Why Survive When You Can Thrive with the Merit-Based Incentive Payment System (MIPS)?

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This white paper is intended to bring clarity and understanding to the Merit-Based Incentive Payment System (MIPS) for any size practice… big or small.

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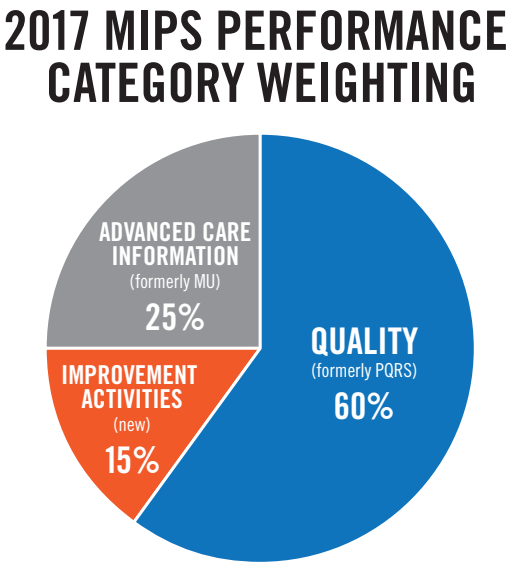
The end of the Sustainable Growth Rate (SGR) marked the beginning of the Medicare Access and CHIP Reauthorization Act (MACRA), which was put into action on January 1, 2017 and which changed how healthcare professionals are paid. The MACRA emphasizes the need to change healthcare from a volume-based system to one that is focused on value and the quality of care provided. Out of MACRA came the Quality Payment Program (QPP), which streamlines several past pay-for-performance programs into a single cohesive program intended to reward healthcare clinicians for higher quality and more cost/resource efficient care.

The QPP is made up of 2 tracks: The Advanced Alternative Payment Model (APM) track and the Merit-Based Incentive Payment System (MIPS) track. CMS intends for many eligible clinicians to participate in Advanced APMs going forward and will reward qualifying participants (QPs) of Advanced APMs with a 5% lump sum bonus along with possible shared savings depending on the APM model. QPs of Advanced APMs will also avoid any payment adjustments under the MIPS.

The MIPS track of the QPP comprises 4 categories:

Figure 1:



- Quality, formerly part of the Physician Quality Reporting System (PQRS)
- Cost, formerly part of the Value-Based Payment Model (VM)
  *weighted to zero for 2017
- Advancing Care Information (ACI), formerly the Meaningful Use program
- Improvement Activities (IA), new

Figure 1 shows the weight percentages for each weighted performance category under MIPS for 2017.

