

Health Policy Review

Merit-Based Incentive Payment System (MIPS): Harsh Choices For Interventional Pain Management Physicians

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The Merit-based Incentive Payment System (MIPS) was created by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to improve the health of all Americans by providing incentives and policies to improve patient health outcomes. MIPS combines 3 existing programs, Meaningful Use (MU), now called Advancing Care Information (ACI), contributing 25% of the composite score; Physician Quality Reporting System (PQRS), changed to Quality, contributing 50% of the composite score; and Value-based Payment (VBP) system to Resource Use or cost, contributing 10% of the composite score. Additionally, Clinical Practice Improvement Activities (CPIA), contributing 15% of the composite score, create multiple strategic goals to design incentives that drive movement toward delivery system reform principles with inclusion of Advanced Alternative Payment Models (APMs).

Under the present proposal, the Centers for Medicare and Medicaid Services (CMS) has estimated approximately 30,000 to 90,000 providers from a total of over 761,000 providers will be exempt from MIPS. About 87% of solo practitioners and 70% of practitioners in groups of less than 10 will be subjected to negative payments or penalties ranging from 4% to 9%. In addition, MIPS also will affect a provider's reputation by making performance measures accessible to consumers and third-party physician rating Web sites.

The MIPS composite performance scoring method, at least in theory, utilizes weights for each performance category, exceptional performance factors to earn bonuses, and incorporates the special circumstances of small practices.

In conclusion, MIPS has the potential to affect practitioners negatively. Interventional Pain Medicine practitioners must understand the various MIPS measures and how they might participate in order to secure a brighter future.

Key words: Medicare Access and CHIP Reauthorization Act of 2015, merit-based incentive payment system, quality performance measures, resource use, clinical practice improvement activities, advancing care information performance category

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1.0 INTRODUCTION

On April 27, 2016, the Centers for Medicare and Medicaid Services (CMS) released the highly anticipated 926-page proposed rule for implementing Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

(1). This proposed rule is the first major step in describing in detail the physician payment system that Congress outlined in MACRA (2,3). MACRA will overhaul Medicare's physician payment system starting in 2019, placing most physicians in the Merit-based Incentive

Payment System (MIPS), a pay for performance system that adjusts payments based on measures derived from prior care (2). Physicians may be exempt from MIPS and receive bonus payments by participation in advanced alternative payment models, or alternative payment models (APMs), which are intended to support greater flexibility in care delivery with increased accountability for efficiency and care improvement. MACRA, a broadly bipartisan legislation, was intended to align physician payments with better quality of care that avoids unnecessary costs, a better alternative to the perpetual payment tightening under the sustainable growth rate (SGR) system that it replaced (1-7). The threat of the SGR was that continuous payment reductions would reduce beneficiary access. Providers no longer need to worry about that threat but need to embrace a value-based future (8). Despite the hopes of value-based care, it is uncertain that these reforms will succeed in improving care (1-7,9-16).

Notwithstanding numerous regulations and adjustments in recent years such as meaningful use (MU), Physician Quality Reporting System (PQRS), value-based payment (VBP), ever-changing requirements of electronic medical records (EMRs), and International Classification of Diseases, 10th Revision (ICD-10) (17-21), MIPS has been described as the most sweeping overhaul CMS has made to physician practices (8). In addition to the present regulations, the MIPS program increases measurement fatigue among physicians, who have been pressured for the last 7 years (13,22,23). Andy Slavitt, acting CMS Administrator, acknowledged that physicians are extremely frustrated with current electronic health record (EHR) systems and that the dislike for these systems has increased from 38% in 2010 to 66% in 2014 (17,24).

While MedPAC has expressed skepticism regarding elements of MIPS (25), CMS strongly believes that the MIPS program is one piece of the broader health care infrastructure needed to reform the health care system and improve health care quality, efficiency, and patient safety for all Americans. In fact, CMS professes that MIPS, ultimately, should support health care that is patient-centered, evidence-based, prevention-oriented, outcome driven, efficient, and equitable.

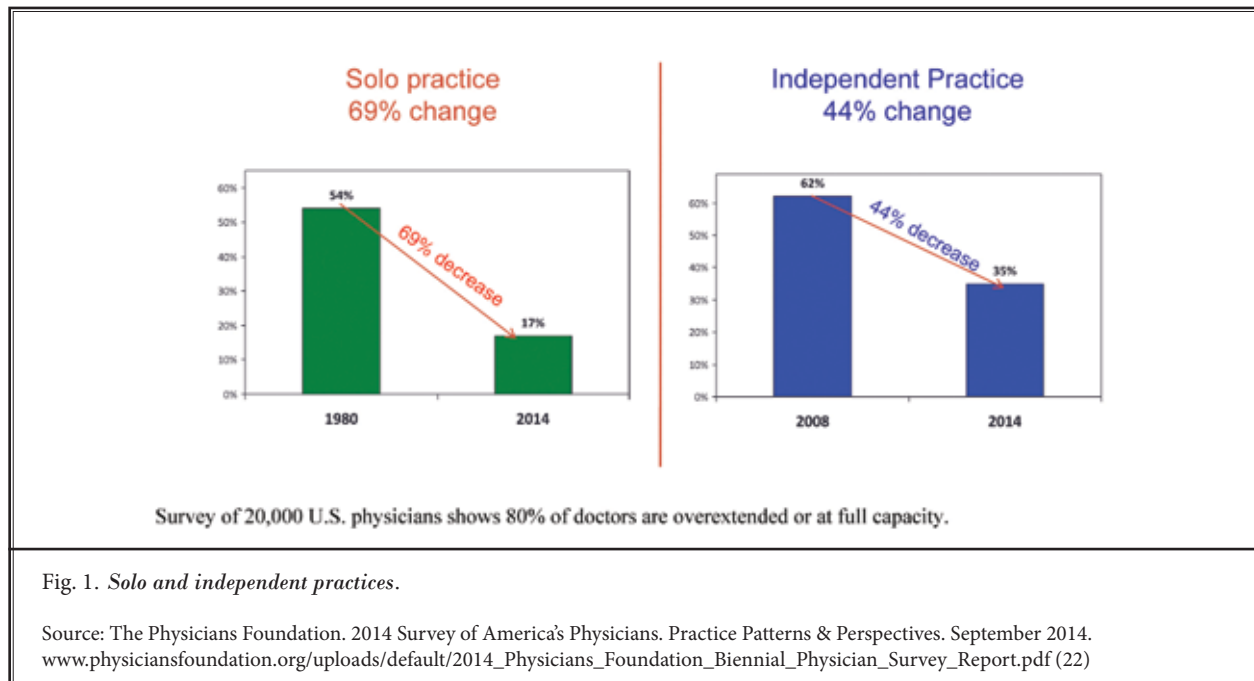
2.0 US HEALTHCARE

In 2014, US health care spending increased 5.3% following the growth of 2.9% in 2013 to reach a historic \$3.0 trillion, or \$9,523 per person, accounting for 17.5% of the gross domestic product, an increase from 17.3%

in 2013 (26). The acceleration of growth in 2014 is likely in part due to coverage expansions under the Patient Protection and Affordable Care Act (ACA), particularly for Medicaid and private health insurance although this may not explain the reasons for the per person increases (26,27). Based on an analysis of health care spending and quality comparisons internationally, the US health care system was described as both the most expensive and the worst of the 11 nations studied (28). In 2004, the United States was fifth, decreasing to 11th out of eleven in 2014 for overall quality despite the enactment of ACA and expansion of regulations (26-40). Three important drivers of escalating health care cost have not been adequately studied. They include information technology, consolidation, and patient consumer movement (41). In addition, there are chronic conditions that have a high prevalence in the United States compared to peer countries, including obesity, diabetes, heart disease, chronic lung disease, arthritis, and disability. In the United States, almost 50% of adults suffer from one or more chronic health conditions and 25% of adults suffer from 2 or more chronic health conditions (34,39).

