THE ACADEMY ADVISORS

MACRA QUALITY PAYMENT PROGRAM FINAL RULE SERIES: PART 2

MIPS PERFORMANCE CATEGORIES

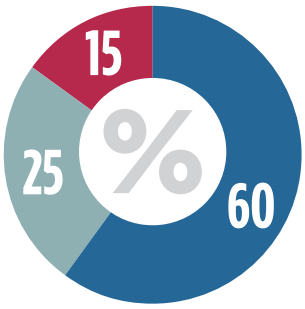
Within the MACRA Quality Payment Program ("QPP"), most clinicians and groups billing Medicare Part B—aside from newly enrolled Medicare clinicians, those not reaching certain low-volume thresholds, and those practicing above a certain level in Advanced Alternative Payment Models ("APMs")—will be subject to the Merit-based Incentive Payment System ("MIPS"). In the MIPS program, clinicians will receive an annual score based on performance in four domains, and clinicians' Part B payments will be adjusted commensurately. CMS' intent with the four performance categories is to build off of the current quality, cost, and EHR use incentive programs for physicians, making reporting and scoring simpler, more flexible, and more meaningful for those practicing in MIPS.

While the structure of the four performance categories did not change significantly from the Proposed Rule to the Final Rule, there are several changes in each of the categories which will be important for Leading Health Systems. This second brief in our series will provide an overview of the four performance domains—focusing on key changes in the Final Rule—and subsequent briefs in this series will explore reporting mechanisms and scoring methodologies in the MIPS Track.

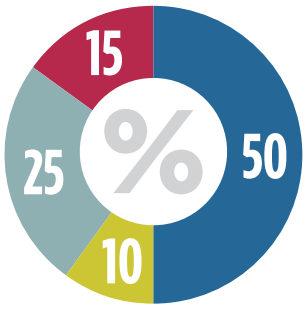
Category Weighting

Each of the four performance domains will be weighted in their contributions to the final score, with the weights for the Quality and Cost categories changing over time. In the Final Rule, CMS eliminated the Cost performance category for the initial performance year, with its proposed 10 percentage points in 2017 reallocated to the Quality domain. Over several years, CMS will phase in the Cost domain, in turn decreasing the weight of Quality.

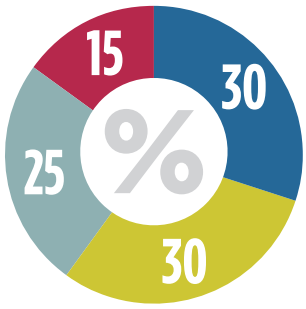
2017 PERFORMANCE YEAR
2019 PAYMENT YEAR



2018 PERFORMANCE YEAR
2020 PAYMENT YEAR



2019 PERFORMANCE YEAR & BEYOND
2021 PAYMENT YEAR & BEYOND



Four Performance Domains

QUALITY

The Quality performance domain—at least in the initial years of MACRA—will look very similar to the current Physician Quality Reporting System ("PQRS"), with several changes intended to decrease the burden for providers. Over time, CMS intends to shift the focus of quality measures away from process and more towards new outcome measures. Several key provisions of the quality domain are as follows:

- Most clinicians and groups will choose six of the most relevant performance measures—including at least one outcome measure—from a list of approximately 200 on which to be evaluated. Clinicians and groups can choose measures either individually or from a set of specialty-specific measures. CMS did not finalize the proposed requirement of reporting at least one cross-cutting measure.
- For groups of clinicians larger than 15, in addition to the six chosen measures, CMS will calculate one additional population health measure—All-Cause Hospital Readmissions—from administrative claims data. CMS did not finalize the two additional population health measures that the agency had initially proposed.
- Groups of 25 clinicians or more choosing to report through the CMS Web Interface will not be required to choose six measures, but will have to provide data on a sample of patients around a set of measures that CMS provides—similar to the current group reporting option in PQRS.
- Clinicians and groups will receive bonus points for reporting in this category through their EHR system, and for reporting additional outcome or other high priority measures.

COST

Of significance for Leading Health Systems, CMS eliminated the Cost domain for the initial performance year, both to give the agency more time to implement new attribution and adjustment methodologies, and to give clinicians more time to familiarize themselves with the existing measures. Though Cost will not contribute to a clinician's final score in 2017, CMS will provide feedback on the finalized Cost measures.

