Meaningful Use 3, MACRA & MIPS

How Does This Affect Physicians?

From MACRA to Promoting Interoperability to MIPS scores, see what you, as a physician, should know in order to obtain a neutral or positive payment adjustment.

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Which Came First: Meaningful Use or MACRA?

Meaningful Use and MACRA have come in full force over the last several years. With many opposing several regulations put forth by Centers for Medicare and Medicaid services (CMS), the adjustments to both Meaningful Use (now in stage 3) and MACRA have thrown many for a loop.

Through all of the adjustments involving the removal or addition of measures, most of which changed over time, it was difficult for anyone to keep up. This whitepaper aims to help clinicians better comprehend Meaningful Use, MACRA, regulations, payment adjustments and more.

Meaningful Use

1
2009

Meaningful Use was first introduced in 2009. With the various computer technology being introduced into the healthcare industry, the policy was designed to provide government subsidies to clinicians and hospitals that used this new technology, ensuring better adoption rates.

2
2012

Stage 2 of Meaningful Use was first introduced in 2012, with the official start being 2014. This stage detailed the requirements for the use of Electronic Health Records (EHR) software. Expanding on Stage 1, it further emphasized:

- Number of electronic transactions to be done
- Changes in menu list items changing from choices to becoming requirements
- New requirement group around patient access to their medical records

3
2016

Going beyond the adoption of technology, Meaningful Use Stage 3, which came into affect in January of 2016, aimed to improve access to information in healthcare. In order to do this, CMS included eight Advanced Use Objectives[1] for Stage 3:

8 Advanced Use Objectives

1. Protect electronic protected health information (ePHI)
2. e-Prescribing
3. Clinical decision support (CDS)
4. Computerized provider order entry (CPOE)
5. Patient electronic access
6. Coordination of care through patient engagement
7. Health information exchange
8. Public health reporting

Although most of these were present in Stage 2, they emphasize greater changes and requirements for EHR vendors than they do for their actual users. This has led to many EHR vendors, both big and small, to wonder if the resources required to attest to Meaningful Use Stage 3 are even worth it, leaving many clinicians wondering what the repercussions are on their end.

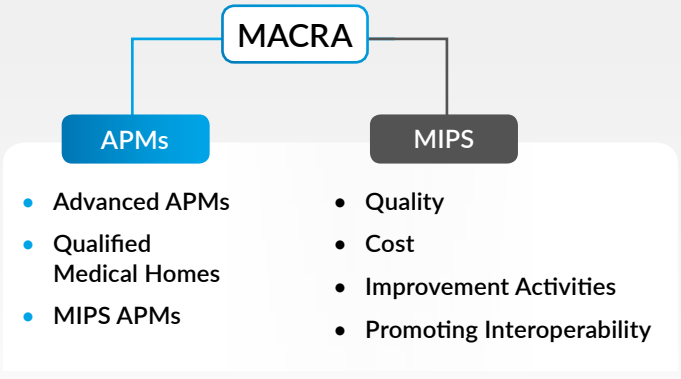
MACRA

Later in 2016, CMS introduced the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). CMS signed MACRA into law on April 16, 2015, ending the Sustainable Growth Rate (SGR) formula.

The goal for introducing MACRA was to provide two Quality Payment Programs:

Alternative Payment Models (APMs)

Merit-based Incentive Payment System (MIPS)



These programs were set forth to move away from fee-for-service to value-based care. Although both programs are driven by quality care, the incentives received from each are different.

