T he Medicare Access and CHIP Reau-
thorization Act of 2015 (MACRA) replaces current value-based performance reporting and establishes a new Quality Payment Program (QPP). QPP essen-
tially creates two pathways forward: the Merit Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs). Currently, every physician-led post-acute/long-term care medical group probably knows it is likely enduring a minimum of a 2% Medicare Part B pay-
ment cut for 2017.

Physicians can download their CMS Quality and Resource Use Report (QRR) (http://go.cms.gov/1Q3ZBp5) to learn specifics. The cut under VM is in addition to another 2% cut many groups face if they failed to successfully submit Physician Quality Reporting System (PQRS) measures for more than 50% of their group. Group members who didn’t succeed in submitting PQRS quality measures are receiving an added 2% individual payment penalty.

MACRA attempted to solve all of this by repealing the Sustainable Growth Rate (SGR) and replacing all of the other current congressionally mandated Part B payment programs — PQRS, Meaningful Use, and the VM. While the terminology in QPP is simplified, the participation requirements and options remain complex.

In the simplest terms, there are two choices for medical groups and indi-
vidual practitioners starting in 2017:

1. Join an APM, or
2. Continue participating in fee-for-

service (FFS) care with quality report-
ying under MIPS.

Know What’s Coming
Every practitioner subject to these pro-
grams should understand two things.
First for reporting year 2017, it is very easy to meet the basic MIPS participa-
tion requirements and avoid all 2019 payment reductions. Second, in report-
ing year 2019 and beyond, the reporting complexities and penalties expand sig-
nificantly. It is important now to begin to define a strategy for participating in one of these two pathways as soon as possible.

Alternate Payment Models. Theoretically, PA/LTC providers have the option to participate through an advanced APM pathway and receive a 5% incentive increase in Medicare reimbursements for 2019. But practically, most provid-
ers will not qualify. That is because only a very small subset of APMs qualify as “advanced.” The APMs that Society members and providers might participate in are two-sided risk accountable care organizations (Shared Saving Programs track 2.3; Next-Gen ACO) or the Primary Care Plus Model. Even if you participate, you must receive 25% of your Medicare patients, or see 20% of your Medicare patients through these models to qualify. CMS has a strategic initiative to eventually drive most prov-
iders into the APM pathway, and the agency has indicated there will be many more qualified APMs to choose from in the coming years.

MIPS. All practitioners are automati-
cally enrolled in MIPS unless they join an APM. Even then, if the APM doesn’t qualify for the advanced designation, much of MIPS still applies. CMS wants all of medicine and health services to migrate to an APM strategy; the MIPS regulations anticipate that change, and incorporate allowances for the transition. Those allowances add significant complexity to the basic rules.

For 2017–2018, MIPS only applies to medical professionals; subsequently, CMS expects to expand it to all licensed professionals who bill Part B. That requires a new term: under MIPS, PA/
LTC providers are now known as eligible clinicians, or ECs.

More on MIPS
MIPS combines the current VM, MU, and PQRS programs. To promote the changes in care delivery systems needed to succeed under the APM scheme, MIPS adds ‘practice transformation’ measures called CPIA (Clinical Practice Improvement Activities). This segment is similar to Quality Assurance and Performance Improvement (QAPI) for nursing facilities.

Congress fashioned MIPS to include both incentives and penalties. The basic scheme! To punish practitioners and groups that failed to successfully par-
ticipate (i.e., cut the Part B payment rates for the lowest performing 50% of practitioners, and redistribute those monies to the 50% whose performance was above average).

That prospect frightens those in PA/
LTC groups based on their poor perform-
ance under current VM methodology. There is some good news, however. Overwhelmingly, practices commented against the quick transition to these pro-
gress, which prompted CMS to descriti-
date MIPS as the ‘get acquainted’ year for MIPS. Practitioners with Part B billings of less than $30K, or serving fewer than 100 Part B patients, are automatically excluded from MIPS. The remaining individuals and medical practices can avoid penalties simply by submitting ‘some’ data to CMS for 2017.

