AAMC
Tomorrow's Doctors, Tomorrow's Cures®

Group Reporting Under MIPS in 2017 (Payment Adjustment Yr. 2019)

In the Merit-based Incentive Payment System (MIPS program) eligible clinicians may choose to report as an individual or as a group. The Table below displays information regarding reporting as a "group" in the Merit-based Incentive Payment System (MIPS) program. The majority of Academic Medical Centers (AMCs) will participate in MIPS as a group and the eligible clinicians within the group will receive the payment adjustment based on the group's performance. In the alternative, a MIPS eligible clinician could participate in an APM that holds their participants accountable for the cost and quality of care provided to Medicare beneficiaries. These are referred to as MIPS APMs and participants in these APMS receive special MIPS scoring under the "APM Scoring standard."

For more details, the MACRA final rule is available at https://www.gpo.gov/fdsys/pkg/FR-2016-11-04/pdf/2016-25240.pdf

Eligible Clinicians	
Eligible Clinicians	• Physicians (MDs, DOs, dentists, optometrists, podiatrists), physician assistants, clinical nurse specialists, nurse practitioners, nurse anesthetists)
Excluded eligible Clinicians (general MIPS)	• Clinicians in their first year of Medicare Part B participation • Low volume: Clinicians billing Medicare Part B up to $30,000 in allowed charges or providing care for less than 100 Part B patients in a year. Low-volume threshold will be applied at individual clinician level (NPI/TIN) for those reporting individually and group practice (TIN) level for group reporting. A clinician may qualify for exclusion at individual level (NPI/TIN) but unless clinician is part of a group in which every EC meets the exclusion criteria, he/she will be required to participate in MIPS as part of group. • Clinicians who are qualified participants in an APM.
Excluded eligible clinicians who are part of Group	• Excluded eligible clinicians (e.g. low volume) who have reassigned billing rights to TIN are part of the group and are considered in the group's score. • The MIPS payment adjustment will only apply to the Medicare Part B allowed charges pertaining to the group's MIPS eligible clinicians and does not apply to clinicians excluded from MIPS. However, the clinicians who would be low volume on their own, will be subject to the MIPs payment adjustment when part of the group • Excluded eligible clinicians (new Medicare enrolled, QPs or Partial QPs who do not report on applicable MIPS measures and activities and do not exceed the low volume threshold) are part of the group and are considered in the group's score.
MIPS Identifiers for Groups and APM Group	
Group Definition	• A single TIN with two or more eligible clinicians, as identified by their individual NPI, who have reassigned their billing rights to the same TIN.

	• The eligible clinicians who are part of the group receive the collective score of the group under MIPS.
Group Identifiers	• A group will be identified by billing TIN. • The same group identifier must be used across all performance categories.
Eligible Clinicians in APMs	• A list of MIPS APMs from CMS is available at: https://qpp.cms.gov/docs/QPP_Advanced_APMs_in_2017.pdf • All eligible clinicians participating in an APM are considered a group under MIPS. The Eligible Clinicians who are participants receive the collective score of the APM.
Identifiers for APM participants	• Each Eligible clinician who is a participant of an APM would be identified by a combination of 4 identifiers: (APM Identifier; APM Entity Identifier; Tax Identification Number; Eligible Clinician's NPI)
Group Aggregate performance/ Collective Score	• Eligible clinicians within a group must aggregate their data for each performance category (correct?) across the TIN. • Eligible clinicians will receive the collective score of the group (group or TIN?)
Quality: Group Reporting via CMS Web Interface (reporting option of 25 or more)	The submission criteria for quality measures for group reporting via CMS web interface for the 12 month performance period is the following: • Must report on all measures included in the CMS Web Interface for a full year • Must report on the first 248 consecutively ranked and assigned Medicare beneficiaries in the sample for reach measure for module • If the sample of eligible assigned beneficiaries is less than 248, then the group must report on 100 percent of assigned beneficiaries • Any measure not reported will be considered zero performance for that measure in CMS' scoring algorithm • In 2017, the group will be required to report on 15 measures, but the group score will be based on 11 measures. (refer to the end of this document for list of GPRO measures) An all-cause hospital readmissions measure was finalized for groups of 15 or more physicians and with 200 attributed cases
Quality Performance Category (60% weight)	
Quality: Group Reporting via CMS Web Interface (reporting option for groups of 25 or more)	The submission criteria for quality measures for group reporting via CMS web interface for the 12 month performance period is the following: • Must report on all measures included in the CMS Web Interface for a full year • Must report on the first 248 consecutively ranked and assigned Medicare beneficiaries in the sample for reach measure for module • If the sample of eligible assigned beneficiaries is less than 248, then the group must report on 100 percent of assigned beneficiaries • Any measure not reported will be considered zero performance for that measure in CMS' scoring algorithm • In 2017, the group will be required to report on 15 measures, but the group score will be based on 11 measures. (refer to the end of this document for list of GPRO measures)

