The Components of the Merit-Based Incentive Payment System

Here's what you need to know about MIPS.

BY RICHARD HAYDEN SELF, MD, MBA, AND JANIS COFFIN, DO

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The passage of the Medicare Access and CHIP Reauthorization Act in April 2015 set the stage for the Part B reimbursement changes. They are set to take place in 2019 based on the 2017 reporting period in relation to performance within core Medicare initiatives through the Merit-Based Incentive Payment System (MIPS). These changes will reflect the new "fee-for-performance" approach to reimbursements through individualized changes to an individual or practice group's conversion factor used in the RVU reimbursement calculation. The metrics being used as a basis for eligible provider (EP) competitive ranking for either positive or negative reimbursement changes are in proportion to performance on chosen Physician Quality Reporting System measures, value-based payment modifier calculations, compliance with Modified Stage 2 or Stage 3 Meaningful Use as part of the Electronic Health Record Incentive Program, and ongoing participation in clinical practice improvement activities. This article describes the core elements that make up MIPS and discusses the likely criteria that will be used as the core elements necessary for competitive reimbursement ranking.

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Eligible Providers

According to the MACRA definitions, anyone who is or has the potential to become a Medicare-eligible provider can have his or her reimbursements significantly affected by the adoption of this system by 2019. Thus, a fundamental understanding of this program may have profound implications for a provider's ability to meet the needs of his or her patient population. MACRA's definition of an eligible provider currently includes practicing physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists, but can be extended to include certified nurse midwives, clinical social workers, clinical psychologists, registered dietitians, or nutrition professionals, physical or occupational therapists, qualified speech-language pathologists, or qualified audiologists.[1,4] Current rules allow for the formation of "virtual groups" of no more than 10 EPs to report as a single entity for evaluation purposes for a given year. Although the details of the regulations involving virtual groups are still being crafted, current language in MACRA suggests that specialty or geographic classifications may dictate limitations of the scope of a virtual group.

Providers are not currently obligated to participate in PQRS due to an alternative Administrative Claim reporting option.

The Four Proposed Components of a 2019 MIPS-Eligible Provider Evaluation

According to MACRA, the foundations of MIPS EP evaluation domains will be based on the "components of the three specified existing performance incentive programs." These three specified initiatives include the Electronic Health Record (EHR) Incentive Program, the Physician Quality Reporting System (PQRS), and the Value-Based Payment Modifier (VBM), plus a new Clinical Practice Improvement Activity domain. Although each of these CMS initiatives currently is established as a discrete entity, the goal of MIPS will be to consolidate these standards into a single set of performance metrics that will be used not only for reimbursement schedules, but also for patient comparison through government-backed websites, such as Physician Compare.[2] A composite score based on four individually weighted key areas will be the basis for performance evaluation (Table 1).

Electronic Health Record Meaningful Use (Modified Stage 2 and Stage 3 Criteria)

Presumably, the MIPS Electronic Health Record requirements will be based on the finalized rules for modified Stage 2 and Stage 3 Meaningful Use that were published in October 2015.[3] Despite ongoing debate regarding the workability of these rules, given the limitations of current EHR interoperability, current legislation presumes that these rules will be in effect at the onset of MIPS performance reimbursement adjustments. Summarized rules for Stage 3 Meaningful Use are shown in Table 2.

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TABLE 1:

Domains of Evaluation for MIPS-Eligible Providers

Evaluation Domain	Description*
Quality	Compliance with evidence-based quality standard measures. Continuation of PQRS measures.
Resource usage	Minimize costs of resource utilization for patient care. Continuation of VBM measures.
Clinical practice improvement activities	Improvement activities of clinical practice or care delivery that will likely result in improved patient outcomes. Specific measures in development as of late 2015.
EHR Meaningful Use	Demonstration that a certified EHR is being utilized in a manner sufficient to improve patient safety, outcomes, and value of care. Continuation of EHR Incentive Program measures.

*Descriptions and components may change based on modifications inspired by ongoing feedback and the request-for-information period for the Medicare Access and CHIP Reauthorization Act.

EHR: electronic health record; MIPS: Merit-Based Incentive Payment System; PQRS: Physician Quality Reporting System; VBM: Value-Based Payment Modifier.

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Physician Quality Reporting System

The PQRS initiative was born from the Tax Relief and Health Care Act of 2006 as a means of gathering individual provider information in regard to one of many possible metrics that are designed to evaluate quality and value of care. As of the 2016 guidelines, 281 metrics in six National Quality Strategy domains were available for providers to report to CMS under the program (Table 3). This is a fairly substantial increase from the 225-measure set of the 2015 reporting period. The comprehensive list of measures can be downloaded in a single compressed file on the CMS website.[4] Current minimum requirements for participation in the program require nine metrics reported across at least three domains. These reported criteria began appearing on websites such as Physician Compare starting in early 2016 and are continuously updated based on reported performance.[2] Although the precise requirements for the adoption of these criteria under MIPS may be significantly different from current rules, their continued published use on publicly accessible government sponsored websites will most likely remain under MIPS.

