse anesthetists. Starting with performance year 2019, CMS plans to add other types of non-physician practitioners, including clinical psychologists and clinical social workers.

The MIPS program only applies to psychiatrists (and other eligible clinicians) who either participate in Medicare or have “non-participating” status in Medicare. It does not apply to psychiatrists who formally “opt out” of Medicare and are paid directly by Medicare beneficiaries under private contract.

The program covers only Medicare Part B payments for “physician services” covered by the Medicare Physician Fee Schedule. This includes separate payments to psychiatrists for seeing patients in Federally Qualified Health Centers and Rural Health Clinics, apart from the federal bundled payment. The MIPS program does not apply to services or payments covered by Medicare Part A (hospitals, etc.); Part C (Medicare Advantage); Part D (prescription drug plans); Medicaid; or private payors.

What if I Have Few Medicare Patients, Just Enrolled in Medicare, or Participate in an Advanced APM?

Many psychiatrists will be exempt from MIPS reporting requirements and payment adjustments, because they fall below the “low-volume threshold.” For the 2017 performance year, CMS defined this threshold to exclude any individual psychiatrist or group practice which either: (a) had annual Medicare Part B allowed charges of no more than \$30,000; OR (b) provided care for 100 or fewer Part B-enrolled Medicare beneficiaries per year. Starting with the 2018 performance year, the threshold increases to \$90,000 OR 200 Medicare Part B patients per year. So only those psychiatrists or practices with over \$90,000 in Medicare Part B covered charges AND over 200 Medicare Part B patients – per year – will be subject to 2018 MIPS reporting requirements and 2020 payment adjustments.

Psychiatrists and other MIPS eligible clinicians are also excluded from MIPS if they just enrolled in Medicare that year. In addition, psychiatrists who are “qualifying participants” in an Advanced APM are exempt from MIPS reporting and payment adjustments. Those who are “partially qualifying

participants” can choose whether to participate in MIPS. If they choose to report, they will receive a MIPS payment adjustment. If they choose not to report, there will be no MIPS adjustment.

How Will I Know if I am Excluded from MIPS?

CMS has created a MIPS Lookup Tool (at <https://qpp.cms.gov/participation-lookup?npi=1407994916#summary>) that allows psychiatrists to check their MIPS participation status. Just enter your National Provider Identifier (NPI) number to see if you are excluded. CMS reviews past claims to see who falls under the low-volume threshold. For each MIPS performance year, psychiatrists will have two 12-month time periods in which to qualify. They can be excluded if their Medicare Part B allowed charges or beneficiaries are within the low-volume threshold in either (or both) of these periods.

The low-volume analysis will be calculated separately at the individual NPI level, and then also at the group TIN (Tax Identification Number) level, depending on how each psychiatrist is paid. Those who are paid through both their NPI and one or more TINs may be excluded with respect to their NPI billings, but not with respect to the TIN(s). This may be true for many psychiatrists, as group practices are subject to the same low-volume threshold as individual practices.

Eligible clinicians who are not subject to MIPS requirements may still submit MIPS data and receive a MIPS composite score. However, they will not receive a MIPS payment adjustment.

MIPS REPORTING, SCORING, AND ADJUSTMENTS

The basic MIPS annual payment adjustments can be up to 4% in 2019, 5% in 2020, 7% in 2021, and 9% starting in 2022. These are budget-neutral, so individual upward adjustments will be “scaled” so the annual totals of all bonuses and penalties are roughly equal. The negative adjustments cannot go above the annual ceiling for that year. There is an additional, separate bonus from 2019 through 2024, for “exceptional performers” who score in the top 30%. This bonus can be up to an extra 10%. The exceptional performance bonuses have separate funding, of up to \$500 million per year.

What are the MIPS Reporting Requirements?

Performance Year 2017: For 2017, the first MIPS performance year, CMS allowed MIPS eligible clinicians more time to transition to the MIPS program by adopting relaxed requirements known as the

“Pick Your Pace” approach. This approach offered the following five options for reporting. April 3, 2018 was the last day to submit MIPS data for 2017.

