MACRA NPRM Series: The MIPS track and what participation means for your practice

Alex Goulding
3-part MACRA NPRM series
The Medicare Access & CHIP Reauthorization Act of 2015 (MACRA)

MIPS Overview
• Overview of MIPS and eligibility
• How CMS structures and defines the four performance categories
• Proposed MIPS timeline

Advanced APMs Overview
• How CMS defines and structures Advanced APMs
• Specific Advanced APMs enumerated in MACRA

Open House
• Brief overview of MACRA
• Extensive Q&A session

*PAHCOM is offering 1 CEU per webinar in this MACRA series
Agenda

1. MIPS overview
   - Eligibility and exemptions
   - Reporting
   - Timeline
   - Payment adjustment

2. Breakdown of MIPS performance categories
   - Quality
   - Resource Use (or Cost)
   - Clinical Practice Improvement Activities
   - Advancing Care Information

3. Additional resources
Acronym cheat sheet

- ACI: Advancing Care Information
- APM: Alternative Payment Model
- CPIA: Clinical Practice Improvement Activities
- EC: Eligible Clinician
- HHS: The U.S. Department of Health & Human Services
- MACRA: Medicare Access & CHIP Reauthorization Act of 2015
- MIPS: Merit-based Incentive Payment System
- MU: Meaningful Use
- NP: Nurse Practitioner
- NPRM: Notice of Proposed Rulemaking
- PA: Physician Assistant
MIPS OVERVIEW
Merit-based Incentive Payment System (MIPS)

1. Streamlines three currently independent programs
2. Adds a fourth component to promote innovation to clinical activities
3. Provides flexibility to choose activities/measures most meaningful to each practice
Who is eligible to participate in MIPS?

**Years 1 and 2**

Physicians (MD/DO and DMD/DDS), PAs, NPs, clinical nurse specialists, certified registered nurse anesthetists

**Years 3+**

HHS Secretary may broaden EC groups to include others such as

Physical or occupational therapists, speech-language pathologists, audiologists, nurse midwives, clinical social workers, clinical psychologists, dietitians/nutritional professionals
Who is not eligible to participate in MIPS?

MIPS does not apply to hospitals or facilities

- First year of Medicare Part B participation
- Below low patient volume threshold
- Certain participants in Advanced APMs

Medicare billing charges
≤ $10,000 and providers care for ≤ 100 patients in one year
Most clinicians will be subject to MIPS

In year one, the majority of clinicians will fall into the MIPS pathway

In non-Advanced APM
Some clinicians in the MIPS track will participate in APMs not considered advanced.

CMS’ goal is to increase the number of clinicians participating in APMs over the course of MACRA.

NOT IN APM
CMS expects the majority of clinicians that fall under the MIPS pathway will not participate in any APM.
Eligible clinician reporting

Eligible clinicians can participate in MIPS as an individual or group

A group, as defined by taxpayer identification number (TIN), would be assessed as a group practice across all four MIPS performance categories

CMS is seeking comment
Proposed MACRA timeline

- Final performance period for Medicare MU/PQRS/VBM
- Payment year for 2014 performance period
- Payment year for Medicare MU/PQRS/VBM (2015 performance)
- Final payment year for Medicare MU/PQRS/VBM (2016 performance)
- First MIPS performance period
- Second performance period for MIPS
- Payment year for 2017 MIPS performance period
- Performance period for 2021

2016

2017

2018

2019

Sunset activities
Payment adjustments

*Adjusted Medicare Part B payment to clinician*

Payment Adjustments

Based on MIPS Composite Performance Score, clinicians will receive +/- or neutral adjustments up to the percentages shown here.

- **2019**: ±4%
- **2020**: ±5%
- **2021**: ±7%
- **2022+**: ±9%

Maximum Adjustments

The potential maximum adjustment % will increase each year from 2019 to 2022.
Performance categories

A single MIPS composite performance score will factor in performance in four weighted categories on a scale of 0-100

- **QUALITY**
  - Replaces PQRS.
  - Accounts for 50% of total performance score in year one.

- **RESOURCE USE/COST**
  - Replaces VBM.
  - Accounts for 10% of total performance score in year one.

- **CLINICAL PRACTICE IMPROVEMENT ACTIVITIES**
  - Accounts for 15% of total performance score in year one.

- **ADVANCING CARE INFORMATION**
  - Replaces Medicare MU.
  - Accounts for 25% of total performance score in year one.
Clinicians bill claims as they normally do, CMS will automatically calculate population measures: 2 for practices with 9 or less, 3 for practices with 10 or more

Reduced from 9 measures to 6 measures with no domain requirement. More specialty options.

Under MIPS, ECs must choose one cross cutting measure. ECs that are patient facing must also select an outcome measurement or alternative.