APMs

Alternative Payment Models include:

- Advanced APMs
- Qualified Medical Homes
- MIPS APMs

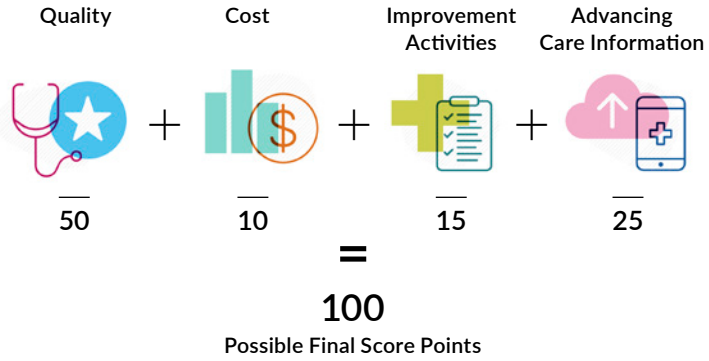
To qualify for the 5% APM incentive payment, the model requires participants to[2]:

- Use certified Electronic Health Record (EHR) technology
- Tie payment to quality
- Require downside financial risk (actual expenditures exceed projected expenditures)

In order to participate in an APM, clinicians must join an existing APM entity such as an Accountable Care Organization (ACO), a Medicare Shared Savings Program (MSSP), or apply to become a new APM entity for a specific APM.

MIPS

The Merit-based Incentive Payment System (MIPS), on the other hand, provides payment adjustments based on performance scores. It requires attestations from four categories, each with their different weights:



Source: CMS MIPS Program

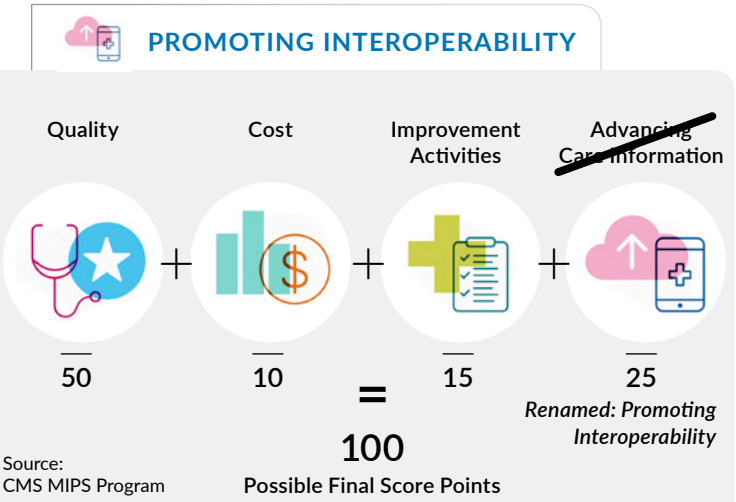
A breakdown of the MIPS performance categories shows that:

- **Quality** replaces ~~PQRS~~
- **Cost** replaces ~~Value-Based Model (VBM)~~
- **Improvement Activities have many categories that assess how you enhance patient engagement in care, improve your care processes, and increase access to care**
- **Advancing Care Information** replaces ~~the Medicare EHR Incentive Program (Meaningful Use)~~, now being renamed Promoting Interoperability

Participating in APMs, through Medicare Part B, earns clinicians incentive payments, whereas participating in MIPS earns performance-based payment adjustments.

MIPS Performance Score

Delving deeper into MIPS categories, the Advancing Care Information category has changed to Promoting Interoperability (PI)[3]. This category is worth 25% (or 25 points) of the final performance score. Quality is worth 50%, Cost is worth 10% and Improvement Activities are worth 15%. Each category includes different measures and has a unique scoring method.



Source:
CMS MIPS Program

This new category, with its many changes, seems to encompass Stage 3 of Meaningful Use. With the goal of easing the flow of information between clinicians and patients, Promoting Interoperability allows providers to choose measures that advance the productive use of healthcare information they create and ease the sharing of this data with peers and patients. This information can include test results, therapeutic plans, visit summaries and more.