	An all-cause hospital readmissions measure was finalized for groups of 15 or more physicians and with 200 attributed cases
Quality: Group Reporting via non web Interface (claims, QCDR, Registry, EHR)	• Report at least six measures including at least one outcome measure. • If fewer than six measures apply, than eligible clinician or group must report on each measure that is applicable. • If a group reports on a specialty-specific measure set which may contain fewer than six measures, then must report on all available measures within the set. • Alternatively, if the specialty-specific measure contains more than six measures, then the eligible clinician is required to report at least six measures with at least one outcome measure or a high-priority measure (appropriate use, patient safety, efficiency, patient experience, and care coordination measures) • In 2017, physicians have to report on a measure successfully on 50 percent of patients, and in 2018, physicians have to report on a measure successfully on 60 percent of patients. • A list of quality measures is available at: https://qpp.cms.gov/measures/quality An all-cause hospital readmissions measure applies to groups of 15 (up from 10 in the proposed rule) or more physicians and with 200 attributed cases
Consumer Assessment of Health Care Provider and Systems (CAHPS)	• Registered groups of two or more MIPS eligible clinicians may voluntarily elect to participate in the CAHPS for MIPS survey. If they participate in the CAHPS survey, they would earn bonus points under the quality performance category. • Groups reporting CAHPS for MIPS survey would be required to register for the reporting of data.
Groups in APMs qualifying for special scoring under MIPS	• Report quality measures through the APM • Shared savings programs APMs use the web interface for reporting quality • CMS determines weight for quality score for each APM (Refer to Tables 11, 12, and 13 in the final MACRA rule for more details)
Advancing Care Information (25% weight)	
Group Reporting	• CMS will allow MIPS eligible clinicians to report as a group and have their performance assessed as a group. The data submission criteria for the ACI performance category is the same as the individual level but the data submitted is aggregated.
ACI: Group Reporting Mechanisms	• Attestation, QCDR, Qualified registry, EHR, CMS Web Interface (groups of 25 or more)
ACI Measures	• **Base Score:** Fulfill the 5 required measures for a minimum of 90 days: (Security Risk Analysis; e-prescribing; provide patient access; send summary of care; request/accept summary of care) • **Performance Score:** Choose to submit up to 9 measures for a minimum of 90 days for additional credit

	• For **bonus credit,** report public health and clinical data registry reporting measures or use certified EHR technology to complete certain improvement activities in improvement activity category • A list of ACI measures is available at https://qpp.cms.gov/measures/aci
Groups in APMS qualifying for special scoring under MIPS	• The weights will be different depending on the APM. • For certain APMs (e.g. oncology care model), this category will be weighted at 75% in the first year
Cost Measures (0% weight)	
Cost	• The cost performance category will have a 0% weight for the 2017 transition year and the weight will be increased in succeeding years. • The performance in the cost category will be assessed using measures based on administrative Medicare claims data and would not require any additional reporting for this category. The total per capita cost measure, the MSPB measure, and 10 episode-based measures were finalized for future assessment. • Eligible clinicians will receive feedback reports during the first year on their performance in this category. • The same attribution methodology will be used as it was under the VM program. CMS will continue to developing care episode groups, patient condition groups, and patient relationship groups and plans to incorporate new measures through future rulemaking
Cost: Group Reporting Data Submission Mechanisms	• Administrative Claims: No submission required
Groups in APMS qualifying for special scoring under MIPS	• Zero weight is given to the cost score.
Improvement Activities (15% weight)	
Group Reporting Data Submission Mechanisms	Attestation, QCDR, Qualified registry, EHR, CMS Web Interface (groups of 25 or more)
Improvement Activities and Weights	• Physicians must attest to two 20-point high weighted activities, four 10-point medium-weighted activities, or another combination of high and medium weighted activities equaling 40 points or more to achieve full credit in the CPIA category. • 90-day performance period for Improvement Activities • A list of improvement activities is available at: https://qpp.cms.gov/measures/ia
Aggregate Score	• A group may include a specific activity (and thus all clinicians in the group will receive credit) if at least one clinician in the group has been engaged in that activity for 90 continuous days.
Groups in APMS qualifying for special scoring under MIPS	• Participants in certified patient centered medical homes, comparable specialty practices, or an APM designated as a Medical home, automatically earn full credit.