1. Avoid the 4% MIPS penalty by reporting one quality measure, one improvement activity, or all the Advancing Care Information Base Score measures for part of 2017;
2. Possibly earn a “small” bonus by reporting complete MIPS data for at least 90 days;
3. Possibly earn a “modest” bonus by reporting complete MIPS data for the whole year;
4. Earn a MIPS exemption by meeting the definition of a qualifying or partially qualifying participant in an Advanced APM; or
5. Not report at all and receive the full 4% MIPS negative payment adjustment in 2019.

Performance Year 2018 and Beyond: The full MIPS reporting requirements and scoring methodology described below apply to all MIPS eligible clinicians starting with performance year 2018, as well as to those who submit complete data for 2017.

What Goes into my MIPS Composite Score?

Each eligible clinician or group – not excluded from MIPS reporting – will receive an annual MIPS composite score that will determine their future MIPS adjustment. They will be compared to a “performance threshold” for that year, based on the median performance of all eligible clinicians from a prior period. Scoring above the performance threshold results in a positive adjustment (addition); scoring below it yields a negative adjustment (reduction). There is no adjustment if you score at the threshold. Adjustments apply to all Medicare Part B payments, during the second year after the performance year. So 2017 performance determines 2019 adjustments, 2018 performance determines 2020 adjustments, etc.

The composite score is made up of individual scores for four different performance categories. There is some flexibility in how these are weighted, but they generally count as described below. More detailed information is provided in the separate APA Fact Sheets for each category.

MIPS Quality Performance Category: Quality counts 60% for the 2017 performance year and 50% for 2018. This category builds on the Physician Quality Reporting System (PQRS) but has more reasonable reporting standards. PQRS required the reporting of nine quality measures across three National Quality Strategy “domains.” The MIPS requirement is to report at least six quality measures, including one outcome measure if one is available – or one measure of appropriate use, patient safety, efficiency, patient experience, or care coordination. The MIPS continues most valid PQRS quality

measures and adds measures used by private payers and for different settings. There is a “Mental / Behavioral Health” measure set with 25 measures for 2018, that may be relevant to psychiatrists. The MACRA also included \$75 million to fund development of new quality measures.

MIPS Advancing Care Information (ACI) Performance Category: This category counts 25% and replaces the EHR Meaningful Use (MU) program. The ACI category retains some measures from the MU program, eliminates others, and replaces the MU “all or nothing” approach with incremental credit for various activities. In order to pass this category, a psychiatrist must either use certified electronic health record technology (CEHRT) or qualify for a hardship exception. The hardship exceptions, starting with the 2017 performance year, are: 1) insufficient internet connectivity; 2) extreme and uncontrollable circumstances (such as natural disasters); 3) lack of control over availability of CEHRT (including practicing in multiple sites or where there was no input in the selection of technology); and 4) lack of face-to-face interaction (telepsychiatry is considered face-to-face). Three more hardship exceptions were added, starting with 2018: 5) hospital-based clinicians who furnish 75% or more of their services in inpatient or outpatient hospital settings; 6) clinicians whose CEHRT was “decertified” during the performance period or preceding year; and 7) clinicians in small practices (of up to 15 clinicians) facing “overwhelming barriers” to comply with ACI requirements. Psychiatrists must report five measures to achieve a Base Score. Then they can earn points for reporting up to eight measures for their Performance Score. Bonus points are also given for certain MIPS Improvement Activities.

MIPS Improvement Activities (IA) Performance Category: This category counts 15%. There were 92 activities for 2017, including eight “Integrated Behavioral and Mental Health” activities, such as collaborative care. For 2018, there are 112 Improvement Activities, and all but a few must be done for at least 90 consecutive days. Psychiatrists may already be doing several of these activities on a regular basis. Forty points are generally required to achieve full credit. High-weighted activities count 20 points each, and medium-weighted activities count 10 points. The requirements are lower for small and rural practices and those in health professional shortage areas (HPSAs). Participants in certain “MIPS alternative payment models,” such as patient-centered medical homes and accountable care organizations, automatically receive half or full credit in this category, depending on the type of APM.

