Health Policy Review

Merit-Based Incentive Payment System: Meaningful Changes in the Final Rule Brings Cautious Optimism

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The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) eliminated the flawed Sustainable Growth Rate (SGR) act formula – a longstanding crucial issue of concern for health care providers and Medicare beneficiaries. MACRA also included a quality improvement program entitled, "The Merit-Based Incentive Payment System, or MIPS." The proposed rule of MIPS sought to streamline existing federal quality efforts and therefore linked 4 distinct programs into one. Three existing programs, meaningful use (MU), Physician Quality Reporting System (PQRS), value-based payment (VBP) system were merged with the addition of Clinical Improvement Activity category. The proposed rule also changed the name of MU to Advancing Care Information, or ACI. ACI contributes to 25% of composite score of the four programs, PQRS contributes 50% of the composite score, while VBP system, which deals with resource use or cost, contributes to 10% of the composite score. The newest category, Improvement Activities or IA, contributes 15% to the composite score. The proposed rule also created what it called a design incentive that drives movement to delivery system reform principles with the inclusion of Advanced Alternative Payment Models (APMs).

Following the release of the proposed rule, the medical community, as well as Congress, provided substantial input to Centers for Medicare and Medicaid Services (CMS),expressing their concern. American Society of Interventional Pain Physicians (ASIPP) focused on 3 important aspects: delay the implementation, provide a 3-month performance period, and provide ability to submit meaningful quality measures in a timely and economic manner. The final rule accepted many of the comments from various organizations, including several of those specifically emphasized by ASIPP, with acceptance of 3-month reporting period, as well as the ability to submit non-MIPS measures to improve real quality and make the system meaningful. CMS also provided a mechanism for physicians to avoid penalties for non-reporting with reporting of just a single patient.

In summary, CMS has provided substantial flexibility with mechanisms to avoid penalties, reporting for 90 continuous days, increasing the low volume threshold, changing the reporting burden and data thresholds and, finally, coordination between performance categories. The final rule has made MIPS more meaningful with bonuses for exceptional performance, the ability to report for 90 days, and to report on 50% of the patients in 2017 and 60% of the patients in 2018. The final rule also reduced the quality measures to 6, including only one outcome or high priority measure with elimination of cross cutting measure requirement. In addition, the final rule reduced the burden of ACI, improved the coordination of performance, reduced improvement activities burden from 60 points to 40 points, and finally improved coordination between performance categories.

Multiple concerns remain regarding the reduction in scoring for quality improvement in future years, increase in proportion of MIPS scoring for resource use utilizing flawed, claims based methodology and the continuation of the disproportionate importance of ACI, an expensive program that can be onerous for providers which in many ways has not lived up to its promise.

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

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1.0 Introduction

On October 14, 2016, the Centers for Medicare and Medicaid Services (CMS) released the highly anticipated, controversial, final rule for implementation of Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, with the inclusion of responses to numerous comments from the public, Congress, and providers (1,2). This rule changed many aspects of the proposed rule, providing the final description in detail of the physician payment system that Congress outlined in MACRA (3-12). As we have described in detail in our previous manuscripts, MACRA and Merit-Based Incentive Payment System (MIPS) Medicare Physician Payment System will, starting in 2019, placemost physicians in the MIPS, a pay for performance system that adjusts payments based on measures derived from prior care (3-5,9-12). It is clear that CMS paid attention to the feedback that was provided; the final rule appears to have changed to meaningful, inclusive, professional solutions (3-6,13-17). The final rule offers flexibility, expanded exemptions, and also provides less painful "pick your pace" options.

