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Practice Management

Merit-Based Incentive Payment System: Preparing Your Practice for Upcoming Change

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Introduction

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 was signed into law in April of 2015 [1]. Although this legislation permanently abolishes the threat of significant payment cuts based upon the Medicare Sustainable Growth Rate formula, it has proposed major changes to reimbursement models that will have a significant impact on practitioners. Details of the MACRA legislation were reviewed previously [2]. MACRA has included payment updates (increases) of 0.5% per year from 2016 through 2018; however, beginning in 2019, the Center for Medicare and Medicaid Services (CMS) will no longer provide any uniform annual payment updates. Instead, CMS will offer eligible physicians 2 paths for payment based upon participation in either the Merit-Based Incentive Payment System (MIPS) or an Alternative Payment Model (APM). An update from CMS was published in May 2016 that provided more details to the proposed MIPS program [3]. This article will focus on MIPS and its implications for the physiatrist.

What Is MIPS?

MIPS is the new payment program for physicians that will combine several currently existing programs: the Physician Quality Reporting System (PQRS), the Value Based Payment Modifier (VBM), and the Meaningful Use (MU) of electronic health records (EHRs). Although, at the moment, these 3 programs have separate reporting mechanisms and requirements that influence physician payments, MIPS will consolidate them into a single program, continuing the majority of the elements of each. Under MIPS, physicians will receive a composite score ranging from 1 to 100 that forms the basis of their reimbursement for Medicare-related services. This score is based upon an eligible clinician's (EC) performance in 4 areas: quality, cost, advancing care information, and clinical practice improvement activities. The composite score will determine whether a positive adjustment (incentive payment) or negative adjustment (penalty) will be applied to all services billed to Medicare for the EC. The relative weight of each category will vary, depending upon the year (Figure 1).

Quality Component

The quality component of MIPS is based on modifications to the current PQRS program. There will be a tiered weighting of the score, initially starting at a maximum of 50 points for 2017 and reducing to a maximum of 30 points in 2019 [1].

Previously, in the QPRS program, ECs had to submit at least 9 measures across 3 quality domains to satisfy reporting requirements [4]. The new quality component has now reduced the reporting requirement to 6 measures. The EC must choose at least 1 outcome and 1 cross-cutting measure that span several domains. Measure reporting will result in a score from 1 to 10 points per measure and appears to be based not simply on reporting (as are many of the current QPRS requirements) but on documenting performance within the measure. In addition to the 6 submitted measures, ECs practicing in groups will automatically have reporting based on claims data on 2 other population measures (for those in groups of 2-9 ECs) or 3 population measures (for ECs in groups of 10 or more). Bonus points are to be awarded for ECs reporting on outcomes, patient satisfaction, safety, and EHR submission of measures. The measures are to be averaged to obtain the score with a maximum point score of 80 or 90 points.

To meet the current PQRS reporting requirements, physiatrists often have to select measures that are not directly relevant to their practice and may be geared more toward primary care providers. As part of MACRA, CMS has instituted a Quality Measure Development Plan (MDP) that seeks public comment on evaluating current measures, determining gaps in existing measures, and partnering with specialty groups and associations to develop measures to be used in MIPS [5]. CMS has developed a measure set for physical medicine that includes 7 measures: osteoarthritis and pain assessment,

