White Paper: **MIPS: The New Meaningful Use**

A comprehensive exploration of MIPS, its measures and impact on healthcare; and the future of Meaningful Use.

ChartLogic

Background

In April 2015, due to overwhelming bipartisan support, President Obama signed the Medicare Access and CHIP Reauthorization Act (MACRA) into law, effectively changing the playing field. The legislation repeals Medicare Part B Sustainable Growth Rate (SGR) reimbursement formula and replaces it with a new Quality Payment Program (QPP).

The proposed QPP consists of two tracks in a bid to reduce quality reporting burdens; Advanced Alternative Payment Models (APMs), and Merit-based Incentive Payment System (MIPS). In this white paper we will take a closer look at MIPS, covering areas of interest such as:

- What is MIPS?
- Eligibility & Exemptions
- Performance Categories & Scoring
- Penalties & Incentives
- MIPS Timeline
- Data Submission Requirements
- Impact of MIPS
- Ways to Prepare

This white paper aims to give readers a comprehensive understanding of what MIPS is, how it affects the immediate future of medical practices, and the long term ramifications on the healthcare industry.

What is MIPS?

The popular misconception is that MIPS has replaced Meaningful Use, and the latter is completely repealed. This is far from the case. Starting from 2017, according to MACRA guidelines, the existing EHR incentive programs of Meaningful Use (MU), Physician Quality Reporting System (PQRS), and Value-Based Modifier (VBM), collectively come under the MIPS umbrella.

This begs the question: Then how are things different?

The difference comes in many ways, but the biggest is the fact that MIPS effectively changes performance measures for payment reimbursements under MU, PQRS, and VBM, outlining four categories:

- Quality – Derived from PQRS
- Advancing Care Information (ACI) – Derived from Meaningful Use measures
- Clinical Practice Improvement Activities (CPIA)
- Resource Use – Derived from VBPM initiative

The Centers for Medicare & Medicaid Services (CMS) measures physician performance in each category, and compares it to a predetermined national performance threshold. The data is then used to make adjustments to Medicare Physician Fee Schedule (MPFS) payments; incentives for those who scored above the national threshold, and penalties for those who scored less.

Reporting under MIPS is vastly different from Meaningful Use. Where MU required 90-day reporting provision, MIPS encourages active reporting throughout the year as well as easier reporting options for clinicians new to MIPS.

The CMS will also release these performance reports to the public at the end of each year in a bid for greater transparency; expediting the aim to improve value-based patient care across the board by allowing patients greater insight and choice while selecting their healthcare provider.

MIPS is not a radically new program, just a more effective one. It builds on the existing programs, consolidating and reinforcing their financial impact, while at the same time making use of their respective rules as they have become progressively familiar to clinicians over the last few years.

Eligibility & Exemptions

Qualification for MIPS is predetermined. All physicians and non-physicians enrolled in Medicare qualify as MIPS-eligible Clinicians. They are required to report on 2017 performance measures, and will receive a 2019 fee schedule payment adjustment.

For the first two performance years starting from CY2017 only those clinicians who bill for Medicare Part B, or Critical Access Hospital Method II, will be eligible for MIPS. Medicare Part A, Medicare Advantage Part C, Medicare Part D, FQHC or Rural Health Clinic payment methodologies, and CAH Method I payments are excluded from MIPS eligibility determination, but will be subject to reporting under MACRA APMs guidelines.

Initially MIPS proposed measures will only cover physicians (MD/DO and DMD/DDS), physician assistants, clinical nurse specialists, and certified registered nurse anesthetists, but will eventually expand to include physical and occupational therapists, speech-language pathologists, audiologists, nurse midwives, clinical social workers, clinical psychologists, and nutritional professionals.

Other than the above sited exemptions, there are a few more that make clinicians ineligible for MIPS:

- Newly enrolled in Medicare in 2017
- A low-volume provider or a clinician who has Medicare-billed charges of $30,000 or less under his or her National Provider Identifier (NPI) and provides Part B services to 100 or fewer Medicare beneficiaries during 2017.
- Determined by CMS as qualifying for alternative payment model (APM) participation (QP)
- Determined by CMS as qualified APM participant (Partial QP) and elects not to be subject to MIPS payment adjustments.

CMS projects approximately 80,000 new enrollees, and another 225,000 Clinicians that will meet the low-volume providers' criteria.

