MIPS APMs and How They May Impact Your MACRA Strategy

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The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) has created significant and complex changes to Part B Medicare reimbursement. As a result of MACRA, the Centers for Medicare and Medicaid Services (CMS) created the Quality Payment Program (QPP) that includes two reimbursement programs: the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs).

Health information management (HIM) professionals have a role in determining which clinicians are eligible for participation in the MIPS, MIPS APMs, or Advanced APMs in their organization. In an article published in the March 2017 *Journal of AHIMA,* the nuances of provider eligibility, exclusion criteria, and dates that determine provider eligibility for MIPS and APMs were reviewed extensively.[1] Please refer to that article as a primer for provider eligibility of the QPP program.

This article will focus on clinicians participating in a MIPS Alternative Payment Model (MIPS APM), primarily on Medicare Shared Savings Program (MSSP) Track 1 Accountable Care Organizations (ACOs). The authors of this article will provide an enhanced discussion of MACRA implications for Qualified or Partially Qualified Advanced APM participants in a future publication.

HIM professionals that support organizations involved with APMs, such as Accountable Care Organization MSSP Track 1 entities, may be impacted by MIPS APM requirements. Payment reform is likely to accelerate. Physicians must decide whether to report under MIPS or try to participate in an APM to avoid penalties in 2018. As Medicare Shared Savings Program (MSSP) Track 1 participants are not eligible for the MACRA Advanced APM incentive payment, it is likely that more organizations will move toward greater risk sharing arrangements, such as the new MSSP Track 1+, 2, or 3, Next Generation model, or other Advanced APMs.[2] As of January 2017, 91 percent of MSSP ACOs are one-sided Track 1 programs.[3] Providers that participate in MIPS APMs are subject to the MIPS criterion but have different and significantly less cumbersome MIPS reporting requirements.

This article will explore MIPS APM provider eligibility, review MIPS APM reporting requirements, and identify key benefits and potential considerations that may impact MIPS APM participation decisions. It will also include an overview of MIPS APM score calculations focusing mainly on key components of the program that will benefit from the involvement of knowledgeable HIM professionals.

MIPS Alternative Payment Models (MIPS APMs)

Certain APMs include MIPS-eligible clinicians as participants and hold their participants accountable for the cost and quality of care provided to Medicare beneficiaries. This type of APM is called a MIPS APM. CMS has approved the following APMs as MIPS APMs for the 2017 reporting year:

- Medicare Shared Savings Program (MSSP) ACO Model Track 1
- MSSP ACO Model Track 2
- MSSP ACO Model Track 3
- Medicare-Medicaid Accountable Care Organization (MMACO) Model Track 1
- MMACO Model Track 2
- MMACO Model Track 3
- Comprehensive Primary Care Plus (CPC+) initiative
- Next Generation Accountable Care Organization (NGACO)

- Vermont Medicare ACO initiative (as part of the Vermont All-Payer Accountable Care Organization (ACO) Model)
- Oncology Care Model (One-Sided Risk Arrangement)
- Comprehensive End Stage Renal Disease Care (CEC) Model (LDO arrangement)
- Comprehensive ESRD Care (CEC) Model (non-LDO two-sided risk arrangement)
- Comprehensive ESRD Care (CEC) Model (non-LDO one-sided risk arrangement)

Also, the Medicare Shared Savings Program (MSSP) ACO Model Track 1+ was recently approved as a MIPS APM for 2018.

To qualify as an alternative payment model under the MACRA statute (primarily MSSP Track 1), a group of providers must use Certified Electronic Health Record Technology, report quality measures comparable to measures under MIPS (similar to PQRS), and share a financial risk determined by the ACO's agreement with CMS. Minimum patient volume and reimbursement levels need to be met in order for clinicians to meet participation requirements, and the thresholds increase substantially over the initial years of the program.

Participants in MIPS APMs have MIPS special reporting requirements and receive special MIPS scoring under the "APM Scoring Standard." All members of the same MIPS APM will receive the same MIPS performance score. Scores will be calculated by averaging the performance score for all clinicians in a group. Hence, final scores will be influenced by the performance of all clinicians within the MIPS APM.

All MIPS-eligible clinicians that are on a MIPS APM's participant list as of March 31, June 30, or August 31 will be required to report through their MIPS APM. CMS has proposed adding a fourth date—December 31—in the Quality Payment Program Proposed Rule for 2018, but only for "full TIN" MIPS APM participating groups. Participants may qualify for positive MIPS payment adjustments and "exceptional" performance adjustments, based on the APM entity's final score. Benefits to participating in a MIPS APM may include receiving full credit for the MIPS Clinical Improvement Activity (CIA) category and a reduction in the quality measure reporting burden on the practice.

Practices will still be required to report Advancing Care Information (ACI) performance data via a registry or other mechanism. (ACI was formerly referred to as "the Meaningful Use of Certified EHR Technology.") CMS will calculate one MIPS composite score for each ACO (at the APM Entity level) based on performance in the Quality and ACI categories. This score will be applied to all MIPS-eligible clinicians in the group that are enrolled in the MIPS APM. MIPS payment adjustments will be applied at the unique TIN/National Provider Identifier (NPI) level for each MIPS-eligible clinician in the APM Entity.

