Merit-Based Incentive Payment System (MIPS)

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ASCRS/ASOA

Medicare Access and Chip Reauthorization Act (MACRA) Overview

- Developed in a bipartisan, bicameral process over 2+ years
  - Several previous versions were not supported by ASCRS and the medical community
  - Worked with committees of jurisdiction to develop compromise that included positive updates, and flexible pay for performance metrics
- Passed House of Representatives March 26, 2015- 392-37
  - Passed Senate April 14, 2015 – 92-8
  - Supported by over 750 national and state-based physician organizations
- Permanently eliminates the SGR, which has been producing Medicare physician payment cuts annually since 2002
  - 5 Years of 0.5% positive updates, began July, 2015; Consolidates the current quality reporting programs, PQRS, VBPM, Meaningful Use and adds clinical practice improvement activities , into a new program: Merit-Based Incentive Payment System (MIPS) beginning in 2019, based on 2017 reporting.

MACRA Improvements VS. Prior Law

Then	Now
• Negative updates for the foreseeable future • Multiple overlapping, rigid, and sometimes contradictory reporting and penalty programs • Limited support for new payment and delivery models through Centers for Medicare and Medicaid Services Innovation	• Modest, but positive updates for 5 years, and then again in 2026 and beyond • Consolidated Merit-Based Incentive Payment System (MIPS) with more flexibility, potential for significant bonuses, lower maximum penalties • Enhanced technical and financial support for small practices, transitional payments for new models, funding for quality measures, more timely physician access to performance data.

2019 Penalties Compared

Prior Law	2019 Adjustments
PQRS	-2%
Meaningful Use	-5%
VBPM	-4% or more*
Total Penalties	-11% or more
Bonus Potential (VBPM only)	Depends on the size and number of penalties
*VBM has been in effect for 3 years, and penalty risk has increased in each of these years; there are no floors on penalties. 2019 number would not have been issued until November 2018. Budget neutral funding for bonuses.	

MIPS	2019 Scoring
Total Penalty	Capped at -4%
Bonus Potential	As high as 4% with the potential to earn as much as 3 times that amount, in addition to a potential 10% for exceptional performers

Physicians Have Choices

Fee for Service (MIPS)

- 0.5% July 2015-2019; 0% 2020-25; and 0.25% after that
- Former reporting programs consolidated into one program with greater flexibility
- Penalty risks reduced, potential bonuses added
- Benchmarks set prospectively, more timely feedback on performance

Alternative Payment Models (APMs)

- Physicians role in creating new models specified
- 5% update bonuses for 6 years from 2019-2024; 0% in 2025; and 0.75% after that
- Two-sided risk model required
- Participants exempt from MIPS

MIPS Assessment Categories

What is the MIPS Program?

- Replaces the SGR
- Streamlines existing PQRS, VPBM and EHR Meaningful Use programs
  - Existing penalties sunset at the end of 2018
- Assesses the performance of EPs based on 4 categories:
  - **Quality**: Features of current PQRS program
  - **Resource Use**: Features of current VBPM program
  - **Meaningful Use:** Features of current MU program
  - **Clinical Practice Improvement Activities**

Composite Score

- Starting January 1, 2019 (based on 2017 performance), CMS will assess performance based on performance standards for measures and activities in the 4 categories.
- A composite score will be developed using a scoring scale of 0 to 100.
- The composite score will be compared to a **performance threshold**.
  - Performance threshold established based on mean or median of all composite performance scores for all MIPS EPs during prior period.

Composite Score

- Scoring of Performance Categories:
  - Quality Measures: **30% of score**
  - Resource Use Measures: **30% of score**
    - In 2019, resource use can't count for more than 10% of the score and in 2020, resource use can't count for more than 15% of the score.
    - The additional 20% in 2019 and 15% in 2020 from the resource use category will be added to the quality measures category.
  - Meaningful Use of Electronic Health Records: **25% of score**
  - Clinical Practice Improvement Activities: **15% of score**
  - *Weights may be adjusted if there are not sufficient measures and activities for each type of eligible professional

Incentives and Penalties

- Positive, negative or neutral adjustment based on composite score.
- Adjustment factor is applied to payments for all Physician Fee Schedule items and services furnished in a year.
- If EP's composite score is at the threshold - will not receive a MIPS payment adjustment.