In 2012 a survey of physicians showed frustration with high levels of government regulation, malpractice liability pressures, inadequate and inconsistent reimbursement, and eroding clinical autonomy as factors leading to discontentment (22). Further, 69% of physicians indicated that their decisions are often compromised – demonstrating a strong potential bearing on the quality of patient care, with the majority of physicians describing their morale as negative. A survey of interventional pain physicians showed similar results with 60%, 36%, and 19% showing high emotional exhaustion, high depersonalization, and a sense of low personal accomplishment, respectively (23).

With numerous factors contributing to escalating health care costs, US health care continues to orient and reorient towards quality and value, incorporating health outcomes and resources allocated to achieve those outcomes, despite the lack of evidence for the effectiveness of these measures (42). Consequently, numerous regulations and a wide spectrum of payment models have been introduced that balance financial rewards and risks based on provider performance on specific measures, such as clinical quality, patient experience, and cost (42). The shift towards VBP was accelerated since January 2015 with the US Department of Health and Human Services announcing their intent to tie 85% of all traditional Medicare payments to quality or value by 2016 and 90% of payments by



2018 (1-7,43,44) and further supported by MACRA (1-7,9-13,43,44).

This current health care milieu has the potential to move independent practitioners towards hospital employment (1,3,9-13,17-22,38,40). As shown in Fig. 1, from 1980 to 2014, solo practices dropped from 54% to 17%, a decline of 69%. Further, in just 6 years, from 2008 to 2014, independent practices dropped from 62% to 35%, a decline of 44% (22). The proposed rule (1-3), if finalized, has the potential to create incentives to steer patients to high cost medical centers rather than steering them away to reduce costs and improve quality (14-16).

3.0 MERIT-BASED INCENTIVE PAYMENT SYSTEM

MIPS defines 4 categories of eligible clinician performance contributing to a composite performance score (CPS) of up to 100 points, with relative weights being provided for the 2017 reporting year and associated with the 2019 performance or penalty/bonus year as shown in Fig. 2. Quality carries a weight of 50%; Advancing Care Information (ACI) renamed from Meaningful Use, has 25% weight; CPIA has 15%; and resource use, 10%. As shown in Table 1, the number of eligible practitioners is over 621,000, whereas the number that could be exempt from MIPS and get a bonus for participating in an advanced Alternative Payment Model

appears to range between 30,000 to 90,000 with first year bonuses and penalties of 4% in MIPS and a bonus of 5% for those participating in an advanced APM.

As shown in Table 2, the penalties and incentive payments will grow to 7% in 2021 and 9% in 2022.

3.1 Impact of MIPS

The impact of MIPS on practices is two-fold: financial and reputational. Financial implications include annual payment adjustments based on the composite performance score; whereas the reputational impact includes publication by CMS of an array of clinician-identifiable performance measures through its physician comparison Web site for consumers to browse and third-party physician rating Web sites that are freely available.

The potential MIPS incentives and penalties via payment adjustments are substantial. A CPS could result in incentives reaching 37% of Medicare Part B payments by the fourth year of the program, while the maximum penalties grow to 9% (Table 2). Thus, the top to bottom MIPS potential impact on Part B payments for 2017 is likely to be from a 14% incentive down to a -4% penalty, or a total of 18% top to bottom swing. The additional swings beyond 4% to 9% are based on an exceptional performance bonus that escalates up to 10% for progressively higher performance within the top 30%. Thus, the sum of the maximum base incentive

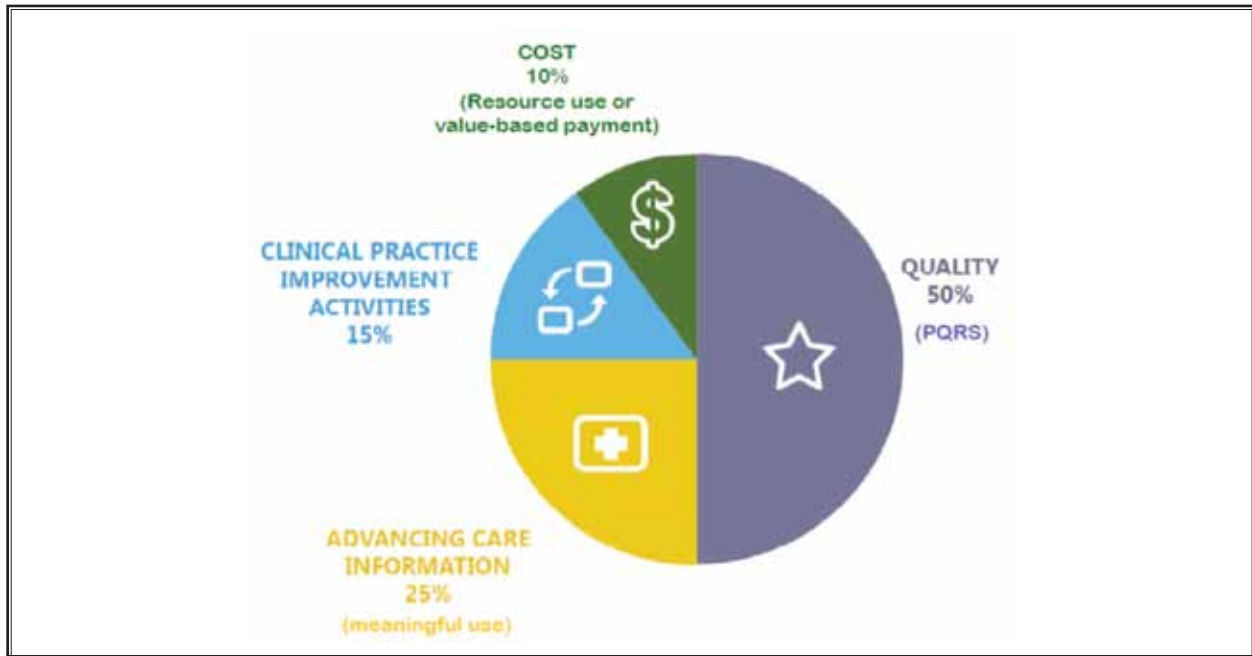


Fig. 2. Performance category weights for MIPS for first year: performance year 2017 and payment year 2019.

