# MIPS Mastery™:
## Optimizing Performance Under the Merit-Based Incentive Payment System





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## First, the Good News:

2016 will be the last year physicians must report scores on specified performance measures to the Centers for Medicare & Medicaid Services (CMS) to avoid up to a 9% reduction in Medicare Physician Fee Schedule (MPFS) payments under the Physician Quality Reporting System (PQRS), the Value-Based Modifier (VM) Program, and the Meaningful Use (MU) Program.

## Next, the Not-So-Good News:

Today's reporting requirements may prove to be "easy" compared to what's ahead. A physician's 2017 scores on performance measures in four weighted categories – quality, resource use, advancing care information, and clinical practice improvement activities – will dictate that physician's 2019 composite performance score (CPS) under the new Medicare Incentive Payment System, or MIPS.

The CPS, expressed as a number from 1 to 100, will be used by CMS to determine the physician's 2019 MPFS payment rate. CMS also will report the physician's CPS publicly on the *Physician Compare* website.

## How Did We Get Here?

Back on April 16, 2015, the President signed into law the Medicare Access and CHIP Reauthorization Act. MACRA repealed the much-despised sustainable growth rate (SGR) formula for determining MPFS payments. In its place, Congress directed CMS to implement MIPS, a new physician payment system that incentivizes quality and efficiency rather than merely rewarding volume.

A year later, on May 9, 2016, CMS published its much-anticipated 426-page MIPS Proposed Rule. According to the agency, it has striven to "propose a program that is meaningful, understandable, and flexible with a critical focus on transparency, effective communication with stakeholders, and operational feasibility."

The underlying MIPS concept is relatively straightforward: a physician whose CPS is above the national performance threshold established by CMS will receive an upward adjustment to his or her MPFS payments (up to 4% in 2019, increasing to 9% by 2023), while a physician whose CPS is below that threshold will be subject to a corresponding downward adjustment.

CMS' proposed processes for identifying specific performance measures, compiling data and calculating each physician's CPS, establishing performance thresholds, and making payment adjustments, however, are anything but straightforward.

The first step on the road to MIPS Mastery™ is gaining a working knowledge of those processes. From that point, you can begin making strategic decisions to maximize your CPS. By making the right choices and following through on those decisions, you can improve reimbursement and enhance your reputation among providers, payers, and patients.

The following highlights key provisions of the proposed rule. CMS will publish the MIPS final rule this fall, just in time for the beginning of the first performance period January 1, 2017.

## Who Is Subject to MIPS?

Each and every Medicare-enrolled physician and non-physician practitioner qualifies as a MIPS-eligible clinician (referred to as "Clinician") (and thus is required to report on 2017 performance measures *and* will receive a 2019 CPS and corresponding MPFS payment adjustment) unless he or she is:

1. Newly enrolled in Medicare in 2017;
2. A low-volume provider, *i.e.*, has Medicare-billed charges of $10,000 or less under his or her National Provider Identifier (NPI) **and** provides Part B services to 100 or fewer Medicare beneficiaries during 2017;
3. Determined by CMS to be a qualifying alternative payment model (APM) participant (QP); or
4. Determined by CMS to be a partial qualifying APM participant (Partial QP) **and** elects not to be subject to MIPS payment adjustments.

CMS estimates there will be approximately 80,000 Clinicians who will not be assigned a CPS for 2019 because they will be new enrollees in 2017. The agency expects another 225,000 Clinicians to meet the criteria for classification as low-volume providers.

According to CMS, 687,000 to 746,000 Clinicians will be required to report on 2017 performance measures and will receive a 2019 CPS and corresponding MPFS payment adjustment. Further, 2019 estimates from CMS project approximately $833 million in MPFS payments will be withheld from those Clinicians scoring below the yet-to-be-determined performance threshold and awarded to those scoring above that threshold.

In addition, beginning in 2019, CMS expects to distribute $500 million in exceptional performance payments annually to those Clinicians with CPSs in the top quartile. Such bonus payments will be capped at 10% of a Clinician's Medicare billings.

