



Insight

PRIMER: MACRA and the Merit-based Incentive Payment System (MIPS)

TARA O'NEILL HAYES | JANUARY 31, 2017

Background

On April 16, 2015, the [Medicare Access and CHIP Reauthorization Act](#) (MACRA) was signed into law, significantly reforming the way physicians and other health care providers will be paid for treating Medicare patients. This legislation repeals the [Sustainable Growth Rate](#) (SGR) formula, which had served as the underlying formula used to determine payment rates for providers of Medicare Part B services, and replaces it with the Quality Payment Program (QPP). This program has two separate payment tracks—the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (AAPMs)—both designed to encourage physicians to improve quality and value. Under both programs, payments for services will be at least partially based on these two factors. The Centers for Medicare and Medicaid Services (CMS) released the [final rule](#) for implementing this legislation on October 14, 2016; implementation began January 1, 2017. This primer will focus on MIPS.

Introduction to MIPS

The MIPS program is intended to be a transitional program, helping providers prepare for eventual participation in an Advanced APM. MIPS combines three existing programs developed by CMS—the Physician Quality Reporting System (PQRS), the Physician Value-based Payment Modifier (VM) and the Medicare Electronic Health Record (EHR) Incentive Program—into a single payment model, with the hope of creating a more cohesive and comprehensive payment model with similar goals and fewer redundancies.

Under MIPS, providers' payments will be adjusted, positively or negatively, based on their performance in four categories: quality, resource use, clinical practice improvement, and advancing care information. The maximum weight of the payment adjustments will increase each year, beginning at 4 percent in 2019, and reaching 9 percent by 2022.

Initially, CMS expects that more than half (approximately 750,000) of clinicians will be excluded from MIPS. Roughly one-third will be excluded due to the low-volume threshold (for providers with \$30,000 or less in Medicare Part B charges or treating 100 or fewer Medicare patients). Another 200,000 will be excluded because they do not meet the definition of an eligible clinician (discussed later in the “Qualifying as a MIPS Provider” section), and the remaining 5-8 percent will be participating in an Advanced APM, and thus not participating in MIPS.

MIPS Composite Score

As noted above, the MIPS program will evaluate providers in four categories, and performance in each category will be translated into a score, with the maximum sum of a provider's score across all four categories (known as

the composite score) equaling 100.

Quality

Evidence-based clinical quality measures will be used to evaluate the quality of care clinicians provide. These measures will include both process and outcome metrics, selected by CMS annually and published by November 1 of the preceding year. For full participation, the clinician or group must report performance on at least six measures, one of which must be an outcome measure, if available. If fewer than six measures are applicable to a provider, then the provider must report on all applicable measures. Specialists and sub-specialists may have separate applicable measure sets designed to be appropriate for the work they do. Clinicians must report at least one outcome measure within the set; if none exist, they must report another high priority measure. High priority measures include outcome, appropriate use, patient safety, efficiency, patient experience, and care coordination quality measures. Reporting additional high priority measures allows the provider to earn bonus points of up to 10 percent of the total points possible under this category. Each quality measure submitted via certified electronic health record technology (CEHRT) will receive one bonus point, up to 10 percent of the total points possible for the first two years; this cap will be reduced in future years.

Quality measures will be evaluated against a benchmark determined by available historical data from a baseline period. If baseline data does not exist, benchmarks will be determined by actual performance. Points will be assigned based on where a provider's performance falls among the benchmarks, which will be separated into deciles.

In 2017, the quality performance category will account for 60 percent of the overall MIPS Composite Score. This is largely because the weight for the cost category in the first year will be zero; as the weight for the cost category increases, the weight for the quality category will decrease accordingly. In 2018, quality will account for 50 percent of the composite score, and in 2019 and beyond, 30 percent.

Clinical Practice Improvement Activities

Under this category, providers will be rewarded for their efforts to improve clinical practice or health care delivery if the Secretary of HHS determines that such activities are likely to result in improved outcomes. Health care delivery improvement activities may include care coordination, beneficiary engagement, population management, and health equity. These activities will be weighted according to their perceived value as determined by CMS, as either "medium" or "high" weight. To earn full credit in this category, providers must partake in four medium-weighted or two high-weighted activities in 2017. Exceptions will be made for small practices and providers in rural areas or geographic health professional shortage areas (HPSAs); these providers must only complete two medium-weighted or one high-weighted activity.