Source: Department of Health and Human Services, Centers for Medicare & Medicaid Services. 42 CFR Parts 414 and 495. Proposed Rule. Federal Register, April 27, 2016 (1).

Table 1. Initial impact of MIPS.

<p>761,342</p> <p>Number of clinicians eligible for the Merit-based Incentive Payment System (MIPS)</p>	<p>30,658 - 90,000</p> <p>Number that could be exempt from MIPS and get a bonus for participating in the advanced Alternative Payment Model (APM)</p>
<p>Maximum bonus or penalty under MIPS in 2019</p> <p>+4% -4%</p>	<p>Medicare bonus in 2019 for participating in an advanced APM</p> <p>5%</p>

Source: Department of Health and Human Services, Centers for Medicare & Medicaid Services. 42 CFR Parts 414 and 495. Proposed Rule. Federal Register, April 27, 2016 (1).

and exceptional performance bonus equals a maximum total upside potential of 4% plus 10%, or 14% for the 2017 reporting year or 2019 performance year.

However, the budget-neutrality x-factor could reach a capped-value of 3.0 should there be many more clinicians penalized than receiving incentives in a given year. Based on the present projections of CMS, for the 2017 reporting year, the base adjustment could reach as high as 12%, resulting in an even higher maximum

incentive plus exceptional performance bonus equaling 22%. Similarly, the maximum possible incentive for the 2022 performance year could reach a total of 37%. The performance threshold is determined annually as the mean or median of MIPS scores for all eligible practitioners in a prior period as selected by CMS. CMS also changes the weighting for the composite score with each individual score being altered. Table 3 shows changes to the weighting for the first 3 years of the

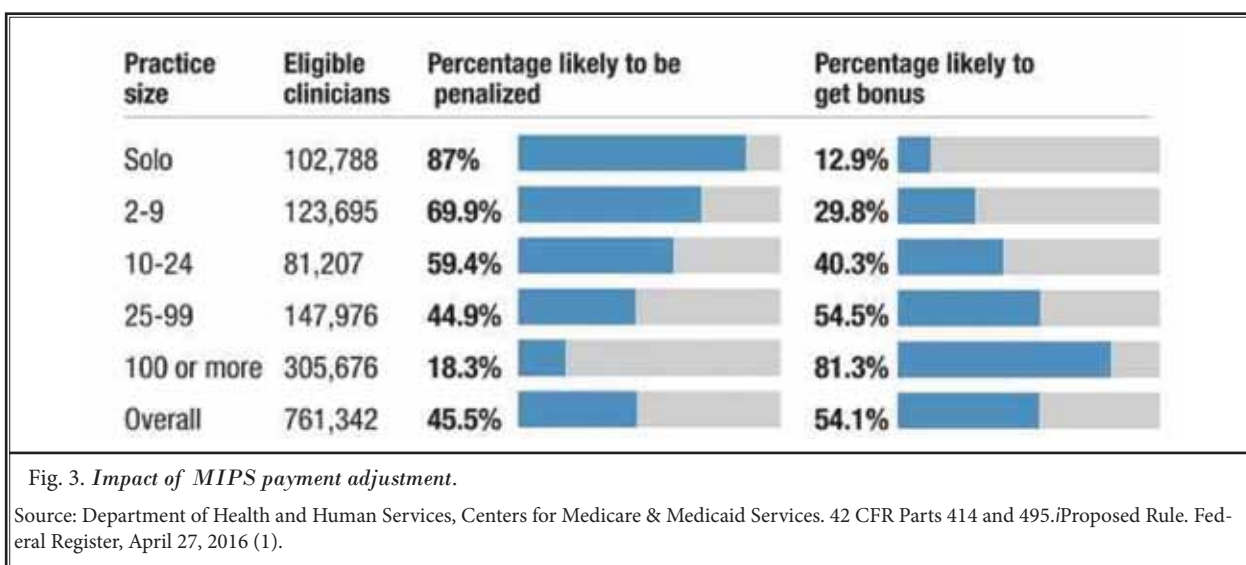
MIPS for Interventional Pain Management Physicians

Table 2. CMS budget-neutral program: incentive offset by penalties.

Program	Reporting Year	Medicare Part B Payment Adjustment or Performance Year	Maximum -% Medicare Part B Payment Adjustment	Maximum +% Medicare Part B Payment Adjustment
PQRS/VBM	2016	2018	-4% penalty	+4%*X incentive
MIPS	2017	2019	-4% penalty	+4%*X incentive
MIPS	2018	2020	-5% penalty	+5%*X incentive
MIPS	2019	2021	-7% penalty	+7%*X incentive
MIPS	2020	2022	-9% penalty	+9%*X incentive

- Precedence: 2014 PQRS/VBM, X = 16 (not capped), so 32% max incentive
- For MIPS, x capped at 3.0 plus a 10% “exceptional performance bonus”
- For Performance Year 2020, up to 9% x 3.0 + 10% = 37% bonus

Source: Department of Health and Human Services, Centers for Medicare & Medicaid Services. 42 CFR Parts 414 and 495. Proposed Rule. Federal Register, April 27, 2016 (1).



payment adjustment with quality changing from 50% to 30%, resource use changing from 10% to 30%, whereas clinical practice improvement activity and ACI remain at 15% and 20%, respectively. In addition, CMS also has commented that ACI quality scores will change substantially based on EHR utilization.

The adjustments in payments as described above are substantial; however, solo and small practices will be affected the hardest under MIPS (Fig. 3). As shown in Fig. 3, 87% of solo practitioners and 70% of practitioners in a practice size of 2 to 9 are likely to be penalized with just a small proportion receiving bonuses. In contrast, physician groups with 100 or more physicians constitute approximately 18% of the ones who will be penalized, whereas the overall proportion of penalized providers is over 45%. This translates into approximately 13% of solo practitioners will receive bonuses compared to 81% of physicians in groups of

100 or more. CMS also shows that approximately 30,000 to 90,000 providers may be exempt from MIPS and get a bonus for participating in an advanced APM, subjecting the majority of over 760,000 eligible providers to participate in MIPS.

Reputational effects include performance measures accessible to consumers and third party physician rating Web sites (32,33,39,40,45). CMS believes that as consumers spend more out-of-pocket for their health care, specifically under the ACA with its high deductibles of approximately \$13,000 for Bronze Plans, they are seeking more transparency into clinician quality and the cost-value equation (30-35). CMS believes that 65% of consumers are aware of online physician rating sites and that 36% of consumers have used a ratings site at least once (1). Consequently, any damage to a clinician's online public reputation could be long-lasting, which may take years to reverse, in contrast to direct Medi-

Table 3. Changes to the weighting for the first 3 years of the payment adjustment.