A significantly smaller number of Clinicians – between 30,658 and 90,000 – will meet the requirements to be a QP or Partial QP in 2017. Instead of a MIPS payment adjustment, QPs will receive a 5% APM Incentive Payment in 2019 (collectively estimated between $146 million to $429 million). Importantly, partial QPs are *not* eligible for this incentive payment, but *can opt out of MIPS payment adjustments that otherwise may be assessed due to their relative CPSs*.

## How Does One Become a QP or Partial QP (and Why Does It Matter)?

To be identified as a QP or Partial QP, a Clinician must be included on the participation list for an ***advanced APM*** as of December 31 of the performance year. For the first two years, MACRA limits advanced APMs to traditional Medicare programs that require participants to bear risk. For 2017, therefore, the list of advanced APMs is short:

- Track 2 and Track 3 Medicare Shared Savings Program (MSSP) accountable care organizations (ACOs)
- Pioneer ACOs
- NextGen ACOs
- Oncology Care Model two-sided risk arrangements
- Comprehensive Primary Care Plus
- Comprehensive ESRD Care

The proposed rule details how CMS intends to expand this list in future years consistent with statutory requirements, *i.e.*, inclusion of Medicare Advantage and commercial payer alternative payment models.

In addition to participation in an advanced APM, CMS will identify a Clinician as a QP or Partial QP only if he or she meets specified thresholds relating to payment amounts and patient counts. Those Clinicians participating in advanced APMs who do not meet the QP or Partial QP threshold will be treated like all other Clinicians. (See later discussion on "MIPS APM Entities.")

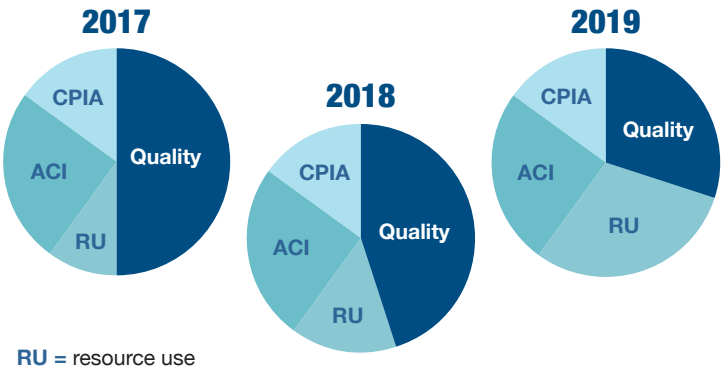
Because the QP and Partial QP threshold determinations are based on data from the performance year, all Clinicians participating in advanced APMs still are subject to the MIPS reporting requirements; only low-volume and newly enrolled providers avoid these requirements.

## How Will CPSs Be Calculated?

For the 2017 performance year, the four categories of the CPS will be weighted as follows:

- 50% quality
- 10% resource use
- 25% advancing care information
- 15% clinical practice improvement activities

For the 2018 performance year, the quality and resource use categories will be weighted at 45% and 15%, respectively. Thereafter, these categories will be weighted equally at 30%; advancing care information and clinical practice improvement activities will remain at 25% and 15%, respectively, as required by statute. CMS is ramping up the resource use category from 10% to 30% over three years as it defines specific clinical episodes of care to be used in evaluating provider efficiency.




**RU =** resource use
**ACI =** advancing care information
**CPIA =** clinical practice improvement activities

## Will CPSs Be Assigned at the Individual Clinician or Group Level?

CMS will assign CPSs at the individual Clinician level (identified by NPI). If a Clinician bills for services under more than one group (identified by Taxpayer Identification Number, or TIN) during a performance year, CMS will assign a different CPS for each NPI/TIN combination. Then, during the adjustment year (the first such year being 2019), CMS will adjust the Clinician's MPFS payments based on the TIN under which the service is billed.

If, during the adjustment year, the Clinician bills under a different TIN than he or she did during the performance year, the Clinician's CPS from the performance year will follow the Clinician to the new TIN. If the Clinician has multiple CPSs from the performance year (*i.e.*, the Clinician billed for services under more than one TIN during the performance year), CMS will calculate and apply a weighted average CPS based on the percentage of allowed charges between the TINs.