MIPS Cost Performance Category: For the 2017 reporting period, the Cost category will not be counted in your MIPS score. It will count 10% for the 2018 performance year. There is no specific reporting for this category, as it will be calculated by CMS. The Cost category replaces the Value-Based Payment Modifier (VM). Future Medicare claims will need to include special codes indicating the correct

1) care episode, 2) patient condition, and 3) physician's relationship to the patient. These codes will help link patients to the right clinicians for measuring the MIPS Cost score. Psychiatrists should also be aware that in 2017 and 2018, Medicare Part B payments to all psychiatrists may be subject to VM bonuses or penalties. Fortunately, CMS lowered the penalties for 2018, and unsuccessful PQRS reporters no longer receive an automatic VM penalty. VM bonuses can range up to 2% for small practices (up to 10 physicians) and up to 4% (for larger practices). In the past, many physicians were considered "average" and did not receive any VM adjustment.

Special Bonuses for Small Practices, Treating Complex Patients, and Improvement: Starting with the 2018 performance year (and 2020 payment adjustments), some eligible clinicians (and groups) can earn additional bonus points on their final MIPS composite score. Those in groups or virtual groups of fewer than 15 clinicians will earn five extra bonus points. Eligible clinicians (and groups) that treat complex patients with multiple conditions, and patients dually eligible for Medicare and Medicaid, can earn up to five extra bonus points, depending on the number of patients and severity of their conditions. The MIPS program allows bonus points for improvement over time. CMS is testing the waters by starting to reward improvement in the Quality category in performance year 2018.

What are the MIPS Reporting Methods and Options?

The MIPS program preserves most reporting methods of the previous Medicare quality programs. These include qualified clinical data registries (QCDRs), qualified registries, electronic health records, claims (for Quality) and administrative claims/no submission required (for Quality and Cost). Attestation is another method, for the IA and ACI categories. Groups of 25 or more may also use the CMS Web Interface. Vendors approved by CMS can report the "CAHPS for MIPS" patient surveys. CMS has also created an online portal for direct submission of all MIPS data. And starting with the 2018 performance year, small and solo practitioners can form "virtual groups" to report and be assessed together.

Reporting Through QCDR (such as PsychPRO): The MIPS program encourages and rewards reporting via QCDRs by individuals and group practices. This is the easiest way to do MIPS reporting, as the QCDR does the actual data capture and reporting. In addition to being less burdensome, QCDR reporting can earn credit under the ACI and IA categories, potentially leading to higher MIPS scores and higher bonuses. QCDR measures can also be directly approved by CMS, which avoids the lengthy, complex review process for approval by the National Quality Forum. PsychPRO, the APA mental health registry, is an approved QCDR and can assist psychiatrists (and other mental health professionals) in MIPS reporting. More information is available at <https://www.psychiatry.org/psychiatrists/registry>.

“Virtual Group” Reporting: Starting with the 2018 performance year, solo practitioners and small practices (of up to 10 MIPS eligible clinicians) can form a voluntary “virtual group” for the purposes of MIPS reporting and assessment. Each participant must exceed the MIPS low-volume threshold. The virtual group can submit their MIPS data together, and their performance will be assessed as a group. This can allow small practices to pool resources and potentially streamline their MIPS reporting. The deadline to sign up as a virtual group for performance year 2018 was December 31, 2017.

CMS Online Portal: Another option is to submit MIPS data using CMS’s new online portal, available through the QPP website at <https://qpp.cms.gov>. You will need an Enterprise Identity Management (EIDM) account to use the portal. To get a new EIDM account or information about an existing EIDM account, visit the CMS Enterprise Portal at <https://portal.cms.gov/wps/portal/unauthportal/home/>. For questions, contact the Quality Payment Program at 1-866-288-8292. CMS has an EIDM Guide at <https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Enterprise-Identity-Data-Management-EIDM-User-Guide.pdf>.