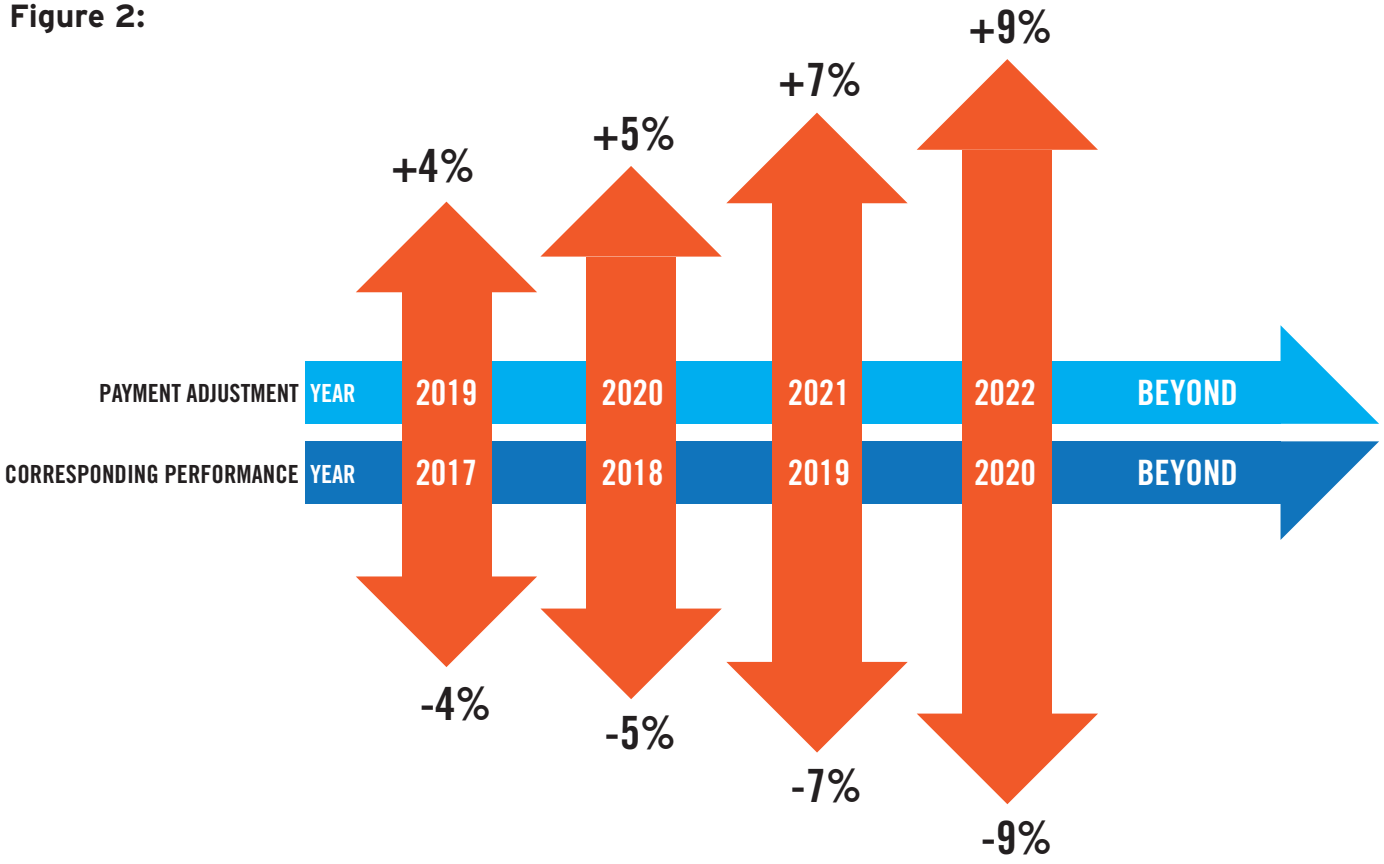
MIPS eligible clinicians can choose to report under MIPS at either the individual provider level or as a group. If 2 or more providers billing under the same TIN choose to report at the group level, they must report all MIPS categories at the group level.

There are various eligibility factors that determine whether or not a clinician is considered a MIPS eligible clinician. For 2017 and 2018 (Year 1 and 2 of the program), clinicians who are considered MIPS eligible are: Physicians (MD/DO and DMD/DDS), PAs, NPs, Clinical Nurse Specialists, and Certified Registered Nurse Anesthetists (CRNAs). Additional eligibility factors like: first-year

Medicare participation, QPs of Advanced APMs, and those who don't meet low-volume threshold criteria, which further limit the population of MIPS eligible clinicians. The low-volume threshold allows providers who don't meet the following to be MIPS ineligible: bill > $30,000 Medicare charges and see >100 Medicare Part B patients in a year. Healthcare professionals can also check their MIPS eligibility by visiting the following CMS QPP website and entering their individual NPI: https://qpp.cms.gov/. It should be noted that even if a clinician is not considered MIPS eligible at the individual level, if their billing TIN reports MIPS at the group level then they may still need to report.

