# The Merit-based Incentive Payment System (MIPS): A Detailed Overview of the Proposed Rule

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# Learning Objectives

- Identify the background and purpose of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
- Review the provisions of the proposed regulation
- Examine the regulatory and business impact on clinicians

# Abbreviations

| | |
|---|---|
| ACI | Advancing Care Information |
| ACO | Accountable Care Organization |
| APM | Alternative Payment Model |
| CAH | Critical Access Hospital |
| CAHPS | Consumer Assessment of Healthcare Providers and Systems |
| CEHRT | Certified EHR Technology |
| CMS | Centers for Medicare & Medicaid Services |
| CPIA | Clinical Practice Improvement Activities |
| CQM | Clinical Quality Measure |
| EH | Eligible Hospital |
| EHR | Electronic Health Record |

# Abbreviations

| | |
|---|---|
| EP | Eligible Provider |
| ESRD | End-Stage Renal Disease |
| FFS | Fee-for-service |
| LDO | Large Dialysis Organization |
| MACRA | Medicare Access & CHIP Reauthorization Act of 2015 |
| MIPS | Merit-based Incentive Payment System |
| MSSP | Medicare Shared Savings Program |
| MU | Meaningful Use |
| NPI | National Provider Identifier |
| NPRM | Notice of Proposed Rulemaking |

# Abbreviations

| | |
|---|---|
| OCM | Oncology Care Model |
| ONC | Office of the National Coordinator for Health IT |
| PFS | Physician Fee Schedule |
| PQRS | Physician Quality Reporting System |
| QCDR | Qualified Clinical Data Registry |
| QP | Qualifying APM Participant |
| QPP | Quality Payment Program |
| SGR | Sustainable Growth Rate |
| VM | Value-based Payment Modifier |

# Agenda

- Setting the Stage on Value-Based Care
- Background on MACRA
- Merit-Based Incentive Payment System (MIPS) Track
- Scoring of the MIPS Track
- MU-Related Provisions in the MACRA Rule
- Open Questions from the Proposed Rule
- Next Steps
- Q&A

# Setting the Stage on Value-Based Care

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# Delivery System Reform will result in better care, smarter spending, and healthier people


**Public and Private Sectors**

## Key characteristics

- Producer-centered
- Incentives for volume
- Unsustainable
- Fragmented Care

## Systems and Policies

- Fee-For-Service Payment Systems

## Key characteristics

- Patient-centered
- Incentives for outcomes
- Sustainable
- Coordinated care

## Systems and Policies

- Value-based purchasing
- Accountable Care Organizations
- Episode-based payments
- Medical Homes
- Quality/cost transparency