Although CPSs are *assigned* at the individual level, they can be *calculated* at *both* the group and individual levels. A group may report its overall scores on specified performance measures, and a Clinician (or the group on the Clinician's behalf) may report on the Clinician's individual scores (which may be based on different measures than the group's scores). In this case, the Clinician's individual performance on the performance measures reported by the group will be included for purposes of calculating the group-level CPS.

If a Clinician reports individually and his or her group also reports, CMS will calculate two CPSs for the Clinician, one based on the Clinician's individual performance and one based on the group's performance. CMS will then use the higher score to determine the Clinician's payment adjustments for services billed under that TIN.

## What Is the APM Scoring Standard?

One of CMS' key considerations in drafting the MIPS rule was eliminating duplicative reporting requirements. Because Clinicians participating in certain Medicare APMs already are required to submit specific data (*e.g.*, the 33 MSSP quality measures), CMS created an ***APM scoring standard*** to allow for the use of that data to generate a CPS.

The APM scoring standard is slightly different than the standard MIPS CPS calculation: 50% weight for quality, 30% for advancing care information, and 20% for clinical practice improvement activity. Note that CMS does not consider the resource use category for MIPS APM entities. Each individual TIN (within the APM entity) is responsible for the advancing care improvement and clinical practice improvement activities reporting as a group.

Those APMs that CMS has deemed eligible for the APM scoring standard are referred to as MIPS APMs. For 2017, the list of MIPS APMs includes all of the advanced APMs listed above (remember, QPs and Partial QPs still are subject to MIPS reporting requirements) *as well as* Track 1 MSSP ACOs and Oncology Care Model one-sided risk arrangements.

Just as all MSSP participants now are excused from PQRS reporting requirements (and thus avoid the current 2% penalty for non-reporting), Clinicians who are members of a group listed as a participant in a MIPS APM as of December 31, 2017, will not be subject to separate MIPS reporting for that year. One can expect this will create a significant incentive for providers to participate in a Track 1 MSSP ACO, even though it does not qualify as an advanced APM.

## What Mechanisms Will Be Available for Individuals and Groups to Report Scores on Performance Measures?

As is the case with PQRS, individuals and groups will have multiple channels through which to report on performance measures. The proposed rule details the specifications for each reporting option and establishes reporting timeframes. As a general rule, reporting must be completed during the first quarter of the year following the performance year.

CMS is strongly encouraging the use of Qualified Clinical Data Registries (QCDRs) and electronic health records (EHRs) for various reporting requirements. That encouragement comes in the form of bonus points for the quality and advancing care information components

when measures are submitted through these mechanisms. Other mechanisms include Part B administrative claims, the CMS Web Interface, and other qualified registries.

## What Are the Four Components that Comprise the CPS and How Are These Scores Calculated?

**1. Quality** The MIPS quality performance reporting requirements are less onerous than the current PQRS requirements. An individual Clinician or group must report on at least six quality measures (as compared to the nine measures now required for PQRS reporting).

The individual or group may select measures from the master measures list (Table A in the appendix to the proposed rule) or from the specialty-specific measure lists (Table E in the appendix to the proposed rule. Note that lists are provided for only 23 specialties; all other specialties must select from the master measures list.)

Of the six measures, one must be from the ten identified "cross-cutting measures" listed in Table C in the appendix to the proposed rule. These measures relate to preventive care and screening, advance care plans, current medications list, and patient satisfaction. However, a non-patient-facing Clinician (an individual or group that bills for 25 or fewer patient-facing encounters during the performance year) is exempt from this requirement.

