WANT TO BRING MIPS 2020 INTO FOCUS – LOOK AT 2018

As we transition from multiple non-connected physician performance programs, practices will begin the second base year of the Medicare and CHIP Reauthorization Act (MACRA). Since there is a two lag, your payments or penalties this year are actually based on your 2015 *reporting*; for purposes of discussion and to not get into the merits or validity of the underlying assumptions, one will need to adapt their *reporting* strategies to keep from being penalized. The good news that there is still time, albeit rapidly fleeting, to submit reporting during 2017 base year for the 2019 calculations. Although we have discussed this base year earlier, there will be some repetition as we discuss the changes *proposed* for 2018 base year that determine your 2020 payments.

Step one is to determine whether this is a journey you need to make. First, one must be an eligible clinician; all members of the Caucus check this box since eligible clinicians include Physicians. Also within the definition are physician assistants and Advanced Nurse Practitioners, which include CRNAs, Nurse Midwives, Clinical Nurse Specialists. This number is projected to increase by around 133K to 1.3M.

Step two is to determine if one falls into an exempt category. As before this includes those in their first year of billing traditional Medicare, participants in qualifying Advanced Alternative Payment Models (APMs), and those meeting a low-volume threshold (LVT). The definitions are unchanged for the first two, but there has been an alteration in the last. In an effort to help small practices, CMS is proposing to increase LVT from $30,000 or 100 patients to $90,000 or 200 patients. The first two account for a small number and are projected to essentially cancel each other out for comparative purposes. However, the change in LVT will shift over 200K additional folks into the exempt category (~585K). The net impact is to decrease the segment of eligible physicians that must report from 43 to 47% down to 37% or around 572K. Although no decision has been made, they are still considering an opt-in provision beginning in 2019 for those exempt who would like to participate. Still not sure, go to *https://qpp.cms.gov* and enter your NPI number.

The proposed rule would postpone original plan to reduce Quality (that replaced PQRS) component to 50% and retain the current 2017 base of 60%. It also delays the increase to the Cost component to 10% from its current 0%. The other two domains of Advancing Care Information or ACI (replacing Meaningless Use) and Clinical Practice Improvement Activities or IA (new this year but called by some as CPIA earlier) are unchanged with a 25% and 15% weighting respectively.

One of the proposed changes is relief specific for small group practices that are defined from 1 to 15 members, rural, and health professional shortage areas. These include reduced IA reporting that continues but with a decrease from four to two for 90 days, technical assistance grants continue, virtual groups created (albeit with details still evolving), ACI hardship exemption for small practices, and bonus points added to final score for small practices. Although not specific to small groups, most of the low-volume threshold increases to $90K/ 200 patients will benefit

those practices. The bottom line is that CMS estimates 81.2% of EPs in practices of 1-15 will experience positive or neutral adjustments in 2020.

The 2018 MIPS Quality Components retain the 2017 modifications of: a) 6 measures (or one specialty set); b) Partial credit allowed; c) Flexibility in measure choice; d) No domains or cross-cutting measures required; e) Bonuses for electronic reporting; f) 50% threshold for successful measure reporting. There are new and modified specialty measure sets available, and cross cutting measures were removed from most sets (except IM, FM, Ped). Also as mentioned above, there is favorable scoring for small practices with "bonus" points.

The changes in the Advancing Care Information (ACI) domain include a hardship exemption created for small practices, many who still do not have functional EMRs, and a new hardship exemption for hospital-based clinicians for performance category. Also, the ACI performance score will be weighted at 0% for ASC-based clinicians. The 2017 improvements will be retained that include bonuses for registry reporting and use of CEHRT in IA, 90 day reporting, elimination of performance score thresholds, and replacement of pass/fail with base and performance scoring. On the technical side, the rules will not require updates to 2015 CEHRT for 2018 and may report modified MU stage 2 measures instead of advancing to new stage 3 measures.

The cost component domain is calculated by CMS via claims data and carries a 0% MIPS component weigh in 2017 and 2018. The reports on total costs per capita and Medicare spending per beneficiary will be provided FYI only. The 10-episode groups proposed in 2017 will be replaced with measures developed with more clinical input.

The Clinical Practice Improvement Activity (IA) domain goal is to give credit for practice innovations that improve access and quality with an additional 20 activities added to the current 90 in eight categories that transcend multiple specialties. There are 40 points needed for larger practices (across 2 high value or 4 medium-weighted activities); however, small practices groups of 15 or less, rural and HPSA practices, and non-patient facing specialists (most physicians fall into these categories) require only 1-2 activities. The other changes for 2018 include CPC+ added to the MIPS APM models that earn full score in 2018 and 50% of practice sites within a TIN must be recognized as PCMHs to receive full IA credit. See https://qpp.cms.gov/mips/improvement-activities for more information.

The reporting periods and bonus calculations are somewhat different in 2018 since there is a full 12-month reporting period for the Quality component. However, the Cost component, although calculated over 12 months is for information only, and the 90-day reporting period for ACI and IA are unchanged. The previously scheduled increases of the maximum bonuses and penalties to a + 5%/ -5%, plus annual update will be implemented. The Exceptional Performance bonuses up to a possible 10% continue be in play. The threshold for bonuses/ cuts would be 15 points, which is up from 3 points for 2017; new options for 2018 include a complex patient bonus of 1-3 points that are based on Hierarchical Conditions Category (HCC) risk scores and a small practice bonus 5 points added to the final score for practices of fewer than 15. CMS provided several examples how a practice could reach the 15 points: a) report all Improvement Activities; b) Meet ACI base

score and report 1 quality measure that meets data completeness criteria c) meet ACI base score and one medium-weighted Improvement Activity; d) Submit 6 quality measures that meet data completeness criteria.

There are several new proposals that we can hopefully discuss in our next issue. I think I have presented enough information for the day; I will give you a break and return to monitoring the unfolding tragedy on our Texas coast. Every time I think we are at the high-water mark, it rains a bit more, and a levy has just given. By the time you read this, we will have a better scope of what has happened. I do want to thank everyone for the numerous expressions of thoughts and prayers; we certainly need them today.

Until next time,

Asa

- Increased opportunities for bonus points