The transition measures of Promoting Interoperability are[4]:

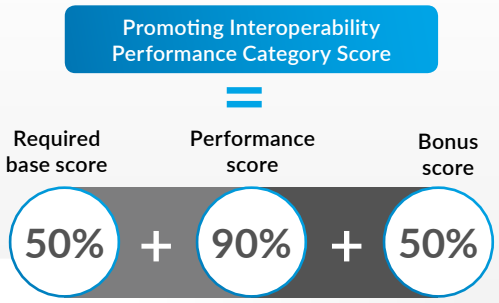
- e-Prescribing
- Health information exchange
- Provider-to-patient exchange
- Public health and clinical data exchange

The use of Electronic Health Records falls under the Promoting Interoperability category of MIPS. The score received under this MIPS category, which accounts for 25% of the final score, has two measure sets for submitting data:

1. Promoting Interoperability Objectives and Measures
2. Promoting Interoperability Transition Objectives and Measures.

The transition objectives and measures are for clinicians and practices using a 2014 or mix of 2014 and 2015 Edition Certified EHR Technology (CEHRT). The first is for the use of CEHRT 2015 Edition only.

The Promoting Interoperability score is obtained through the addition of the base score, performance score and bonus score.



The 5 base score PI measures are[5]:

1. Security Risk Analysis
2. e-Prescribing
3. Provide Patient Access
4. Send a Summary of Care
5. Request/Accept Summary of Care

The 4 base score 2018 PI transition measures are[5]:

1. Security Risk Analysis
2. e-Prescribing
3. Provide Patient Access
4. Health Information Exchange

The following are the 2018 PI transition measures for Performance[5]:

Measures for Performance Score	% Points
Provide Patient Access	↑ Up to 20%
Health Information Exchange	↑ Up to 20%
View, Download, or Transmit (VDT)	↑ Up to 10%
Patient-Specific Education	↑ Up to 10%
Secure Messaging	↑ Up to 10%
Medication Reconciliation	↑ Up to 10%
One of the Public Health Reporting Measures	0 or 10%

In short, Promoting Interoperability, within MIPS, has transitioned to be the new Meaningful Use Stage 3, with eased regulatory burdens and a smoother transition.

ONC Certified HIT 2014 EDITION

Using 2014 Edition CEHRT will allow you to qualify for scores under the transition objectives and measures and still grant you a good PI score if you meet the required measures.

QUALITY

The 2018 performance period includes over 270 quality measures[6] found within three quality measure classifications:

1. Process measures
2. Outcome measures
3. High priority measures

For the year 2018, clinicians must collect data for at least 6 quality measures, including at least one outcome measure or a high priority measure. The Quality measures category is calculated as follows:

Quality Performance Category Percent Score
(Not to exceed 100%)

=

Total Measure Achievement Points
+
Measure Bonus Point

Total Available Measure Achievement Points

+

Improvement Percent Score

The measures are scored against a benchmark, allowing clinicians to receive between 3 and 10 points per quality measure. Bonus points are earned based on improvements made to the Quality performance category year over year.

The improvement percent score is calculated as follows:

Improvement Percent Score

=

Increase in Quality Performance Category Achievement Percent Score
(From Prior Performance Period to Current Performance Period)

Prior Performance Period Quality Performance Category Achievement Percent Score

× 10%

The complete list of quality measures can be found on the Quality Payment Program (QPP) website[7].

COST

The Cost category of MIPS is the only one that does not require clinicians to submit data. In fact, the Centers for Medicare and Medicaid Services (CMS) calculates the cost measure peformance category by using Medicare claims data[8].

It draws on standards for payment standardization, patient attribution, risk adjustment and measure reliability from the Value Modifier (VM) program.

There are two cost measures used to evaluate the 2018 performance of this category:

1. Total Per Capita Costs for All Attributed Beneficiares measure (TPCC)
2. Medicare Spending Per Beneficiary measure (MSPB)

As a reference point, the TPCC measure was used in the beginning of 2015 in the VM program given through performance feedback in the annual Quality and Resource Use Reports (QRURs). The MSPB measure, which began during the 2016 payment adjustment period of MIPS, was also used in the VM program given through feedback in annual QRURs that began in 2014.