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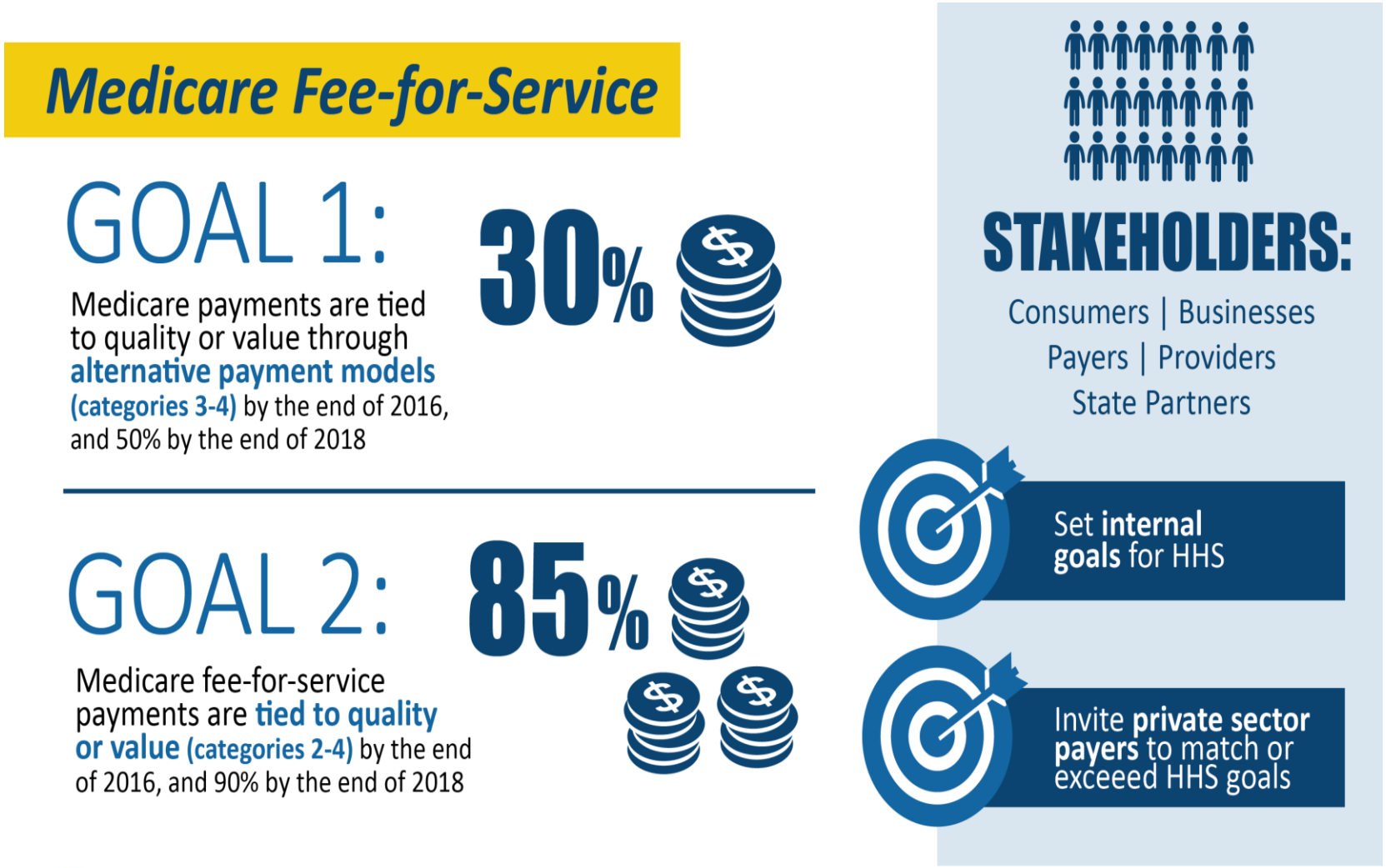
Graphic courtesy of the Centers for Medicare & Medicaid Services

# In January 2015, HHS Announced Goals for Medicare Value-Based and Quality-Related Payments

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# The Medicare Access & CHIP Reauthorization Act of 2015

- Passed into law April 2015
- Repeals the SGR Formula
- Streamlines multiple quality reporting programs into a Merit-based Incentive Payment System (MIPS) – a goal is to decrease clinician burden
- Incentive payments for participating in Advanced Alternative Payment Models (APMs)
- Sustain Medicare by paying for what works

# MACRA and Healthcare Transformation

- **Requires CMS to change how Medicare** rewards clinicians -- **value** over volume
- Merit-Based Incentive Payment System (**MIPS**)
  - Streamlines PQRS, VM, and MU programs to work as one, adding flexibility
  - Adds a fourth component to promote and reward practice improvement and innovation
- **Bonus payments** for participation in **Advanced Alternative Payment Models (APMs)**

# MACRA Focus: The Medicare Clinician Community

- MACRA Proposed Rule focuses on clinicians who bill Medicare for Part B Services
  - No direct impact on hospitals or Medicaid providers
- Proposed Rule also includes modifications to the Meaningful Use (MU) Program
  - Impacts **all Medicare** MU Eligible Professionals, Eligible Hospitals and Critical Access Hospitals

