Health Law Daily Wrap Up, STRATEGIC PERSPECTIVES: Save time and money with careful MIPS preparation, (Jul. 7, 2016)

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CMS' Proposed rule to implement the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114-10) builds on quality improvement measures from the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148) by streamlining and strengthening quality-based payments to physicians. The Proposed rule creates the Quality Payment Program, offering Medicare providers two payment paths: the Merit-based Incentive Payment System (MIPS)—under which, initially, most providers will be paid—and Advanced Alternative Payment Models (APMs). MIPS replaces three existing programs, consolidating components of, and replacing redundancies in the Physician Quality Reporting System (PQRS), Physician Value-based Payment Modifier (VM), and Meaningful Use (MU). MIPS participants will submit information about four different performance categories to CMS, which will use the submitted information to calculate Medicare payment adjustment rates for later years.

This Strategic Perspective discusses the proposed regulations for MIPS eligibility, the timeline CMS is suggesting, the proposed performance categories, and looks at some of the comments providers have given to CMS to improve the Proposed rule. It also includes information about how providers can prepare for MIPS reporting.

Proposed MIPS specifics. The Proposed rule (81 FR 28162) would give providers fewer measures on which to report, remove redundant reporting requirements, and allow for more flexibility in delivering quality care to Medicare beneficiaries than previous physician fee schedule regulations. Although HHS Secretary Sylvia Burwell noted that the agency has "more work to do," she called the Proposed rule "the first step in a complicated process" outlined in CMS' Quality Measure Development Plan (MDP).

Carole A. Lambert, MPA., RN., Vice President, Practice Optimization, Residents Program Director, Cooperative of American Physicians, Inc. (CAP), told Wolters Kluwer that "The goal, and the hope, is that increased flexibility in quality reporting will allow physicians to customize their reporting to accommodate for differences in specialty and practice, with an emphasis on outcome measurement. There is also the goal of more timely feedback to physicians to enable them to make changes." In replacing the sustainable growth rate, a failed attempt to limit Medicare spending, Lambert said, MACRA provided stability to providers by ending "the annual last-minute action of Congress to avoid draconian reimbursement cuts."

Eligibility. Participants in the MIPS program will be known as "MIPS eligible clinicians"—replacing the previous term "eligible professionals" or EPs—and include physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and groups including such clinicians. Hospitals are ineligible for participation in MIPS. According to CMS, all Medicare Part B clinicians will report through MIPS during the first performance year (see below), though there are exemptions to the payment adjustment for new enrollees, certain low-volume providers, and APM participants. For the first year of MIPS, clinicians are able to report as individuals or as a group of clinicians, defined by a common taxpayer identification number.

Timeline. To accelerate the alignment of quality measurement and program policies, MACRA sunsets payment adjustments for the Physician Quality Reporting System (PQRS), the Value-based Payment Modifier (VM), and the Medicare EHR Incentive Program for Eligible Professionals at the end of 2018 and establishes MIPS beginning January 1, 2019. Under the Proposed rule, MIPS would use the calendar year (CY) for its performance period.

CMS plans on CY 2017 as the first performance period, which would be used to calculate the 2019 payment adjustment. This timeframe would provide enough time to allow submission and analysis of data and claims and base adjustments on a full year of measurement. Lambert called the timeline "extremely short," but expressed confidence that the deadlines will not be a difficulty for physician practices that have been reporting PQRS, MU,
and VM, because those practices "have structures in place and staff accommodated to meeting deadlines."
However, Lambert noted, practices that wish to begin participating for the first time "will be challenged to ramp
up and adapt their systems and train staff in the new lexicon."

**Performance categories.** MIPS ties Medicare payment rates to the provision of high-value care, measured
through four performance categories. Information can be submitted individually or through a group and will use a
unified approach across all performance categories. The four performance categories are given different weights
toward a MIPS composite performance score (CPS). Each participant’s CPS would be compared against a
MIPS performance threshold, which would be used to determine the participant’s payment adjustment (upward,
none, or downward). For exceptional performance, an additional positive adjustment factor would be available.
Participants would be able to receive partial credit across the performance categories, rather than the "all-or-
nothing" scoring previous systems used.