Performance Category	2019	2020	2021
Quality	50%	45%	30%
Resource Use	10%	15%	30%
Clinical Practice Improvement Activity	15%	15%	15%
Advancing Care Information	25%	25%	25%

Source: Department of Health and Human Services, Centers for Medicare & Medicaid Services. 42 CFR Parts 414 and 495. Proposed Rule. Federal Register, April 27, 2016 (1).

care reimbursement impact, which changes year to year based on clinician performance (40,45). In this analysis by Medical Economics, multiple groups were utilized, including the editorial advisory board, a 200-member reader reaction panel, and e-newsletter subscribers to grade the various elements of the ACA based on their own experiences. In reference to physician ratings via the Physician Compare Web site, the score was a failing grade of 26. Conversely, consistently high performance scores and ratings can become not only a survival tactic, but also provide a strategic advantage. MIPS will publish each eligible clinician's annual CPS and scores for each MIPS performance category within approximately 12 months after the end of the relevant performance year. In addition, all statistically significant measure values in quality, resource use, clinical practice improvement activities, and ACI categories for each clinician will be available on the Web site (1).

3.2 Eligibility Requirements and Exemptions

Initially, over 700,000 Part B clinicians will receive a MIPS performance score for 2017 reporting year. This will expand to over 800,000 clinicians when the eligibility net widens for reporting year 2019 (Tables 1 and 2).

With 700,000 clinicians eligible during the first reporting year, there are also some exemptions for clinicians who do not meet eligibility requirements. These include:

- Clinicians in their first year of Medicare Part B participation.
- Clinicians only billing Medicare Part B up to \$10,000 and providing care for up to only 100 Part B patients in one year.
- Clinicians participating in an Advanced APM entity which is at least 10% of all patients.
- Clinicians may choose to be rated on an individual-clinician basis or as a group of clinicians billing through a common tax ID.

4.0 MIPS PERFORMANCE CATEGORIES

CMS describes the quality performance category as a crucial piece in the MIPS program of the broader health care infrastructure needed to reform the health care system and improve health care quality, efficiency, and patient safety. CMS also professes to balance the sometimes competing considerations of the health care system and minimize the burden on health care providers given the short time frame available under MACRA for implementation. CMS hopes that ultimately, MIPS should, in concert with provisions of the Act, support health care that is patient-centered, evidence-based, prevention-oriented, outcome driven, efficient, and equitable.

There are 4 categories of performance categories contributing to the MIPS CPS, with a total of 100 points (Fig. 2). However, these categories and weights will change in future years, as shown in Table 2.

4.1 Quality Performance Measures

Quality measurement has taken an increasingly central role in the rapidly evolving health care landscape in the United States, particularly with the implementation of MIPS (2-7,18,27-43,46-52). The Institute of Medicine (IOM) published a series of groundbreaking reports in the early 2000s about quality of care and the influence of provider behavior (49,53,54). IOM developed a strategy to improve quality of care which was termed "pay for performance" or "financial incentives" to transform behaviors to achieve greater value (48,49,53,54). Appropriate execution of quality measures can empower all members of the health care community (47). The accumulation of high quality risk-adjusted data advances the objective of patient-centered health care, targeted quality improvement, effective resource utilization, and may allow policy makers and payers to more easily and accurately understand the true value of clinical interventions. CMS

developed and released its quality strategy in 2013 in alignment with the National Quality Registry (50,51). While CMS started these programs with lofty goals and good intentions, most National Quality metrics developed to date have been generic and do not reflect the needs of specialty medicine or meaningfully improve care. At times, measures often rely solely on administrative claims data. Specialties such as IPM lack specificity due to coding limitations. CMS has established that quality measures should relate to one or more goals which involve effectiveness, safety, efficacy, patient centered care, and equitable and timely care (52). Over the years, attention has shifted to outcomes from measures of process (48).

The quality measures are developed by a lengthy and expensive review process of 3 years by the National Quality Forum (NQF) (55-57). The length and cost of this process makes NQF endorsement prohibitive for small medical societies such as interventional pain management. Recently, NQF has taken steps to change its approach to measure development and endorsement with the goal of being more strategic and efficient (47). CMS has the authority to adopt non-NQF-endorsed measures in high priority areas. But the adoption of quality measures by CMS is also a prolonged, complicated, and expensive process (46). CMS relies on a standardized approach, known as the Measures Management System, for developing and maintaining measures used in the various quality programs (58). Over the years, through multiple sources, 1,600 measures across 33 different quality programs have been developed for Medicare alone. Further, a study of 30 private health plans identified approximately 550 distinct measures in use, with little overlap between the measures used by Medicare and private programs (59).

PQRS and pay for performance were linked with value-based purchasing to improve the value of care over the entire continuum of patient treatment (60,61). The strategy of a VBP system hinges on recognition, rewards, and sharing of accountability among providers. Consequently, PQRS, as a component of VBP, has been embraced by CMS to further its goals in transforming the Medicare program to an active purchaser of high quality health care services by connecting payment to the quality and value of the service provided (25,48,62-69).

The quality component of MIPS retains many parts of the current PQRS and VBP system. For MIPS, CMS is proposing self-reporting of 6 quality measures with one of the measures being cross-cutting and one relating

Table 4. *Proposed rule MIPS: quality performance category.*

- ◆ Selection of 6 measures
 - 1 cross-cutting measure
 - 1 outcome measure, or another high priority if outcome is unavailable
- ◆ Select from individual measures or a specialty measure set
- ◆ Population measures automatically calculated
- ◆ Additional credit for submission of:
 - Outcome and high priority measures claims
 - Reporting through certified EHRs
- ◆ Key changes from current program (PQRS):
 - Reduced from 9 measures to 6 measures with no domain requirement
 - Emphasis on outcome measurement
 - Year 1 weight: 50%

Source: Department of Health and Human Services, Centers for Medicare & Medicaid Services. 42 CFR Parts 414 and 495. Proposed Rule. Federal Register, April 27, 2016 (1).

to outcomes (1,25). The final approved measures will be released in November, but the proposed list includes 268 possible measures, about a quarter of which relate to intermediate outcomes. Table 4 summarizes the proposed quality performance category measures. Clinicians can receive additional credit for submitting outcome and high priority measures, and for reporting quality measures through certified EHRs. In addition, the MIPS quality category will also include 2 or 3 claims-based population-based measures calculated by CMS which incorporate readmissions, avoidable hospitalizations from chronic conditions, and avoidable hospitalizations from acute conditions, depending on group size (1,25).

Thus, quality performance measures provide:

- Reduction in reporting burden
- Greater reporting options
- Flexibility
- Encouragement of the use of qualified clinical data registries (QCDRs) and electronic resources.