# MACRA Creates Two Tracks for Providers

## Providers Must Choose either MIPS or APM Track, not both

### Merit-Based Incentive Payment System (MIPS)

**2015 – 2019:** 0.5% annual update

**2020 – 2025:** Frozen payment rates

**2026 and on**: 0.25% annual update

**2018**: Last year of separate MU, PQRS, and VBM penalties

**2020**: -5% to +15% at risk

**2022 and on**: -9% to +27% at risk

**2019**: Combine PQRS, MU, & VBM programs: -4% to +12% at risk

**2021**: -7% to +21% at risk

### Advanced Alternative Payment Models (APMs)

**2015 – 2019:** 0.5% annual update

**2020 – 2025:** Frozen payment rates

**2026 and on**: 0.75% annual update

**2019 - 2024**: 5% participation bonus

**2019 - 2020**: 25% Medicare revenue requirement

**2021 and on**: Ramped up Medicare or all-payer revenue requirements

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# The Merit-Based Incentive Payment System (MIPS) Track

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# MIPS Performance Categories


Graphic courtesy of the Centers for Medicare & Medicaid Services

# Defining MIPS Eligible Clinicians

- MIPS applies to Medicare Part B clinicians, including:
  - Physicians
  - Physician Assistants
  - Nurse Practitioners
  - Clinical Nurse Specialists
  - Certified Registered Nurse Anesthetists
- All Medicare Part B clinicians will report through MIPS during the first performance year
  - Proposed as a full year of reporting
  - Beginning in January 2017 for 2019 payment