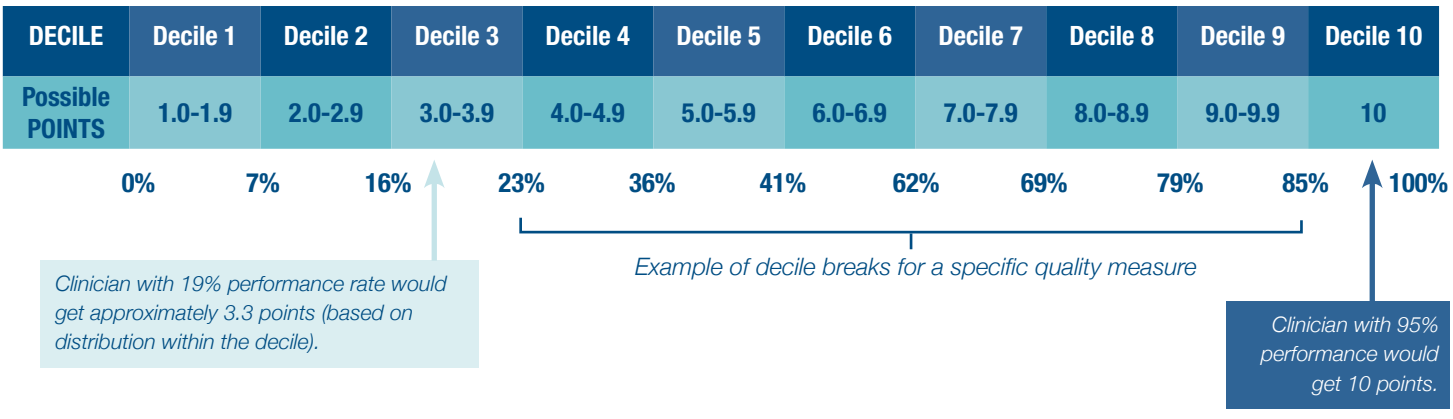
Another one of the six reported measures must be categorized as an outcome measure. If an individual or group is utilizing a specialty-specific list that does not include any outcome measures, the Clinician or group must report on a measure categorized as a high-priority measure. The aforementioned tables include measure types and priority levels.

Although CMS only requires reporting on six measures, a Clinician or a group may elect to report on additional measures. CMS will select the best six scores to calculate the quality component. Thus, reporting on additional measures may give a provider a better opportunity to earn a higher overall score.

For 2017, CMS intends to include up to three population-based measures derived from claims data in calculating Clinician and group quality scores. These measures are detailed in Table B of the appendix to the proposed rule.

For each measure on the master measures list, CMS will establish a separate benchmark based on national performance during a baseline period. For those measures for which there is no historical data (*e.g.*, new measures), CMS will use performance year data to establish the benchmarks.

CMS will break baseline-period performance into deciles. Then, CMS will compare a Clinician's or group's actual performance to those deciles to determine the number of points to be assigned to the Clinician or group for that measure. CMS offers the following example of point assignment based on decile scoring:



A Clinician or group may earn bonus points to increase its overall performance measures score by up to 10%. Specifically, a Clinician or group may earn 2 points by reporting an additional outcome or patient experience measures or one point by reporting another high-priority measure. Also, a Clinician or group may earn one additional point for every measure reported using a certified EHR for end-to-end electronic reporting.

Groups or individual Clinicians who choose to report via QCDRs, qualified registries, or EHRs must report on at least *90% of **all** patients* who meet denominator criteria. Reporting on non-Medicare patients is a significant change from PQRS requirements. This requirement also may impact benchmarks for various quality measures that now include non-Medicare patients.

**2. Advancing Care Information** Advancing care information is CMS' new (and improved) version of meaningful use. A Clinician's or group's score in this category is a combination of a base score and a performance score.

To earn up to the 50 possible base score points, a Clinician or group must simply provide a (non-zero) numerator/denominator or yes/no response on specific measures tied to six objectives:

- Protection of patient health information
- Electronic prescribing
- Patient electronic access
- Coordination of care through patient engagement
- Health information exchange
- Public health and clinical data registry reporting

A "yes" response to the "protection of patient health information" objective is required to receive *any* points in the advancing care information category. And, unlike meaningful use, providers will not be required to report on clinical decision support or computerized provider order entry. Instead, a provider need only report to a public health immunization registry.

A provider may earn up to 80 advancing care information performance score points. Any provider who scores 100 or more total points will receive full credit under the advancing care information category. These points are based on reported results for measures tied to three objectives: patient electronic access, coordination of patient care through patient engagement, and health information exchange.

For those Clinicians for whom these measures and objectives are not relevant (*e.g.*, hospital-based physicians), this category is weighted at zero, with corresponding adjustments to the remaining categories' weights.