While the above changes improve the quality of reporting and also reduce the burden to some extent, there are multiple issues to be addressed (14-16,70). These include:

- Specialties such as interventional pain management that do not have outcome measures or measures

in “high priority” areas will be at a disadvantage under the proposed quality performance scoring methodology.

- CMS also proposes to utilize administrative claims-based population health measures that were previously part of VBM. These measures were developed for use at the hospital and community level and have low statistical reliability when applied at the individual physician level, and at times, at the group level (70).

MedPAC supported the focus on outcome measures, but was disappointed that clinicians still will have about 200 non-outcome measures out of 268 total measures from which to choose some quality measures. Further, the commission maintains that many of these measures weakly correlate with health outcomes, measure basic standards of care, can reinforce the incentive to provide low-value care, and reinforce “silos” by specialty (25). Consequently, MedPAC has urged CMS to improve the value set by removing topped out measures, duplicative measures, measures of basic standards of care, and other marginally relevant measures. MedPAC also expressed doubts in reference to CMS’s ability to distinguish between high- and low-performing clinicians. Further, they commented that clinicians have an incentive to select and report measures on which they perform well and may not select certain high priority measures because of unfavorable results such as overuse measures (e.g., imaging for low back pain), or because of the effort required to collect the measure (e.g., Consumer Assessment of Healthcare Providers and Systems [CAHPS]). Further, self reporting will tend to produce compressed ranges for measures that are scored in MIPS, which means clinicians will re-

ceive a different incentive payment based on very small gradations in performance. Ultimately, MedPAC feels that this highlights the limitation of using self-reported measures to distinguish between high and low performing clinicians.

MedPAC’s alternative to the proposed design of MIPS would be for CMS to establish a measure set that the agency could calculate on behalf of the clinicians using claims, QCDR data, and potentially other clinical data that clinicians report with their claims or through EHRs. These claims-based measures should include some measures that apply to a broad scope of clinicians and also some overuse measures such as imaging for nonspecific low back pain. These changes, as suggested by MedPAC, would facilitate CMS to understand the overall (local and national) provider performance on certain measures, since all measures would be calculated for each clinician.

4.2 Resource Use Performance Category

Resource use is an integral part of the values measurement. CMS envisions that the measures in the MIPS resource use performance category would provide MIPS eligible clinicians with the information they need to provide appropriate care to their patients and enhance health outcomes (Table 5). CMS has proposed starting with existing conditions and episode-based measures. All resource use measures would be adjusted for the geographic payment rate and beneficiary risk factors. In addition, a specialty adjustment would be applied to the total per capita cost measures. Further, the rule proposes to apply a specialty adjustment to the total per capita cost measure and retire the specialty adjustment currently applied to the Medicare spending per beneficiary (MSPB) measure. They are also asking for comments on whether to adjust episode-based measures by specialty (25).

CMS recognizes the need for improved attribution and plans on making refinements to its attribution methodology starting in 2018, which will impact the 2019 payment adjustment (70).

Additional issues that need to be addressed include the elimination of flawed cost measures utilized in the VBM, and the proposed initial methodology which makes it difficult to make accurate and equitable comparisons of costs in physician practices (70). Consequently, CMS must focus on replacing the current intended hospital cost measures and focus on various methodological improvements, including a more sophisticated risk adjustment, more granular specialty

Table 5. *Proposed rule MIPS: resource use performance category.*

<ul style="list-style-type: none"> ◆ Assessment under all available resource use measures, as applicable to the clinician ◆ CMS calculates based on claims so there are no reporting requirements for clinicians ◆ Key changes from current program (value modifier) <ul style="list-style-type: none"> • Adding 40+ episode specific measures to address specialty concerns • Year 1 weight: 10% <p>Source: Department of Health and Human Services, Centers for Medicare & Medicaid Services. 42 CFR Parts 414 and 495. Proposed Rule. Federal Register, April 27, 2016 (1).</p>
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comparison groups, and attribution methods that are relevant across specialties. Finally, CMS should focus on eliminating flaws that have made practices with the most high risk patients more susceptible to penalties than other physicians (70).

MedPAC has supported proposals to use both the total per capita and per Medicare beneficiary cost measures for MIPS, continue adjusting for geographic payment rate differences and beneficiary risk factors, and remove the specialty adjustment for MSPB measure (25). However, MedPAC does not support applying a specialty adjustment to the per capita cost measure, and opposes adjusting any of the resource use measures for a specialty. MedPAC emphasizes that by design, applying specialty adjustments, following beneficiary risk adjustments, rewards specialties that provide more expensive treatments that are not explained by patient differences and penalizes specialties with more efficient practice patterns (71). In addition, the commission also has raised concerns about the reliability of measures applied to individual and small group clinicians, but also has a policy principle that resource use measures should ideally be applied to both individuals and group practices (71,72). The commission in the past has called for CMS to develop a Medicare-specific episode grouper (71,73,74) which are software packages that use clinical logic to assign claims to clinically distinct episodes of care. These packages typically consist of hundreds of episode types to capture the breadth of health care services. MedPAC also expressed its concern about the state of readiness of the 2 episode grouper methods that CMS is proposing, since it has been over 6 years since the agency awarded contracts to assess episode grouper methodologies (25). Furthermore, 41 episodes available for use in the first year of MIPS are relatively new and untested and none have been used for adjusting payment. Further, 20 have never been used for clinician feedback. These 41 episodes were also developed by 2 contractors using separate, incompatible methodologies. The commission and the majority of physicians have expressed that neither methodology may prove to be an acceptable foundation for building a complete set of episodes going forward. The commission has developed its own set of policy principles to include transparency and independent assessment for clinician resource use measurement and has encouraged CMS to adapt in implementing MIPS (71).

4.3 Clinical Practice Improvement Activities

CPIA is a new performance category for MIPS. It emphasizes activities with a proven association of improved health outcomes based on the notion that

improving the health of all Americans can be accomplished by developing incentives and policies that drive improved patient health outcomes. The CPIA performance category also focuses on another MIPS strategic goal, which is to use design incentives that drive movement toward delivery system reform principles and APMs. CMS also adds that another MIPS strategic goal is to establish policies that can be scaled in future years as the bar for improvement rises. Under the CPI performance category, CMS proposed baseline requirements that will continue to have more stringent requirements in future years, essentially laying the groundwork for expansion towards continuous improvement over time.

Under CPIA, a portion of clinicians' MIPS scores will be based on clinicians attesting that they have activities in place that aim to improve care coordination, beneficiary engagement, and patient safety. The current proposal includes 90 activities that clinicians can choose to report. Some activities however will be weighted more highly than others, so if clinicians attest to those activities, they will receive more points. Clinicians can receive automatic credit for the category if they participate in APMs or patient-centered medical homes.

In summary, CPIA offers a choice as CMS proposes to allow physicians to select from a list of more than 90 activities which include completion of various programs offered by organizations including the American Medical Association (AMA) Steps Forward program, hiring diabetes educators, and participation in QCDR (70). ASIPP is in the process of developing a QCDR applicable to IPM practitioners.