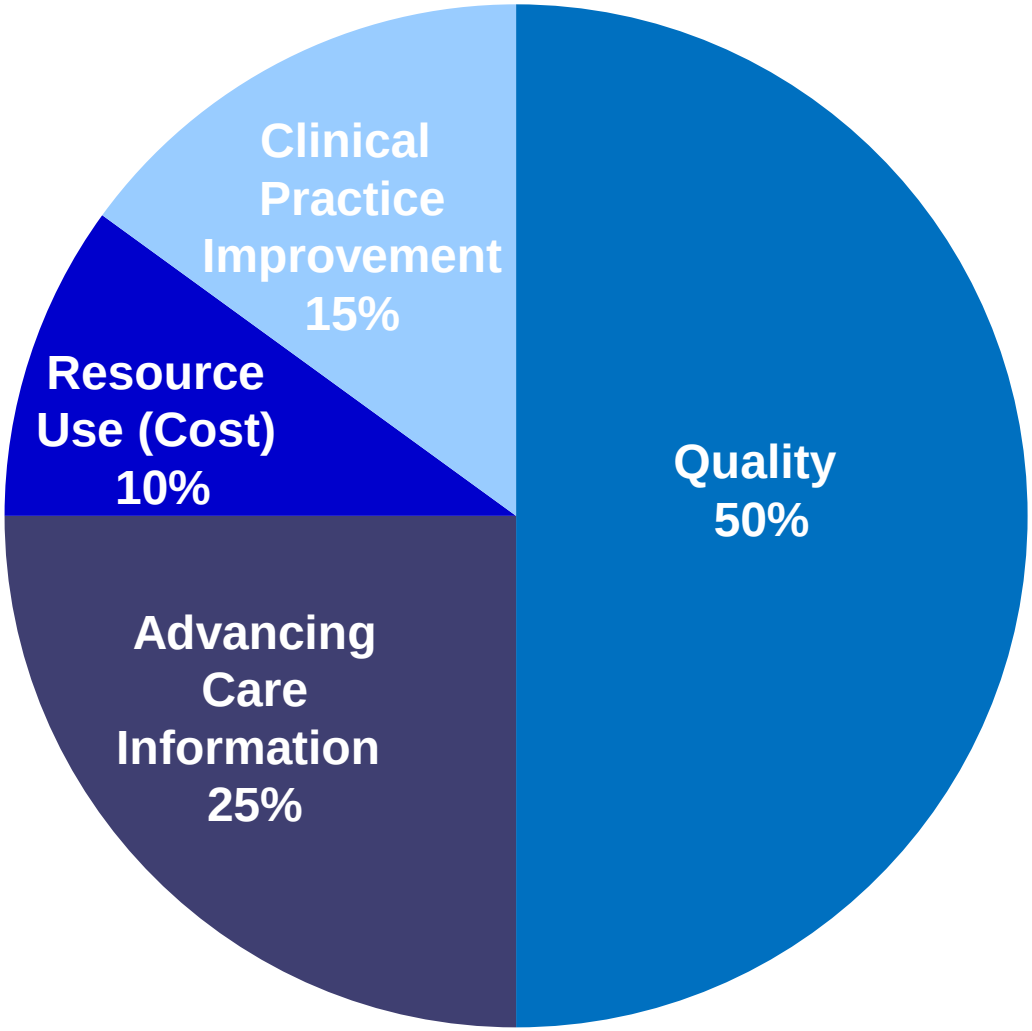
# Defining MIPS Eligible Clinicians

- In Performance Year 3 (2019) HHS Secretary **has the option** to expand MIPS participation to other types of clinicians, such as
  - Physical or Occupational Therapists
  - Speech-language Pathologists
  - Audiologists
  - Clinical Social Workers
  - Clinical Psychologists

# Clinicians Can Choose to Participate Individually or a Group

- Clinicians will have the option to be assessed as a group across all four MIPS performance categories
- Medicare Part B clinicians may be exempted from payment adjustment under MIPS if they
  - Are newly enrolled in Medicare
  - Have $10,000 or less in Medicare charges and 100 or fewer Medicare patients
  - Are significantly participating in an Advanced APM

# Year 1 of the MIPS Program

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# Performance Category Weight Changes by Year—Proposed

| Performance Category | 2019 MIPS Payment Year | 2020 MIPS Payment Year | 2021 MIPS Payment Year and Beyond |
|---|---|---|---|
| Quality | 50% | 45% | 30% |
| Resource Use | 10% | 15% | 30% |
| CPIA | 15% | 15% | 15% |
| Advancing Care Information | 25% | 25% | 25% |

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# MIPS Performance Category Scoring

| Quality | Maximum Points | Percentage of Overall MIPS Score |
|---|---|---|
| Clinicians choose six measures to report to CMS that best reflect their practice.<br>• One must be an outcome measure or a high-priority measure<br>• One must be a cross-cutting measure<br>• Clinicians also can choose to report a specialty measure set | 80 to 90 points depending on group size | 50 percent<br>(Performance Year 1 - 2017) |

# CMS is Striving to Include Core Quality Measures that Private Payers Already Use

- Clinicians would choose 6 measures to report out of a possible 200
  - More than 80% of the quality measures proposed are tailored for specialists
- MIPS also calculates population measures based on claims data to also reduce the reporting burden
  - For individual clinicians and small groups, MIPS calculates two population measures
  - For groups with 10 clinicians or more, MIPS calculates three population measures

# Required Quality Measure Types: Examples

| Quality Measure Type | Examples (from NPRM Appendix Tables A-D) |
|---|---|
| Outcome Measure (TABLES A–E) | • Coronary Artery Bypass Graft (CABG): Stroke<br>• Functional Status Change for Patients with Knee Impairments<br>• Controlling High Blood Pressure |
| High Priority Measure (TABLES A–D) | Outcome, Appropriate Use, Patient Safety, Efficiency, Patient Experience, Care Coordination<br>• Diabetes: Hemoglobin A1c (HbA1c) Poor Control<br>• Adult Sinusitis: Antibiotic Prescribed for Acute Sinusitis (Overuse) |
| Cross-cutting Measure (TABLE C) | • Documentation of Current Meds<br>• Preventive Care and Screening: Tobacco Use |
| Specialty Measure Set (TABLE E) | Gastroenterology<br>• Colorectal Cancer Screening<br>• Colonoscopy Interval for Patients with a History of Adenomatous Polyps |