Value-Based Payment Modifier

Starting in 2015, CMS began instituting the VBM for groups of 100 or more eligible providers as a means to alter individual providers' reimbursement rates based on data obtained from the 2013 reporting period.[5] All EPs will be assessed for a change in their individualized Physician Fee Schedule (PFS) from 2017 onward. As of the 2018 adjustment final rule,[6] the geographically, specialty, and risk-adjusted VBM composite score from the 2016 reporting period will be calculated through a bell curve evaluation of both weighted contributions of three quality and outcome performance metrics and weighted contributions of seven primary cost metrics (Table 4) The latter cost metrics are designed to

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TABLE 2:

Summary of Final Measures for Stage 3 Meaningful Use*

1) Maintain HIPAA-compliant EHR
2) >60% medication scripts transmitted to pharmacy electronically
3) Implement five clinical decision support interventions for at least four quality measures
4) Full implementation of drug interaction and drug allergy tool
5) >60% of medication orders for period are through CPOE
6) >60% of lab orders for period are through CPOE
7) >60% of radiology orders for period are through CPOE
8) >80% of patients are allowed to view, download, or transmit electronic records
9) >35% of office visits receive patient education materials identified through the EHR
10) >10% of patients view, download, or transmit electronic records
11) >25% sent/received secure electronic messages
12) >5% of patients have nonclinical data entered into EHR
13) >80% of transfers of care/referrals/new patients have medication, medication allergy, and current problem list reconciliation performed
14) >50% of transfers of care/referrals to other providers require use of EHR to generate care summary and be electronically submitted
15) >40% of transfers of care/referrals received require entry into EHR
16) Provider actively submits electronic immunization data to a public health agency
17) Provider actively submits electronic syndromic surveillance data to a public health agency
18) Provider actively submits electronic reportable case data to a public health agency
19) Provider actively submits electronic public health data to a public health registry
20) Provider actively submits electronic clinical data to a clinical data registry
21) Provider actively submits reportable laboratory results to a public health agency

*List does not include applicable exclusion criteria.
CPOE: computerized provider order entry; EHR: electronic health record.

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determine the value-based use of clinical resources.

Although 2015 was the first year in which providers may have witnessed either supportive increases or punitive individualized reductions, this positive versus negative incentivizing method is the capacity in which the VBM is designed to function from 2015 onward. This PFS modifier is expected to be continued in either its current or an expanded form starting with the 2019 introduction of MIPS. Providers are not currently obligated to participate in PQRS due to an alternative Administrative Claim reporting option. However, the VBM probably will become more intimately connected to the PQRS prior to a final consolidation under the MIPS umbrella due to complementarily triggered PFS reductions for nonparticipation in either or both.

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TABLE 3:

2016 PQRS NQS Domains and Number of Metrics Available for Reporting

PQRS NQS Domain	No. Metrics
Person- and caregiver-centered experience and outcomes	16
Patient safety	43
Efficiency and cost reduction	20
Effective clinical care	145
Community/population health	15
Communication and care coordination	42
Total	**281**

NQS: National Quality Strategy; PQRS: Physician Quality Reporting System.

TABLE 4:

Current Composite Score Compositions, Metrics, and Definitions for the Value-Based Payment Modifier Measured in 2016 to Be Implemented in 2018

Quality/outcome composite score (50% of value modifier)	PQRS or equivalent measure performance	Performance of EP to national average of elected domains, with performance in each domain equally weighted regardless of the number of measures submitted from each
	Acute preventive quality composite	Rates of preventable admissions for bacterial pneumonia, UTIs, and dehydration
	Chronic preventive quality composite	Rates of preventable admissions for COPD, diabetes, and heart failure
Cost composite score (50% of value modifier)	Per capita total costs (for Medicare Parts A and B)	Evaluates comparative average costs per beneficiary for the period
	Per capita costs for beneficiaries with CAD, COPD, diabetes, and heart failure	Specifically evaluates average costs for the period for beneficiaries with any or all of the specified conditions
	Per capita costs for beneficiaries 3–30 days post-inpatient hospitalization (for Medicare Parts A and B)	Specifically evaluates comparative average Medicare spending per beneficiary during the 30 period post–inpatient discharge window for the period

CAD: coronary artery disease; COPD: chronic obstructive pulmonary disease; EP: eligible provider; PQRS: Physician Quality Reporting System; UTI: urinary tract infection.

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Clinical Practice Improvement Activities

Currently, the domain of Clinical Practice Improvement Activities is not specifically defined by any of the CMS initiatives currently in place. The MACRA Request For Information (RFI) period has elicited feedback from many providers, however, on how this category should be defined. As it stands, the current proposal identified suitable metrics of the domain "as an activity that relevant eligible professional organizations and other relevant stakeholders identify as improving clinical practice or care delivery and that the Secretary determines, when effectively executed, is likely to result in improved outcomes."[7] The current proposal identifies five potential subcategories:

- Integration of behavioral health and primary care;
- Emergency preparedness and response;
- Achieving health equality;
- Promoting health equity and continuity; and
- Social and community involvement.[7]

Current Issues and Looking Forward

Despite the advantages MIPS offers over the previous Sustainable Growth Rate (SGR) model for avoiding potential short-term devastating reimbursement cuts across the board, there is still concern in the industry in regard to how the sub-criteria specific to MIPS currently in place will affect providers' ability to meet the requisite functionality and infrastructure necessary to hit minimum requirements. Many organizations have written open letters to the Department of Health and Human Services expressing concern over this and other points during the October 1, 2015, through November 17, 2015, RFI period.[8]

Although the specifics of MIPS have been left open to input and interpretation at the discretion of the Secretary of Health and Human Services, it is important to understand that, in some capacity, the current programs designed to alter individual PFS reimbursements based on conformity to value-based measures will be present under MIPS. Many applaud the repeal of the SGR as a major step toward a more sustainable approach to the PFS;[9] however, there remains lingering concern that this "permanent doc fix" will inevitably place the PFS in a worse position in regard to provider reimbursement compared with SGR after 2048.[10] Only time will tell if this "doc fix" remains truly permanent. **PM**

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Dr. Self is a Family Medicine Resident, Augusta University, Augusta, Georgia.

Dr. Coffin is Professor/Chair of Primary Care, Joplin Campus, Kansas City University of Medicine and Biosciences, 2901 St. Johns Blvd., Joplin, MO 64804; phone: 417-208-0630; e-mail: jacoffin@kcumb.edu.