Some activities may qualify as both clinical practice improvement activities and activities that will qualify for the advancing care information bonus score. Clinicians or groups practicing in a certified patient-centered medical home (PCMH) will be given the highest score possible for this category, and CMS has expanded the definition of recognized patient-centered medical homes.

Clinicians participating in an APM (but not an Advanced APM recognized by CMS) will receive at least half of the highest potential score for this category. This category will account for 15 percent of the total MIPS composite score.

Advancing Care Information

This category essentially replaces the [EHR Incentive Program](#) and expands upon its [Stage 3 meaningful use](#) requirements. Though, many MIPS eligible clinicians were not eligible to participate in the EHR Incentive Program, and therefore may be unfamiliar with the technology and/or some of the required functionalities. As such, some of the required thresholds are lower than the requirements imposed in “Modified Stage 2” and Stage 3.

The objectives of the measures evaluated in this category will focus on the advancement of patient engagement and health care quality through the use of Certified Electronic Health Record Technology (CEHRT), as well as the secure exchange of health information electronically from one provider to another. Providers will be required to report on five specific measures under this category, and will have the option of reporting on additional measures to earn a higher score.

The total weight of this category will equal 25 percent. The score will be comprised of two components, evenly weighted: the “base score” and the “performance score”. The base score will be based on participation and reporting; simply, did the provider use the technology and report such use? Under this component, certain measures will be required (currently, the following five: e-Prescribing, sending a Summary of Care, requesting/accepting a Summary of Care, performing a Security Risk Analysis, and providing patients electronic access to their record). Providers must report on these required measures in order to obtain any score in the ACI category, and must affirmatively report on the required measures to receive any points in the base score component.

Performance score measures will relate to the following objectives: Patient Electronic Access, Coordination of Care through Patient Engagement, Health Information Exchange, and Public Health and Clinical Data Registry Reporting. The nine measures under these four objectives will each be worth up to 10 points. Reporting to other public health or clinical data registries will allow a 5 percent bonus. Providers completing at least one improvement activity from a specified list utilizing CEHRT will receive a 10 percent bonus. The total number of points that may be earned under this category, including bonus points is 105. Added together with the 50 points available in the base score component, providers could earn 155 total points; however, the point total is capped at 100, and anyone earning 100 or more points will receive full credit for this category in the overall MIPS composite score. Providers scoring at least a 75 in this category will be considered “meaningful EHR users” and will be rewarded for their “high performance”.

CMS will accept a minimum of 90 days of reporting for CY 2017 and 2018; afterwards, providers will be required to report for the full calendar year. There will be consideration of “hardship exemptions” for certain providers.

Hospital-based clinicians—those who deliver 75 percent or more of their services in an inpatient hospital, on campus outpatient hospital, or emergency room—will be exempted from the advancing care information category because CMS believes these individuals may not have sufficient experience using EHRs. The weight of the other categories will be increased to offset this exclusion. A hospital-based clinician may forgo this exclusion and choose to report as other clinicians; in such a case, the weight of the categories would return to their original weights.

Cost

Referred to as “resource use” in the proposed rule, this category, as the name implies, is simply a measure of cost effectiveness. It does not require any reporting on the provider’s behalf, because Medicare will already have this data in its claims files for each provider. CMS will evaluate providers’ performance on measures which have previously been used in the VM program or the 2014 Supplemental Quality and Resource Use Report (sQRUR). CMS will calculate providers’ total per capita costs for all attributed beneficiaries (which must be at least 20) and a Medicare Spending Per Beneficiary (MSPB) measure (which requires a minimum of 35 beneficiaries). The cost performance score will be the equally-weighted average of all scored cost measures.

Resource use will not be counted in 2017 (it will be given a weight of zero), though, providers will nonetheless be provided feedback on their performance in this category. This weight will gradually increase to 30 percent, as required by MACRA, by the third payment year, 2021.

Summary

The following provides an overview of the requirements for a typical provider, and the weight given to each component of the MIPS Composite Score.

Score Component	Requirements	Component Weight (upon full implementation in 2021)
Quality	Report at least six quality measures, including both process and outcome metrics	30 Percent
Clinical Practice Improvement Activities	Perform health care delivery improvement activities aimed at care coordination, beneficiary engagement, population management, and health equity	15 Percent
Advancing Care Information	Advance patient engagement and health care quality through use of CEHRT	25 Percent
Cost	Providers not required to submit anything; CMS will use claims data	30 Percent

Qualifying as a MIPS Provider

Any provider considered to be a MIPS eligible clinician is required to participate in the MIPS program. MIPS eligible clinicians, at least in the first two years, include physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists, as defined under the Social Security Act; in the third year, other clinicians may be considered. Clinicians who are ineligible to be considered as MIPS providers are allowed the option of voluntarily reporting measures under MIPS; while these providers will not be subject to MIPS payment adjustments, doing so may help prepare them for when they do become MIPS-eligible in the future.