# MIPS Makes Specialty Measure Sets Available

- Allergy/Immunology/ Rheumatology
- Anesthesiology
- Cardiology
- Gastroenterology
- Dermatology
- Emergency Medicine
- General Practice/Family Medicine
- Internal Medicine
- Obstetrics/ Gynecology
- Ophthalmology
- Orthopedic Surgery
- Otolaryngology
- Pathology
- Pediatrics
- Physical Medicine
- Plastic Surgery
- Preventative Medicine
- Neurology
- Mental/Behavioral Health
- Radiology
- Surgery
- Thoracic Surgery
- Urology

# MIPS Performance Category Scoring

| Clinical Practice Improvement | Maximum Points | Percentage of Overall MIPS Score |
|---|---|---|
| • Over 90 activities from which to choose<br>• Clinicians can choose the activities best suited for their practice<br>• Clinicians participating in medical homes earn “full credit” in this category<br>• Participants in Advanced APMs will earn at least half credit | 60 points | 15 percent<br>(Performance Year 1 - 2017) |

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# Clinical Practice Improvement Activities Account for 15% of the MIPS Score

- MIPS would reward CPIA focused on care coordination, beneficiary engagement, and patient safety
- CMS proposes to determine a clinicians' score by weighting the activities on which they report
  - Highly weighted activities would be worth 20 points, and others worth 10 points
  - Examples of highly weighted activities include
    - Support patient-centered medical homes
    - Activities that support the transformation of clinical practice or a public health priority

# MIPS Performance Category Scoring

| Resource Use | Maximum Points | Percentage of Overall MIPS Score |
|---|---|---|
| • CMS will calculate these measures based on claims and availability of sufficient volume.<br>• Clinicians do not need to report anything. | Average score of all cost measures that can be attributed | 10 percent<br>(Performance Year 1 - 2017) |

# The Cost Category Replaces the VM Program

- MIPS calculates scores based on Medicare claims, meaning there no additional reporting requirements
- Sufficient number of patients required for each cost measure to be scored
  - Generally a minimum of a 20-patient sample
- The cost score would be calculated based on the average score of all the cost measures attributed
- If no patient volume, cost category would be reweighted to zero, and the other MIPS categories would be adjusted to make up the difference in the MIPS score

# MIPS Performance Category Scoring

| Advancing Care Information | Maximum Points | Percentage of Overall MIPS Score |
|---|---|---|
| • Clinicians will report key measures of interoperability and information exchange.<br>• Clinicians are rewarded for their performance on measures that matter most to them. | 100 points | 25 percent<br>(Performance Year 1 - 2017) |

# Advancing Care Information has a Maximum Score of 100 Points


Courtesy of the Centers for Medicare & Medicaid Services

# Changes to Meaningful Use in MACRA NPRM

| Meaningful Use | Advancing Care Information |
|---|---|
| Must report on all objective and measure requirements | • Streamlines measures<br>• Emphasizes interoperability, information exchange, and security measures<br>• Reporting on Clinical Decision Support and Computerized Provider Order Entry no longer required |
| One-size-fits-all—every measure reported and weighed equally | • Customizable—Physicians or clinicians can choose which best measures 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<br>• No need to report quality measures as part of this category |

# The Advancing Care Information Category Base Score

- Dropped “all or nothing” scoring for measurement
- Overall, six objectives and their measures that would require reporting
  - Four Numerator/Denominator Dependent
    - Patient Electronic Access
    - Coordination of Care Through Patient Engagement
    - Electronic Prescribing
    - Health Information Exchange

# Additional Information on the Advancing Care Information Category Base Score

- Two additional objectives and their measures that would require reporting
  - Require a Yes/No Answer
    - Protect Patient Health Information
    - Public Health and Clinical Data Registry Reporting
- To earn any score in the Advancing Care Information performance category, a clinician would need to meet the requirement to protect patient health information created or maintained by CEHRT