- CMS finalized the total per capita cost measure and Medicare Spending Per Beneficiary ("MSPB") measure as proposed—both of which will be only moderately adapted from similar Value-based Modifier ("VM") measures. Additionally, CMS finalized 10 of the proposed 41 episode-specific measures.
- Beginning in 2018, CMS will require the use of new codes and claims around care episodes, patient conditions, and patient relationships to enable CMS to more accurately compare resources used to treat similar patients across practices, and to better distinguish a physician's responsibility for any given patient.
- Clinicians and groups will not be responsible for additional reporting on Cost measures—CMS will utilize administrative claims data to calculate scores on behalf of participants.

ADVANCING CARE INFORMATION

The Advancing Care Information domain will incorporate measures from the current Medicare EHR Incentive Program, with CMS adjusting the methodologies such that clinicians will have greater flexibility in reporting and scoring. Notably, scoring in the Advancing Care Information domain will no longer be wholly "all-or-nothing"—clinicians will have the opportunity to earn partial points in this category if they are working towards, but are not able to fully meet, certain EHR requirements. Several key provisions of the Advancing Care Information domain are as follows:

- In the initial performance year—2017—clinicians and groups will be able to use EHR technology certified to either the 2014 or 2015 Edition; participants will thus be able to choose to either report on measures that correlate to Meaningful Use Stage 2 or Stage 3. Beginning in 2018, clinicians will be required to utilize EHR technology certified to the 2015 Edition, and will be required to report on objectives and measures which correlate to Meaningful Use Stage 3.

- Clinicians will receive a base score, determined by submitting yes/ no and numerator/ denominator responses around five objectives—electronic prescribing, send summary of care, request/accept summary of care, security risk analysis, and provide patient access. On top of the base score, clinicians will receive a performance score by selecting a set of measures that best fits their practice around patient electronic access, patient engagement, and health information exchange.

- Clinicians will earn 50 points by satisfying the requirements of the base score, and can earn up to 90 points through performance measures—any score equal to or exceeding 100 will earn clinicians maximum points in the domain. A clinician or group will not be able to earn points in this category without fulfilling the requirements of the base score.

- Clinicians and groups will be able to earn a variety of bonus points in this category—an additional 5 percent for reporting to additional public health registries beyond the immunization registry, and an additional 10 percent by reporting certain Improvement Activities using CEHRT.

IMPROVEMENT ACTIVITIES

Improvement Activities is the only performance category in MIPS that is not pulling measures from previously existing physician incentive programs. That said, Leading Health Systems and affiliated clinicians should be better prepared than most to score well in this category, as it involves reporting activities in which many systems are already engaged. Several key provisions of the Improvement Activities domain are as follows:

- Clinicians will be able to select measures from a list of nearly 100 activities, largely focused around expanded access, population management, care coordination, beneficiary engagement, and patient safety/ practice.

- Measures are given either a "high" or "medium" weight, with the former earning more points towards the total domain score than the latter. Depending on whether the clinician or group is reporting high or medium weighted activities, participants will generally need to report two to four activities to receive the maximum score in the category.

- Clinicians and groups will not be measured on performance in these activities, at least initially; rather, they will have to attest to having participated during the performance year, which at least initially is at a least a consecutive 90-day period. Of note, at least initially, if reporting as a group only one clinician within the group will need to participate in an Improvement Activity for the performance period in order to earn points for the entire group.

- MIPS clinicians participating in Patient Centered Medical Home ("PCMH") models will be guaranteed to receive the maximum score in the performance domain, and those participating in other APMs will be guaranteed to receive no less than half of the maximum score in the domain. In the Final Rule, CMS expanded the PCMH definition to include certification from a not only a national program, but a regional or state program, private payer, or other body that administers PCMH accreditation.

Alternative Performance Category Requirements

For certain types of clinicians—to include non-patient-facing and hospital-based clinicians—that may not be well positioned to participate fully or score well in the performance categories, CMS proposed to establish a set of alternative requirements for each of these domains. Of note, CMS finalized more generous thresholds than proposed for both categories of clinicians.

	Non-Patient-Facing Clinicians *Clinicians billing 100 or fewer patient-facing encounters (including telehealth); If reporting as a group, more than 75% of clinicians need to meet this definition*	**Hospital-Based Clinicians** *Clinicians furnishing 75+% of services in inpatient hospital, ER, or on-campus outpatient hospital settings*
Quality	No change	No change
Cost	No change	No change
Improvement Activities	Lessened requirements--only 1 or 2 activities needed to chieve maximum score	No change
Advancing Care Information	Domain reweighted to zero	Domain reweighted to zero

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