(The Society, and the authors of this article, have produced a free webinar for members that describes the full set of MIPS measures, and possible reporting options (www.palrc.org/product-store/ archived-webinar-overview-macra-palc-practitioners). This MIPS discussion focuses on the basics of reporting, and what the word ‘some’ means.)

MIPS has four components, each with a relative value for 2017’s calculations:

- Quality: 60%
- Advancing Care Information (re-
worked MU): 25%
- CPIA: 15%
- Resource Use (VM’s cost): 0%

The zero-value assigned to resource use is a victory for PA/LTC medicine; – we hope CMS will fix their flawed cal-
culations during 2017. It is scheduled to return to MIPS in 2018. The proposed rule did include an exclusion for resource use for SNF (skilled, POS 31) visits due to the Society’s advocacy efforts, and it plans to continue to work with CMS for more equitable resource use calculation.

CMS outlined four levels of MIPS par-
ticipation, and the expected economic results – this is a simplified version:

- Nonparticipation, score of 0-2: 4% payment adjustment. Only 10% of practitioners are expected to fall into this bucket.
- Testing, score of 3: no effect on pay-
ment. If a practice or practitioner submits ‘some MIPS data’ to CMS for 2017, their 2019 fee schedule will not be affected.
- Partial participation, score of 4-69: may earn modest incentives (pos-
sibly up to 0.5%). CMS wants to encourage groups to practice re-
porting on multiple components so they are better prepared for 2018.
- Full participation, score of 70 or more. Scores above this threshold can participate in sharing a $500 million ‘bonus pool’. CMS proj-
ects incentive money plus bonus money totaling about 4% of Part B payments. Who are these fully par-
ticipating groups? Those that suc-
cessfully reported PQRS and MU in 2016 – if they continue into 2017, their score is certain to exceed that 70-point threshold. Very few PA/
LTC groups are among these elite practices.

The Society recommends aiming for at least partial, if not full, participation in reporting quality measures so you are bet-
ter prepared for the full MIPS program; however, successfully reporting a single measure will sidestep any penalties. One strategy that PA/LTC groups may con-
consider if they have not adopted a strategy, that helps with data tracking necessary to participate in MIPS is to report on a single quality measure for a single patient on a Part B claim — for example, PQRS measure #110: influenza immunization during the flu season.

The Society will develop strategies for achieving participation goals during the first half of 2017. In addition, the Society has been actively working on strategies to help PA/LTC clinicians suc-
ced in QPP. Key issues include:

- The development and alignment of quality measures that actually re-
fect and improve the quality of the medically complex population in PA/LTC. Through its involvement with the National Quality Forum (NQF) and the Physician Consor-
tium for Performance Improvement (PCPI), the Society is working to develop measures that fill gaps in the current quality measure set. Likewise, the Society is working with CMS to align physician qual-
ity reporting with facility-based measures under the IMPACT Act and the Nursing Home Value Based Purchasing Program.
- To ensure an equitable approach to cost and resource measurement, the Society has met with CMS on multiple occasions to discuss is-
sues around the VM application. The Society remains committed to ensuring that clinicians practicing PA/LTC medicine are not disad-
vantaged by virtue of the patient population they treat. The Soci-
ey is also engaging with CMS to identify a potential specialty code modifier (similar to the one recent-
ly assigned to hospital medicine) to ensure more appropriate compari-
son groups.
- The Society is working with CMS, the American Medical Association, and other stakeholders to develop advanced APMs for PA/LTC clini-
cians. This effort is to ensure current APMs such as the BCPI and CCJR are included in the list of advanced APMs, and to develop new APMs focused around key clinical improve-
ment areas, such as dementia.

Rod Baird is president of Geriatric Practice Management, Asheville, NC. Alex Bardakh, MPP, is director of public policy and advocacy for AMDA – The Society for Post-Acute and Long-Term Care Medicine. Kerry Weiner, MD, is chief medical officer, hospital and post-
acute medicine for IPC of TeamHealth, North Hollywood, CA.