# The Advancing Care Information Category Performance Score

- Clinicians select the measures that best fit their practice from the following objectives, which emphasize patient care and information access:
  - Patient Electronic Access
  - Coordination of Care Through Patient Engagement
  - Health Information Exchange
- If a physician or other clinician only has data for a portion of the year, the proposal would allow the clinician to still participate in this category

# Bonus Point Available For Additional Registry Reporting

- Although immunization registry reporting is required, if clinicians choose to report to other public health registries, they will receive one additional point for reporting beyond the immunization category
- Beginning in 2017, clinicians who currently participate in the Medicare EHR Incentive Program will no longer report or attest for this program and will instead report through MIPS

# ECs can use EHR Technology Certified to Either 2014 or 2015 Certification Criteria in 2017

- The objectives and measures specified for ACI are dependent on which certification criteria you use
- ECs can use a combination of the 2014 and 2015 Edition
  - ECs that only have technology certified to the 2014 Edition would not be able to report on any measures that correlate to MU Stage 3
- For the 2018 performance period, ECs can only use technology certified to the 2015 Edition

# Flexible Data Submission Mechanisms for Individuals and Groups

| Performance Category | Individual Reporting | Group Practice Reporting |
|---|---|---|
| Quality | • Claims<br>• Qualified Clinical Data Registries (QCDRs)<br>• Qualified registry<br>• EHR<br>• Administrative claims (no submission required) | • QCDR<br>• Qualified registry<br>• EHR<br>• CMS Web Interface (groups of 25 or more)<br>• CMS-approved survey vendor for CAHPS for MIPS<br>• Administrative claims (no submission required) |
| Resource Use | • Administrative claims (no submission required) | • Administrative claims (no submission required) |

# Flexible Data Submission Mechanisms for Individuals and Groups

| Performance Category | Individual Reporting | Group Practice Reporting |
|---|---|---|
| Advancing Care Information | • Attestation<br>• QCDR<br>• Qualified registry<br>• EHR | • Attestation<br>• QCDR<br>• Qualified registry<br>• EHR<br>• CMS Web Interface (groups of 25 or more) |
| CPIA | • Attestation<br>• QCDR<br>• Qualified registry<br>• EHR<br>• Administrative claims | • Attestation<br>• QCDR<br>• Qualified registry<br>• EHR<br>• CMS Web Interface (groups of 25 or more)<br>• Administrative claims |

# Scoring of the MIPS Track

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# MIPS Creates a Composite Score Based on each Performance Category

- Clinicians' MIPS scores would be used to compute a positive, negative, or neutral adjustment to their Medicare Part B payments
  - The aggregated MIPS composite performance score would be compared against a MIPS performance threshold
  - CMS updates threshold on an annual basis

# In Year 1, Negative Adjustments Not to Exceed 4%

- Depending on variation in MIPS scores, adjustments are calculated so that negative adjustments are capped at -4%
- Positive adjustments are generally up to 4%
  - Scaled up or down to achieve budget neutrality
  - Could be lower or higher than 4%

# Adjustments Continue to Increase Over Time

- Negative adjustments and positive adjustments increase over time
- In the first five payment years, $500 million in additional performance bonuses for exceptional performance will be available (exempt from budget neutrality)
  - Provides high performers a gradually increasing adjustment based on their MIPS score that can be no higher than an additional 10 percent

# MIPS Payment Adjustments
## (Positive and Negative)


Negative Adjustment | Neutral Adjustment | Positive Adjustment

| | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022+ |
|---|---|---|---|---|---|---|---|---|
| **PQRS+VM+ EHR Incentive Penalties (combined)** | -4.5% | -6.0% | -9.0% | -10% or more | -11% or more | -11% or more | -11% or more | -11% or more |
| **MIPS Bonus/Penalty (max)** | -4.5% | -6.0% | -9.0% | -10% or more | +4%* -4% | +5%* -5% | +7%* -7% | +9%* -9% |