Measure-Specific Methodology: MSPB

This measure includes all Medicare Parts A & B claims of the following types:

- Outpatient
- Skilled nursing facility
- Inpatient hospital
- Home health
- Hospice
- DMEPOS
- Non-institutional physician/supplier claims

The claims need to start within an episode window, which is a period of time starting three days before an admission through 30 days after discharge.

Individuals = (Sum of Ratio* × National Average*) / Total # of MSPB Episodes**

* Payment-standardized observed to expected MSPB episode cost for all MSPB episodes attributed to an individual MIPS eligible clinician's TIN-NPI

** Total number ofMSPB episodes attributes to anindividual MIPS eligible clinician's TIN-NPI

Measure-Specific Methodology: TPCC

The TPCC measure assesses total Medicare Parts A & B costs during the performance period for a beneficiary[8]. This involves calculating the risk-adjustment, per capita costs for beneficiaries within an individual or group of clinicians. This is expressed at the TIN or TIN-NPI level by CMS and calculated as follows:

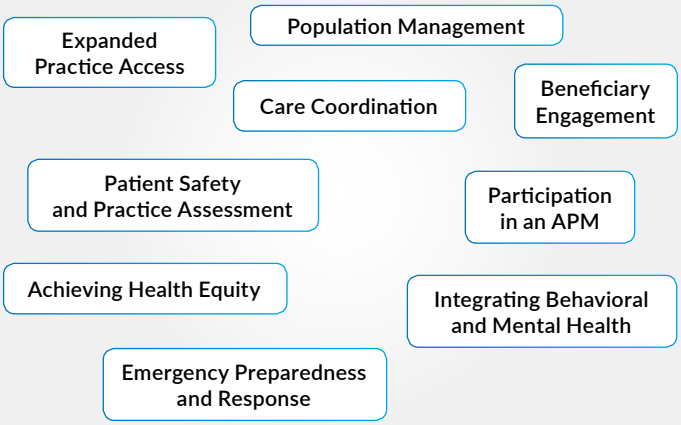
Sum of annualized, risk-adjusted, specialty-adjusted Medicare Parts A & B costs incurred by all beneficiaries attributed to an individual MIPS eligible clinician (TIN-NPI)

/

# of Medicare beneficiaries who are attributed to an individual MIPS eligible clinician's TIN-NPI

IMPROVEMENT ACTIVITIES

The MIPS Improvement Activities category is worth 15% of the final performance score. They include Clinical Practice Improvement Activities (CPIA) found within the following 9 subcategories[9]:



There are over 100 activities found within these subcategories. Bonus improvement activities have been added to the 2018 performance period. Some of these even qualify within the Promoting Interoperability (PI) performance category.

In order to score the maximum of 40 points for the Improvement Activity category, individuals, groups or virtual groups must choose any of the following combinations:

More than 15 clinicians that aren't in a rural area or HPSA[9]

- 2 high-weighted activities (any subcategory)
- 1 high-weighted activity and 2 medium-weighted activities (any subcategory)
- 4 medium-weighted activities (any subcategory)

The medium-weighted activities are worth 20 points of the total score, with the high-weighted activities being worth 40 points of the total score.

Less than 15 clinicians, non-patient facing clinicians, and/or clinicians located in a rural area or HPSA[9]

- 1 high-weighted activity (any subcategory)
- 2 medium-weighted activities (any subcategory)

Clinicians can choose two medium-weighted activities or one high-weighted activity to earn the total of 40 points for the category. It is important to note that some of the activities that clinicians attested to in 2017 have been reweighted for the 2018 performance period.