Incentives and Penalties

- Positive adjustment: higher performance scores receive proportionally larger incentive payments
  - Scaling factor applied to positive adjustment factors for budget neutrality – can be up to 3 times the annual cap for negative payment adjustments
  - For 6 years starting in 2019, there is also additional incentive payment for exceptional performance (above 25th percentile).
    - $500 million is available each year for these payments.
- Negative adjustment: capped at 4% in 2019, 5% in 2020, 7% in 2021 and 9% in 2022 (positive or negative).
  - EPs between 0 and ¼ of threshold get maximum negative penalty
  - EPs closer to threshold score get small negative payment adjustments

MIPS Maximum Payment Adjustments

MIPS Maximum Negative Payment Adjustments by Year			
2019	**2020**	**2021**	**2022 and after**
4%	**5%**	**7%**	**9%**

More on MACRA Statute

- MACRA is not the law we would have written ourselves.
- Securing policy changes and additional updates will be simpler starting from a positive baseline, rather than making up for steep SGR cuts.
- ASCRS is participating in an AMA workgroup on the MACRA program.

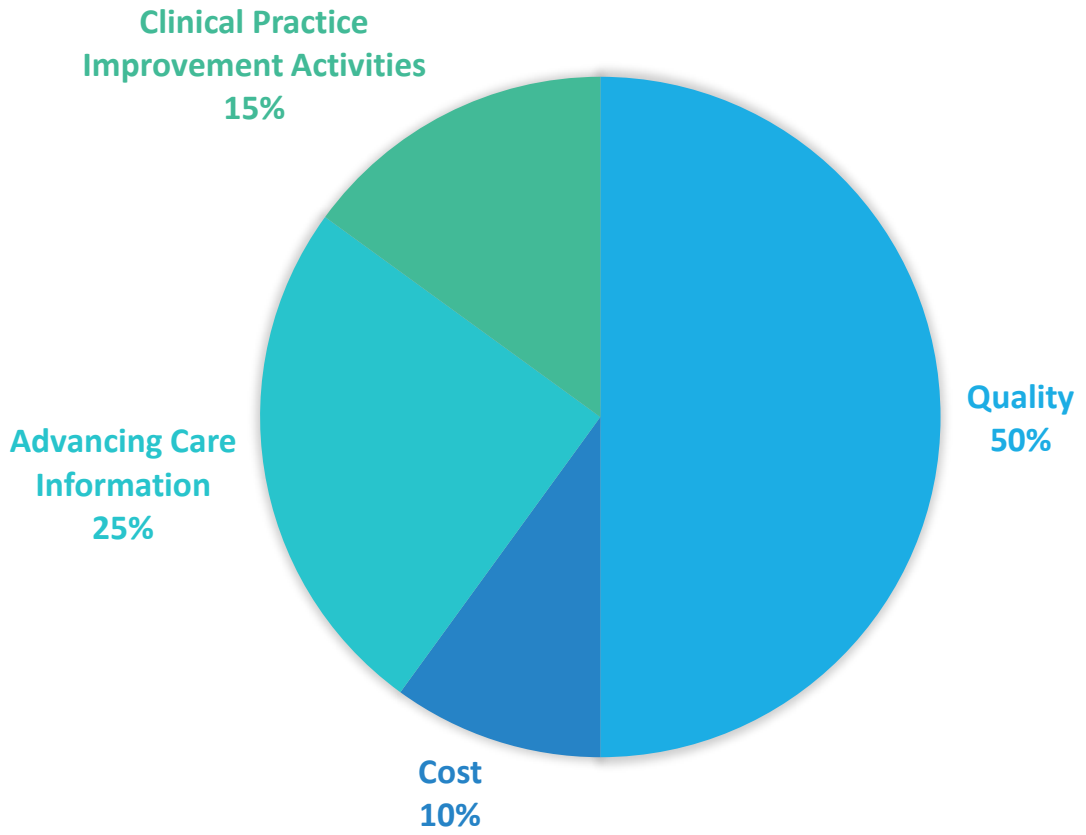
Quality Payment Program Proposed Rule

- Proposed rule released April 27
- 60 day comment period- June 27th
- Incorporates some of the flexibility and reduced reporting burdens advocated by ASCRS and the medical community
- First payment year for MIPS will be in 2019 based on the first performance period of 2017

Quality Payment Program Proposed Rule

- Provides for group reporting – gives providers option to be assessed as a group or individual clinician
- Continues 2-year look back period (2017 performance affects 2019 payment)

MIPS Performance Categories



Quality

- **50% of Total Score in Year 1**
- **Report a minimum of 6 measures, with at least one cross-cutting measure, and an outcome measure, if available.** If no outcome measure is applicable to the clinician, they will report a "high quality" measure.
- Also, for groups of 1-9 clinicians, CMS will calculate two population measures based on claims data; for groups of 10+ clinicians, CMS will calculate three population measures.
- All measures worth 10 points for a total of 80 or 90 points.
- On May 2nd, 2016 CMS published final plan for development of quality measures for MIPS and APMs
  - Measure development plan identifies gaps where no or few measures exist
  - On Nov. 1st of each year, CMS will publish the measure list for MIPS for the upcoming year.