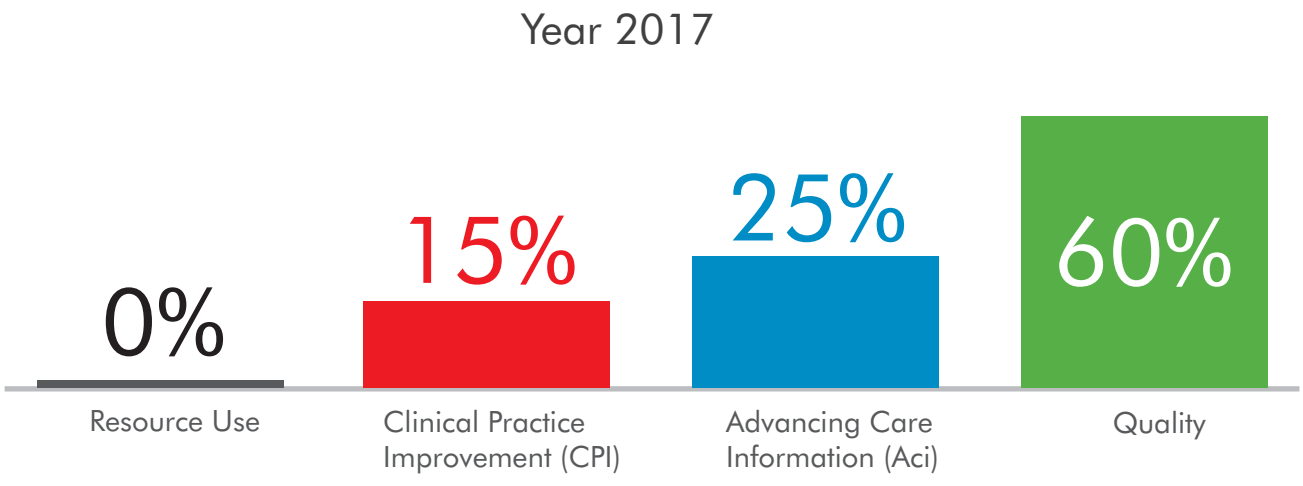
CMS estimates the number of Clinicians reporting performance measures under MIPS in 2017 to be 687,000 to 746,000

Performance Categories & Scoring

As mentioned before, physicians are required to report under four MIPS performance categories. These are then compiled in a composite performance score (CPS) that will determine MPFS adjustments.

Each category is scored separately, and has a percentage of maximum possible performance within the category. The scores are then weighted by the appropriate category quotient, then consolidated to produce the CPS. The categories are distributed as follows:

- Quality – 60%
- Advancing Care Information (ACI) – 25%
- Clinical Practice Improvement Activities (CPIA) – 15%
- Resource Use – 0%



Clinicians under MIPS can choose to be scored on either individual basis or as part of a group of clinicians that must be defined by a tax ID. The only constraint to this is that once the clinician has made a choice it is applicable across all performance categories. This, of course, affects a clinicians CPS drastically. MIPS clinicians also participating in certain alternative payment models, such as Medicare ACOs, must be rated as a group of clinicians and do not have the choice to be rated as individuals.

The ratio proportion of Quality and Resource Use will gradually change over the years, with Quality reducing proportionally to make adjustments for Resource Use weightage increases to 10% in 2018. There will be no changes to ACI and CPIA quota, as per statute requirement.

The reason Resource Use weightage is at 0% is due to the transitional nature of 2017. The weightage will increase in 2018, because Resource Use defines specific clinical episodes of care to be used in evaluating provider efficiency, something the CMS projects will take some time to achieve under the new regulations.

Quality

Though MIPS inherits most of its Quality measures from PQRS, the MIPS measures are far less arduous. Clinicians must report on at least six quality measures, as compared to the nine under PQRS, and groups must report 15 quality measures.

Clinicians can choose the measures from a master list, or a specialty-specific measure list. CMS requires physicians to choose one measure from the outcome category.

Though CMS requires six reported measures for quality it does not discourage clinicians from reporting more. In fact, where more than six measures are reported the best six are selected to comprise the quality score.

For the CY2017, CMS will include three population-based measures to encourage clinicians to think in terms of larger community care. CMS intends to set a benchmark for each measure using data from a baseline year. For recent measures that don't have any available data as precedence, CMS will use performance year data to determine a benchmark.

