Quality Payment Program:
Eligibility & Discussing Group versus Individual Reporting
#2 in an Education Webinar Series for IHS

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Disclaimer

This presentation was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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Important Note: This presentation was developed in collaboration with Centers for Medicare & Medicaid Services (CMS).

Some slides are courtesy of CMS from various CMS webinars and presentations about the Quality Payment Program.

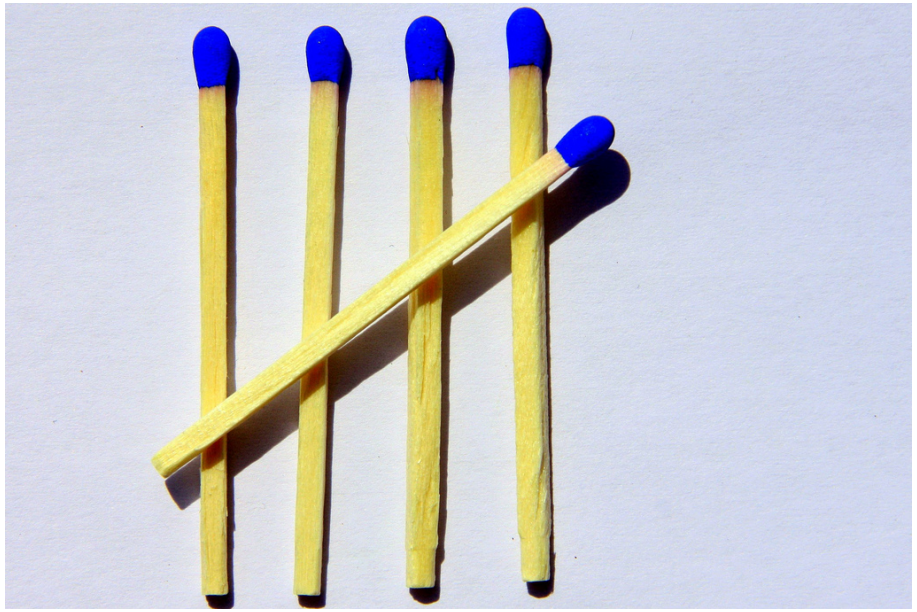
Objectives

1. Identify eligible clinicians for the Quality Payment Program
2. Discuss eligibility as a group versus individual
3. Discuss implications of choosing group versus individual participation

Quality Payment Program Eligibility

For 2017, types of clinicians:

- **Physician**
  - Doctors of Medicine
  - Doctors of Osteopathy
- **Dentists**
- **Optometrists**
- **Chiropractors**
- **Podiatrists**
- **Physician assistant**
- **Nurse practitioner**
- **Clinical nurse specialist**
- **Certified registered nurse anesthetist**



Quality Payment Program Eligibility

To be eligible a clinician must:

1. Bill *more than* $30,000 on the Medicare Part B Physician Fee Schedule

AND

2. See *more than* 100 Medicare patients per year

Notes on Eligibility

To be eligible, you must meet both criteria

This billed amount is specific to Medicare Part B Physician Fee Schedule. When looking at Medicare billing to determine eligibility, do not count other Medicare billing methodologies such as any sort of encounter rate options through IHS, tribal, or FQHC designations the clinic may have.

Who is Exempt?

- Providers below the Low Volume Threshold
- Newly enrolled Medicare Providers
- Providers significantly participating in Advanced Alternate Payment Models (APMs)

Eligibility Examples

Example 1: Provider A bills $50,000 to Medicare Part B, and sees 89 Medicare patients.