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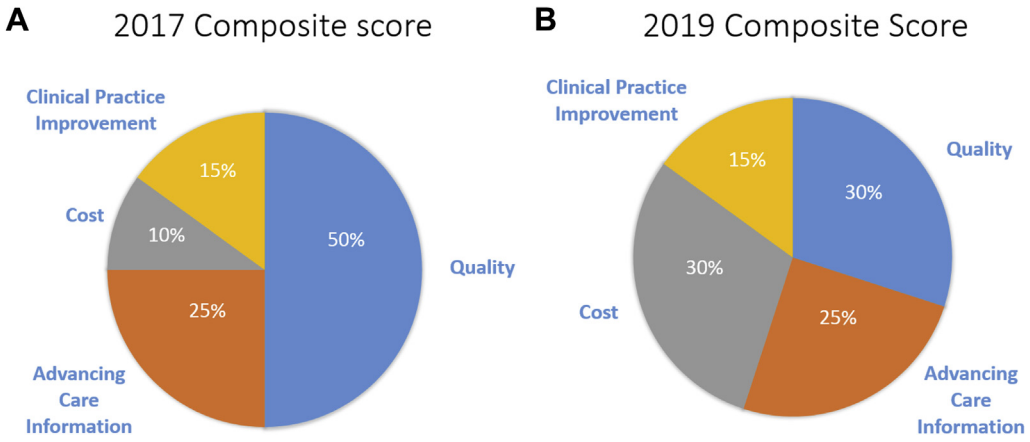

Figure 1. (A) 2017 Merit-Based Incentive Payment System (MIPS) composite score calculation. (B) 2019 MIPS composite score calculation.

pain assessment and follow-up, functional outcome assessment, use of imaging for low back pain, opioid therapy and follow up evaluation, documentation of signed opioid treatment agreement, and evaluation or interview for risk of opioid misuse. However, some physiatrists may find that these measures may not have much relevance to their practice. There are additional proposed measures for patients with Parkinson disease as well as functional deficits and measurement of change in functional status for the following areas: hip, lower leg and ankle, shoulder, and hand. These latter measures may expand the pool of appropriate options for physiatrists.

Currently, only a fraction of the PQRS quality measures are reportable by direct EHR submission, and it is unknown how robust direct EHR submission will be under MIPs, even though this can substantially aid those who use an EHR for their reporting. It is also unclear whether the MDP will adequately address gaps in the quality measures for specialties such as physiatry, given the relatively small size of our field and the diversity of the patient population. There is limited time to develop new measures that may meet the needs of physiatrists. Collaboration with other specialties that have similar needs is essential to pool resources to create additional relevant quality measures. As an example of this type of work, the American Academy of Physical Medicine and Rehabilitation and the American Association of Neurological Surgeons have announced a collaboration to create a Spine Patient Registry, which will support the collection and submission of quality data specific to spine patients and track patient outcomes over time. The intent of this registry is to focus initially on spine patients, with the ability to expand to other clinical areas relevant to physiatry.

Advancing Care Information Component

The Advancing Care Information (ACI) component is based on the current Medicare program on the meaningful use of EHR [6]. The score will contribute up to 25 points in the composite score initially. If there is high adoption of MU among QPs, the threshold can be lowered in subsequent years to 15 points [1].

For the MIPS program, MU has essentially been modified and rebranded as ACI. Detailed descriptions of the MU program are available elsewhere [7]. The changes for the ACI component of MIPS include a reduction in the number of measures to attest as well as inclusion of performance within measures as a factor in the scoring. ECs now must report on 6 measures to achieve a base score: protecting health information, electronic prescribing, electronic health access, coordination of care through patient engagement, health information exchange, and public health and clinical data registry reporting. ECs select from additional measures in which their performance within the measure will determine a performance score. These additional measures are in the following areas: patient electronic access, coordination of care through patient engagement, and health information exchange. Immunization registry reporting is required, and ECs may earn a bonus point by reporting to other public health—reporting agencies. A total of 50 points can be awarded for the base score and 80 points for the performance score. Those earning 100 or more points will automatically be awarded the highest score of 25 points for the ACI composite subscore.

The objectives of the current MU program have been criticized as not having much relevance to specialists, with adoption tending to be higher for primary care physicians [8]. It remains unclear whether the changes with the new ACI component will adequately address the criticisms by practitioners that the objectives create an unnecessary burden to practitioners [9].

Cost Component

The cost component (also known as resource use) is based on quality and cost scores from the existing VBM