Cost

- **Replaces VBPM**
- **10% of total score in year 1**
- CMS calculates score based on claims, so no additional reporting requirements in this category.
- Includes two cost measures previously used in VBPM program: total per capita costs for all attributed beneficiary and Medicare spending per beneficiary.
  - Attribution method unchanged
- Over 40 episode-based measures will be used to evaluate resource use as applicable.

Cost

- Each cost measure will be worth up to 10 points. Cost score calculated based on average score of all cost measures attributed to clinician.
- Minimum 20-patient sample for each measure.
- MACRA also requires CMS to develop care patient condition groups and patient relationship categories to assist in evaluating resources used to treat patients.
- If no cost measures apply, cost score not weighted and CMS reweights other MIPS performance scores to make up the difference.

Advancing Care Information

Changes from Medicare EHR Incentive Program to Advancing Care Information Performance Category	
Existing Medicare EHR Incentive Program Requirements	**New Proposal**
Must report on all objective and measure requirements, including Clinical Decision Support and Computerized Provider Order Entry.	Streamlines measures and emphasizes interoperability, information exchange, and security measures. Clinical Decision Support and Computerized Provider Order Entry are no longer required.
One-size-fits-all—every measure reported and weighted equally	Customizable—Physicians or clinicians can choose which measures best fit their practice.
All-or-nothing EHR measurement and quality reporting	Flexible—multiple paths to success
Misaligned with other Medicare reporting programs	Aligned with other Medicare reporting programs. No need to report quality measures as part of this category.

Advancing Care Information

- **Based on current Meaningful Use program; Accounts for 25% of MIPS score in year 1**
- Comprised of two scores: Base Score and Performance Score
- Base Score: for participating and reporting
  - Must report on 6 objectives with different measures included in each objective
  - Accounts for 50 points of total Advancing Care Information Category
- Performance Score: for reporting at various levels above the base score
  - Three measures: Patient Electronic Access, Coordination of Care through Patient Engagement and Health Information Exchange
  - Potential to earn up to 80 points
- Public Health Registry Bonus Point: Immunization registry reporting required (exclusion)
  - Can choose to report on more than one public health registry and will receive one additional point

Advancing Care Information Base Score

Protect Health Information

(yes/no)

Electronic Prescribing

(numerator/denominator)

Patient Electronic Access

(numerator/denominator)

Coordination of Care through Patient Engagement

(numerator/denominator)

Health Information Exchange

(numerator/denominator)

Public Health and Clinical Data Registry Reporting

(yes/no)

Advancing Care Information

MIPS Advancing Care Information Objectives and Measures	
Objectives	**Measure**
Protect Patient Health Information	Security Risk Analysis
Electronic Prescribing	ePrescribing
Patient Electronic Access*	Patient Access
	Patient-Specific Education
Coordination of Care Through Patient Engagement*	View, Download, and Transmit (VDT)
	Secure Messaging
	Patient-Generated Health Data
Health Information Exchange*	Exchange Information with Other Physicians or Clinicians
	Exchange Information with Patients
	Clinical Information Reconciliation
Public Health and Clinical Data Registry Reporting	Immunization Registry Reporting
	(optional) Syndromic Surveillance Reporting
	(optional) Electronic Case Reporting
	(optional) Public Health Registry Reporting
	(optional) Clinical Data Registry Reporting
*These measures may be selected for the performance score.	

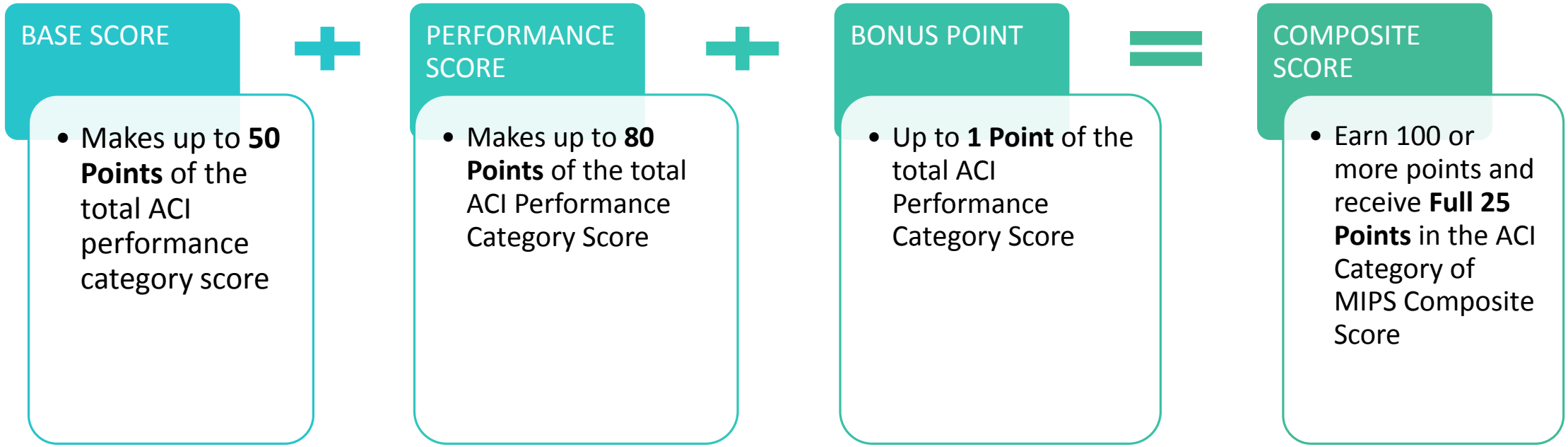
Advancing Care Information Performance Score