For several weeks after the release of proposed rule, physicians, health system leaders, and members of Congress were working under a tight time frame to try to figure out how to prepare for Medicare's new incentive payment framework in time to report performance data to the CMS or alter the proposed rule. CMS was flooded with nearly 4,000 comment letters after issuing its draft rule. Of interest, the American Society of Interventional Pain Physicians (ASIPP) submitted a comment letter with 4,534 signatures, visited Capitol Hill, and offered legislation to reduce the burden of proposed rule for MIPS and improve the quality of patient care without hindering access (3,14). During the Capitol visits, ASIPP offered the legislation, which was sent to CMS by leaders of the Congress for technical assessment. The proposed legislation (3) sought to "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 (payment year) and change participation of MIPS to 3 months per year, with 2017 serving as a training year to meet criteria for meaningful use, physician quality reporting system (PQRS), and value-based payment (14). CMS believes that the final rule preserves its commitment to creating a flexible and streamlined program, aligning prior quality and technology initiatives into one program. The changes that CMS has made are thus specifically in line with the recommendations in the ASIPP comment letter to the proposed rule. Congress, while expressing concerns (15,16), also urged CMS to be flexible by lowering patient minimum reporting threshold. The agency wanted providers to report quality measures on 90% of their patients from all payers, and 80% of Medicare patients. Lawmakers felt that such a high minimum threshold would be impossible for many physicians, particularly those in small practices, to meet. Consequently, they recommended that CMS maintain the minimum threshold at a maximum of 50% of Medicare patients. Congress also requested CMS to broaden its MIPS exclusion for providers who treat a low volume of Medicare patients. They requested that CMS should consider increasing the threshold to $30,000 in Medicare allowed charges or fewer than 100 unique Medicare patients which would exclude 30% of physicians, instead of 16% under the proposed rule. The comments from Congress mirrored multiple comments submitted by many providers, along with ASIPP (14-17).

Overall, CMS, in the final rule, provided avoidance of the penalty even with reporting of one patient, provided flexibility of 90 days, increased physician volume threshold to $30,000 in Medicare revenue or 100 or fewer Medicare patients per year, reduced the reporting burden with reduction of quality measures to 6 and advancing care measures to 4 or 5 and, finally, modified reporting requirements to 50% of patients for all reporting methods with reduction of data threshold. CMS also seems to be seeking to ease physicians' administrative burdens (17). Acting CMS Administrator, Andy Slavitt, explained that as CMS implements the quality payment program under MACRA, CMS cannot do it without making a sustained, long-term commitment to take a holistic view on the demands on the physician and clinical workforce. Essentially, the new initiative will launch a nationwide effort to work with the clinician community to improve Medicare regulations, policies, and interaction points to address issues and to help get physicians back to the most important thing they do – taking care of patients (17)." This manuscript focuses on the final rule of MIPS, financial impacts, the timeline, advanced alternative payment models, eligibility requirements and exemptions, categories of MIPS and scoring with impact of MIPS on meaningful use, PQRS, and value-based modifier (VBM).

2.0 Merit-Based Incentive Payment System

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 repealed the Medicare sustainable

growth rate (SGR) methodology for updates to the physician fee schedule and replaced it with a new approach to payment (4-8). MACRA also provided additional approaches to payments called the quality payment program that rewards the delivery of high quality patient care through either advanced alternative payment models (APMs) or MIPS for eligible clinicians or groups under fee-for-service (FFS) Medicare. The proposed rule on April 27, 2016, provided details of the program which necessitated hard choices for those in independent practices (2,9). This final rule with comment period established the MIPS to consolidate components of 3 existing programs, PQRS, the physician VBM, and the Medicare electronic health record (EHR) incentive program for eligible professionals, with continuation of the focus on quality, cost, and use of certified EHR technology (CEHRT) in a cohesive program that avoids redundancies. It also established incentives for participation in certain APMs.

The final retains 4 components of MIPS: quality, Advancing Care Information (ACI), improvement activities, and cost. However, cost will not be calculated for 2017/2019, whereas proportions of quality have changed for all years, with cost taking a far more significant role in future years. MIPS is the pathway that will be used for most eligible clinicians.

2.1 Quality Performance Measures

With the implementation of MIPS and a purported shift of practice of medicine from individual authority to societal accountability, the quality of medical practices continue to be under increasing and continuous scrutiny, not only by policy makers, but peers, payers, and patients (9,18-33). The strategy developed by IOM in the early years to improve quality of care known as pay for performance or financial incentives to transform behaviors to achieve greater value substantially changed to PQRS and now quality measures as a component of MIPS (18,33-36). MIPS substantially altered PQRS measures with the ability to provide non-PQRS or non-MIPS measures to provide meaningful quality measurements. The development of MIPS quality measures, previously known as PQRS measures, continues to be associated with a lengthy and expensive review process (18,37-40). However, the development of non-MIPS measures provides not only an inexpensive, but also shorter review process, allowing smaller societies to submit these measures, which would in essence reflect quality of care in ways relevant to specific specialties.

In changing from PQRS to MIPS, the proposed rule required reporting on 6 quality measures, including one cross cutting measure and one outcome, or high priority measure (Table 1). The final rule allows physicians to report 6 quality measures including one outcome or high priority measure with elimination of the cross cutting measure requirement. The proposed rule also required physicians to report on 90% of all patients, regardless of payer, if using EHR, registry, or QCDR submission methods and report on 80% of all Medicare Part B patients if using claim submission method (Table 1). However, in the final rule, in 2017 reporting year, physicians have to report a measure for 50% of patients, and in 2018 reporting year, they must report on 60% of patients. If only avoiding a penalty and not attempting to earn an incentive is the focus, a practitioner is only required to report on one patient. Thus, the final rule has removed requirement of reporting of one year to 90 days to one patient.

