MIPS Program: Choosing Individual vs. Group Reporting

On October 14, 2016, CMS released the final rule on the Quality Payment Program, which includes both the Merit-Based Incentive Payment Program (MIPS) and Advanced Alternative Payment Models (APMs). The final rule establishes regulations on the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), signed into law in April 2015. The new law changes the way Medicare incorporates quality measurement into payments and includes incentives for participation in alternative payment models.

The MACRA statute also allows physicians to choose whether they will participate in the MIPS program as an individual or a group. Under the previous quality reporting programs, group reporting—and only for PQRS—was only available to larger practices. However, under MACRA, any physician practicing in a group of two or more has the option to report MIPS data collectively. This option may ease administrative burden for some practices and assist some physicians, especially sub-specialists, in succeeding under MIPS. Use this guide to assist in determining which option works best for your practice.

Please consult ASCRS•ASOA’s guides on MIPS categories, available at ascrs.org/macracenter, for full details on program requirements.

How Do I Decide to Report as a Group or an Individual?

Each physician and practice must carefully evaluate how best to complete the requirements for MIPS. The MIPS program is customizable, with many options for measures, submission mechanisms, and flexible reporting periods in the first year. These factors will impact each practice differently. There is no one-size-fits-all formula to determine who should report as a group and who should report individually. This guide summarizes requirements for group vs. individual reporting in 2017.

Here are a few ideas to help you make your decision:

- Determine what your goals are for the 2017 performance period. Are you reaching for a bonus in 2019? Or just looking to avoid the penalty? If you simply want to submit a minimum amount of data and avoid the penalty, it may not be worth changing administrative processes, so it may be easier to submit some data individually. If you are going for full participation and a bonus, group reporting may reduce the administrative burden and make meeting the requirements easier.

- Review the performance of every Medicare provider in your group—ophthalmologists, optometrists, CRNAs, etc.—and determine each participant’s strengths and weaknesses in the previous programs, PQRS and Meaningful Use. Do certain sub-specialists, such as corneal specialists or oculoplastic surgeons, have difficulty finding at least six quality measures? In many cases, cataract surgeons would have ample measures available to make up for other partners in the group who do not. For Advancing Care Information (ACI) measures, many ophthalmology practices struggle to identify other practices they refer to that have EHR and can complete health information exchange. Similarly, many ophthalmology patients are not willing to visit patient portals to complete the patient engagement measures. If your practice struggles with these measures, reporting as a group may reduce the pressure to complete each base measure at least once for each practitioner.

- Identify the submission mechanism you plan on using for MIPS. If you do not have an EHR or registry and plan to report Quality data through claims, the group option is not available. Make sure you have the requisite systems in place to participate as a group.
What is Individual Reporting and How Will It Impact My MIPS Score?

Individual reporting for MIPS is essentially unchanged from previous quality reporting programs. Each MIPS-eligible clinician, identified by a unique TIN/NPI combination, is responsible for completing the requirements for MIPS. In the first performance year of the program, 2017, physicians must individually report data for the Quality, Advancing Care Information, and Improvement Activities categories. CMS will score the individual physician’s performance for 2017, and adjust his or her Medicare payments accordingly for 2019.

Individual MIPS participants may report their data using claims, registry, or EHR. There is no sign-up required, and physicians opting for full participation in 2017 may begin reporting any time between January 1, 2017, and October 2, 2017. Groups of physicians practicing under the same TIN may report individually if all providers in the TIN report as individuals.

What is Group Reporting and How Will It Impact My MIPS Score?

The MACRA final rule established a process for groups of physicians to report data and be scored collectively. Essentially, group scoring treats all physicians in the group as if they were one individual. All of the eligible patient encounters for every physician in the group are aggregated together as a total population for the Quality and ACI categories (i.e., measure denominators), and each physician’s performance in the group is aggregated (i.e., measure numerators). For the Quality category, the group must select six total measures to report, one of which must be an outcome measure. For ACI, the group works together to meet all the base measures, and can choose which measures in the performance score to complete. For the Improvement Activities category, the group is required to attest once for the activity or activities it completed. The group’s performance is scored collectively and each physician participating in the group will earn the same MIPS final score—and the same payment adjustment.

For example, a practice of five ophthalmologists, three of whom perform cataract surgery, decides to report as a group. One of the quality measures selected by the group relates to cataract surgery. When reporting the measure, the practice must include all the eligible patients who meet the measure specifications and report the performance from each of the physicians who performed the procedures. So, if the other two physicians did not perform any cataract surgeries, they are not included in the measure calculations; however, they will get credit for the measure through the group reporting. For the ACI, all physicians in the group will work toward achieving the measures together. To meet the base score requirements, there must be a 1 in the numerator of each measure. Therefore, the practice only has to have one patient in each measure, and not one for each individual physician. The group performance score will be calculated similarly to individual reporters, with a total percentage of all additional patients seen by the group making up the measure numerators and denominators.

Can I Use the Group Reporting Option Just to Avoid a Penalty?

Yes, the flexibility offered for the 2017 performance year to “pick your pace” allows groups, as well as individual reporters, to submit a minimum of data to avoid a penalty in 2019. To avoid the penalty, a group may submit one of the following:

- One quality measure, on one patient, and not have to meet measure benchmarks;
- One improvement activity; or
- The required base measures of the Advancing Care Information category.

It is important to remember, however, that claims reporting is not an option for groups, so if the group reports one quality measure, it must be through a registry or EHR.

Visit ascrs.org/macracenter for full details on performance period options.

How Do I Register My Practice for Group Reporting?

There is currently no formal process for registering as a group with CMS, unless you plan to use the Web Interface program (formerly GPRO). Group data may be reported via registry, EHR, or the CMS Web Interface. The Web Interface registration deadline is June 30, 2017. CMS noted in the final rule that it may develop a voluntary registration process sometime in the
Who Can Form a Group?

Any group of two or more physicians billing under the same Tax Identification Number (TIN) can report as a group. If choosing group reporting, all physicians billing under the TIN must report as part of the group for every MIPS category.

Exclusions: Certain physicians who are not MIPS-eligible may be excluded from the group.

- Advanced APM participants: If a physician billing under a TIN that elects group reporting participates in an advanced APM, his or her performance is excluded from the group and the group payment adjustments will not impact the APM participant.
- New Medicare providers: Physicians in their first year of billing Medicare are excluded from group reporting and payment adjustments.

Low-volume physicians: Physicians who bill less than $30,000 in allowed Medicare charges or see fewer than 100 Medicare patients in a year fall under the low-volume threshold and are excluded from MIPS. However, if a physician who is considered low volume works in a practice that is reporting MIPS as a group, he or she will no longer be considered exempt from MIPS. The low-volume physician’s performance will be included in the group score, and he or she will receive the same Medicare payment adjustment as the rest of the group.

Physicians practicing under more than one TIN: If one of the members of a group also bills under a different TIN, he or she is responsible for meeting the MIPS requirements under each TIN. Only the services billed under a particular TIN that is reporting as a group will be included in the group’s MIPS score. Services billed under different TINs may be reported individually or as a group. For example, Dr. Smith, a retina specialist, works at Practice A three days a week, and Practice B two days a week. Practice A reports as a group and includes Dr. Smith’s performance as part of the group. Practice B does not report as a group, so Dr. Smith must report individually for services rendered under that TIN.

Additional Resources

For additional information, you may contact Allison Madson, manager of regulatory affairs, at amadson@ascrs.org or 703-591-2220.