In addition, CPIA creates a shorter reporting period of at least 90 days during the performance period rather than requiring a full year of reporting.

MedPAC (25) was skeptical about the value of the CPIA category because evidence on whether these activities lead to improved health outcomes is limited. Table 6 summarizes the CPIA performance category.

4.4 Advancing Care Information Performance Category

The ACI category replaces the Medicare EHR incentive program, also known as the MU. Under the American Recovery and Reinvestment Act of 2009 (75), eligible professionals and hospitals were able to receive incentive payments for the MU of certified EHR technology from 2011 through 2014 through either Medicare or Medicaid. Under the Medicare EHR incentive payment program, up to \$44,000 was available to clinicians who demonstrated MU. However, beginning

Table 6. *Proposed rule MIPS: clinical practice improvement activity performance category.*

- ◆ Minimum selection of one CPIA activity (from 90+ proposed activities) with additional credit for more activities
- ◆ Full credit for patient-centered medical home
- ◆ Minimum of half credit for APM participation
- ◆ Key changes from current program:
 - Not applicable (new category)
 - Year 1 weight: 15%

Source: Department of Health and Human Services, Centers for Medicare & Medicaid Services. 42 CFR Parts 414 and 495. Proposed Rule. Federal Register, April 27, 2016 (1).

Table 7. *Proposed rule MIPS: advancing care information performance category.*

- ◆ Scoring based on key measures of health IT interoperability and information exchange
- ◆ Flexible scoring for all measures to promote care coordination for better patient outcomes
 - Key changes from current program (EHR incentive):
 - Dropped “all or nothing” threshold for measurement
 - Removed redundant measures to alleviate reporting burden
 - Eliminated clinical provider order entry and clinical decision support objectives
 - Reduced the number of required public health registries to which clinicians must report
 - Year 1 weight 25%

Source: Department of Health and Human Services, Centers for Medicare & Medicaid Services. 42 CFR Parts 414 and 495. Proposed Rule. Federal Register, April 27, 2016 (1).

in 2015, eligible professionals who do not successfully demonstrate EHR MU are subject to a payment penalty, starting at 1% and increasing each year that an eligible professional does not demonstrate MU to a maximum of 5%. Recently some changes have been made in MU implementation (76-79).

The ACI-proposed requirements revise MU with the goals of reducing reporting effort while emphasizing interoperability, information exchange, and security measures.

CMS proposes adding a required attestation to the current MU program that clinicians have cooperated with the surveillance of certified EHR technology under the Office of National Coordinator for Health Informa-

tion Technology (ONC) certification program.

CMS also proposes adding an attestation requirement that an eligible clinician, eligible hospital, or eligible critical access hospital has not knowingly and willfully taken action to disable functionality in order to limit or restrict the compatibility or interoperability of certified EHR technology. Table 7 summarizes ACI performance category.

Thus, ACI changes the scoring methodology, reduces measures, and eases reporting processes. It moves away from a pass-fail program design, otherwise known as all or none scoring, by combining a base score and performance score into an overall score.

ACI also reduces measures and does not require physicians to report on 2 measures that hindered usability – computerized provider order entry and clinical decisions support (70). Further, ACI also removes clinical quality measures to streamline overall quality reporting in MIPS.

An additional aspect of ACI has eased reporting processes. It allows group data submission and performance to be assessed as a group as opposed to an individual creation. It also permits physicians to submit data for the first time through QCDRs.

However, there are multiple issues that still need to be addressed. One is the lack of significant overhaul without changing the actual measures. It also retains the pass-fail element in the base performance score (protecting patient information), which can make up half of the ACI total score. This measure requires a security risk analysis, which has historically been challenging for physicians. It also fails to provide any incentives for innovation. Further, the proposed rule would eliminate exclusions that many physicians utilized in the past to avoid reporting on certain measures and requires a new participant to start reporting under a full calendar year instead of a 90 day reporting period (70).

MedPAC also commented on ACI with their displeasure that they are not convinced that these activities benefit the patient and improve health outcomes. This is similar to the physicians who have described this as Meaningless Use and provided a failing grade to the ACA (40). Further, the commission continues to express its longstanding concern in reference to the overall approach in MU of paying clinicians to purchase an EHR, and requiring clinicians to report information demonstrating its use. The commission feels that a better approach is to ensure that the payment system itself creates a business case for the use of EHRs and encourages vendors to market products that improve care and interoperability (10,11,17,22,24,80).

5.0 MERIT-BASED PAYMENT SYSTEM SCORING

MIPS utilizes 4 categories to evaluate eligible clinician performance, with a maximum of 100 points. MIPS clinicians can choose to be rated on either an individual-clinician basis or as a group of clinicians, with the constraint that the choice applies across all performance categories. Further, MIPS clinicians who also participate in certain alternative payment models, such as Medicare Accountable Care Organizations (ACOs), must be rated as a group of clinicians and do not have the choice to be rated as individuals.

Each performance category is scored separately as a percentage of maximum possible performance within that category, and then the category level scores are weighted by the appropriate category, and then summed to produce the CPS.

5.1 Scoring for Quality Performance Measures

Each PQRS and population quality measure is assigned a possible 10 quality points. Consequently, either 80 or 90 quality points are available, respectively, depending upon the number of clinicians in the group being rated for MIPS. Each measure earns up to 10 points based upon the percentile basis performance of that measure relative to national peer benchmarks.

MIPS also provides additional paths to achieve a quality score of 100% by granting bonus points for certain quality reporting activities. For example, if 2 bonus points were earned, the quality score would increase, but never greater than 100 is achievable as CMS will truncate it back down to 100%. Bonus points may be accrued as follows:

- Two bonus points for reporting each extra outcome measure beyond the one required.
- Two bonus points for reporting the patient experience measure (CAHPS for MIPS survey counts as one patient experience measure).
- One bonus point for reporting each extra high priority measure.

The total bonus points from the above are capped at 5 or 10, to be decided in the final rule of the denominator of the quality score.

Specifically for the Group Practice Reporting Option (GPRO) Web Interface quality reporting methodology, with the ability to use a greater number of preselected measures, the denominator of the quality score would be the number of measures x 10. However, CMS also states that it will determine the number

of possible bonus points for this reporting method at a later date.

5.2 Resource Use Category Scoring

Resource use is rated based on 40+ cost measures to account for differences among specialties with assignment of Medicare costs of attributed patients and contributing 10% to the composite score of MIPS. Similar to the quality category, measures can earn up to 10 points each on a percentile benchmark scale. A resource use percentage score is earned by dividing the total points across included measures by the total possible points. Thus, a clinician may earn 6 and 8 points respectively on 2 included cost measures, with category contributing to 7 CPS points.