**3. Clinical Practice Improvement Activities (CPIA)** In the proposed rule (specifically, Table H in the appendix), CMS has listed more than 90 CPIAs for which Clinicians may receive credit, with a specific number of points assigned to each. Clinicians or groups that certify engagement in activities totaling 60 points will receive full credit in this category.

There are a few exceptions to the standard scoring criteria for CPIA. For Clinicians that are non-patient-facing and/or are located in rural areas or health professional shortage areas (HPSAs), each activity is worth 30 points. Thus, these Clinicians need report only two activities to get full CPIA credit.

Clinicians who participate in an APM automatically receive 30 (of 60) CPIA points. Lastly, groups that have a formal patient-centered medical home designation automatically receive 60 (of 60) CPIA points.

**4. Resource Use** For 2017, Clinicians are not required to submit any data relating to the resource use category. Instead, CMS will use claims data to calculate scores on these measures.

First, CMS will calculate the total per capita costs and the Medicare Spending Per Beneficiaries Measures now utilized under the VM Program. However, CMS proposes to modify the manner in which it attributes beneficiaries to a Clinician or group to more accurately reflect providers' roles in patients' care.

Second, CMS proposes to use new episode-based measures in lieu of the total per capita cost measure for specific populations now used in the VM Program. Some (but not all) of the 41 proposed episode-based measures have recently been included in the Physician Value Modifier Program feedback reports (for informational

purposes only). These episode-based measures have been identified as high-cost, high-variability in resource use. The list of 41 measures is included in the proposed rule; however, CMS may only finalize a subset of the measures.

## How Will Individuals or Groups Receive Feedback on MIPS Performance?

CMS solicited feedback from the public on performance feedback data under MIPS. By law, CMS is required to provide confidential, timely feedback to Clinicians on the quality and resource use categories. CMS has proposed this initial feedback to Clinicians by July 1, 2017.

The data will be provided similarly to how information was provided in the Quality and Resource Use Report (QRUR) under the VM Program. CMS plans on releasing data just one time during the first performance year, but acknowledges that data reporting may evolve as MIPS becomes more mature – potentially as frequently as quarterly feedback reports.

## What Happens if a Clinician or Group Does Not Report in a Timely Manner?

The failure of an individual Clinician or group to report required information relating to any category in a timely and compliant manner will result in a zero score for that category.

## How Will Payment Adjustments Be Made?

A Clinician's CPS determines his or her MPFS payments during the adjustment year (*i.e.*, two years after the performance year). By statute, CMS must inform each Clinician of his or her adjustment factor by no later than December 1 of the year prior to the payment adjustment year (*i.e.*, by December 1, 2018, for the 2019 adjustment year).

| Performance Year | Payment Year | Low-End Adjustment | High-End Adjustment[1] |
|---|---|---|---|
| 2017 | 2019 | -4% | +4% |
| 2018 | 2020 | -5% | +5% |
| 2019 | 2021 | -7% | +7% |
| 2020 | 2022 | -9% | +9% |

[1]Aggregate Clinician adjustments must be budget neutral. Therefore, CMS has the flexibility to include additional upward payment adjustments (scaling factor) to ensure overall budget neutrality.

Payment adjustment factors range from -4% to +4% in 2019. Adjustment factor ranges for subsequent years max out at +/-9% by 2023.

CMS assigns payment adjustments based on a Clinician's CPS compared to the national threshold. Each year, CMS will set a threshold so that roughly half of Clinicians will rank above and approximately half will rank below it. Payment adjustments can be negative, neutral, or positive depending on your position relative to the threshold.

For example, those that fall just below the threshold may only experience a -1% adjustment, whereas someone near the 99th percentile may earn the full 4% increase (plus a potential scaling factor).

The payment adjustment amount will apply to any item or service furnished by a Clinician otherwise paid under Medicare Part B. This also includes co-payments, which will be adjusted by the payment adjustment amount.

## Will Any of This Information Be Made Publicly Available?

CMS is advancing its plan to make information publicly available with MIPS. Quality and meaningful use data slowly has been made available on the *Physician Compare* website. Under MIPS, CMS has proposed new plans to make similar information publicly available.