Payment Adjustments

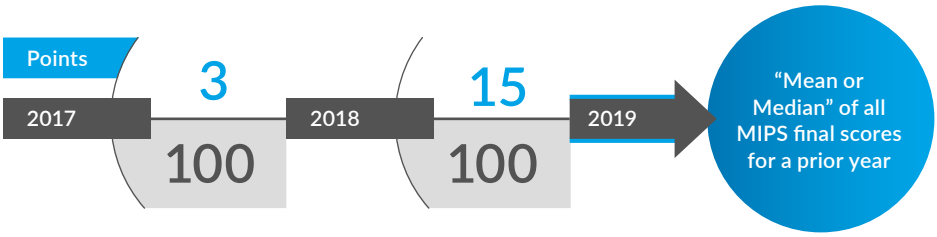
As a clinician, the focus is on meeting the various measures, most of which are not tied to EHR use.

As 2017 was a transition year, MIPS required clinicians to score only 3 points out of a possible 100 for all four categories over a three-month period. **In 2018, clinicians will have to attest throughout the entire year and score at least 15 out of 100 to receive a neutral payment adjustment.**

Any score received that is higher than 15 will result in a positive payment adjustment. For the following years, the final score that will determine the neutral payment adjustment mark will be the mean or median of all MIPS final scores of the previous year.

With the various methods of receiving points from each category and their different weights, most clinicians will be able to receive at least a neutral payment adjustment in 2018.

The year 2019 will most likely still result in neutral or positive payment adjustments if the mean MIPS final score of the year 2018 falls close to 15 points out of 100. The following years will prove to be more volatile as everything will depend on the importance clinicians put into meeting MIPS scores and what processes and technology they have in place to meet categories and measures.



Currently, whether using 2014 or 2015 Edition CEHRT, clinicians can receive a PI score that can positively contribute to a MIPS payment adjustment.

It is important to note that not all categories require a 12-month minimum performance period. Promoting Interoperability, for example, only requires a consecutive 90-day performance period. **The MIPS Performance Periods for year 2 (2018) are the following[4]:**

Performance Category	Minimum Performance Period
Quality	12-months
Cost	12-months
Improvement Activities	90 days
Promoting Interoperability	90 days

2019

For more details on changes to calendar year 2019, please see CMS' Proposed Rule for Year 3 (2019).[10]

Key Takeaways

Meaningful Use started in 2009 — 2009

MACRA started in 2015 — 2015

Alternative Payment Models (APMs)

MACRA has 2 Quality Payment Programs:

Merit-based Incentive Payment System (MIPS)

Clinicians can still score in the Promoting Interoperability category for 2018 by using Transition measures for a 2014 CEHRT

To receive a positive payment adjustment under MIPS, clinicians need to score at least 15 points out of a possible 100 for 2018

APMs can provide a 5% payment incentive if participants:

- Use certified Electronic Health Record (EHR) technology
- Tie payment to quality
- Require downside financial risk (actual expenditures exceed projected expenditures)

MIPS Performance Periods for 2018:

- = 12 months
- = 90 days
- = 12 months
- = 90 days

MIPS scores for calendar year 2018:

- Quality is worth 50 points
- Cost is worth 10 points
- Improvement Activities are worth 15 points
- Promoting Interoperability is worth 25 points

Details for calendar year 2019 found in Proposed Rule Year 3

References

1 https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/TableofContents_EP_Medicaid_Stage3.pdf

2 https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Advanced-Alternative-Payment-Models-HIMSS-2018-slides.pdf

3 https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/EHrIncentivePrograms/

4 https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/QPP-Year-2-Final-Rule-NPC-Slides.pdf

5 https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Promoting-Interoperability-Fact-Sheet.pdf

6 https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Quality-Performance-Category-fact-sheet.pdf

7 https://qpp.cms.gov/mips/explore-measures/quality-measures?py=2018#measures

8 https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Cost-Performance-Category-Fact-Sheet.pdf

9 https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Improvement-Activities-Performance-Category-fact-sheet.pdf

10 https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Overview-of-Proposed-Rule-for-Year-3-2019-slides.pdf