2.2 Advancing Care Information

As described in MIPS proposed rule, meaningful use criteria have been replaced by ACI performance category as a MIPS component system. Over the years, this category has been described as meaningless, increasing cost of doing business, and reducing patient contact (18,40,41). Even though significant changes have been made in ACI in the proposed and even further changes in final rule, ACI and by default MIPS continue to increase the burden on practicing physicians. The proposed rule required physicians to report on the base score of 11 to 16 measures to receive credit in the ACI performance category with ACI consisting of 8 measures with performance scoring based on 100% of the patients (Table 1). The final rule reduced the required number of ACI measures in the base score with an additional 9 optional measures in the performance score, which facilitates to achieve the state of exceptional performance or receive additional percentage points. The final rule also allows physicians to earn bonus points in the ACI performance category by using certified electronic health record technology (CEHRT) to complete certain activities in the improvement activities performance category.

2.3 Improvement Activities

Clinical Practice Improvement Activities (CPIA) that is now known as Improvement Activity (IA) is a new performance category introduced for MIPS. It emphasized activities with a proven association of improved health outcomes (2,9). IA performance category also focused

Table 1. *Summary of change of provisions of MIPS from proposed to final rule.*

SUBJECT	PROPOSED RULE	FINAL RULE
Avoiding the QPP Penalty	Physicians must successfully report in all 4 MIPS categories in order to avoid the MIPS penalty.	In 2019, only physicians who choose to report no data will experience a penalty. • Physicians who report for 1 patient on 1 quality measure, 1 improvement activity or the 4 required ACI base measures in 2017 will avoid a penalty in 2019.
Performance Period	Physicians must report for a full calendar year to be eligible for a positive payment adjustment	Physicians who report for at least 90 continuous days will be eligible for positive payment adjustments. • Reporting revised for all components of MIPS.
Scoring Weight Quality of Measures	• 2019 – 50% • 2020 – 45% • 2021 – 30%	• 2019 – 50% • 2020 – 45% • 2021 – 30%
Scoring Weight of Cost Measures	• 2019 – 10% • 2020 – 15% • 2021 – 30%	• 2019 – 0% • 2020 – 10% • 2021 – 30%
Scoring Weight of ACI Measures	25%	25% • No change
Scoring Weight of Improvement Activities	15%	15% • No change
Low-Volume Threshold	Physicians with less than $10,000 in Medicare allowed charges AND fewer than 100 Medicare patients per year.	Low volume threshold physicians with less than $30,000 in Medicare revenue or 100 or fewer Medicare patients per year.
Reporting Burden of Quality	Physicians are required to report on 6 quality measures including one cross-cutting measure and one outcome or high priority measure.	Physicians are required to report 6 quality measures including one outcome or high priority measure. • CMS eliminated the cross-cutting measure requirement.
Reporting Burden of ACI	Physicians are required to report on the Base Score of 11-16 measures to receive credit in the ACI performance category. The Performance Score consists of 8 measures with performance scoring based on 100 percent of patients.	Physicians are required to report on a reduced number of ACI measures in the Base Score with an additional 9 optional measures in the Performance Score, for which physicians may receive additional percentage points.
Data Thresholds of Quality	Data completeness requires physicians to report on 90 percent of all patients, regardless of payer, if using EHR, registry, or QCDR submission methods and report on 80 percent of all Medicare Part B patients if using claims submission method.	In 2017, physicians have to report a measure for 50 percent of patients, and in 2018, they must report on 60 percent of patients. • If only avoiding a penalty and not attempting to earn an incentive, only required to report on 1 patient.
Reporting Burden of Improvement Activities	Physicians must report three 20-point high-weighted activities or six 10-point medium-weighted activities (or another combination of high and medium weighted activities equally 60 or more points) to achieve full credit in the improvement activity performance category	Physicians must attest to two 20-point high-weighted activities, four 10-point medium-weighted activities, or another combination of high and medium-weighted activities equaling 40 points or more to achieve full credit in the improvement activity performance category.
Coordination Between Performance Categories	The concept of a holistic approach to health IT to directly link health IT adoption and use to patient outcomes, and moving EHR into a more patient-focused health IT program with MIPS.	Physicians can earn bonus points in the ACI performance category by using CEHRT to complete certain activities in the Improvement Activities performance category.
Definition of "More Than Nominal Risk" of APMS	To qualify as a Medicare Advanced APM, the APM must meet the requirements for marginal risk, minimum loss rate, and total risk.	To qualify as a Medicare Advanced APM, the APM must only meet the requirement for total risk.
Amount of Risk that is "More than Nominal" of APMS	Physicians are required to pay up to 4 percent of total Medicare spending to qualify as an Advanced APM.	An APM will qualify as an Advanced APM in 2019 and 2020 if the APM Entity is either (1) at risk of losing 8 percent of its own revenues when Medicare expenditures are higher than expected, or (2) at risk of repaying CMS up to 3 percent of total Medicare expenditures, whichever is lower.

