9/14/2018

THE ACADEMY ADVISORS

POLICY BRIEF:
MERIT BASED INCENTIVE PAYMENT SYSTEM IN 2019

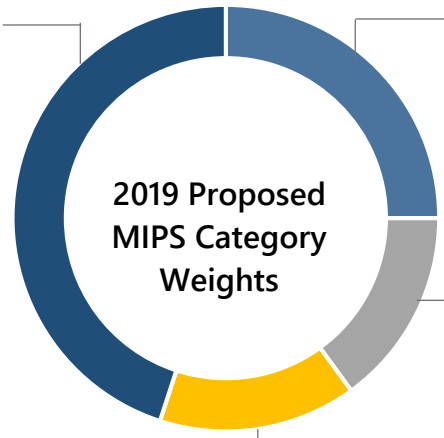
INTRODUCTION

On July 12th, the Centers for Medicare and Medicaid Services (CMS) released the Medicare Access and CHIP Reauthorization Act (MACRA) Proposed Rule for 2019. With significant changes for both the Merit Based Incentive Payment System (MIPS) and Advanced Alternative Payment Model (A-APM) tracks, CMS continues to evolve the Quality Payment Program (QPP) to align with broader administrative priorities. This brief will focus on the major changes proposed for the MIPS track of the QPP in 2019 and potential implications for large providers.

MIPS PERFORMANCE CATEGORIES

CMS has renamed the Advancing Care Information performance category Promoting Interoperability and increased the weighting of Cost to 15% of the overall score, up from 10% in 2018.

Quality (45%)
6 measures + 1 outcome



Promoting Interoperability (25%)
Report measures from four objective categories for a total of 100 points.

Clinical Practice Improvement Activities (15%)
2 high-weighted or 4 medium-weighted activities

Cost (15%)
Medicare Spending Per Beneficiary + Total Per Capita Costs + 8 episode-based cost measures

Additional types of clinicians may be included in MIPS in 2019.

CMS has proposed to include physical therapists, occupational therapists, clinical social workers, and clinical psychologists in MIPS; however, these clinicians would receive a 0% weight for the Promoting Interoperability category and CMS may create a ramp-up policy to transition these clinicians into MIPS.

CMS will allow clinicians meeting only one low-volume threshold criteria to opt-in to MIPS.

CMS has proposed three low-volume threshold criteria for MIPS ECs in 2019. To be eligible to participate in MIPS, a clinician must either see more than 200 Medicare Part B beneficiaries, receive greater than $90,000 in Part B billing, or provide more than 200 covered professional services. CMS predicts that roughly one-third of clinicians eligible to opt-in will do so.

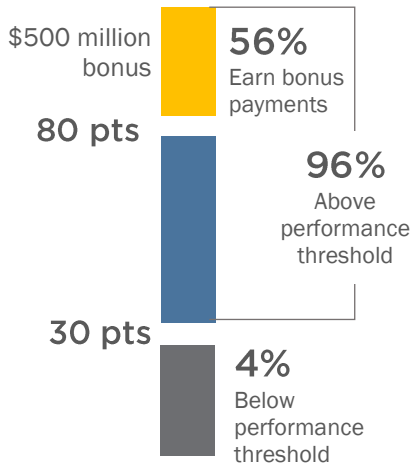
MIPS BY THE NUMBERS

- **650,000** eligible clinicians participating in MIPS in 2019
- **482,000** eligible clinicians excluded or choosing not to participate
- **42,000** eligible clinicians expected to opt-in under new low-volume threshold policy
- **2.9%** increase in the number of physicians participating in MIPS through the expansion of eligibility criteria
- **+2%** overall estimated impact of negative, positive, and exceptional performance adjustments on Part B billing

IMPACT ON PERFORMANCE

The performance threshold, distinguishing between negative payment adjustments and positive or neutral payment adjustments, is slated to increase to 30 points, up from 15 points in 2018. Similarly, the exceptional performance threshold will also increase to 80 points, up from 70 points in 2018.

The impact of the performance threshold increase remains minimal—while roughly 3% of clinicians will receive a penalty in 2018, increasing the performance threshold is expected to result in 4% of MIPS ECs in the program receiving a penalty. However, the impact of increasing the exceptional performance threshold will yield more significant results. In 2018, 77% of those achieving a positive payment adjustment were expected to qualify for an exceptional performance bonus. Increasing the exceptional performance threshold to 80 points will mean that approximately 56% of those avoiding a penalty will do well enough to achieve a bonus.



QUALITY: While reporting requirements remain similar, a number of quality measures are proposed to be removed in line with broader efforts CMS is taking to streamline quality in MIPS and focus on outcomes. The six-measure requirement remains in place, and new scoring options will be available in 2019.

Meaningful Measures initiative proposes to remove 34 MIPS measures with 10 measure additions.

The newly added measures are a mix of patient-reported outcomes measures and high-priority measures, and CMS will require a full year of quality reporting for MIPS moving forward. Participants must submit 6 measures and 1 outcome.