Clinicians will be considered “non-patient facing clinicians” if they have 100 or fewer patient-facing encounters during a performance period. This determination will be based on a 24-month assessment period prior to the start of the performance period to allow clinicians to know whether they fall into this category before the performance period begins. For groups billing together under a single Taxpayer Identification Number (TIN), 75 percent of the clinicians in the group must meet the standard that an individual clinician would have to meet for the group to be considered non-patient facing.

Clinicians who wish to report as a group may do so using a single TIN, and all clinicians within the group will be assessed as a group. This requires aggregating all performance data for each performance category for all clinicians within the group; however, some clinicians within the group may not be MIPS eligible clinicians. These clinicians would not have their payments adjusted by MIPS, just as they would not otherwise.

Some clinicians will be excluded from MIPS due to the low-volume threshold which will apply to all clinicians with \$30,000 or less in Medicare billing charges or those with 100 or fewer beneficiaries enrolled in Part B, according to historical claims data from before the performance period begins. Additionally, new Medicare providers, Qualifying APM Participants (QPs) and Partial QPs are excluded from MIPS. Partial QPs, however, may choose to report and be scored under MIPS.

MIPS Payment Adjustments

The Medicare Physician Fee Schedule (PFS) and relative value units will be the underlying basis for MIPS payment adjustments, just as it was the basis for Part B payments under the SGR payment model. MACRA mandates that the PFS will automatically increase by 0.5 percent annually between 2015-2019, receive no update between 2020-2025, and—for MIPS providers—increase by 0.25 percent annually in 2026 and beyond. (The PFS will see larger annual increases for APM providers beginning in 2026; this is intended to encourage physicians to transition to APMs.) This base score will then be adjusted, positively or negatively, based on the providers performance and relative MIPS composite score. Because payment adjustments are based on relative performance each year, the adjustment will change each year, within a given range.

The first performance period for this new program is calendar year 2017 and the first payment period under QPP will be 2019, though these will be considered transitional and development periods. The transitional period is intended to ease the conversion to this new payment program by not requiring full implementation of all provisions in the initial year. During the transitional period, there will be an emphasis on education and encouraging participation. Full implementation will begin in performance year 2018/payment year 2020. (Providers participating in any of the three current payment programs that are being wrapped up into MIPS will continue to have their payments adjusted accordingly under those programs until the end of 2018.[1])

In 2017, providers can **choose** the extent to which they wish to participate from four different options, each with their own benefits and consequences. To qualify for any positive adjustment, providers must report data for any continuous 90-day period. For potentially larger bonuses, providers must report for the entire year. Alternatively, to simply avoid a negative payment adjustment, providers may report a single quality measure, a single improvement activity, or just the required measures in the advancing care information performance category. The final composite score will be considered relative to a performance threshold of 3 points in the transition year. These requirements and thresholds will increase in later years. Finally, providers may choose to participate in an Advance APM and be paid under that system. Not participating in any way will result in the full 4 percent penalty.

Performance standards and thresholds will, as required by law, be based upon historical performance standards, improvement, and the opportunity for continued improvement. Providers will know in advance the methodology for setting performance standards and for calculating their scores in each category.

Scores equal to the performance threshold will not receive any payment adjustment, positive or negative. Scores above and below the threshold will receive positive and negative adjustments, respectively, which will increase with distance from the threshold.

Providers may report as an individual or as part of a group, though, this choice must be consistent across all score components. The MIPS payment adjustment will be applied at the TIN/NPI (National Provider identifier) level. In order to report as a group, all clinicians within the group must be included in the same TIN.

Performance feedback for all categories will initially be provided on an annual basis, but CMS hopes to increase the frequency in later years. It is hoped that providers will be able to use this feedback effectively to improve their performance. Additionally, each providers' composite score will be listed on the Physician Compare website so that beneficiaries can make more informed decisions about which doctors they choose to see.

CMS expects roughly 600,000 clinicians will be required to participate in MIPS in 2017, and that base positive payment adjustments will equal \$199 million. These adjustments will be offset by an equal amount of negative payment adjustments, as MACRA requires budget neutrality. A linear sliding scale positive payment adjustment factor will be used to preserve budget neutrality, capping bonuses at up to three times the maximum payment adjustment percentage for a given year, unless the provider earns the exceptional performance bonus.