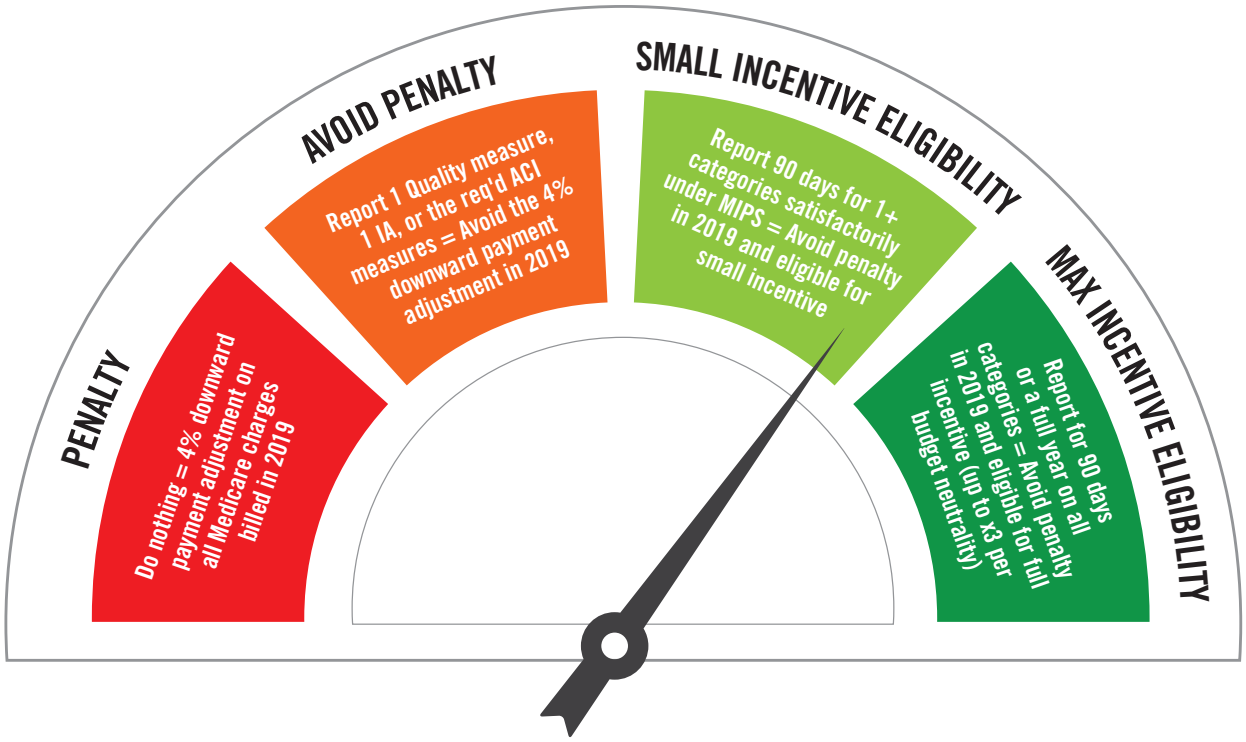
Those MIPS eligible clinicians who fail to report anything under the MIPS program in 2017 will face a 4% negative payment adjustment, which will be implemented during the 2019 payment year. That 4% payment adjustment grows at the rate shown in Figure 2 below until it tops out at 9% for the 2022 payment adjustment year.

Figure 2:



A MIPS eligible clinician has several options for reporting in 2017 as the final rulemaking established 2017 as a transition year and therefore lessened the stringent reporting requirements originally set out in the 2017 proposed rulemaking. Figure 3 below shows the 4 options for reporting starting with the option of reporting nothing and therefore receiving a 4% downward payment adjustment.

Figure 3:



The options in orange and light green describe 2 limited action options for reporting that will result in either a neutral or a slight upward payment adjustment. The option in dark green details how reporting all 3 weighted categories (cost is weighted to zero for 2017 transition year) will result in maximum incentive eligibility for a clinician or group practice.

The MIPS Composite Performance Score (CPS), also known as the "MIPS score" is the scoring method CMS will use to determine payment adjustment eligibility under MIPS. Referring to Figure 3 above, reporting the orange to the dark green options will result in a MIPS score ranging from 3 to 100 points and will result in a corresponding neutral or upward payment adjustment, which will be distributed using a scaling factor that could go up to a possible 12%, as long as there is money in the pot to be distributed. In addition to the +/-4% payment adjustment, there is also an exceptional performance bonus for MIPS eligible clinicians who earn a MIPS score of between 70 to 100 points.