5.3 Clinical Practice Improvement Activity (CPIA) Scoring

Under MIPS, a clinician can earn up to 60 points within the CPI category as described above which contributes to 15% of the composite score. CPIA percentage score is calculated by dividing the total CPIA points by 60. For example, 50 points would yield 12.5 CPS points. Multiple activity categories include expanded practice access, population management, care coordination, beneficiary engagement, and patient safety.

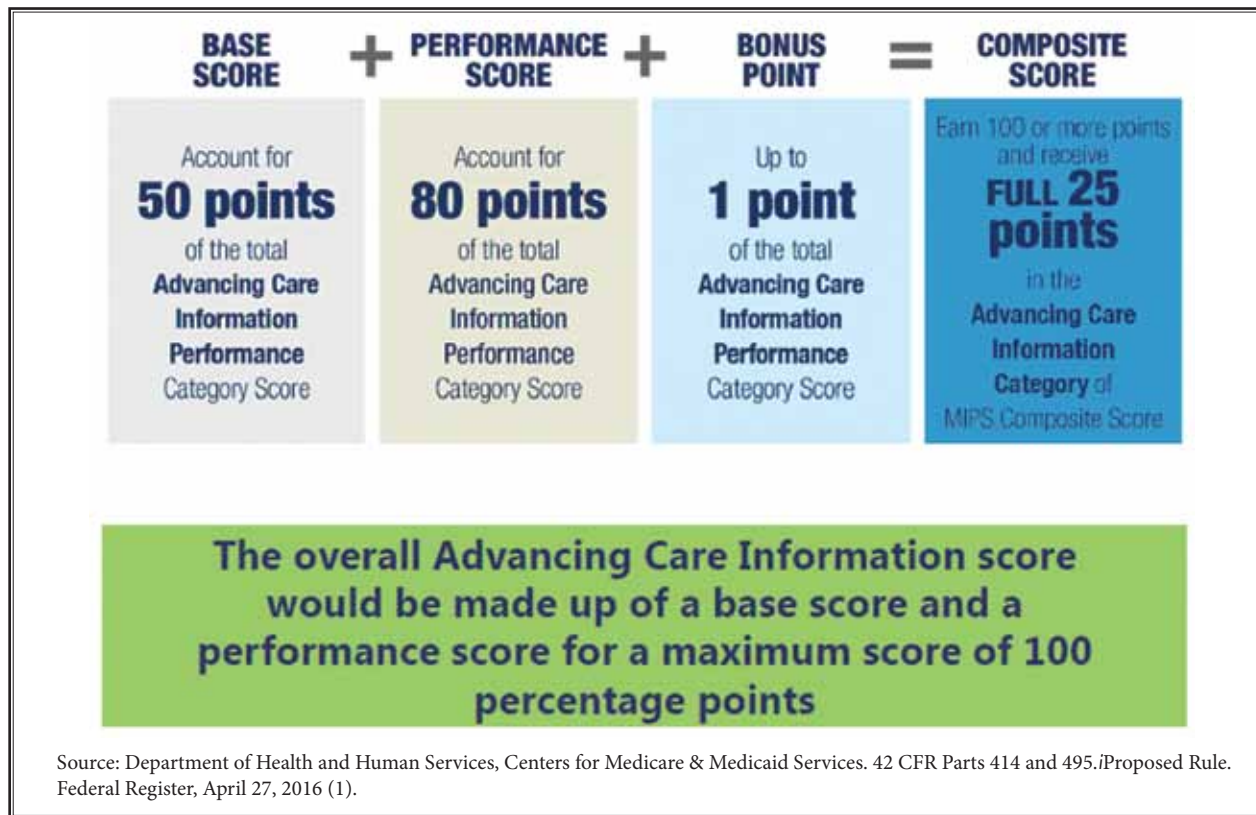
5.4 Scoring for Advancing Care Information

Scoring for ACI is different from MU, even though ACI is only the new name for MU. The ACI performance category contributes to 25% of the composite score. The ACI category defines 131 ACI performance points that can be earned as follows (Table 8):

- Base Score: 50 points for reporting either a non-zero numerator or a "yes," as applies, for selected measures from the MU Modified Stage 2 or MU Stage 3 measure sets.
- Performance Score: Up to 80 points for performance on 8 measures per the decile scoring scale described above.
- Bonus Point: Up to 1 bonus point for reporting to an additional public health registry.

The ACI percentage score is capped at no more than 100 ACI points. The ACI percentage score is calculated by dividing the number of ACI points by 100. When less than 100 ACI points are earned, a proportionate decrease in ACI performance scores will be observed. Thus, 60 ACI points equates to 60% ACI performance, resulting in 15 CPS points contributed by ACI.

Table 8. Proposed rule MIPS: advancing care information performance category.



5.5 Calculation of the Composite Score

The composite score is calculated from the component scores as shown in Table 9.

- Quality = (56 of 80 points) x 50% weight x 100 = 35 CPS points
- ACI = (60 of 100 points) x 25% weight x 100 = 15 CPS points
- CPIA = (50 of 60 points) x 15% weight x 100 = 12.5 CPS points
- Resource Use = (14 of 20 points) x 10% weight x 100 = 7 CPS points
- Total CPS points = 35 + 15 + 12.5 + 7 = 69.5

Clinicians can use the MIPS financial calculator to see how a MIPS score translates into a Medicare Part B payment adjustment in percentage-based and dollar-based terms.

6.0 ADVANCED ALTERNATE PAYMENT MODELS

Advanced APMs are defined as a subclass which includes only the payment models run by CMS, excluding

the payment models run by commercial payers. These include the CMS Innovation Center model, Medicare Shared Savings Program, Accountable Care Organizations, demonstration under the Health Care Quality Demonstration Program, and demonstration required by federal law.

Other payer-advanced APMs, which can be run by commercial payers, must fulfill additional requirements as follows:

- Requires participants to use certified EHR technology.
- Bases payment on quality measures comparable to those in the MIPS Quality performance category.
- Either APM entities must bear more than nominal financial risk for monetary losses, or the APM is a Medical Home Model expanded by the CMS Innovation Center.

CMS describes 5 things to do now to prepare for the January 2017 start of MIPS, unless there are significant modifications and a delay in the implementation date. The proposed rule stands; however, based on the present mood in Washington and CMS's promise to accommodate requests from Congress and the public,

Table 9. Proposed rule MIPS: calculating the composite performance score (CPS) for MIPS.

