

Understanding MACRA: Everything you need to know about MIPS and positive payment adjustments

July 2017

Contents

How MIPS fits into MACRA	3
Who needs to report under MIPS?	5
The 4 phases of MIPS	6
Achieving the highest positive adjustment possible with improved care coordination	6
Summary	11
Sources	12

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The landmark passage of the Medicare Access and CHIP Reauthorization Act (MACRA) marked one of the most significant changes to Medicare legislation that the healthcare industry has seen.

MACRA repealed the Medicare Part B Sustainable Growth Rate reimbursement formula and replaced it with a new method of distributing payments to providers called the Quality Payment Program (QPP).

There are two reporting tracks clinicians can adopt when participating in MACRA—the Merit-based Incentives Payment System (MIPS) and the Alternative Payment Model (APM). And within each of MIPS and APM there are two stepping-stone tracks, yielding a total of four MACRA participation tracks that are important for physicians and specific categories of clinicians (see list on page 5) to understand.

Of the four reporting tracks, the MIPS Eligible Clinician category (see Table 1) will apply to most practicing clinicians and providers and will become the “new default” category for providers treating Medicare Part B patients.

Very few clinicians are exempt and must report at least 90 consecutive days of MIPS performance data beginning this year. And because the ultimate outcome of this year’s performance measurements will determine payment adjustments in 2019, the focal point for clinicians for the duration of 2017 should be to fully understand the MIPS reporting requirements—who needs to report, what they need to report and how it will ultimately affect their bottom line.¹

How MIPS fits into MACRA

There are four MACRA QPP participation categories, and every physician will fall into one of these: MIPS Eligible Clinician, MIPS APM Participant, Partial Qualifying APM Clinician and Advanced APM. The most well-known and discussed tracks are the two that are featured on either end of the chart below: MIPS Eligible Clinician (which we’ll simply refer to as MIPS for the remainder of this paper) and Advanced APM Qualifying Clinician.

Table 1

The four MACRA QPP participation categories and criteria for determining category eligibility. Source: The Health Management Academy, 2017.

MACRA QPP participation categories			
Subject to MIPS			Advanced APM Qualifying Clinician
MIPS Eligible Clinician	MIPS APM Participant	Partial Qualifying APM Clinician	
Eligible clinicians not meeting APM thresholds, or low-volume or new to Medicare exclusions	MIPS eligible clinicians participating in advanced APM models — plus MSSP Track 1 & 1-sided OCM — but below partial qualifying thresholds	Eligible clinicians not meeting Advanced APM thresholds, but coming close	Eligible clinicians meeting full participation thresholds in Advanced APMs

The two tracks in the middle of the table — MIPS APM Participant and Partial Qualifying APM Clinicians — are bridge areas, and won't apply to many providers right now. They can, however, be considered stepping stones from MIPS to APM.

Most clinicians, at least initially, will fall into the MIPS category — which requires them to report several performance metrics to CMS that will impact the level of positive or negative payment adjustment they'll receive in 2019.

On the other end of the spectrum is the advanced APM category. To reach APM status, clinicians must engage in a threshold of downside risk. In this track, participating clinicians will enjoy fewer reporting requirements and more financial incentives — while still being held accountable for delivering high-value care.

Very few participants are going to land in the APM category initially, but eliminating inefficiencies that stand in the way of providing high-value care and assuming enough downside risk to become APM eligible is the goal. Because if clinicians can achieve APM eligibility they'll be exempt from the bureaucracy of MIPS reporting requirements and become eligible for certain financial incentives.²

Who needs to report under MIPS?

Physicians aren't entirely unfamiliar with performance reporting. Programs like Meaningful Use (MU) and the Physician Quality Reporting System (PQRS) measure many of the same elements that MIPS will measure, but under MIPS the scope of participants has widened and a larger, specified set of clinicians are required to report on their performance in 2017. And that larger, specified set of clinicians is expected to expand even farther to encompass more healthcare roles by 2020.