on another MIPS strategic goal, to design incentives that drive movement toward delivery system reform principles and APMs. IA offered a choice of 90 activities, which included completion of various programs offered by multiple organizations (2,9). As an anomaly in the proposed rule IA created a shorter reporting period of at least 90 days during the performance period rather than requiring a full year of reporting. This aspect provided support for ASIPP's position that the rule be modified to reduce overall reporting requirements and also provide an option of 3 months for MIPS (9,14).

The proposed rule mandated physicians to report 3-20 point high-weighted activities or 6 10-point medium-weighted activities or another combination of high and medium weighted activities equally, 60 or more points, to achieve full credit in the improvement activity performance category as shown in Table 1 (2,9). The final rule modified this aspect to mandating physicians to attest to 20-point high-weighted activities, instead of 3; 4-10 point medium-weighted activities, instead of 6 medium-weighted activities. Further, a combination of high and medium-weighted activities equaling 40 points or more to achieve full credit in the improvement activity performance category has been provided, with a reduction from 60 or more points. In addition, only 11 out of more than 90 IAs in the proposed rule were identified as high-weighted, whereas the final rule increased the number of high-weighted activities available to physicians.

2.4 Cost or Resource Use

The health care industry and policy makers have always considered resource use as an integral part of the values measurement (9). CMS felt 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. CMS proposed additional 40 plus episode specific measures to address specialty concerns. However, the major point of contention among physicians and others, including Medicare Payment Advisory Commission (MedPAC) and Congress, has been the calculation of resource use. Essentially CMS methodology was flawed, making practices with the most high risk patients more susceptible to penalties than other physicians (42). This aspect of the MIPS has been the most contentious with numerous comments outlining flaws in the proposed methodology, as well as numerous conflicts of the 2 contractors developing the measures using separate, incompatible methodologies (1,2,9,14-17,42-45). Finally, the major flaw of this methodology continues to be, even in the final rule, is that global assignment of the cost to individual providers, irrespective of their involvement.

As described earlier, CMS proposed to use total cost per capita and Medicare spending per beneficiary measures to evaluate physicians' resource use, with cost performance category making up 10% of physicians' composite performance score. The final rule reduced the cost performance category to 0% of the composite performance score in 2017; however, unfortunately, CMS continues to retain the total cost for beneficiary and Medicare spending per beneficiary administrative claims measures. CMS also provided a reprieve on proposed 41 controversial episode-based measures with finalizing to 10 episode-based measures in 2017. They will also provide information to physicians on how they did on these measures in the past; however, it is considered as irrelevant for 2017 since performance category is reduced to 0%.

3.0 MIPS Eligible Clinicians

In the final rule, CMS has revised the terminology and defined MIPS participants as, "MIPS eligible clinicians" rather than "MIPS eligible professionals (EPs)." Under the statute, eligible clinicians include physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists. They must participate in MIPS during 2017 and 2018 performance years for 2019 and 2020 payment years unless they qualify for the advanced APM pathway or an exclusion.