It should be noted that because CMS made 2017 a transition year, there will be fewer MIPS eligible clinicians susceptible to the MIPS penalties based on the increased low-volume threshold for eligibility. Additionally, because the transition year performance threshold was changed to a score of 3, the bar is set much lower for achieving a performance that prevents any penalization. Because of this, the +4% payment adjustment may end up being more along the lines of +1% payment adjustment because there is less penalty money in the pot to pay out in positive payment adjustments.

To report the Quality performance category for incentive eligibility, a MIPS eligible clinician or group practice must select six measures (or a measures set) to report on. One of the six measures must be an outcome measure. If no outcome measure is applicable, a high-priority measure can be used in lieu of an outcome measure. If reporting via Registry, a MIPS eligible clinicians or group practices must report at least 50% of at least a 90 day reporting window in 2017 and must report on all eligible events, regardless of payer. This is a modification from the PQRS program in years past, where providers reported on Medicare Part B patients only. For group practices of ≥ 16 MIPS eligible clinicians and sufficient cases, CMS will calculate a hospital readmissions measure using administrative claims. Group practices reporting at the group level have the option to report the CAHPS for MIPS survey measure to fulfill a high-priority measure element, if they choose to for 2017. Reporting CAHPS for MIPS requires registration with CMS to do so no later than June 30th, 2017. Bonus points are achievable by reporting Outcome and/or High Priority measures beyond the minimum requirement as well as by reporting Quality measures using Certified EHR Technology (CEHRT).

As noted above, the Cost performance category is weighted to zero for the 2017 performance year. CMS still plans to calculate the cost category and the measures under this category using Administrative Claims and will report out on the Cost measures using the Quality Resource and Use Reports. This will be for information purposes only and will not have any impact on the scoring under the MIPS program for 2017.

To report the Improvement Activities (IA) performance category for incentive eligibility, a MIPS eligible clinician or group practice in a group of 16 or more clinicians must select activities from a list of over 90 activities that equate to 40 points to achieve the full 15% for the category. Medium weighted activities are worth 10 points each and high weighted activities are each worth 20 points. An activity must be reported for at least 90 days of the performance period to earn full credit. Small groups (≤ 15 clinicians), groups in rural areas or geographic Health Professional Shortage Areas (HPSAs, and/or non-patient facing clinicians/groups only need to perform activities that equate to 20 points to achieve the full 15% for the category. The list of 90+ Improvement Activities can be found here.

To report the Advancing Care Information (ACI) performance category for incentive eligibility, a MIPS eligible clinician or group practice must select from 2 sets of measures: the transitional ACI measures or the 2015 CEHRT ACI measures. Practices using 2014 CEHRT can use the transitional ACI measures. Practices using 2015 CEHRT can choose to report on either the transitional or the non-transitional ACI measures. MIPS eligible clinicians or group practices need to report satisfactorily on the base measures in order to get any scoring under the ACI category. MIPS eligible clinicians or groups will also report data for the performance based measures in order to get additional performance points for the category. There are also bonus points available for reporting Public Health or Clinical Data Registry Reporting measures as well as by using CEHRT to report certain Improvement Activities. There are certain types of base score and ACI category reporting

exclusions that may or may not require submission of an application to be considered for category reweighting. The list of transitional ACI measures can be viewed here. The list of 2015 CEHRT ACI measures can be viewed here.

The submission window for Registry and QCDR submission of 2017 MIPS data is from January 1, 2018 to March 31st, 2018. It is recommended that you speak with your Registry/QCDR vendor to find out when all data is required to be finalized and/or submitted to the vendor as that date may differ from the 3/31/17 end of submission window date from CMS.

Company background:

ReportingMD® provides high quality **Medical Intelligence**™ (**MI**) products, health information consulting, and custom solutions. We are a qualified registry by the Center for Medicare and Medicaid Services (CMS) for Physician Quality Reporting Systems (PQRS) and e-prescribe since 2008 and a data submission vendor (DSV) for PQRS and Meaningful Use. We help our clients meet the technical challenges of reporting through customizable applications through health information technology engineering, MI analytics, cloud computing and web-based solutions.