Centers for Medicare & Medicaid Services Quality Payment Program

Fact Sheet for Independence at Home Participants

What are MACRA, QPP, MIPS, and APMs?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) replaced the previous fee-for-service Medicare Part B reimbursement with a new value-based format: the Quality Payment Program (QPP). There are two tracks in the Quality Payment Program: (1) Merit-based Incentive Payment System (MIPS) and (2) Advanced Alternative Payment models (Advanced APMs). MIPS was designed to update and consolidate previous Centers for Medicare & Medicaid Services (CMS) programs, including the Medicare Electronic Health Records (EHR) Incentive Program for Eligible Clinicians, the Physician Quality Reporting System (PQRS), and the Value-Based Payment Modifier (VBM).

What is the difference between a MIPS APM and an Advanced APM?

MIPS APMs are a sub-track of MIPS, referring to models that include MIPS-eligible clinicians. MIPS APMs hold their participants accountable for the cost and quality of care provided to Medicare beneficiaries. In particular, MIPS APMs are APMs that meet these 3 criteria:

- APM entities that participate in the APM under an agreement with CMS or through regulation;
- APM entities that include 1 or more MIPS-eligible clinicians on a Participation List; and
- APM entities that base payment incentives on performance (either at the APM entity or eligible clinician level) on cost/utilization and quality measures.

Therefore, not all APMs are MIPS APMs.

Advanced APMs are a track of the Quality Payment Program that offer a 5 percent incentive for achieving threshold levels of payments or patients. If providers in Advanced APMs achieve these thresholds, they become a Qualifying APM Participant (QP) and are excluded from the MIPS reporting requirements and payment adjustment. To be an Advanced APM, the model must meet these three criteria:

- Requires participants to use certified EHR technology (CEHRT);
- Provides payment for covered professional services based on quality measures comparable to those used in the MIPS quality performance category; and
- Either: (1) is a Medical Home Model expanded under CMS Innovation Center authority OR (2) requires participants to bear a significant financial risk.

Otherwise, the model or its track may be deemed a MIPS APM if it meets the MIPS APM criteria above and if participants are still subjected to the MIPS requirements.

What is the relationship between the QPP and IAH?

Although the Independence at Home (IAH) Demonstration predates the 2015 MACRA legislation that established APMs, CMS has determined that the IAH extension, effective January 1, 2019, for Years 6 and 7 of the Demonstration, now falls under the MIPS APM designation.

Why are IAH providers not exempted from MIPS?

The IAH Model does not qualify as an Advanced APM due to its financial risk structure and not meeting the use of CEHRT requirements. As a result, participants under IAH are not eligible to be exempted from MIPS as QPs. However, CMS has determined that the IAH Model is a MIPS APM because it includes MIPS-eligible clinicians as participants and holds its participants accountable for the cost and quality of care provided to Medicare beneficiaries. As a MIPS APM, IAH participants will be scored under the APM Scoring Standard to minimize provider burden.

Which providers in IAH are affected by the MIPS APM scoring standard for QPP purposes?

IAH providers who are MIPS-eligible clinicians and who are participating in the model on one of the three QPP snapshot dates (March 31, June 30, August 31) are affected by the MIPS APM scoring standard. These include provider types such as physicians, physician assistants, and nurse practitioners, among several others.

What's a Snapshot?

The QPP uses three snapshot dates each year (March 31, June 30, and August 31) to determine which providers are included on the participant list for each MIPS APM. This participant list is searchable by provider National Provider Identifier (NPI) on the CMS QPP website here.

If you participate in IAH but are not on the APM Participation List on one of the three snapshot dates, you will not be scored using the APM scoring standard and should instead report to MIPS separately, either as an individual or as a group.

How often will practices be asked to share information?

Practices should keep their provider information updated in the IAH Reporting System throughout the year. In February, May, and July of each year, practices will be asked to confirm that provider information is up to date in the IAH Reporting System. It is critical that all practices maintain their provider information and NPIs in the Reporting System so that MIPS APM provider scoring is accurate.

What do I have to do to satisfy the MIPS requirements?

There are four categories under MIPS that make up the final MIPS score. They are (1) Quality; (2) Cost; (3) Improvement Activities; and (4) Promoting Interoperability. CMS is keenly aware of the need to minimize provider burden while achieving its goal to improve patient care. Therefore, for three of the four categories below, IAH participants do not have to do anything extra beyond participating in IAH under its existing model rules.

1. For the Quality Performance Category under MIPS, IAH participants will be assessed based on existing IAH quality measures (QMs) for providing care in the home. There are six QMs associated with incentive payments in the IAH model, and these six will be scored separately by CMS under the APM Scoring Standard to satisfy MIPS reporting.
2. For the Cost Category, this category has a weight of zero under the APM Scoring Standard in PY2019 and will not be calculated.

3. For the Improvement Activities Category, MIPS Eligible Clinicians under IAH will automatically receive the full score for this category by virtue of participating in IAH because your APM already requires you to meet certain improvement activities standards. For example, APM activities include *expanded practice access* by providing patients with 24/7 access to MIPS-eligible clinicians or groups who have real-time access to patient medical records; *beneficiary engagement* through documenting patient preferences in the medical record; and improving *care coordination* by contacting beneficiaries within 48 hours following admission to the hospital and discharge from the hospital and/or ED.
4. For the Promoting Interoperability Category, IAH providers will need to report to QPP at either the individual or TIN-level. They must log in and attest to their promoting interoperability measure data, or work with third-party intermediaries to upload promoting interoperability measure data in an approved file format. More information on this category can be found here.

Note that for PY2019, because the Quality Performance Category is not scorable given the timing of the IAH quality data, this category will be reweighted from 50% to 0%. As a result, the Improvement Activities category will be reweighted from 20% to 25%, and the Promoting Interoperability Category will be reweighted from 30% to 75%. Therefore, for PY2019, the MIPS final score for IAH participants who are MIPS-eligible clinicians will be based on only the Improvement Activities and the Promoting Interoperability Category, respectively weighted at 25% and 75%.

What does IAH as a MIPS APM mean to participating practices?

Being a MIPS APM does not change the structure of the IAH Demonstration. The quality measures, eligibility requirements, and incentive calculations remain unchanged under the IAH Model. However, participants in IAH will have a reduced reporting burden under MIPS for the 2019 performance year, as they will not be required to report additional quality measures for MIPS scoring.

Will I, as an IAH provider, be affected by the MIPS payment adjustments?

First, it is important to know that MIPS is separate from the financial arrangements you have as a participant under the IAH demonstration. As an IAH participant, you will still be assessed and financially reconciled based on all the rules and regulations under IAH. At the same time, if you are a MIPS-eligible clinician, you are still subject to the MIPS payment adjustment on Part B fee-for-service reimbursements based on your MIPS final score. Your MIPS final score for the performance period (January 1st through December 31st each year) determines what your payment adjustment will be two years after the performance period ends (e.g., 2019 MIPS final score will be used for payment adjustment in 2021).