For the 2017 performance period, CMS estimates that more than half of clinicians – approximately 738,000 to 780,000 – billing under the Medicare FFS will be excluded from MIPS due to several factors, including the MACRA itself. The estimates include that nearly 200,000 clinicians, or approximately 14.4%, are not one of the eligible types of clinicians for the transition year 2017 of MIPS. The largest cohort of clinicians excluded from MIPS is low-volume clinicians, defined as those clinicians with less than or equal to $30,000 in allowed charges or less than or equal to 100 Medicare patients representing approximately 32.5% of all clinicians billing Medicare Part B services or over 380,000 clinicians. Under the proposed rule with $10,000 in Medicare charges and fewer than 100 unique Medicare patients per year, 16% of all MIPS eligible clinicians would have been exempt under the proposal in contrast to 32.5% in estimated under the final rule. In addition, approxi-

mately 70,000 to 120,000 clinicians comprising 5% to 8% of all clinicians will be excluded from MIPS due to being qualified providers (QPs) based on participation in advanced APMs. However, in aggregate, eligible clinicians are excluded from MIPS if they are new clinicians in their first year of Medicare participation; these represent only 22 to 27% of total Part B allowed charges. Even though CMS expects the low volume threshold to exclude almost one-third of the clinicians from the MIPS, some specialties are more likely to be excluded, such as chiropractors (84%) and dentists (73%).

Thus, the vast majority of eligible clinicians (over 90%) will participate in MIPS in the first year.

4.0 Reimbursement Under MIPS

Medicare reimbursement under MIPS will be adjusted upward or downward based on quality performance. While CMS is capping the Medicare payment adjustment in 2019 to no more than 4% upward or downward based on eligible clinicians' 2017 performance, it intends to increase the adjustment limit to 5% in 2020, 7% in 2021, and 9% in 2022. However, for exceptional performance, the bonuses may reach as high as 37%. As shown in Table 1, even though MIPS is a budget-neutral program and incentives are funded by penalties, there may be substantial bonuses.

CMS estimates that, based under the policies of the final rule, approximately 592,000 to 642,000 eligible clinicians will be required to participate in MIPS in its transition year. In 2019, MIPS payment adjustments will be applied based on MIPS eligible clinicians' performance on specified measures and activities within 3 integrated performance categories. However, the fourth category of cost, as previously described, will be weighted to zero in the transition year. CMS projects that with an assumption that 90% of the eligible clinicians of all practice sizes participate in the program, MIPS payment adjustments will be approximately equally distributed between negative MIPS payment adjustments of $199 million and positive MIPS payment adjustments of $199 million to MIPS eligible clinicians, to ensure budget neutrality. However, positive MIPS payments to MIPS adjustments also will include an additional $500 million for exceptional performance payments to MIPS eligible clinicians whose performance meets or exceeds a threshold final score of 70.

This is in contrast to the proposed rule, wherein penalties and bonuses equaled almost $900 billion collected from and distributed to providers.

CMS also estimated that approximately 70,000 to 120,000 clinicians will participate in 2017 and 125,000 to 250,000 clinicians will participate in 2008 through advanced APMs receiving approximately $333 million to $571 million in APM incentive payments for 2019.

5.0 Participation Pace

CMS has devised a philosophy of pick-your-pace, based on numerous comments and called the first year the transitional year instead of delaying the implementation. Under the flexible rules, eligible clinicians can avoid value-based penalties and potentially earn incentive payments without submitting data on all required MIPS measures. CMS has provided multiple options for 2017 performance year, varying from no participation to 3 options as shown in Fig. 1.

- No participation: Clinicians not exempt from MIPS that do not submit any data in 2017 will receive a -4% payment adjustment.
- Submit something: A clinician may report one measure for a minimum of 90-day period to avoid a penalty. Reporting only one quality, ACI, or Improvement Measure (IA) will earn enough MIPS points to avoid a penalty and possibly earn a small incentive.
- Partial submission: A clinician may report more than one measure for a minimum of 90-day period in any or all of the quality, ACI, or IA categories, thus avoiding penalty, and may maximize the MIPS score and potentially earn the highest possible incentive, which may be small.

6.0 MIPS Performance Parameters

CMS determines Medicare payment adjustments based on a MIPS composite score. The score is made up of 4 performance categories: Quality, ACI, IA, and health care costs.

The first performance year or transitional year, the quality performance component will represent 60% of MIPS composite score with ACI representing 25% and improvement activities representing 15% with 0% for cost. Unless eligible clinicians are participating in a flexible attestation track, clinicians must report data on 6 quality measures, including an outcome-based measure, for a minimum of 90 days (Fig. 2).