For example, clinicians who practice largely in fee-for-service models and those who bill more than \$30,000 annually in Part B charges must report under MIPS—in other words nearly every provider who is not already a part of the APM category. There are, however, a few notable exceptions.

For example, clinicians who are in their first year ever participating in Medicare are not required to report any of the performance categories. After their first year, however, they will be subject to MIPS reporting.

The only group of clinicians fully exempt from the MIPS reporting mandates are clinicians who already practice in an ACO, or have enough of their money going through bundled payment models—the new ultimate goal for all clinicians.⁴

Clinicians subject to MIPS participation

2017

- Doctors of Medicine (MD)
- Doctors of Osteopathy (DO)
- Doctors of Dental Surgery/
Dental Medicine (DMD/DDS)
- Doctors of Podiatry
- Doctors of Optometry
- Chiropractors
- Physician Assistants (PA)
- Nurse Practitioners (NP)
- Clinical Nurse Specialists
- Certified Registered Nurse
Anesthetists

2020

- Physical Therapists
- Occupational therapists
- Speech-language
pathologists
- Audiologists
- Nurse midwives
- Clinical social workers
- Clinical psychologists
- Dietitians
- Nutritional professionals³

The 4 phases of MIPS

There are four chronological steps in the MIPS track that lead to determining how payments will be adjusted in 2019: measuring performance, calculating compositing scores, conducting threshold comparisons and accounting for additional adjustments.

In phase one, performance will be measured by the scores or metrics clinicians report in four weighted categories. Those numbers will be used to generate a composite score that will be compared to the composite scores of other reporting clinicians. Depending on the over/under threshold of the composite score, clinicians will receive a neutral, positive or negative payment adjustment in 2019.

Step 1: Measure performance

The year of MIPS performance measurement is here. January 1, 2017 marked the beginning of the first year that clinicians will be responsible for collecting and reporting performance based data in four weighted categories: Cost, Quality, Advancing Care Information and Improvement Activities. Of the four, only three apply in 2017 because the Cost category measurement has been deferred for one year.

At the end of 2017, all clinicians participating in MIPS must report three consecutive months—just 90 days—of performance data. The scores that CMS calculate based on that data will determine payment adjustments for 2019. The performance/payment schedule will be a two-year look-back period, so the data collected in 2018 data will impact scores and payment adjustments in 2020, and so on.

Before they report performance scores, clinicians need to decide if they plan to report in MIPS as individuals or as a group under one taxpayer identification number (TIN).

When deciding how to report, it's important to consider that by choosing to report as a group, performance scores will be averaged across all the clinicians in the group. If a physician scores low in one category, it can negatively affect the score of the group as a whole. Likewise, if one physician makes significant strides in a category, it can bolster the score of the whole group.