- Provider A would be not be eligible because only 1 of the criteria is met

Example 2: Provider B bills $25,000 to Medicare Part B, and sees 115 Medicare patients

- Provider B would not be eligible because only 1 of the criteria is met

Example 3: Provider C sees 200 Medicare patients, and bills $100,000 to Medicare as an OMB Encounter Rate, but also does bill a few items on the Medicare Part B Physician Fee Schedule that amount to $20,000

- Provide C is not eligible because only 1 of the criteria is met

Determining Eligibility

CMS will notify individual providers in early 2017

CMS is planning on a web based tool in which an **National Provider Identifier** (**NPI**) could be searched to determine eligibility

Estimate for yourself:

- Review Medicare Part B Physician Fee Schedule (PFS) billing and payments for the previous year. The exact number is actually the "Allowed Charges" for which RPMS does not have a standard report, but reviewing the payments specifically for items billed on the PFS should give you an idea of what Allowable Charges were.
- Review number of Medicare patients seen per provider in the previous year

Group versus Individual

Group reporting is simply an option available to you

You do NOT have to choose it

We hope to provide information to help you decide if it is a good option for your clinic

What is a Group ?

A group is defined as a 2 or more clinicians (identified by their NPIs) who have reassigned their billing rights to a single Tax Identification Number (TIN)

Notes on Groups

It is “all or none”

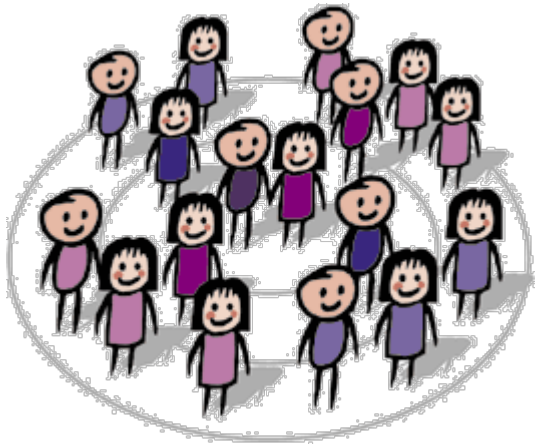
- You can’t have a few of your providers report as a group and others as individuals.

If reporting more than one category (Quality, Advancing Care Information (ACI), Improvement Activities), you will report all of them as either group or individual.

- Example: You can’t report as a group for Quality category and as an individuals for ACI category.

Notes on Groups

If you report your MIPS data as a group, the group will get one final score and one payment adjustment based on the group's performance.



1 score applied to everyone in the group

More on Groups

At your clinic, you may have situations where some, none, or all of providers are eligible as individuals and you may be wondering how this translates into your options for reporting as a group.

We hope the following examples help to clarify your options.

Exemptions

Any provider that is exempt from reporting (for any reason) can still choose to report to gain experience for future years when they may need to report.

However, exempted providers will not be eligible for a payment adjustment (+/-) based on 2017 performance.

Group Scenario 1

You have 5 providers, each of them billing about $20,000 in Medicare Part B allowable charges and seeing about 60 Medicare patients each.

The providers are exempt from reporting individually and will not receive any payment adjustments.

However, if they want to report as a group, they could. They would then be eligible for payment adjustments because, together, they bill above $30,000 in Medicare Part B and see more than 100 Medicare patients.

This is a choice they make. Just because they do qualify as a group, it does not mean they MUST participate as a group.

Group Scenario 2

You have a group of 5 providers and each provider individually falls below the low volume threshold.

Together they bill $40,000 in Medicare Part B allowable charges and see 80 Medicare patients.

These providers are exempt from reporting individually and do not qualify as a group either.

They still always have the option to report voluntarily for experience but receive no payment adjustments.

Group Scenario 3

You have a group of 5 providers.

One of the providers only bills $10,000 in Medicare Part B allowable charges and sees 105 Medicare patients

- This provider is exempted from reporting individually.

The other 4 each bill more than $30,000 in Medicare Part B allowable charges and see more than 100 Medicare patients

- These 4 are eligible and need to report in some way.

Here you have the choice to report these 4 individually and not worry about the 1 that is exempted

- The 1 exempted provider could choose to report voluntarily

You also have the option to report as a group. If reporting as a group in this case, you will need to include all 5 providers in the reporting.