A. Composite score components

B. Unified scoring system

- Converts measures/activities to points
- Eligible clinicians will know in advance what they need to do to achieve top performance
- Partial credit available

C. Scoring summary

- MIPS composite performance scoring method that accounts for:
 - Weights of each performance category
 - Exceptional performance factors
 - Availability and applicability of measures for different categories of clinicians
 - Group performance
 - The special circumstances of small practices, practices located in rural areas, and non-patient-facing MIPS eligible clinicians

D. Scoring methodology

Category	Weight	Scoring
Quality	50%	<ul style="list-style-type: none"> • Each measure 1-10 points compared to historical benchmark (if avail.) • 0 points for a measure that is not reported • Bonus for reporting outcomes, patient experience, appropriate use, patient safety and EHR reporting • Measures are averaged to get a score for the category
Advancing care information	25%	<ul style="list-style-type: none"> • Base score of 50 percentage points achieved by reporting at least one use case for each available measure • Performance score of up to 80 percentage points • Public Health Reporting bonus point • Total cap of 100 percentage points available
CPIA	15%	<ul style="list-style-type: none"> • Each activity worth 10 points; double weight for "high" value activities; sum of activity points compared to a target
Resource Use	10%	<ul style="list-style-type: none"> • Similar to quality

Source: Department of Health and Human Services, Centers for Medicare & Medicaid Services. 42 CFR Parts 414 and 495.iProposed Rule. Federal Register, April 27, 2016 (1).

changes seem to be feasible. Without changes, CMS recommends the following:

1. Educate clinicians and organizations utilizing the MIPS financial calculator.
2. Estimate MIPS score using current Meaningful Use, PQRS, and VBM scores.
3. Optimize MU and PQRS/VBM quality to maximize the MIPS score.
4. Evaluate staff, resources, and organizational structure converting different factions into one.
5. Identify 2016 deadlines affecting the 2017 MIPS.

7.0 Discussion

MACRA has been described as the most sweeping overhaul of the Medicare payment system in a long time affecting the business of running a physician practice. While MACRA eliminated the SGR, MIPS will potentially affect physicians negatively. MIPS utilizes a combination of incentives and payment adjustments to promote numerous quality measures by both individual physicians and group practices. Essentially, eligible providers and group practices that fail to satisfactorily report data on MIPS measures during 2017 will be subject to a 4% reduction to their Medicare fee-for-service amounts for services furnished during 2017, the reporting year for payment in 2019. However, it also appears that it may be essential to follow through PQRS and MU with VBM in 2017 and 2018 in addition to MIPS, which may be interrelated. Overall, 87% of solo physicians and 70% of physicians in groups of less than 10 providers face negative payments or payment cuts which will increase from 4% in 2019 to 9% in 2022. The silver lining is that one may actually successfully participate in the MIPS program and reap bonuses of 12% which essentially avoids 9% cuts and gains 12%, a 21% difference in payments or as much as a 37% bonus.

With numerous issues related to EHR technology, the intended goals have been significantly muted with considerable failures and have been described in detail by many (10,17,19-21, 24). Current Medicare performance on key goals of MU are highly variable, with clinicians demonstrating high performance on some objectives while others present a greater challenge. CMS, in implementing MIPS, intends to develop requirements for the ACI performance category to continue supporting the foundational objectives of the Health Information Technology for Economic and Clinical Health (HITECH) Act, and to encourage continued information exchange and patient engagement. In developing the requirements and structure for the ACI performance category, CMS considered a framework based on the historical performance of the EHR incentive program objectives and measures and designed a modified framework from MU that would allow for flexibility and multiple paths to achievement under this category. Part of this framework requires moving away from the concept of requiring a single threshold for a measure, and instead provides incentives for continuous improvement. It also recognizes ongoing efforts among late adopters and MIPS eligible clinicians facing continued challenges in full implementation of certified EHR technology in their practices.

The question often raised is how does MIPS affect MU? CMS clarifies that MIPS does not affect Medicaid MU, nor eligible hospital MU programs. Essentially, for these programs, the MU modified Stage 2 and Stage 3 measures and associated incentives and payment adjustments are not affected by MIPS nor the broader MACRA legislation.

The purpose of MIPS is to align value-based and patient-centered care. Accountable Care Organizations, similar to APMs, have been designed as innovative models of care (81); however, at least in some circles, ACOs have been a disappointment with their lackluster or even lack of savings and their inability to deliver better health care (81-92). Key deficiencies with ACOs which may be translated to MIPS include that they do not empower consumers to be stakeholders in their own care and they do not encourage provider accountability; however, they do create an unfair competitive advantage for large organizations (86). Bob Kocher, an architect of the ACA, acknowledged that having every provider in health care "owned" by a single organization is more likely to be a barrier to better care (38).

The overall MIPS requirements necessary to obtain a bonus may be too stringent for the majority of practices. Instead of bonuses having an encouraging effect, they may become a discouragement and an incentive to stop providing services to Medicare patients. Consequently, ASIPP, in its comment letters, along with other organizations, has requested:

- Exemption of interventional pain management from penalties but leaving open the possibility of bonuses for those who would like to participate.
- Reducing the reporting time to 3 months out of a year, which would allow practices to regroup and report again within the reporting period of that year.
- A delay of MIPS implementation by 2 years to provide practices and CMS time to prepare.
- With all the experiences gained through PQRS, which may not improve quality at all, we also are requesting elimination of the MIPS program which has no relevance to the repeal of SGR.

With recent information, gathering and advocacy efforts of ASIPP in Washington with contact of many leaders in Congress, ASIPP's proposed legislation is as follows:

Delay the implementation of merit-based incentive payment system (MIPS) by one-year, to January 1, 2018, reporting year, retaining 2019 as penalty/bonus year (performance year), and change

participation of MIPS for 3 months per year, with 2017 serving as a training year to meet criteria for meaningful use, physician quality reporting system, and value-based payment.

Meanwhile, due to intense advocacy efforts by multiple organizations including ASIPP and concerns expressed by Congress, CMS has issued multiple modifications for MIPS implementation strategy (93) and members of the Congress also issuing their concern, as well as support for newly introduced measures (94). However, the issue continues with further modifications forthcoming before, during, or after the final rule publication.

With multiple developments and advocacy efforts to obtain exemption for interventional pain management, or delay with implementation for 3 months of a year, and with the development of a registry by ASIPP to include MIPS measures, as well as outcome measures, we may look forward to a brighter future.

8.0 CONCLUSION

MIPS is essentially a quality reporting program established under MACRA to provide effective, safe, efficient, patient-centered, equitable, and timely care to patients. The program includes multiple measures combined from 3 previously separate programs, namely, MU, PQRS, and the VPB system, and creates a new program. As we have shown with PQRS (18), we will

be able to identify an appropriate set of measures for interventional pain physicians moving into the future. Even then, the question continues to linger if these programs are worth the time, cost, and intensity of provider effort which may be far greater than the proposed negative payments. Hopefully Congress and CMS will understand and make appropriate modifications based on evidence, necessity, and transparency.

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Conflicts of Interest:

Dr. Manchikanti has provided limited consulting services to Semnur Pharmaceuticals, Incorporated, which is developing nonparticulate steroids.

Dr. Helm is a clinical investigator with Epimed and receives research support from Cephalon/Teva, Astra-Zeneca, and Purdue Pharma, LP. He has attended an advisory group meeting for Activas.

Dr. Benyamin is a consultant and lecturer for Boston Scientific and Kimberly Clark.

Dr. Hirsch is a consultant for Medtronic.

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