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* May be increased by up to 3 times to incentivize performance
$500 mil funding for bonuses allocated through 2024

# MU-Related Provisions in the MACRA Rule

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# Additional Requirements in MACRA NPRM for All MU Providers

- CMS is adding two requirements for certified EHR technology to the attestation requirements under MU, the ACI performance category score under MIPS, and reporting under the APM track

| New Requirements for ACI Clinicians and All MU Providers | |
|---|---|
| Providers must attest that they have cooperated with the authorized ONC surveillance of Certified EHR Technology under the ONC Health IT Certification Program | Providers must attest to facilitating health information exchange, not blocking information, and demonstrate their adherence to model interoperability and exchange practices |

# Reducing Physician Burden is a Consideration for the Surveillance Attestation

Cooperation on this attestation would include the following points

- Responding in a timely manner and in good faith to RFIs about the performance of the CEHRT technology capabilities
- Accommodating requests for access to the provider's CEHRT as deployed by the provider in its production environment for the purpose of carrying out authorized surveillance or direct review
  - The data stored in CEHRT is also included in this review

# Three-Part Attestation for HIE Requirements

Providers must attest to the following points

- Not knowingly and willfully taking actions to limit or restrict the compatibility or interoperability of CEHRT
- Implementing technologies, standards, policies, practices, and agreements reasonably calculated to ensure that CEHRT was connected, compliant, and implemented in a manner that allowed for timely access by patients
- Responding in good faith and in a timely manner to requests to retrieve or exchange electronic health information, including from patients and other providers
  - Regardless of the requestor's affiliation or technology vendor

# Open Questions from the Proposed Rule

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# Open Questions From MACRA Proposed Rule

- Full-year reporting year in 2017
  - Possibility of partial-year reporting?
- Overall complexity
- Reporting burden
- Attestation to surveillance/exchange Provisions
- Feedback loop for clinicians from CMS

# Estimates on Clinician Participation in MIPS

- MIPS would distribute payment adjustments to between approximately 687,000 and 746,000 ECs in 2019
  - Equally distributed between negative adjustments ($833 million) and positive adjustments ($833 million) to MIPS ECs, to ensure budget neutrality
- For APMs, 30,658 and 90,000 ECs would become qualifying providers through participation in Advanced APMs
  - APM Incentive Payments for CY 2019 of between $146 million and $429 million

# Estimated MIPS Impact on Total Allowed Charges by Practice Size

| Practice Size | Eligible Clinicians | Aggregate Impact Negative Payment Adjustment ($Mil) | Aggregate Impact Positive Adjustment ($Mil) | Aggregate Positive Adjustment, exceptional Performance Payment only ($Mil) |
|---|---|---|---|---|
| Solo | 102,788 | -$300 | $105 | $65 |
| 2-9 eligible clinicians | 123,695 | -$279 | $295 | $182 |
| 10-24 eligible clinicians | 81,207 | -$101 | $164 | $103 |
| 25-99 eligible clinicians | 147,976 | -$95 | $230 | $147 |
| 100 or more clinicians | 305,676 | -$57 | $539 | $336 |
| Overall | 761,342 | -$833 | $1,333 | $833 |

2014 data used to estimate 2017 performance. Payments estimated using 2014 dollars

