MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT (MACRA)

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) REVIEW

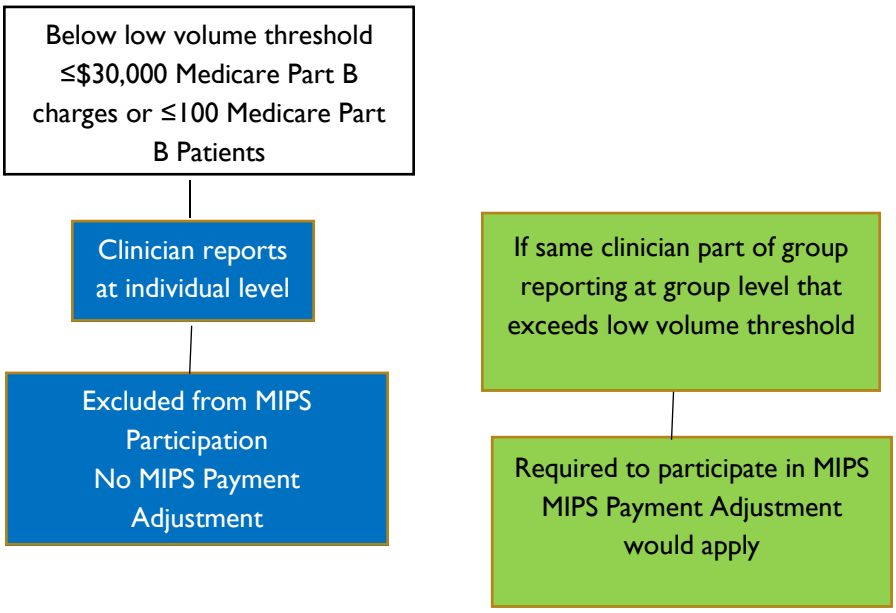
I. MIPS Overview

1) Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
    i) Signed into Law 4/16/2015
    ii) Repeals 1997 Sustainable Growth Rate Physician Fee Schedule (PFS) Update; it locks provider payment rates at near zero growth.
    b) MIPS payment adjustments: Performance data from 2017 will be used to determine payment adjustments in 2019.
    c) Changes Medicare PFS Payment to Quality Payment Program. Two track to select from:
        i) Merit-Based Incentive Payment System (MIPS)
        ii) Advanced Alternate Payment Model (APM)
2) How many clinicians are excluded?
    a) More than half (53-57 percent) of 1,380,209 Medicare clinicians billing to Part B will be ineligible for or excluded from MIPS
    b) The excluded or ineligible clinicians represent approximately one-fourth (22-27 percent) of allowed Medicare Part B charges.
3) How many clinicians are affected?
    a) Based on the estimates of excluded clinicians, CMS estimates that between approximately **592,119 and 642,119 eligible clinicians will be required to submit MIPS data to CMS in year 1.** They are clinicians with eligible clinician types that (a) are not QPs participating in Advanced APMs (b) exceeded the low volume threshold and (c) have been enrolled as Medicare physicians for more than 1 year.
    b) Under standard participation assumptions, the majority (94.7percent) of MIPS eligible clinicians are anticipated to receive positive or neutral payment adjustments for the 2019 MIPS payment year, with only 5.3 percent receiving negative MIPS payment adjustments.
    c) Using the alternative participation assumptions, 91.9 percent of MIPS eligible clinicians are expected to receive positive or neutral payment adjustments.
    d) Qualifying APM participants between a range of 70,000-120,000
4) Eligibility requirements for participation
    a) Medicare Part B clinicians billing more than $30,000 a year **AND** providing care for more than 100 Medicare patients a year.

5) MIPS Requirements & Participation options for 2017

	MIPS Test Pace	MIPS Partial Year	MIPS Full Year
Quality	1 Quality measure	6 Quality measures including 1 outcome measure	6 Quality measures including 1 outcome measure
Advancing Care Information	4 or 5 required Base measures depending on CEHRT 2014 or 2015 edition	More than required 4 or 5 base measures	Required 4 or 5 base measures 9 or 7 Performance Measures
Clinical Performance Improvement Activities	1 CPIA Activity	2 Medium weighted + 1 High weighted or	2 Medium weighted + 1 High weighted
	(medium or high-weighted)	4 Medium weighted or	4 Medium weighted
		2 High weighted	2 High weighted
	MIPS Test Pace	**MIPS Partial Year**	**MIPS Full Year**
Reporting Time period	No minimum time period	90-day reporting period	Full Year
Start Date	Submit some data after January 1, 2017	Any time between January 1 – October 2	January 1-December 31 (Full year submission data)
Data Submission Dates	01/01/2018 to 03/31/2018	01/01/2018 to 03/31/2018	01/01/2018 to 03/31/2018
Deadline to submit performance data	31-Mar-18	31-Mar-18	31-Mar-18
Payment adjustment	Avoid penalties/downward adjustment	May earn a small positive adjustment or maximum positive adjustment depending on the performance data submitted	May earn a small positive adjustment or maximum positive adjustment depending on the performance data submitted
When do MIPS payment adjustments begin?	January 2019	January 2019	January 2019
Is an EHR required?	No	Yes	Yes
Practices suited for reporting option	Small Practices/Individual clinicians who never participated in Legacy CMS programs (PQRS, MU, VBM)	Small practice planning to upgrade EHR in mid-2017	Practices who have successfully participated in PQRS/MU/VBM previously
	Review and evaluate systems to understand program and data collection and submission methodology		
	Prepare for complete participation in 2018 & beyond		