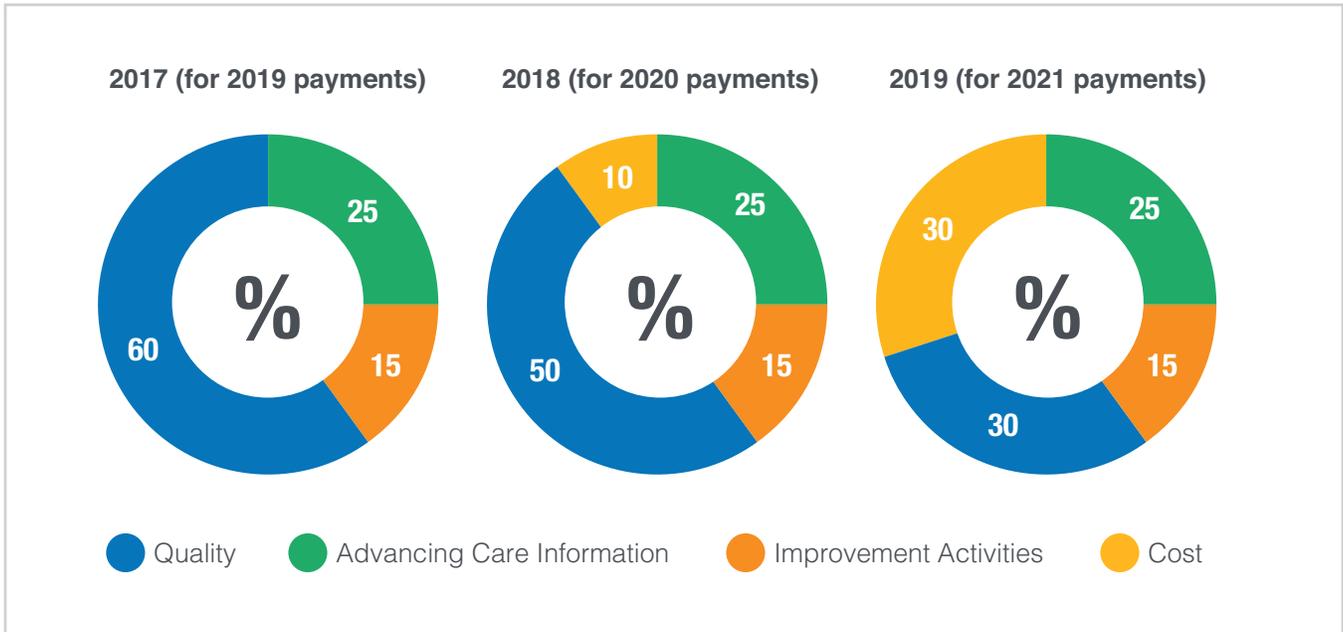
Here's what you need to know about each of the four weighted performance categories:

Special Scoring Considerations

- Non-patient-facing clinicians: Clinicians billing 100 or fewer patient encounters (including telehealth) will not need to report Advancing Care Information scores. These clinicians also have lessened reporting requirements for Improvement Activities.
 - Hospital-based clinicians: Clinicians who conduct 75% or more of their services in a hospital setting will not need to report Advancing Care Information scores.
 - Clinicians in rural or geographic health professional shortage areas: These clinicians are only required to report Improvement Activities scores.⁵
- **Cost** measures include the total per capita costs for all attributed beneficiaries, Medicare spending per beneficiary and up to 10 other episode-based measures. The cost measurement will not be factored into composite scores for 2017 or payment adjustments in 2019, but will take effect in 2018 and impact payments in 2020.
 - **Quality** measures are similar to PQRS and CMS has projected that physicians who have been successful under PQRS will also perform well in the MIPS Quality category. Clinicians will report six quality measures to CMS that best reflect the clinician’s practice; and specialists will have specialty-specific measures they can choose to report. While at least one of those should be an outcome measure, clinicians are given the leeway to select a high-priority measure to report if no outcome measure is available.
 - **Advancing Care Information (ACI)** measures are similar to MU and, again, CMS is projecting that physicians who have been successful under MU will also be successful under ACI. The goal is to advance how clinicians are using EHR technology in their day-to-day practice, with an emphasis on information exchange and interoperability. To ensure positive performance in this category, CMS has comprised the total ACI score of: a “base score” that counts as 50%, a “performance score” that counts as 90% and an opportunity to earn additional bonus points that count as 15%. So, clinicians who score perfectly in each category and receive all of the bonus points can earn a score of 155% in this category. Top performers are capped at 100%, though, and this ensures that clinicians can focus on the measures that are most important to their practice or specialty and still receive top marks.⁶
 - **Improvement Activities** is the only brand new way CMS is measuring clinicians’ performance in 2017. In this category, clinicians can report on over 90 activities that are best suited for their practice that focus on patient-centered activities like care coordination, beneficiary engagement, population management and health equity.⁷

Each performance category will account for a certain percentage of the final composite score and the weight changes year to year — but only for the first three year as clinicians adjust to the new reporting requirements.⁸

MACRA QPP participation categories



Source: The Health Management Academy, 2017.