Advancing Care Information

The CMS version of Meaningful Use, Advancing Care Information (ACI) requires clinicians to submit the following measures for a minimum of 90 days:

- Security Risk Analysis
- E-Prescribing
- Provide Patient Access
- Send Summary of Care
- Request/Accept Summary of Care

Clinicians can choose to submit up to 9 measures for a minimum of 90 days to gain additional credit, or gain bonus credit by:

- Reporting Public Health and Clinical Data Registry Reporting measures
- Using certified EHR technology to complete certain improvement activities in the improvement activities performance category

Clinical Practice Improvement Activities (CPIA)

According to CMS proposed rules, clinicians can receive credit for more than 90 listed CPIAs, with a specific number of points assigned to each. Clinicians or groups that certify engagement in 4 activities for a minimum of 90 days will receive full credit in this category.

However, there are a few exceptions to the scoring criteria for CPIA. For clinicians that work in rural areas, are non-patient-facing, or work in areas where there is a shortage of healthcare professionals, only need to report two measures to achieve a full credit.

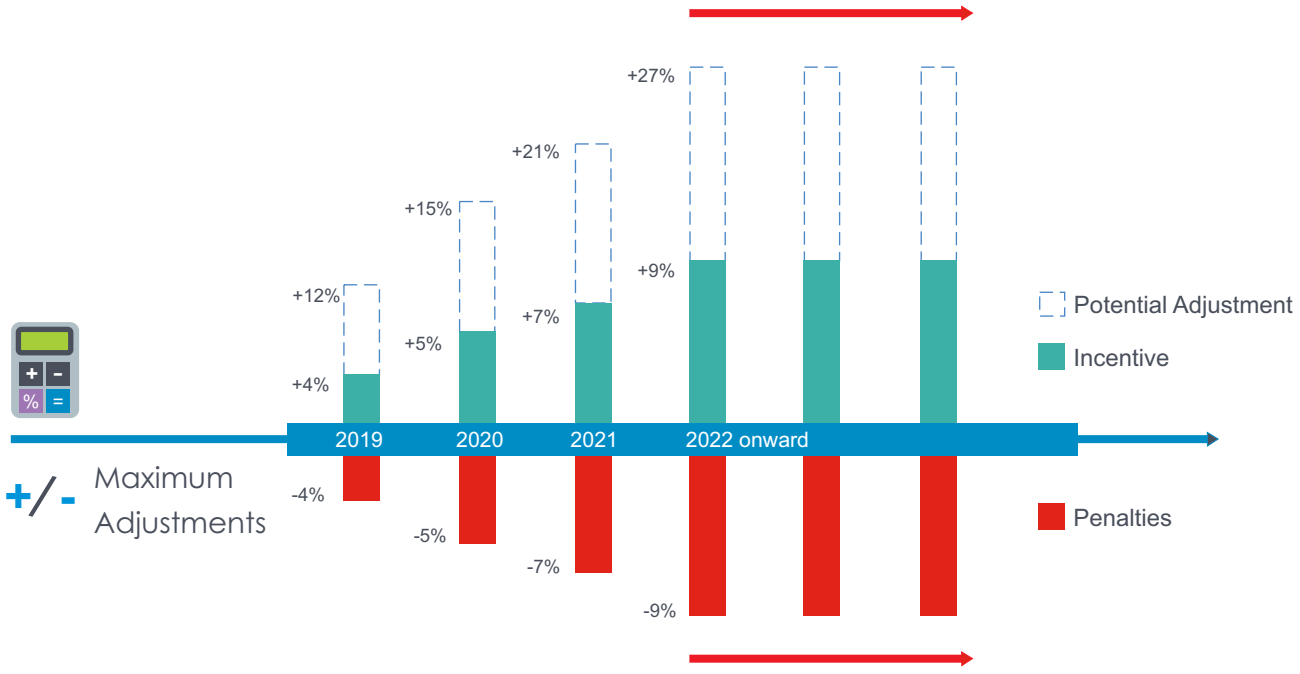
Resource Use

Under MIPS, clinicians are not required to report for Resource Use measures in 2017. Yet this does not mean that CMS will not be calculating performance in adjudicated claims. CMS intends to calculate performance on certain cost measures and give this information in performance feedback to clinicians. In addition to finalizing 10 episode-based measures, CMS will calculate measures of total per capita costs for all attributed beneficiaries and a Medicare Spending per Beneficiary (MSPB) measure.

Penalties & Incentives

Under MIPS, good performances will be rewarded with incentives in the form of bonus payments; clinicians that fall below the CMS benchmark will face payment reductions according to their score. Providers that exceed the final threshold score of 70 in 2017 will qualify for exceptional performance incentives.

MIPS Payment Adjustments



Both negative and positive adjustments start off at 4% in 2019 and go up to 9% in 2022.