Topped-out measures will continue to be subject to the seven-point cap, and extremely topped out measures will be removed.

CMS defined extremely topped-out as measures with mean performance in the 98th -100th percentile. The agency has proposed to remove these measures through rulemaking regardless of how long the measure has been topped out in MIPS.

Facility-based measurement and the use of multiple submission mechanisms will be available in 2019.

CMS will allow facility-based clinicians to calculate MIPS quality and cost scores using their facility's performance in the Hospital Value-Based Purchasing Program. Clinicians may also use more than one submission mechanism to submit data within a performance category.

Measures undergoing significant clinical guideline changes will be nulled.

Measure stewards must notify CMS if a measure is significantly impacted by guideline changes during the performance period. Entities reporting these measures will not be penalized and the measure score will be nulled.

CLINICAL PRACTICE IMPROVEMENT ACTIVITIES: Measure removals lessen the difficulty of this category, and MIPS APMs are expected to retain the full points granted in earlier years.

Alignment with the Meaningful Measures initiative has impacted the number of available measures.

CMS has added six measures, modified five, and removed one. New measures focus on the opioid epidemic and will be optional for the first year. Participants can now report any number of high and medium-weighted activities to achieve a total of 40 points. Bonus points for attestation using Certified EHR have been removed, though small practices and rural participants will still receive a doubled weighting.

COST: While CMS did not scale cost weighting to 30% as planned, eight additional episode-based cost measures will be added in 2019. The number of cost measures may increase in future rule-making, and CMS may seek to add high-volume, costly outpatient episodes. The variance and distribution of cost scores will dictate flexibility and measure choice in future performance periods.

TABLE 1: EPISODE-BASED MEASURES
Elective Outpatient Percutaneous Coronary Intervention (PCI)
Knee Arthroplasty
Revascularization for Lower Extremity Chronic Critical Limb Ischemia
Routine Cataract Removal with Intraocular Lens (IOL) Implantation
Screening/Surveillance Colonoscopy
Intracranial Hemorrhage or Cerebral Infarction
Simple Pneumonia with Hospitalization
ST-Elevation Myocardial Infarction (STEMI) with PCI

Episode-based measures are poised to impact specialists, while existing population-based measures will stay in place.

CMS has introduced procedural, acute inpatient, and population-based cost measures for 2019 (**Table 1**). Each measure is based on allowed Part A and B costs and will be payment-standardized and risk-adjusted. While patient relationship codes have not been made mandatory, the increased weighting on the cost category has the potential to make it a significant differentiator of performance.

Cost measure benchmarks will be determined using peer performance during the performance period.

As opposed to using historical benchmarks, CMS intends to use peer performance-based benchmarks set during the performance period. While this may address historical efficiency concerns, peer benchmarks are harder to anticipate and manage than historical expenditures.

Procedural and acute inpatient episodes will be attributed differently.

Procedural episodes will be attributed to the clinician issuing the HCPCS/CPT code for the trigger service in the episode. Acute inpatient episodes will be triggered by MS-DRGs and attributed to the TIN that provides more than 30% of the Evaluation & Management codes during the episode window.

PROMOTING INTEROPERABILITY: Rebranding the Advancing Care Improvement category, CMS proposes similar measures with a new scoring system. The Promoting Interoperability category will be scored out of 100 points, potentially increasing the difficulty of achieving a high score.

To promote the adoption of Certified EHR Technology, CMS will require 2015 CEHRT by 2019.

Ramping up their EHR adoption goals, CMS will require MIPS participants reporting through the Promoting Interoperability category to use 2015 Certified EHR technology by 2019. The bonus options for 2015 CEHRT use will also be discontinued. Nurse practitioners, Physician's Assistants, Clinical Nurse Specialists, Certified Registered Nurse Anesthetists, physical therapists, occupational therapists, clinical social workers, and clinical psychologists will have the PI category weighted at 0% of the overall MIPS score.

KEY TAKEAWAYS:

In year three of the program, the MIPS track of the QPP continues to evolve. While large providers are better prepared from a reporting and performance standpoint, expanding the types of physicians participating in the program may require a renewed education and engagement effort. The upside in MIPS remains low—however, health systems scoring above 80 points could see higher upwards adjustments given the threshold increases. Accountability for cost episodes remains a major challenge ahead for MIPS, and episode adjustments will likely be necessary to ensure costs are meaningfully being measured moving forward. As CMS ramps up their regulatory agenda, the MIPS program will be buffeted by broader administrative goals to improve interoperability, flexibility and transparency.

MEDHA VYAVAHARE, MPH
SENIOR DIRECTOR, HEALTH POLICY & STRATEGY
703.647.3184 | MEDHA@HMACADEMY.COM

JARRETT LEWIS
EXECUTIVE DIRECTOR, THE ACADEMY ADVISORS
703.647.3194 | JARRETT@HMACADEMY.COM