Year one weight is 50% under MIPS as opposed to the current all-or-nothing approach under PQRS.
Sample quality specialty measures

CMS proposes 23 new measure sets targeting specialists

Specialties with proposed quality measures:

1. Allergy/Immunology/Rheumatology
2. Anesthesiology
3. Cardiology
4. Gastroenterology
5. Dermatology
6. Emergency Medicine
7. General Practice/Family Medicine
8. Internal Medicine
9. Obstetrics/Gynecology
10. Ophthalmology
11. Orthopedic Surgery
12. Otolaryngology
13. Pathology
14. Pediatrics
15. Physical Medicine
16. Plastic Surgery
17. Preventative Medicine
18. Neurology
19. Mental/Behavioral Health
20. Radiology
21. Surgery
22. Thoracic Surgery
23. Urology
Value-based Modifier to Resource Use

Resource use is also referred to as “cost”

1. MIPS calculates score based on Medicare claims — meaning no additional reporting requirements

2. Uses 40+ episode-specific measures to account for differences among specialists

3. EC’s cost score is calculated based on the average score of all the cost measures that can be attributed to the clinician
Clinical Practice Improvement Activities (CPIA)

CMS proposes 90+ activities that clinicians may choose from the following categories:

- Beneficiary Engagement
- Achieving Health Equity
- Population Management
- Patient Safety and Practice Assessment
- Emergency Preparedness and Response
- Care Coordination
- Expanded Practice Access
- Participation in an APM, including a medical home model
- Integrated Behavioral and Mental Health
- Population Management

CPIA categories
MU to Advancing Care Information (ACI)

Key changes from current program (EHR Incentive):

- Eliminated Clinical Provider Order Entry and Clinical Decision Support objectives
- Removed redundant measures to alleviate reporting burden
- Dropped “all or nothing” threshold for measurement
- Reduced the number of required public health registries to which clinicians must report
ACI composite score

*ECs to which the objectives are not applicable will be assessed a reweighted score in this category*

**Base Score**
- Makes up to **50 points** of the total ACI performance category

**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

ACI Composite Score
**MU vs. ACI: base score**

*ACI eliminates a couple of MU3 requirements while mirroring the balance of the others*

<table>
<thead>
<tr>
<th>MU Objective</th>
<th>Stage 2</th>
<th>Stage 3</th>
<th>ACI</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Protect Patient Health Information</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>2. Clinical Decisions Support (CDS)</td>
<td>✔️</td>
<td>✔️</td>
<td>-</td>
</tr>
<tr>
<td>3. Computerized Provider Order Entry (CPOE)</td>
<td>✔️</td>
<td>✔️</td>
<td>-</td>
</tr>
<tr>
<td>4. Electronic Prescribing (eRx)</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>5. Health Information Exchange</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>6. Patient Specific Education</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
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<tr>
<td>7. Medication Reconciliation</td>
<td>✔️</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>8. Patient Electronic Access</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
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<tr>
<td>9. Secure Electronic Messaging</td>
<td>✔️</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>10. Public Health Reporting</td>
<td>✔️</td>
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</tbody>
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**Principal changes from Medicare MU**

- ACI streamlines measures and emphasizes interop, information exchange and security measures.
- Customizable — clinicians can choose which best measures fit their practice
- Flexible — multiple paths to success
- Aligned with other Medicare reporting programs. No need to report quality measures as part of this category.
ACI base score

CMS proposes six objectives that require reporting to receive points towards the base score

- Electronic Prescribing (numerator/denominator)
- Protect Patient Health Information (yes required)
- Patient Electronic Access (numerator/denominator)
- Coordination of Care Through Patient Engagement (numerator/denominator)
- Health Information Exchange (numerator/denominator)
- Public Health and Clinical Registry Reporting (yes required)
### Performance category scoring

**Performance year one – 2017:**

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Description</th>
<th>Max Possible Points</th>
<th>Percentage of Overall MIPS score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Each measure 1-20 points. 0 points for unreported measures. Bonus for reporting outcomes, patient experience, appropriate use, patient safety and EHR reporting. Measures are averaged to get a score for the category</td>
<td>80 – 90 depending on group size</td>
<td>50%</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>Base score of 50 percentage points achieved by reporting at least one use case for each available measure. Performance score of up to 80 percentage points. Public Health Reporting bonus point. Total cap of 100 percentage points available</td>
<td>100 points</td>
<td>25%</td>
</tr>
<tr>
<td>Clinical Practice Improvement Activities</td>
<td>Each activity is worth 10 points; double weight for “high” value activities; sum of activity points compared to a target.</td>
<td>60 points</td>
<td>15%</td>
</tr>
<tr>
<td>Resource Use (Cost)</td>
<td>CMS will calculate these measures based on claims. ECs do not need to report anything.</td>
<td>Avg. score of all cost measures that can be attributed</td>
<td>10%</td>
</tr>
</tbody>
</table>
ADDITIONAL RESOURCES
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MIPS Greenway resources

MACRA guide
https://goo.gl/Ys3ceV

MIPS blog
http://goo.gl/IA4A6R

Knowledge Center
http://goo.gl/G8xnq7
Upcoming MACRA webinars

- MIPS Webinar
  - June 16

- Advanced APM Webinar
  - June 23

- Open House Webinar
  - June 28: Prime Suite
  - June 29: Intergy
  - June 30: SuccessEHS
  - July 7: Prospective Greenway customers
MACRA NPRM

4 ways to submit:

1. Electronically
   https://federalregister.gov/a/2016-10032

2. Regular mail
   Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-5517-P, P.O. Box 8013, Baltimore, MD 21244-8013

3. Express or overnight mail
   Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-5517-P, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850

4. Hand courier
   DC & Baltimore locations available

*Comments due: June 27*
Contact information

Email
- alex.goulding@greenwayhealth.com

Twitter
- @AlexJGoulding

LinkedIn
- https://www.linkedin.com/in/ajgoulding
THANK YOU!