- That 1 provider is no longer exempt

Group Scenario 4

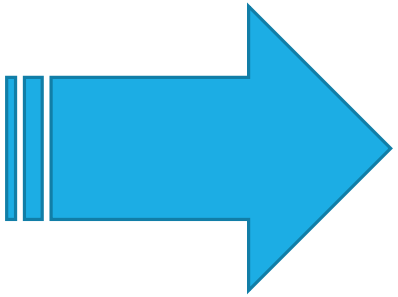
You have a group of 6 providers.

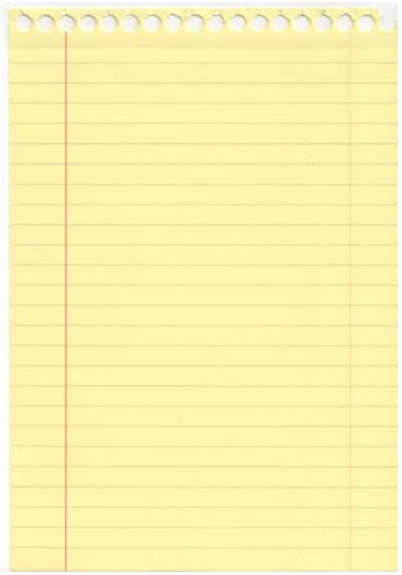
Individually, each bills about $50,000 in Medicare Part B and sees 150 Medicare patients.

These providers will need to report and can choose to report individually or as a group

Considerations for Group Reporting

Potentially decreased administrative burden through reporting 1 set of data for the whole group





Considerations for Group Reporting

May be easier to meet some of the ACI measures

Example: Patient Electronic Access Objective

If some providers are struggling with the Patient Electronic Access, but others are doing well, reporting as a group would be a benefit. This would allow those providers successes to count for the entire group. Providers who did not get any patients in the numerator of the measure would benefit from the providers who did.

Considerations for Group Reporting

May be easier to find and report on quality measure for the Quality category

Example: There may be specialists that were having trouble finding patients that would be in the denominator for the quality measures your clinic would like to use. When reporting as a group, all providers billing under the TIN will be included, so the providers who are seeing patients that fall in the numerators/denominators of the chose quality measures will benefit the entire group.

Considerations for Group Reporting

You may need to manually aggregate some numbers if choosing group reporting.

Considerations for Group Reporting

Not all reporting mechanisms are available to groups

Of note: Claims based for the Quality category could be an easy way to test the system and avoid penalties, but it is not available for groups.

Using claims based reporting also avoids the need to use a Qualified Registry and potential costs associated with that.

Claims based reporting does require some effort and expertise.

Submission Methods

	Individual	Group
Quality	• Qualified Clinical Data Registry (QCDR) • Qualified Registry • EHR • Claims	• QCDR • Qualified Registry • EHR • Administrative Claims • CMS Web Interface • CAHPS for MIPS Survey
Improvement Activities	• QCDR • Qualified Registry • EHR • Attestation	• QCDR • Qualified Registry • EHR • CMS Web Interface • Attestation
Advancing Care Information	• QCDR • Qualified Registry • EHR • Attestation	• QCDR • Qualified Registry • EHR • Attestation • CMS Web Interface

Undecided?

Good news! You do not need to decide right away.

You do not need to notify CMS of your intentions to report as a group or individual.

Exception – For groups to use the CMS Web Interface or CAHPS for MIPS Survey as a reporting tool, you must register by June 30, 2017

Resources

Centers for Medicare & Medicaid Services. MIPS Overview (slide deck). Available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient- Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Merit-based-Incentive-Payment-System-MIPS-Overview-slides.pdf

Centers for Medicare & Medicaid Services. QPP for Small and Rural (slide deck). Available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/QPP-for-small-and-rural-slides.pdf

Federal Register. Proposed Rule 42 CFR Parts 414 and 495. Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; Proposed Rule. May 9, 2016. Available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-09/pdf/2016-10032.pdf

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Questions

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