The ACI category will account for 25% of the MIPS composite score. Eligible clinicians will need to fulfill required measures similar to those in the EHR incentive programs for at least 90 days. The required measures include the very detailed security risk analysis, e-prescribing, patient access to health data, summary of care

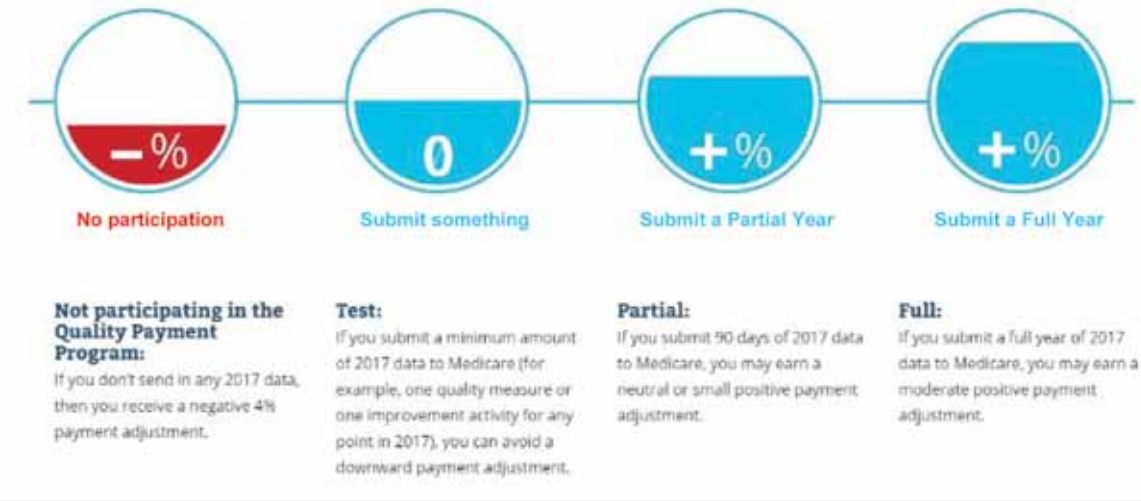

Fig. 1. *MIPS participation options.*
Source: Department of Health and Human Services, Centers for Medicare & Medicaid Services. 42 CFR Parts 414 and 495. Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models. Final Rule. Federal Register, October 14, 2016 (1)

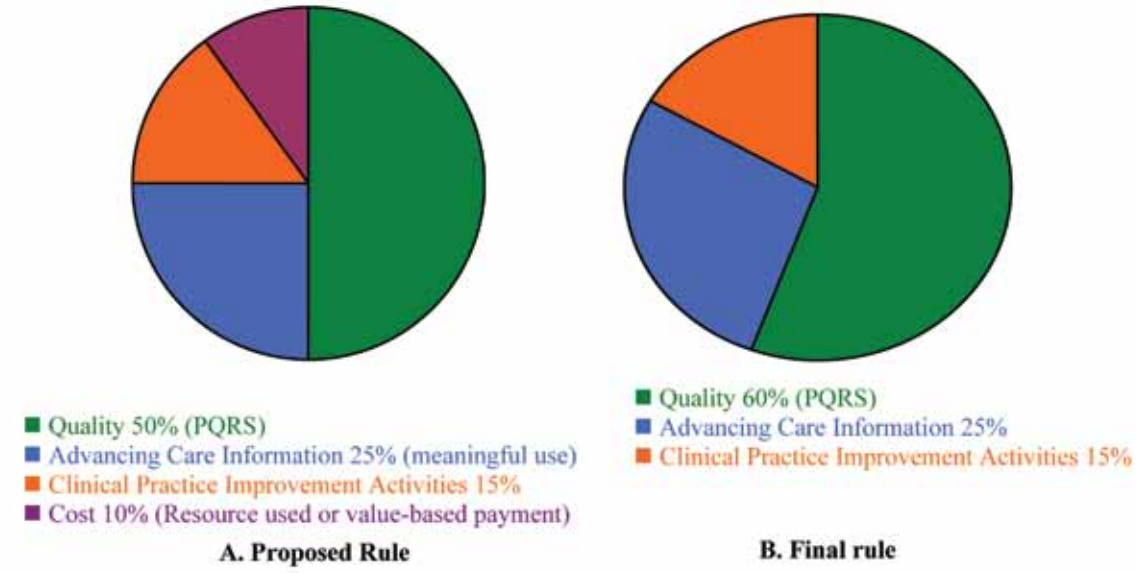

Fig. 2. *Comparison of 2017 MIPS performance – proposed rule vs. final rule.*

submissions, and summary of care requests and acceptance. Physicians are required to report on a reduced number of ACI measures in the base score, 4 in 2017, and 5 thereafter, with an additional 9 optional measures in the performance score, for which physicians may receiving additional percentage points.

CMS also will award additional credits to eligible clinicians who submit data on up to 9 ACI measures, report to public health and clinical data registries, and demonstrate certified EHR.