There is \$500 million available each year from 2019-2024 for bonus payments for exceptional performance; in the initial year, this threshold will be set at 70. The bonus payment received by a clinician must be paid as a percentage of the provider's claims, and may not exceed 10 percent. CMS has decided to award bonus payments on a linear sliding scale, ranging from 0.5 percent for clinicians achieving a score equal to the threshold, and increasing to the maximum 10 percent for providers earning a score of 100. Depending on how well the providers perform in aggregate, the full \$500 million may not be awarded each year. If the earned bonuses would exceed \$500 million based on these current parameters, CMS will decrease the starting percentage accordingly until a linear sliding scale may be used without exceeding the 10 percent threshold for the top performers.

Potential Payment Adjustments Under MIPS



MIPS APMs

Some individuals may be participating in an APM that does not qualify as an Advanced APM, according to CMS standards, and therefore will not be eligible for payment under the APM track. These APMs will instead be considered MIPS APMs provided that they are operating under a contract with CMS or by law or regulation; the entity participating in the APM must include at least one MIPS eligible clinician on a Participation List; and the APM must base payment incentives on performance relating to cost/utilization and quality measures. The clinicians participating in these MIPS APMs will be subject to the MIPS reporting requirements and payment adjustments. Similarly, clinicians participating in an Advanced APM, but failing to meet the participation threshold, will be subject to MIPS. However, these individuals will be scored under a different system—the MIPS APM scoring standard.

The MIPS APM scoring standard aims to reduce the reporting burden since clinicians participating in APMs will have their own separate APM reporting requirements. Its standard will only apply to clinicians that are included on the APM's Participation List, but all MIPS eligible clinicians participating in the APM must be assessed together. The weights assigned to the cost and quality performance categories may differ from the weights assigned for MIPS clinicians not participating in MIPS APMs; the weights for the other categories would be adjusted as needed. The final score will be applied at the APM Entity level, and used to determine the MIPS payment adjustment for all the MIPS APM participants in that Entity. The APM scoring standard is similar to group assessment under MIPS, but differs in that the APM Entity could include more than one TIN and not all clinicians under the same TIN are required to be APM participants.

Under the MIPS APM scoring standard for Shared Savings Program ACOs and Next Generation ACOs, the quality performance category will account for 50 percent of the overall score. The quality data submitted by the APM to CMS for evaluation under the APM contract will be used for purposes of meeting the MIPS reporting and evaluation requirements. Cost will not be scored in the APM scoring standard so as not to create conflicting directives since the APMs must be evaluated for their resource use as a condition of being an APM. The weight of this category will be redistributed across the other categories. The APM Entity's score for the advancing care information performance category will account for 30 percent of the overall score. This will be calculated as a weighted average of the scores achieved by the individual TINs within the APM, weighted by the number of eligible clinicians within each TIN. For the improvement activities category, which will be weighted at 20 percent, APM Entities will be evaluated based on the improvement activities required by the APM, which CMS will compare to the requirements of the MIPS program. If CMS determines that the improvement activities requirements of the APM are insufficient, APM Entities will be allowed to report on more activities and earn additional points. CMS will publish in advance of the performance period how the requirements of the APM measure up to the MIPS requirements so that Entities will know whether they need to do more to score additional points. For other MIPS APMs, which may include the CPC+ program, the improvement activities category will account for 25 percent of the score and the advancing care information category will account for 75 percent; the cost and quality categories will have no weight, though these will be accounted for in the requirements of the APM contract itself.

Summary

More than 700,000 Medicare Part B service providers are being evaluated under the new MIPS payment program for the first time this year; payment adjustments based on this year's performance will be applied in 2019. Performance will be evaluated based on the quality of care provided, the cost effectiveness of the services provided, the providers' effort to improve patient outcomes, and the use of advanced health information technology. Payments may be adjusted, positively or negatively, by as much as 4 percent in the first payment

year; though it is likely most providers will receive no payment adjustment in the first year, as CMS has intentionally allowed for significant leniency in the transitional period as physicians adjust to these considerable new requirements. In future years, MIPS providers may see payments adjusted by as much as 9 percent by 2022.

[1] Incentive payments for the Medicaid EHR Incentive Program will continue through payment year 2021, so long as the provider continues to meet the requirements and submit the data as required under that program. This will require separate reporting from the MIPS program.