Step 2: Composite score

After the performance measurement data is analyzed, CMS will give each physician or group a composite/final score between 0 and 100.

Participants and their practice partners could have completely different composite scores based on their own performance, but if they choose to report as a group, everybody in the group is going to receive the same score. That's why it is important to think about how to report under MIPS, and it's a decision that must be made by the end of 2017.

Composite scores are not only important because they directly impact CMS payment adjustments, but also because they will be public scores, accessible by patients and other providers through the CMS website and may be picked up by other websites like Yelp and Zocdoc.⁹

Step 3: Threshold comparison

For the first two years of the program, CMS has the freedom to decide what the threshold comparison score is going to be. After that, the threshold will be more-or-less set in stone without as much fluctuation. Clinicians who score above the threshold will receive a positive payment

adjustment. Likewise, clinicians who score below the threshold can expect a negative adjustment.

Again, to ensure as much positive performance as possible, CMS has set the comparison threshold score for 2017 at just 3 out of 100 possible points. That means:

- Clinicians who receive a composite score of exactly 3 will receive a neutral adjustment – neither positive nor negative in 2019.
- Clinicians who receive a composite score of less than 3 are at risk of receiving a negative payment adjustment between 1-4% in 2019, depending on the threshold comparison.
- Clinicians who receive a composite score of higher than 3 can expect a positive payment between 1-4% in 2019, depending on the threshold comparison.

Both the risk and reward increase as the program ages and the maximum negative and positive adjustments in the coming years are as follows: 5% in 2020, 7% in 2021 and 9% beginning in 2022.

For the first year, at least, CMS has set a very low bar to clear in terms of the threshold comparison. By just attempting to report any data at all, it's expected that clinicians will easily clear the threshold and receive a positive payment adjustment in 2019.¹⁰

Step 4: Additional adjustments

This is a MIPS step that aims to truly reward the exceptional participants. Clinicians who score high in terms of the average composite scores are eligible for additional positive adjustments up to 3x the threshold adjustment. For example, top performers in 2017 will surpass the 4% positive adjustment allocated for their threshold comparison rank, and are eligible for a positive adjustment up to 12% in 2019. These incentives also increase as the program ages and top performers in will be eligible for a 15% positive adjustment in 2020, a 21% positive adjustment in 2021 and a 27% positive adjustment beginning in 2022.¹¹

Achieving the highest positive adjustment possible with improved care coordination

“Seamless care team communication and collaboration among interdisciplinary, and often disparate, providers will be a foundation on which you can lay the groundwork for improved care coordination, which leads to less waste, improved efficiencies, and ultimately better outcomes, all of which underlie value-based care”

-Caitlin Greenbaum,
*Director of Health Policy & Strategy, The Health Management Academy*¹²

It's important to perform well in the MIPS performance categories to achieve a high composite score and maximize the potential for positive payment adjustments. There are process-based and technological strategies that healthcare leaders can begin implementing now that will improve their chances of accumulating high scores in these MIPS performance categories:

- **Cost:** The processes and treatment plans used by clinicians to deliver patient care are directly tied to costs. In the face of potentially negative payment adjustments, it's more important than ever to realize cost savings, a feat that will be heavily impacted by providers' ability to manage chronically ill populations. Success in population health management is highly dependent upon efficient communication, collaboration and care coordination across all care team members and care settings. Communication workflows and unified communication tools need to be assessed and implemented to improve the speed and efficiency with which disparate care team members can communicate with each other to coordinate care.
- **Quality:** Clinicians have a lot of personal freedom when it comes to the quality of the care they deliver. One of the more manageable ways to improve the quality of healthcare is to overcome communication obstacles that have long degraded and delayed care. Obstacles such as not knowing who to contact for a given situation; searching for and struggling to find contact information and leaving messages with intermediaries; never knowing if the right message will be delivered to the right recipient, thus suspending and disrupting care, etc., are easily overcome with the help of intelligent communication routing and automatic escalation tools.
- **Advancing Care Information (ACI):** EHR functionality is a key component of ACI, but an EHR's capabilities to support care coordination are limited. Care team members in a physician's network may or may not share the same EHR, and the need to seamlessly communicate with them — and those outside of the network who are even less likely to have the same EHR — is equally important. There's an increased need to implement a system of secure communications that transcend disparate EHRs to ensure timely bilateral exchange of patient information. Interoperability is an important factor for the ACI performance score.