The third category captures 15% of the MIPS composite score for 2017 performance period (2019 payment period) for quality improvement activities. Eligible clinicians need to attest that they completed up to 4 approved improvement activities for at least 90 days. To earn maximum credit in this category, eligible clinicians can report on 4 medium weighted or 2 high weighted improvement activities. The quality payment program's website currently lists 93 approved activities. As part of the quality payment program transition year, CMS eliminated the health care cost component of the MIPS composite score for the first performance year. The weight of this claims-based category; however, the weight of this claims-based category appears to gradually increase from 0 to 30% of the total score by 2021.

7.0 Summary Of Changes From Proposed Rule To Final Rule

As described, there have been multiple changes in the final rule which improve the quality of the program with increased flexibility and, finally, improve the health care quality without impacting the access. With the establishment of Qualified Clinical Data Registry (QCDR), organizations such as ASIPP will be able to develop outcome parameters in various categories which will certainly improve the care and provide satisfaction for participation. The summary of changes of provision of MIPS from proposed to final rule are shown in Table 1. Key issues related to the proposed rule are avoidance of the penalty with reporting for at least one patient on one quality measure, one improvement activity, or the 4 required ACI base measures, performance period reduced to 90 days, increase in the low volume threshold from $10,000 to $30,000 and, finally, with no change in the definition of virtual groups.

Quality reporting still requires 6 quality measures; however, the final rule eliminates cross-cutting measure requirement and only includes one outcome or high priority measure. There also have been significant changes in data thresholds with reporting requirement of 50% of the patients in 2017 and 60% in 2018 instead of 90% of all patients.

In the category of ACI, the changes include changes in final rule of physician requirement to report on a reduced number of ACI measures in the base score of 4 in 2017 and 5 thereafter, with an additional 9 optional measures in the performance score. In addition, reporting period also has been reduced for a minimum of 90 days and physicians can earn bonus points on the ACI performance.

Improvement activities also have reduced reporting burden, availability of increasing number of highly weighted activities, and accommodations to various types of practices.

In the cost or resource use category, there is no cost reporting in 2017. Unfortunately, the final rule continues to retain the total cost per beneficiary and Medicare spending per beneficiary administrative claims measures despite extensive advocacy efforts. CMS has committed that they will consider ways to eliminate and streamline the process. This is an area of major concern for interventional pain physicians and ASIPP. We will continue our efforts to significantly change or revise the resource use parameters and also focusing on allocated performances under MIPS categories in the future with focus on improving the quality and less attention paid to ACI.

7.1 Impact of Final Rule on Meaningful Use

MIPS impacts clinicians eligible for Medicare meaningful use (MU) in multiple ways.

1. The MIPS sunsets Medicare Part B payment adjustments and replaces them with MIPS payment adjustments where 25% of the MIPS final score is determined by ACI performance category, which is based upon MU modified stage II measures (for 2014 addition CEHRT) and MU stage III measures (for 2015 addition CEHRT).
2. Eliminates all or nothing MU compliance based on measure thresholds to a hybrid scoring system for ACI where clinicians earn an all or nothing base score for reporting required measures, but a continuous performance score for measure rate performance relative to a decile scale and a 5% point bonus for reporting to more than one public health registry.
3. MIPS removes all measures exclusions defined under MU program as the hybrid scoring system for ACI is deemed to serve the same goal of providing clinicians flexibility and how to achieve high performance.
4. MIPS removes the requirement to report electronic clinical quality measures as quality reporting is already addressed by the MIPS quality category.
5. Enables ACI to be reported either to individual clinicians or to a group of clinicians and through additional data submission methods beyond attestation such as registry and EHR methods. These were previously available only for PQRS reporting.

6. MIPS also requires clinicians agreed to cooperate with surveillance CEHRT by the Office of the National Coordinator for Health Information Technology (ONC) and to implement CEHRT in good faith such that no inhibition of health information exchange, nor information blocking occurs.

MIPS performance category quality measures are shown in Table 2.

7.2 Impact of Final Rule on PQRS and the Value-Based Modifier

MIPS essentially sunsets the standalone PQRS and value-based modifier programs. Instead, MIPS quality performance category inherits aspects of the PQRS quality measures and reporting infrastructure created by the PQRS program and leveraged by the value-based modifier quality measurement system. A wide array of PQRS reporting methods, including registry, EHR, and web interface are largely preserved for purposes of reporting quality performance under MIPS. Further, the MIPS resource use performance category largely mirrors the VBM resource use measurement system in terms of measures, patient attribution methodology and benchmarking.