Negative adjustments are capped off each year, but clinicians can earn positive adjustments up to three times the amount of a negative adjustment. This way CMS encourages clinicians to perform better each year, rewarding extra performance with bonuses, without penalizing clinicians that don't perform above 25% of the national benchmark.

CMS will provide clinicians confidential and timely feedback on quality and resource use performance. At the moment CMS is expected to give their first and only feedback for the CY2017 in July, but as MIPS evolves the projected feedback could increase to quarterly reports.

Data Submission Requirements

Under MACRA proposed rules physicians will move towards a single data submission method for multiple performance categories of MIPS. In order to do this MIPS intends to expand on the existing data submission methods in place for PQRS, such as Electronic Health Record (EHR), and Quality Clinical Data Registry (QCDR), enabling their compatibility with Quality, ACI and CPIA. Resource Use is scored based on claim submissions and does not need a separate data submission method.

The final MACRA rule introduced reporting options so clinicians could pick their pace in the transition year of 2017, in hopes of encouraging active reporting for greater incentives. Under the final rule clinicians can submit:

- Minimum reporting to avoid penalties
- 90-day reporting for positive adjustment
- Report the full year to maximize incentives

The last date for data submission of all reporting methods across all MIPS performance categories will be March 31st of the calendar year following the relevant performance year; which means that the submission date for CY2017 will be March 31st 2018.

Data Submission Requirements

Category	Individual Clinician	Group of Clinicians
Quality	• Claims • QCDR • Qualified Registry • EHR Vendors • Administrative Claims (No submission required)	• QCDR • Qualified Registry • EHR Vendors • CMS Web Interface (groups of 25 or more) • CAHPS for MIPS Survey • Administrative Claims (No submission required)
ACI	• Attestation • QCDR • Qualified Registry • EHR Vendor	• Attestation • QCDR • Qualified Registry • EHR Vendor • CMS Web Interface (groups of 25 or more)
CPIA	• Attestation • QCDR • Qualified Registry • EHR Vendor • Administrative Claims (No submission required)	• Attestation • QCDR • Qualified Registry • EHR Vendor • CMS Web Interface (groups of 25 or more)
Resource Use	• Administrative Claims (No submission required)	• Administrative Claims (No submission required)

Impact of MIPS

The proposed MACRA measures influence clinicians financially in two ways:

- Through small, annual inflationary adjustment to the Part B fee schedule
- MIPS payment adjustments based on the MIPS 100-point CPS

Due to its stricter quality measures, MIPS will affect the way clinicians conduct their practices. It will also increase competition. Under MU, physicians could choose the measures that they wanted to report on based on their strengths. Now it's not so simple. The four category scoring criteria, and the implicit scoring of zero in case of no reporting, might set the standard for value-based care very high but in the first performance year (2017) it will see a lot of clinicians struggle to reach the national benchmark, setting them up for penalties in the adjustment year (2019).

As far as value-based care is concerned, MIPS is a step in the right direction. As patients are expected to spend more on inflated healthcare costs, they demand greater transparency, and specialized care. MIPS ensures that clinicians are incentivized to engage patients, and design their practice to be more patient friendly. CMS will also be making the CPS reports available to the public.

CMS has also introduced a Physician Compare Initiative. It is a public portal that can be accessed by physicians and patients alike to view the scores of clinicians allowing consumers to make informed choices about the health care they receive through Medicare.

Ways to Prepare

Now that you have a better understanding of the fundamentals of MIPS how will you prepare for the coming changes with so little time?

1. Analyze your practices current compliance. While MIPS will replace the current Meaningful Use program the main concept will remain very much intact. Clinicians that have been successful with MU will need to demonstrate the same level of competence in all four categories. MIPS will be an ever bigger challenge for clinicians that performed below par. This is the perfect time to dive into your practices performance history and plan for the coming year.

2. The Resource Use category will score from claims data. Now would be a great time to brush up on coding and documentation to assess accurate practice claims, and patient risk capture, especially since the adjustment period for ICD-10 has come to an end (as of October 1st 2016).

3. Educate your organization. Take the time to train your staff about the changes they can expect and how to prepare for them. Involve them in the transition, designing a practices workflow that is specific to patient engagement. They might have some great ideas.

We Can Help!

Since Meaningful Use Stage 1, ChartLoigc has been able to maintain its readiness with each new stage and program. The MACRA and MIPS legislation is no different and we are able to meet any level of participation in the new Quality Payment Program.

Let us help your practice transition your workflow to best meet MIPS performance measures, keep track of your score at all times, ultimately gaining a positive payment adjustment. Learn more at www.chartlogic.com.

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