Patient Electronic Access

Coordination of Care Through Patient Engagement

Health Information Exchange

Advancing Care Information (ACI) Composite Score Calculation



Earn > **100 Points**, overall MIPS Score declines proportionally

Clinical Practice Improvement Activities (CPIA)

- 15% of total score in year 1
- Clinicians can choose from a list of more than 90 CPIA options
- In addition, clinicians would receive credit toward scores in this category for participating in APMs and Patient-Centered medical homes
- Clinicians work toward a total of 60 points by selecting CPIAs.
  - Medium-level activities worth 10 points, high-level activities worth 20 points.
- CPIA performed for at least 90-days during the performance period.

Clinical Practice Improvement Activities

- Categories include:
  - Expanded Practice Access
  - Beneficiary Engagement
  - Achieving Health Equity
  - Population Management
  - Patient Safety and Practice Assessment
  - Emergency Preparedness and Response
  - Care Coordination
  - Participation in an APM, including medical home model
  - Integrated Behavioral and Mental Health
  - ASCRS has pushed for CMS to include procedures and services physicians are already doing in their practices and have this category not be scored.

Summary of MIPS Performance Categories

Performance Category	Points Needed to Get a Full Score	Percent of Total Composite Score
Quality	80 to 90 points depending on group size	50%
Advancing Care Information	100 points	25%
Clinical practice Improvement Activities	60 Points	15%
Cost	Average score of all resource measures that can be attributed	10%

Advanced Alternative Payment Models (APMs)

- Beginning in 2019 and for 6 years, there is an incentive payment for eligible professionals who participate in qualified Advanced Alternative Payment Models (APMs) and who meet specified payment thresholds.
  - Payment made in lump sum on annual basis
  - APM must involve 'more than nominal' risk of financial lost
  - APM must involve a quality measure component
  - APM must require participants to use certified EHR technology (CEHRT)
  - Excluded from MIPS requirements

Advanced APM Participation Thresholds

Requirements for Incentive Payments for Significant Participation in Advanced APMs (Clinicians must meet payment or patient requirements)						
	2019	**2020**	**2021**	**2022**	**2023**	**2024 or later**
Percentage of **Payments** through an Advanced APM	25%	25%	50%	50%	75%	75%
Percentage of **Patients** through an Advanced APM	20%	20%	35%	35%	50%	50%

Advanced Alternative Payment Models (APMs)

- Two types of APMs – Advanced APMs and Other Payer Advanced APMs
- **Advanced APMs** include ACOs (2-sided risk), medical homes and episode payment models.
- **Other Payer APMs** include payment arrangements under any payer other than traditional Medicare Advantage and other Medicare-funded private plans. This option begins in 2021 (performance year 2019).
- *Medicare Advantage will count toward the APM threshold but not toward the payment calculation in the APM Incentive Payments program.

Advanced Alternative Payment Models (APMS)

- Most anticipate many clinicians will participate to some extent, but not meet the law's requirements for sufficient participation in most advanced models.
  - CMS hopes to increase APM participation going forward.

- Allows clinicians to switch between components of the Quality Payment Program based on what works best for their practice and patients.

Partial Qualifying APMs

- A partial qualifying APM participant is defined as an EP who does not meet the thresholds established but meets slightly reduced thresholds.
- Partial qualifying APM participants do not receive the 5% incentive payment.
- They can participate in MIPS but are held harmless if they do not participate in MIPS.
- To be a partial qualifying APM participant the clinician must receive 20% of their Medicare payments through an Advanced APM or must see 10% of their Medicare patients through an Advanced APM.

More on MIPS

- CMS is required to make feedback reports to each MIPS eligible professional available starting July 1, 2017.
- Information about the performance on MIPS must be made available on Physician Compare.
- ASCRS will have the opportunity to provide input and comments back to CMS in response to the proposed rule.
- We will continue to keep ASCRS/ASOA members updated through alerts and *Washington Watch* articles.

Questions?

For future questions about the Quality Payment Program Proposed Rule, MIPS, or APMs contact:

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