- **Improvement Activities:** Clinicians who utilize patient-centered approaches to achieve better, smarter and healthier care will perform well in this category. Implementing tools that enable patient-centric communications is one step toward achieving a high score in the Improvement Activities performance category.

Key Takeaways

- All clinicians who score above the performance threshold will be eligible for a positive payment adjustment.
- To get incentives, clinicians must submit data.
- Benchmarks and thresholds will be known in advance¹³.

More than 600,000 clinicians will be responsible for reporting MIPS performance criteria for at least 90 days this year. MIPS reporting is complicated, complex and extremely important to understand because it will impact CMS payment adjustments beginning in 2019.

The threshold to receive a positive payment adjustment has been set very low for 2017, so there's less financial risk for eligible clinicians in the first year. The clinicians who want to cross the low composite score threshold to receive the maximum positive adjustment possible in 2019 need to score high in the performance measurement areas of Quality, Advancing Care Information and Improvement Activities. Reporting in the Cost category will begin in 2018.

Unified communication platforms like PerfectServe® help clinicians decrease costs and improve quality by eliminating inefficient and time-consuming communication processes that delay treatment. Our cloud-based architecture allows clinicians to transcend the communication capabilities of the EHR and securely coordinate care with disparate interdisciplinary providers regardless of their location; and the patient-centered communication capabilities neatly fulfill all of the criteria for the Improvement Activities performance category.

Sources

1. “Frequently Asked Questions: Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).” December 2016. <http://www.aafp.org/practice-management/payment/medicare-payment/faq.html>
2. “Making Sense of MACRA” webinar. The Health Management Academy and PerfectServe. March 2017.
3. June 2016. <http://www.practicefusion.com/blog/cms-broadens-meaningful-use-eligible-professionals-eligible-clinicians>.
4. “Making Sense of MACRA” webinar. The Health Management Academy and PerfectServe. March 2017.
5. “THE MERIT-BASED INCENTIVE PAYMENT SYSTEM: MIPS Scoring Methodology Overview” PPT deck. CMS. March 2017. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MIPS-Scoring-Methodology-slide-deck.pdf>
6. “Quality Payment Program Advancing Care Information Performance Category Fact Sheet. CMS. March 2017. https://qpp.cms.gov/docs/QPP_ACI_Fact_Sheet.pdf
7. “MIPS Composite Score 101: How you will be scored under the Merit-Based Incentive Payment System.” Able Health. June 2016. <http://ablehealth.com/2016/06/30/mips-scoring-101-achieve-your-best-but-know-youll-still-be-compared-to-others/>
8. “Making Sense of MACRA” webinar. The Health Management Academy and PerfectServe. March 2017.
9. “Making Sense of MACRA” webinar. The Health Management Academy and PerfectServe. March 2017.
10. “Making Sense of MACRA” webinar. The Health Management Academy and PerfectServe. March 2017.
11. “Making Sense of MACRA” webinar. The Health Management Academy and PerfectServe. March 2017.
12. What to expect from MACRA: The early years”. Caitlin Greenbaum. TheConnectedClinician. May 2017.

13. "THE MERIT-BASED INCENTIVE PAYMENT SYSTEM: MIPS Scoring Methodology Overview" PPT deck. CMS. March 2017. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MIPS-Scoring-Methodology-slide-deck.pdf>