6) Who are the eligible clinicians? (Please see Appendix A)
   a) Physicians
      i) Doctor of medicine
      ii) Doctor of osteopathy (including osteopathic practitioner)
      iii) Doctor of dental surgery
      iv) Doctor of dental medicine
      v) Doctor of podiatric medicine
      vi) Doctor of optometry
      vii) Doctor of chiropractic legally authorized to practice by a State in which he/she performs this function.
   b) Physician Assistants
   c) Nurse Practitioners
   d) Clinical Nurse Specialists
   e) Certified Registered Nurse Anesthetists
7) Who are exempt from QPP?
   a) Hospital payments
   b) Medicaid payments
   c) Newly enrolled Medicare clinicians
   d) Clinicians significantly participating in Advanced APMs
   e) Clinicians below the low-volume threshold
      i) Medicare Part B allowed charges ≤ $30,000 **OR** ≤ 100 Medicare Part B patients



8) MIPS and APM Adjustments
   a) Payment adjustments under PQRS, VM, and EHR-MU will sunset Dec. 31, 2018
   b) **January 1, 2017-First Performance Year begins**
   c) **January 1, 2019 – MIPS and APM incentive payment adjustments begin**
   d) MIPS – Can receive positive, negative or zero payment adjustment
      i) Eligible clinicians will be assigned a **performance score between 0-100**
      ii) Score compared to **performance threshold (PT) is 3** for 2017
      iii) The score is used to apply a **MIPS adjustment factor from 2019**
   e) APM Participant – If criteria are met, can receive 5 percent incentive payment for 6 years
9) MIPS Performance categories for 2017 (Weights can be adjusted in certain circumstances)
   a) Quality measures (60%)
   b) Advancing Care Information (25% of Score)
   c) Clinical Improvement Activities (15% of Score)
   d) Resource Use/Cost (0% of Score)

Categories	MIPS Eligible Clinicians	Non-patient facing	Hospital-Based	Medicare Shared Savings Program	Next Gen ACO	Other APMs
Quality	60%	85%	85%	50%	50%	0%
IA	15%	15%	15%	20%	20%	25%
ACI	25%	0%	0%	30%	30%	75%
Cost	0%	0%	0%	0%	0%	0%

10) Reporting Requirements & Scoring Methodology
   a) Performance assessment in four categories using weights established
   b) Weights may be adjusted if there are not sufficient measures and activities applicable for each type of Eligible clinician, including assigning a scoring weight of 0 for a performance category
   c) MIPS Final Score will range from 0-100
   d) The **Final score** is the sum of the products of each performance category score and each performance category's assigned weight multiplied by 100.

      Final score = [(quality performance category score x quality performance category weight) + (resource use performance category score x resource use performance category weight) + (CPIA performance category score x CPIA performance category weight) + (advancing care information performance category score x advancing care information performance category weight)] x 100

e) MIPS Performance Threshold for 2017 is 3

Final Score	Payment Adjustment
≥70 points	• Positive adjustment • Eligible for exceptional performance bonus—minimum of additional 0.5%
4-69 points	• Positive adjustment • Not eligible for exceptional performance bonus
3 points	• Neutral payment adjustment
0 points	• Negative payment adjustment of -4% • 0 points = does not participate

f) A positive adjustment factor if final score is above the performance threshold and a negative adjustment factor if final score is below threshold. As specified under the statute, negative adjustments would increase over time, and positive adjustments would correspond.

+4%*	+5%*	+7%*	+9%*

Above Performance Threshold, positive payment adjustment

AT PERFORMANCE THRESHOLD= NO ADJUSTMENT

Below Performance Threshold; negative adjustment with lowest 25% with maximum reduction of -4%

-4%	-5%	-7%	-9%
2019	2020	2021	2022 & beyond

g) Additional Adjustment for Exceptional Performance

i) For 6 years beginning in 2019, EPs with scores above additional performance threshold (defined in statute) receive additional positive adjustment factor ($500 million is available each year for 6 years for these payments.)

ii) Additional performance threshold is 70 points for 2017

iii) Eg., Eligible clinician with **exceptional performance** will have the following adjustments:

FINAL SCORE POINTS	MIPS ADJUSTMENT
0-0.75	-4% (Note: this range will comprise mostly of MIPS eligible clinicians with a final score of 0.)
0.76-2.9	Negative MIPS payment adjustment > - 4% and < 0% on a linear sliding scale. (Note. We do not anticipate many MIPS eligible clinicians to fall into this range)
3.0	0% adjustment
3.1-69.9	Positive MIPS payment adjustment ranging from greater than 0 percent to 4 percent × a scaling factor to preserve budget neutrality, on a linear sliding scale
70.0-100	Positive MIPS payment adjustment AND additional MIPS payment adjustment for **exceptional performance**. (Additional MIPS payment adjustment starting at 0.5 percent and increasing on a linear sliding scale to 10 percent multiplied by a scaling factor.)

10) Data Submission Methods

Data Submission Methods*	**Quality (60%)**	**ACI (25%)**	**CPIA (15%)**	**Cost (0%)**
Certified EHR	×	×	×	
Qualified Clinical Data Registry	×	×	×	
Qualified Registry	×	×	×	
Attestation		×	×	
Claims	×			×
CAHPS	×			
CMS Web Interface** (for Group Reporting of 25 or more)	×	×	×	
*Determine the best reporting mechanism as an individual/group-IMPORTANT				
**Register as a group by June 30, 2017 to use CMS Web Interface submission				
If reporting as a group, clinicians will be assessed as a group across all 4 MIPS performance categories				

Source: Centers for Medicare & Medicaid Services (CMS), HHS (2016). *Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician Focused Payment Models Final Rule with comment period.*

https://www.gpo.gov/fdsys/pkg/FR-2016-11-04/pdf/2016-25240.pdf.
https://qpp.cms.gov/resources/education
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-Events.html

II. APPENDIX

Appendix A

Eligibility and Exclusions

You are Eligible Clinician if answer is YES to BOTH Questions		
	YES	NO
Bill Medicare > $30,000 a year in allowable charges		
See > 100 Medicare Patients		
You are excluded if answer is YES to EITHER one of the questions		
	YES	NO
Bill Medicare ≤ $30,000 a year in allowable charges		
See ≤ 100 Medicare Patients		
First year as Medicare Participants in 2017		
Participate in Advanced APM		
How to calculate your Medicare Patient Counts & Medicare Payment Amounts for 2017?		
Review your claims for service provided between September 1, 2015 and August 31, 2016, and where CMS processed the claim by November 4, 2016.		

Appendix B

Checklist for list of Advanced APMs for 2017

	Are you in an Advanced Alternative Payment Models for 2017?	**YES**	**NO**
1	Comprehensive ESRD Care (CEC) Model (LDO arrangement)		
2	Comprehensive ESRD Care (CEC) Model (non-LDO two-sided risk arrangement)		
3	Comprehensive Primary Care Plus (CPC+) Model		
4	Medicare-Medicaid Accountable Care Organization Model (MMACO) (for participants in Shared Savings Program Track 2)		
5	Medicare-Medicaid Accountable Care Organization Model (MMACO) (for participants in Shared Savings Program Track 3)		
6	Medicare Shared Savings Program Accountable Care Organizations — Track 2		
7	Medicare Shared Savings Program Accountable Care Organizations — Track 3		
8	Next Generation ACO Model		
9	Oncology Care Model (OCM) (two-sided Risk Arrangement)		
10	Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1 - CEHRT)		
11	Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)		

Source: https://qpp.cms.gov/docs/QPP_Advanced_APMs_in_2017.pdf

Appendix C

Checklist for list of MIPSs APMs for 2017

	Are you in an MIPS APM for 2017?	**YES**	**NO**
1	Comprehensive ESRD Care (CEC) Model (LDO arrangement)		
2	Comprehensive ESRD Care (CEC) Model (non-LDO two-sided risk arrangement)		
3	Comprehensive ESRD Care (CEC) Model (nonLDO arrangement one-sided risk arrangement)		
4	Comprehensive Primary Care Plus (CPC+) Model		
5	Medicare-Medicaid Accountable Care Organization Model (MMACO) (for participants in Shared Savings Program Track 1)		
6	Medicare-Medicaid Accountable Care Organization Model (MMACO) (for participants in Shared Savings Program Track 2)		
7	Medicare-Medicaid Accountable Care Organization Model (MMACO) (for participants in Shared Savings Program Track 3)		
8	Medicare Shared Savings Program Accountable Care Organizations — Track 1		
9	Medicare Shared Savings Program Accountable Care Organizations — Track 2		
10	Medicare Shared Savings Program Accountable Care Organizations — Track 3		
11	Next Generation ACO Model		
12	Oncology Care Model (OCM) (one-sided Risk Arrangement)		
13	Oncology Care Model (OCM) (two-sided Risk Arrangement)		
14	Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)		

Source: https://qpp.cms.gov/docs/QPP_Advanced_APMs_in_2017.pdf