CMS will begin publishing Clinicians' performance on each of the four MIPS categories, as well as their overall CPS. CMS also will make available the national threshold CPS to give the public context for individual provider performance. There also are plans for users to view and download more detailed performance data from CMS' publicly available datasets.

## How to Master MIPS

Given that MIPS brings fundamental changes to the Medicare physician payment system to incentivize quality and efficiency, healthcare professionals should anticipate investing significant time and effort into fully understanding the new rules. And, with that understanding, providers and provider organizations can begin making strategic decisions regarding measure selection, performance improvement activities, internal tracking, and reporting mechanisms to protect and maximize future reimbursement.

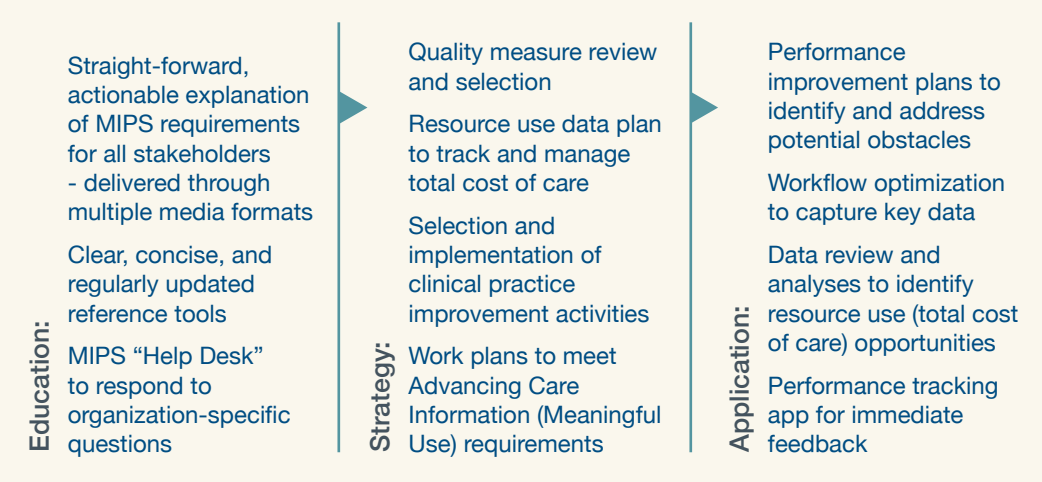
### *What should providers be doing right now to prepare for MIPS?*

1. The first step in preparing for MIPS is getting current programs "under control." While MIPS replaces current Medicare fee-for-value programs – PQRS, VM, and MU – their themes/concepts very much remain intact. Groups and individuals that can succeed with existing programs will find that MIPS is an extension of current programs. Those who have yet to engage current CMS programs can use the rest of 2016 as a "test lap" before MIPS goes into effect in 2017.
2. Just like the VM Program, accurate risk capture for providers' patient population is crucial. The resource use category of MIPS (and many other CMS programs) depends heavily on accurate risk capture. The end of 2016 would be an excellent time for a coding and documentation review to ensure patient risk capture is accurate.
3. Pay attention to the final rule, which is scheduled to be released late this year. While we do not expect major changes to MIPS in the final rule, CMS likely will fine-tune several provisions based on public comments. When the rule is finalized at the end of the year, it would be much better to re-paint the side of the house rather than build the entire thing from scratch. In other words, start preparing now, and make adjustments later as necessary!

## PYA Can Help

PYA's MIPS Mastery™ program cuts through the regulatory complexity to bring a common-sense approach to the MIPS challenge.

- Content delivered in an engaging, interactive manner by recognized experts
- Engagements tailored to organizations' specific needs
- In-depth understanding of practice operations to optimize performance
- Focused use of data analytics to optimize performance




**MIPS Mastery™ is part of PYA's Population Health Ascend suite of products designed to assist providers in the transition to value-based reimbursement. To learn more about these products, visit pyapc.com.**

For more information, contact PYA Principals **David McMillan** (dmcmillan@pyapc.com) or **Martie Ross** (mross@pyapc.com) at **(800) 270-9629**.