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

<table>
<thead>
<tr>
<th>Then</th>
<th>Now</th>
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</table>
| • 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

<table>
<thead>
<tr>
<th>Prior Law</th>
<th>2019 Adjustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>PQRS</td>
<td>-2%</td>
</tr>
<tr>
<td>Meaningful Use</td>
<td>-5%</td>
</tr>
<tr>
<td>VBPM</td>
<td>-4% or more*</td>
</tr>
<tr>
<td>Total Penalties</td>
<td>-11% or more</td>
</tr>
<tr>
<td>Bonus Potential (VBPM only)</td>
<td>Depends on the size and number of penalties</td>
</tr>
</tbody>
</table>

*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.

<table>
<thead>
<tr>
<th>MIPS</th>
<th>2019 Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Penalty</td>
<td>Capped at -4%</td>
</tr>
<tr>
<td>Bonus Potential</td>
<td>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</td>
</tr>
</tbody>
</table>
Physicians Have Choices

<table>
<thead>
<tr>
<th>Fee for Service (MIPS)</th>
<th>Alternative Payment Models (APMs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 0.5% July 2015-2019; 0% 2020-25; and 0.25% after that</td>
<td></td>
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<tr>
<td>• Former reporting programs consolidated into one program with greater flexibility</td>
<td></td>
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<tr>
<td>• Penalty risks reduced, potential bonuses added</td>
<td></td>
</tr>
<tr>
<td>• Benchmarks set prospectively, more timely feedback on performance</td>
<td></td>
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<tr>
<td>• Physicians role in creating new models specified</td>
<td></td>
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<tr>
<td>• 5% update bonuses for 6 years from 2019-2024; 0% in 2025; and 0.75% after that</td>
<td></td>
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<tr>
<td>• Two-sided risk model required</td>
<td></td>
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<tr>
<td>• Participants exempt from MIPS</td>
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</tbody>
</table>
MIPS Assessment Categories

PQRS + Resource Use (VBPM) + EHR/ Meaningful Use + Clinical Practice Improvement Activities = Composite Score
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 25\textsuperscript{th} 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

<table>
<thead>
<tr>
<th>MIPS Maximum Negative Payment Adjustments by Year</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022 and after</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>4%</td>
<td>5%</td>
<td>7%</td>
<td>9%</td>
</tr>
<tr>
<td>2020</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2021</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2022 and after</td>
<td></td>
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</table>
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%
- Advancing Care Information: 25%
- Clinical Practice Improvement Activities: 15%
- Cost: 10%
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 2\(^{nd}\), 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. 1\(^{st}\) 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.
### Changes from Medicare EHR Incentive Program to Advancing Care Information Performance Category

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

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protect Patient Health Information</td>
<td>Security Risk Analysis</td>
</tr>
<tr>
<td>Electronic Prescribing</td>
<td>ePrescribing</td>
</tr>
<tr>
<td>Patient Electronic Access*</td>
<td>Patient Access</td>
</tr>
<tr>
<td>Patient Electronic Access*</td>
<td>Patient-Specific Education</td>
</tr>
<tr>
<td>Coordination of Care Through Patient Engagement*</td>
<td>View, Download, and Transmit (VDT)</td>
</tr>
<tr>
<td>Coordination of Care Through Patient Engagement*</td>
<td>Secure Messaging</td>
</tr>
<tr>
<td>Coordination of Care Through Patient Engagement*</td>
<td>Patient-Generated Health Data</td>
</tr>
<tr>
<td>Health Information Exchange*</td>
<td>Exchange Information with Other Physicians or Clinicians</td>
</tr>
<tr>
<td>Health Information Exchange*</td>
<td>Exchange Information with Patients</td>
</tr>
<tr>
<td>Health Information Exchange*</td>
<td>Clinical Information Reconciliation</td>
</tr>
<tr>
<td>Public Health and Clinical Data Registry Reporting</td>
<td>Immunization Registry Reporting</td>
</tr>
<tr>
<td>Public Health and Clinical Data Registry Reporting</td>
<td>(optional) Syndromic Surveillance Reporting</td>
</tr>
<tr>
<td>Public Health and Clinical Data Registry Reporting</td>
<td>(optional) Electronic Case Reporting</td>
</tr>
<tr>
<td>Public Health and Clinical Data Registry Reporting</td>
<td>(optional) Public Health Registry Reporting</td>
</tr>
<tr>
<td>Public Health and Clinical Data Registry Reporting</td>
<td>(optional) Clinical Data Registry Reporting</td>
</tr>
</tbody>
</table>

*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

**BASE SCORE**
- Makes up to **50 Points** of the total ACI performance category score

**PERFORMANCE SCORE**
- Makes up to **80 Points** of the total ACI Performance Category Score

**BONUS POINT**
- Up to **1 Point** of the total ACI Performance Category Score

**COMPOSITE SCORE**
- Earn **100 or more points** and receive **Full 25 Points** in the ACI Category of MIPS Composite Score

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

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

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
<th>2023</th>
<th>2024 or later</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Percentage of Payments through an Advanced APM</strong></td>
<td>25%</td>
<td>25%</td>
<td>50%</td>
<td>50%</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td><strong>Percentage of Patients through an Advanced APM</strong></td>
<td>20%</td>
<td>20%</td>
<td>35%</td>
<td>35%</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>
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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