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- Participants in certain APMs (e.g. shard savings) will be automatically scored based on the requirements of participating in the APM. For all current APMs under the APM scoring standard, this assigned score will be full credit. For all future APMs under the APM scoring standard, the assigned score will be at least half credit.

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<tr><td colspan="2">Special Treatment for Certain Physicians</td></tr>
<tr><td>Non-patient facing clinicians and group</td><td>

Non-patient facing MIPS eligible clinician means an individual MIPS eligible clinician that bills 100 or fewer patient facing encounters (including Medicare telehealth services defined in section 1834(m) of the Act) during the non-patient facing determination period, and a group provided that more than 75 percent of the NPIs billing under the group's TIN meet the definition of a non-patient facing individual MIPS eligible clinician. (CMS defines by a list of CPT codes what a patient facing encounter is)

- Non-patient facing physicians are not excluded from MIPS but they do get special treatment regarding the weighting of the performance categories.
- Non-patient facing MIPS eligible clinicians and groups receive full credit for improvement activities by selecting one high-weighted improvement activity or two medium-weighted improvement activities.
- Non-patient facing physicians may get a weight for the Advancing Care Information category; they are not required to submit data under ACI component.

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<tr><td>Hospitalists</td><td>

- Definition: a MIPS eligible clinician who furnishes 75 percent or more of his or her covered professional services in sites of services identified by the codes used in the HIPAA standard transaction as an inpatient, on-campus outpatient hospital or ER setting in the year.
- Hospitalists within the group may get a 0 weight for the ACI score; are not required to submit data under the ACI component.

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<tr><td colspan="2">Payment Adjustments (2019)</td></tr>
<tr><td>Performance Period</td><td>

- 2017 performance determines payment in 2019
- Pick Your pace options available in 2017

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<tr><td>Payment Adjustment Amounts</td><td>

Year	Payment Adjustments
2019	±4%
2020	±5%
2021	±7%
2022 and beyond	±9%

- Based on composite performance score, eligible clinicians receive positive, negative, or neutral payment adjustments
- In 2019 most ECs can expect no negative adjustment or small positive adjustment unless they submit nothing.
- All clinicians in the group receive the same payment adjustment amount
- Exceptional Performers may receive additional payments. To be an exceptional performer, the threshold is 70 points which will qualify for a 0.5% adjustment. If score 100 points, could get an additional 10% for 2019.

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Hierarchy of Score and payment adjustments Payment Adjustments.	• Each TIN/NPI will receive only one final score for purposes of the MIPS payment adjustment determination. • CMS will use the TIN/NPI's historical performance period for the payment adjustment (e.g. 2017 is the performance period for the 2019 payment adjustment). • If an NPI bills under multiple TINs in the performance period and bills under a new TIN in the MIPS payment year, CMS will take the highest final score associated with that NPI in the performance period. • If a physician participates in more than one MIPS APM, the physician gets the score from the highest APM. • If the physician participates in a MIPS APM and a group practice, the physician would receive the score of the MIPS APM. *The only time the TIN/NPIs score will vary across a group practice will be when a TIN/NPI: (1) is excluded from MIPS; (2) has multiple possible final score submissions (for example an APM Entity final score and a TIN final score); or (3) the TIN/NPI is new to a TIN or a TIN is new and therefore does not have historical data associated with the TIN/NPI.
Physicians Reporting Under Same TIN (mix of physicians who are participants in APMs with non-participants in same group)	
Next Generation	• Some physicians under the group TIN may participate in Next Generation while others in the TIN are part of the Group Practice but not Next Generation. In this case, the Next Gen participants receive score of Next Gen and the other physicians receive the group score.
ACO Track 1, 2,3	• All physicians under the TIN must be participants of the ACO.
Oncology Care Model	• Some physicians under the group TIN may participate in oncology care model (e.g. Oncologists) while others in the TIN are part of the Group Practice but not the oncology care model. In this case, the oncology care model participants receive the score of the oncology care model and the other physicians receive the group score.
CPC plus	• Some physicians under the group TIN may participate in CPC plus (e.g. primary care) while others in the TIN are part of the Group Practice but not the CPC plus model. In this case, the CPC plus model participants receive score of CPC plus model and the other physicians receive the group score.