Some of the changes, which are rather significant, include the reporting of quality and rating under MIPS. The MIPS quality performance category deviates from PQRS and VBM as follows for measure selection and reporting methods as shown in Table 3.

7.2.1 Measure Selection

- Under the final rule, PQRS measures are reduced to 6 measures which can span any combination of quality domains, with inclusion of one outcome measure. In contrast, previously, it required 9 measures and 3 quality domains.
- Based on the final rule, a clinician may select 6 measures from a list of predefined specialty measure sets from the list of the individual measures and/or in addition, a specialty measure set may be utilized.
- MIPS also broadens and revamps the measure-applicability validation (MAV) process which allows another means for clinicians to report fewer than the required 6 measures for the registry, EHR, and QCDR reporting methods.

7.2.2 Reporting Methods

- For the registry and QCDR reporting methods, the data completeness standard, which defines the minimum subset of patients within a measure denominator that must be reported, is 50% of Medicare patients for 2017 and increases to 60% in 2018.
- Physicians using group practice reporting option (GPRO) will only need to declare their specific reporting method by June 30 of the performance year.
- The PQRS registry measures group method requiring reporting a minimum of 20 patients per measure has been eliminated in MIPS.

Table 2. *MIPS advancing care information: Performance category.*

For those using EHR certified to the 2015 Edition:		For those using 2014 Certified EHR Technology	
Option 1	**Option 2**	**Option 1**	**Option 2**
Advancing Care Information objectives and measures	Combination of the 2 measure sets	2017 Advancing Care Information transition objectives and measures	Combination of the 2 measure sets
25% If objectives and measures are not applicable to a clinician, CMS will reweight the category to zero and assign the 25% to the other performance categories to offset difference in the MIPS final score.			

Table 3. *MIPS Quality performance category.*

• Category Requirements • Replaces PQRS and quality portion of the value modifier • "So what?" – provides for an easier transition due to familiarity		
60% of final score	Select 6 of about 300 quality measures (minimum of 90 days to be eligible for maximum payment adjustment);1 must be: • Outcome measure OR • High priority measure –defined as outcome measure, appropriate use measure, patient experience, patient safety, efficiency measures, or care coordination	Different requirements for groups reporting CMS Web Interface or those in MIPS APMS May also select specialty-specific set of measures as developed by NIPMDR

Table 4. *MIPS Improvement activities: Performance category.*

• Attest to participation in activities that improve clinical practice - Examples: Shared decision-making, patient safety, coordinating care, increasing access • Clinicians choose from 90+ activities under 9 subcategories:		
1. Expanded Practice Access	2. Population Management	3. Care Coordination
4. Beneficiary Engagement	5. Patient Safety and Practice Assessment	6. Participation in an APM
7. Achieving Health Equity	8. Integrating Behavioral and Mental Health	9. Emergency Preparedness and Response

7.3 Improvement Activities

Improvement activities are a newer category with some changes from the proposed rule as shown in Tables 1 and 4. Essential changes of clinical improvement activates is described in Section 2.3 and 7.0.

8.0 Conclusion

As we enter the final phase of initial MIPS implementation, CMS has modified the proposed rule substantially bringing cautious optimism of the opportunity to improve the quality of medical services through payment policy. In the final rule, CMS has made many significant changes in large part based on public comments; including ASIPP's. ASIPP focused its efforts on changing to a 3 month reporting period and providing reprieve from penalty with reporting of at least one patient during 2017. They have also provided a different participation phase which can be variable based on provider abilities.

CMS has changed performance parameters significantly, increasing the quality component to 60% during the first year; however, reducing it to 30% in the final years. Unfortunately, CMS has not made any changes in scoring weight of ACI. Scoring weight for improvement activities remained the same at 15% with no change in future years, which, in our opinion, should be changed. Finally, the most onerous issue related to is the cost, which has been reduced to 0% for 2017 reporting year, but jumping to 30% in 2019 and beyond from 10% in 2018.

The reporting requirements of MIPS continues to be a source of concern for many practicing physicians. CMS took many steps in the right direction in the final rule. ASIPP is optimistic that the establishment of a QCDR focused on interventional pain and our ability to develop high quality, practical, non-MIPS measures, IPM specialists will be well positioned to succeed.

Conflict 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, AstraZeneca, and Purdue Pharma, LP. He has attended an advisory group meeting for Activas. Dr. Calodney is a consultant for Stryker, Inc., Medtronic, Inc., and Nimbus Concepts. Dr. Hirsch is a consultant for Medtronic.

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