MIPS Calculator Guide

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The New MACRA after changes

The law aims to bring in unified policies that will add greater value to the healthcare system through the new Quality Payment Program (QPP). The program rewards for value in two ways:

- Merit-based Incentive Payment System (MIPS)
- Advanced Alternate Payment Models (Advanced APMs)

Merit-based Incentive Payment System

Under this program, Eligible clinicians will get payment adjustments based on the quality, cost and other measures related to care. This program will see the “sunset” of three existing programs namely:

- Physician Quality Reporting System
- Physician Value-based Payment Modifier
- EHR Incentive Program

CMS will use the Composite Performance Score (CPS) to measure the performance of participants. This score was designed to comprise four components. The new rule has seen some significant changes in each category and the biggest change being the exclusion of the resource category to calculate the performance of the participant. The weight of each category has been accordingly changed:

- Quality 60%
- Advanced Care Information 25%
- Clinical Practice Improvement Activities 15%
- Resource Use (or Cost)

Terms to know

1. **Part-B Providers -**Physicians, PAs, NPs, Clinical nurse specialists, and CRNAs for the year ‘17 & ‘18.

2. **Budget Neutrality Factor** - MIPS is designed to be a budget neutral program, to being the neutral value, Entire penalized amount will be distributed among the good performers under base payment adjustment. BNF ranges from 0 to 3.

3. **Average Exception Perform Bonus** - It is an additional payment adjustment of up to 10 percent possible for the performers who are exceptionally performed.

4. **Medicare Part-B Amount per Provider per Year** - The average amount of Part-B payments per provider per year.

5. **MIPS performance threshold** - CMS will set a performance threshold value for every year. For 2017,it is 3. If the value is above 3, you will be awarded with an incentive and if it is below 3, you will be penalised. CMS will set an Exceptional performance threshold value for every year. For 2017, it is 70. If the value is above 70, you will be awarded with base Payment Adjustment & Exceptional Performance Bonus % from $500 million which is funded by CMS.

6. **ACI Achievement** - Based at 25% for 2017 Performance year. It has total of 15 measures. User can get maximum of 155 points (base(50) + performance(90) + bonus(15)). If his score is more than 100 he will get full points as per ACI weightage(25). If it is less than that it will be calculated accordingly.

7. **CPIA Achievement** - Based at 15% for 2017 Performance year. It has total of 93 activities which are categorised into High Weight and Medium Weight activities, and are given 20 points and 10 points respectively.

8. **Quality Achievement** - Based at 60% for 2017 Performance year. It has 6 measures and each measure is given 10 points, that makes total of 60 points.

9. **Cost Achievement** - Cost Achievement weighting has been set to zero for 2017, but in 2018, that increases to 10%.

More About MIPS

CMS would still measure the performance of practices in the Resource category to provide feedback. These weights are subject to change and by 2021 Cost category will weight 30%.

CMS has changed the criteria to determine whether a practice would be exempt from MIPS or not. The small practices are exempt from MIPS if they do not reach the low volume threshold. The low volume threshold has been increased to $30,000 in Medicare part B allowed charges or less than 100 Medicare patients. A significant change from the previous threshold which was set on "$10,000 in Medicare Part B charges AND less than or equal to 100 Medicare Patients.

CMS will provide technical assistance of total $100 million ($20 Million each year) to small practices, rural areas, and practices located in Health Professional Shortage Areas (HPSAs) and other forms of assistance to MIPS EC (Eligible Clinician) practices with fewer than 15 ECs.

Quality Category

Every year on 1st November, a list of quality measures will be published in the Federal Register. According to the Final Rule, an Eligible Clinician under MIPS is required to report on at least six measures which, if possible, should include an outcome measure. If fewer than six measures are applicable then the Eligible Clinician is required to report on all the applicable measures. A MIPS Eligible Clinician must continue this process for 90 days in order to receive positive adjustments.

A MIPS EC or group can report on six measures or specialty-specific measure set or subspecialty measure set. If there are more than six applicable measures than EC can choose to report on any six measures within a set. No matter how many measures are there in the set, an EC is required to report on at least one outcome measure and if there is no outcome measure than he has to report on a high priority measure (appropriate sue, patient safety, efficiency, patient experience, and care coordination).

Clinical Practice Improvement Activities (CPIA)

CMS has defined 'improvement activities' as the ones that aid the broader aims of the healthcare industry such as enhanced care coordination, engagement, population health management, and equitability in health.

After receiving the feedback from many experts, CMS has reduced the number of activities that are required to achieve the full score from six medium-weighted or three high weighted activities to four medium-weighted or two-high weighted activities. Besides this, for small practices, rural areas, and practices located in Health Professional Shortage Areas (HPSAs) and non-patient facing MIPS ECs, it is just one high-weighted or two medium-weighted activities.

Advancing Care Information (ACI)

This category focuses on and health information exchange through the use of Certified Electronic Health Record (CEHRT). CMS in the final rule with comment period has reduced the number of measures from eleven to five, and all the remaining ones would be optional to report on. Reporting on optional measures will help MIPS ECs qualify for a bonus.

Cost

For the transition year, the weight of Cost category is zero percent. However, after the transition year, there will be a gradual increase in the weight of it. However, CMS does not require the ECs to report on this measure. Additionally, CMS has finalized ten episode-based measures

Chance to adapt

To help the physicians get used to the program CMS has declared the first year i.e. 2017 as 'transition' year. There will be four options available to physicians in the 'transition year':

1. Clinicians can choose to report one measure in the quality performance category; one activity in CPIA or report the measures in ACI to avoid the negative adjustments. Alternatively, if they choose to report none, they will receive negative adjustments of 4%.
2. Report for minimum 90 days more than one quality measure, more than one CPIA or more than the required ACI to avoid negative adjustments and qualify for possible MIPS positive adjustments.
3. Ideally, report for a year or more than 90 days and maximize the chances to receive higher positive adjustments.
4. Participate in the Advanced APMs program, and if can to see 'sufficient' portion of the Medicare Patients, they will be able to qualify for 5% bonus incentive payment to be paid out in the year 2019.

Advanced APMs

All the providers who receive a significant amount of reimbursements from Advanced APMs and are able to bear more than the nominal risk will be recognized as advanced APM. The set standard by CMS is that a potential downside of eight percent of all Medicare reimbursements or three percent (reduced from four percent in proposed rule) of the expected expenditure for which the provider is responsible under APM.