INCENTIVES FOR “ADVANCED” ALTERNATIVE PAYMENT MODELS

Psychiatrists, other physicians, and non-physician practitioners may qualify for Medicare payment incentives for participating in new models of care and delivery that improve quality, lower health care spending, or both.

Some may be eligible for 5% incentive payments, from 2019 through 2024, if they have sufficient revenue or patients tied to these new models of care to be considered a “qualifying participant” in an “Advanced” Alternative Payment Model (APM). They are also exempt from the MIPS program and will receive slightly higher annual payment increases starting in 2026.

Those with slightly lower levels of revenue or patients tied to Advanced APMs may be considered “partially qualifying participants.” They can elect not to do MIPS reporting, and not incur a penalty.

To be considered an Advanced APM, a model must be approved by CMS and meet four criteria:

1. It must be approved by the CMS Innovation Center, part of the Medicare Shared Savings Program, or a certain type of federal demonstration program.
2. It must require at least 50% of its participants to use certified electronic health record technology (CEHRT). Any hospital within the Advanced APM must also use CEHRT.

3. It must tie at least some payments to performance on one or more quality measures comparable to those under the MIPS program, including at least one outcome measure.
4. It must accept “more than nominal” financial risk, i.e., suffer financial consequences for failing to meet cost and/or quality metrics. These could be lower payments, deductions, or repayments. The nominal risk standard is 8% for most models.

CMS has approved the following models as Advanced APMs, as of January 2018: (1) Bundled Payments for Care Initiative Advanced (BPCI Advanced) Voluntary Bundled Payment Model; (2) Comprehensive Care for Joint Replacement (CJR) Payment Model – Track 1 (CEHRT); (3) Comprehensive End-Stage Renal Disease (ESRD) Care Model – Large Dialysis Organization (LDO) and two-sided risk arrangements; (4) Comprehensive Primary Care Plus (CPC+) Model; (5) Medicare Accountable Care Organizations (ACOs) – Track 1+ Model; (6) Medicare Shared Savings Program ACOs; (7) Next Generation ACO Model; (8) Oncology Care Model – Two-sided risk arrangement; and (9) Vermont Medicare ACO Initiative.

There is currently no Advanced APM strictly for mental health or substance use disorders. The Physician-Focused Payment Model Technical Advisory Panel (PTAC) reviews proposals for new APMs. But current policies make it very difficult to develop Advanced APMs for mental health. Psychiatrists who are currently underpaid would have to risk up to an 8% payment reduction if the APM fails to produce cost savings. Meeting the CEHRT requirements is also a challenge. Unless these policies improve, psychiatrists will probably continue to see few options for participating in Advanced APMs.

RESOURCES

Where can I find other APA resources?

- The APA Payment Reform Toolkit has fact sheets about MIPS reporting, the MIPS performance categories, and incentives for participating in Advanced APMs. The Toolkit is available at: [psychiatry.org/PaymentReform](https://www.psychiatry.org/PaymentReform).
- Information about the APA mental health registry, PsychPRO (Psychiatric Patient Registry Online), including how to sign up, is available at: <https://www.psychiatry.org/psychiatrists/registry>.

What CMS resources are available? CMS has many resources on the Quality Payment Program website (<https://qpp.cms.gov>) including:

- **QPP Resource Library:** <https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Resource-library.html>
 - **2018 QPP Final Rule Overview Fact Sheet:** <https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/QPP-Year-2-Final-Rule-Fact-Sheet.pdf>
 - **2018 QPP Final Rule Executive Summary:** <https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/QPP-Year-2-Executive-Summary.pdf>

What if I still have questions?

- APA members may consult APA staff experts by sending an email to qualityandpayment@psych.org or by calling the Practice Management Helpline at 1-800-343-4671.
- CMS has a QPP Service Center that accepts questions from the public at QPP@cms.hhs.gov or 1-866-288-8292.