The four performance categories to calculate the MIPS CPS are:

- **Quality.** CMS proposes including a minimum of six quality measures, including at least one cross-
cutting measure and an outcome measurement if available. Providers would choose among available
quality measures to account for differences in specialty and practice. Quality would account for 50
percent of the CPS in year one and replaces the PQRS and the quality component of the VM.

- **Advancing care information.** CMS would assess this performance category based on advancing
care information measures and objectives, which participants could customize to reflect the use of
technology, focusing on interoperability and information exchange. It would account for 25 percent of
the CPS in year one, and replaces MU.

- **Clinical practice improvement activities (CPIA).** CMS would not require a minimum number of
CPIAs, but would encourage participants by rewarding clinical practice improvements, particularly
those that improve care coordination, beneficiary engagement, and patient safety. Providers would
choose from a list of more than 90 CPIAs to match their practice’s goals. CPIAs would account for 15
percent of the CPS in year one.

- **Cost.** Cost or resource use would be based on Medicare claims and require no additional reporting
from participants. Differences among specialties would be accounted for by the use of 40 episode-
specific measures. It would account for 10 percent of the CPS in year one and replaces the cost
component of the VM.

**Comments on the Proposed rule.** During the comment period, CMS received 3,912 comments from
beneficiaries, providers, professional organizations, and other stakeholders on the contents of the Proposed
rule. The American Medical Association (AMA), American College of Physicians (ACP), and the Medical Group
Management Association (MGMA) all published lengthy comments, each in excess of 50 pages. All three
organizations commended Congress for passing MACRA and working toward value-based reimbursement and
quality care, but offered critiques and suggestions for improving upon the proposed regulations for MIPS. All
three ask for fewer reporting requirements and more time before the updates are implemented; the organizations
also agree that the advancing care information performance category needs changes.

The AMA requested a transitional reporting period for the first year, and said that MIPS is unnecessarily
complex. It would prefer that the payment system operate as a single program rather than four separate parts
and would like additional opportunities for partial credit and fewer required measures. The AMA also wants
the pass-fail component of the advancing care information score to be removed. The MGMA wants at least an
additional year before the first MIPS performance period to bring the measurement period closer to the payment
year, fewer reporting requirements, credit to be awarded across performance categories, and asked that CMS
finalize the group practice assessment option. It would like shorter performance periods for the advancing care
information category, and asks that the category be simplified. The ACP, on the other hand, developed and
proposed its own alternative scoring system to MIPS. It also requested a shorter advancing care information
performance period and simplified requirements.
Preparation. Lambert recommended that physicians begin to prepare for MIPS by taking "every opportunity to attend webinars and other educational offerings to become familiar with the new names and acronyms." She noted that determining whether a physician practice is a better fit for MIPS or APM requires a "careful reading" of the text, but that due to the estimated time and money savings involved with MIPS compared with earlier systems, careful preparation will "quite literally pay off."

Lambert called her suggested method of preparation a "crosswalk," explaining that staff should consider how the practice approached its reporting in the past and what information it was reporting. Then practices should compare the past approaches with MIPS. This comparison will allow them to recognize parallels to "ease the transition." She added, "Physicians want to be sure that the care of their patients is reflected in the precision, accuracy, and timeliness of their documentation, and paints a true picture of their dedication." This sort of preparation method is flexible enough to allow for the changes that CMS may incorporate into the Final rule based on the comments the agency received, but also ensures that providers are ready if the first reporting year is not pushed back from the proposal.

Conclusion. In some ways, MIPS is a large change from previous reporting systems—it is more flexible, encompasses more measures, and will apply to more providers than PQRS, MU, and VM. In other ways, however, it is very similar to the earlier programs, which will benefit providers who are familiar with these types of reporting. Lambert projects that the Final rule will issue in November 2016, giving practices very little time before the first MIPS reporting year begins in January 2017. To ease the transition, providers should begin preparing for MIPS now.

Companies: Cooperative of American Physicians

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