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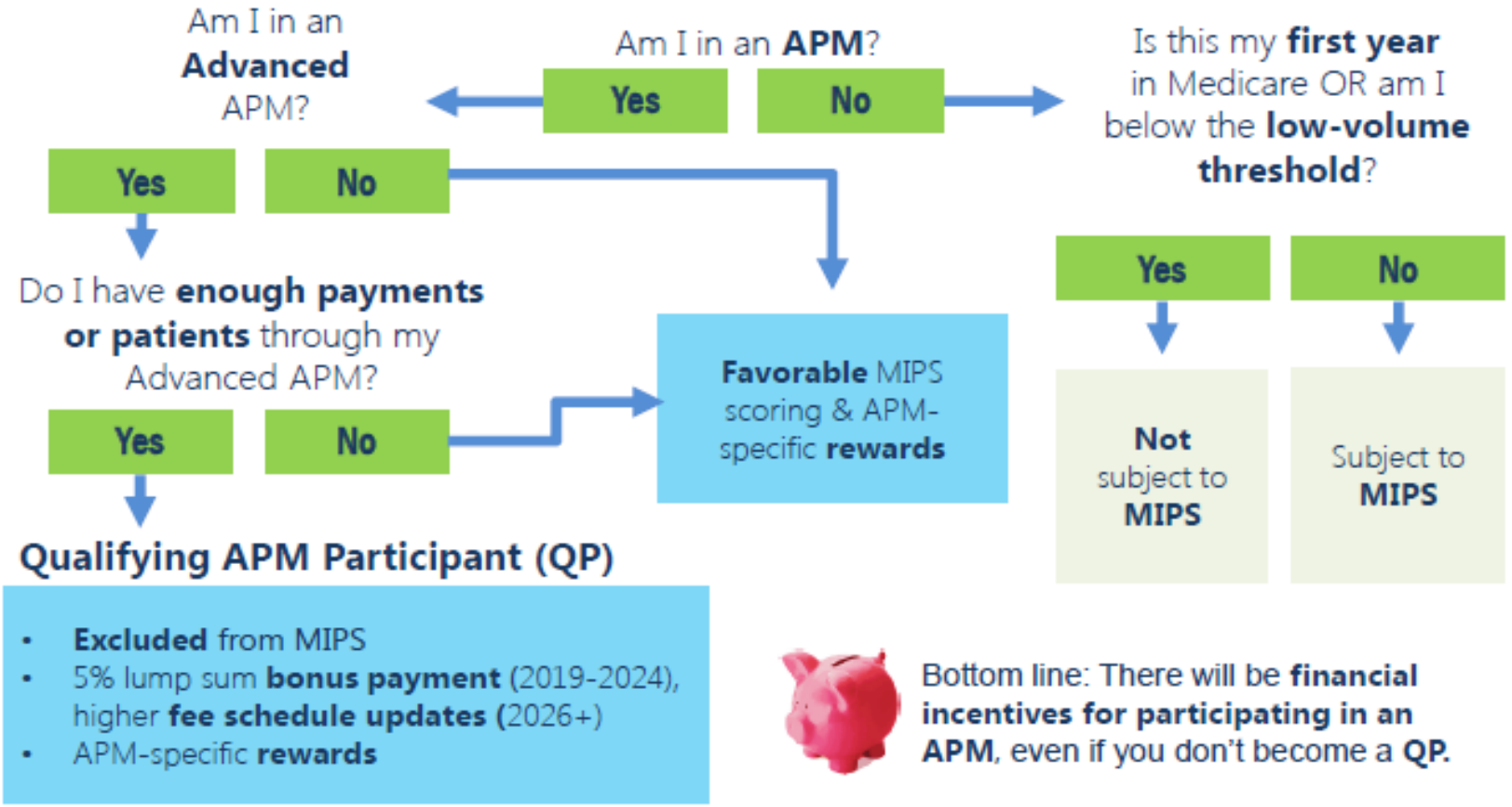
# As a Medicare Clinician, what are my Options under MACRA?

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# Please Submit Questions Through the Chat Box

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# Join Us on June 1 for an APM Webinar

- HIMSS is hosting one additional MACRA webinar
  - **June 1, 2016, 1:00 - 2:00 pm EDT** Advanced Alternative Payment Models (APMs): A Detailed Overview of the Proposed Rule
- Sign up for the webinar at the HIMSS Learning Center: http://www.himss.org/health-it-education/learning-center

# MACRA Resources from HIMSS

- Visit the HIMSS MACRA Resource Center at http://www.himss.org/MACRA-resource-center
- Look to the Resource Center for Fact Sheets on specific MACRA topics, an executive summary, and a link to the MACRA proposed rule

# Thank you for your participation

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