HIM professionals may be tasked with helping their organizations determine the optimal MACRA-related payment model that should be used by their organization, and assessing whether an Advanced APM, MIPS APM, MIPS group reporting, or individual clinician MIPS reporting is in their best interest. Regardless of the model chosen by their organization, HIM professionals will be central to efforts to achieve high levels of MACRA-related performance.

Using the APM Standard Category Weightings

Using the APM Scoring Standard, the final score for the APM entity is based on performance in the Quality, ACI, and/or Improvement Activity categories. This final score is applied to each provider within the APM entity regardless of the provider's individual MIPS score. The weighting of each of the four MIPS performance categories (Quality, Advancing Care Information, Improvement Activities, and Cost) are different for MIPS APM entities than for individual clinicians or groups reporting under MIPS (i.e., those that are not participating in a MIPS APM).

MSSP Track 1-3 ACOs and Next Generation ACO MIPS APMs have the following performance category weightings:

- Quality: 50 percent
- Advancing Care Information: 30 percent
- Improvement Activities: 20 percent
- Cost: zero percent

For MIPS APMs other than MSSP and Next Generation ACO models, including the Comprehensive ESRD Care Model, the Comprehensive Primary Care Plus Model (CPC+), and the Oncology Care Model, the category weightings are:

- Quality: zero percent
- Advancing Care Information: 75 percent
- Improvement Activities: 25 percent
- Cost: zero percent

In the 2018 Quality Payment Proposed Rule, CMS has proposed reweighting the categories for the Comprehensive ESRD Care Model, the Comprehensive Primary Care Plus Model (CPC+), and the Oncology Care Model, to be the same as ACOs, starting in 2018. In other words, the weighting for the quality performance category would change from zero percent to 50 percent, ACI's weighting would change from 75 percent to 30 percent, and improvement activities' weighting would change from 25 percent to 20 percent. Cost would remain at zero percent.

The 2018 Quality Payment Proposed Rule also lists tables that contain the specific quality measures for each of the non-ACO MIPS APMs.

A large subset of MIPS-eligible clinicians—specifically, physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse anesthetists—have the option of reporting ACI ("meaningful use" EHR Incentive Program) performance category data in 2017. If they do not submit data, the ACI category will be weighted at zero percent during the 2017 performance year; however, these clinicians may be required to fully engage ACI in 2018.

The importance of HIM professional activities related to coding, clinical documentation improvement (CDI), ACI, interoperability, and cost containment in their enterprise have been increased under MACRA. For example, HIM professionals engaged with MIPS APMs—in particular MSSP Track 1-3 and Next Generation ACOs—are positioned to assist these organizations and their participating clinicians by providing assistance in the following areas:

- Attaining optimal ACO quality scores
- Achieving optimal ACI performance
- Providing support for cost measures

Quality Scores in MIPS APMs

For the MIPS APM Scoring Standard, ACOs will submit CMS Web Interface measures on behalf of their participating MIPS-eligible clinicians. No additional quality reporting will be required. ACO quality performance is determined by performance on a specific set of quality measures compared to benchmarks. Many of the benchmarks make achieving high performance scores for the quality measures challenging. Quality measure performance can be improved through staff education, workflow assessments, EHR customization, analytics, and an iterative process where feedback is provided to clinicians when performance is less than optimal. It is also very important that reporting and documentation be synchronized to prevent "check box" recording of measure compliance activities by clinicians without supporting documentation.

Table 1

ACI 2017 Advancing Care Information Transition Objectives, Measures

Base Score Required Measures:

- Security Risk Analysis
- e-Prescribing
- Provide Patient Access
- Health Information Exchange

Performance Score Measures:

- Provide Patient Access

- View, Download, Transmit
- Patient-Specific Education
- Secure Messaging
- Health Information Exchange
- Medication Reconciliation
- Immunization Registry Reporting

ACI 2018 Advancing Care Information Objectives and Measures

Base Score Required Measures:

- Security Risk Analysis
- e-Prescribing
- Provide Patient Access
- Send a Summary of Care
- Request/Accept a Summary of Care

Performance Score Measures:

- Provide Patient Access
- View, Download, Transmit
- Patient-Specific Education
- Secure Messaging
- Patient-Generated Health Data
- Send a Summary of Care
- Request/Accept a Summary of Care
- Clinical Information Reconciliation
- Immunization Registry Reporting

ACI Scores in MIPS APMs

Practices will need to use 2014 Edition (Modified Stage 2) or 2015 Edition (Stage 3) Certified EHR Technology (CEHRT) in 2017, but as per the 2017 Quality Payment Program Final Rule, all practices will need to use 2015 Edition CEHRT for the 90-day minimum reporting period in 2018. The required (base) and optional (performance) measures that are reported depend upon the EHR certification edition. For practices using 2014 Edition CEHRT, there are four required base measures and seven performance measures (see Table 1 above). For organizations using 2015 Edition CEHRT, there are five required base measures and nine performance measures (see Table 1 above). Both certification editions have the option of reporting two bonus measures—one for participating with a registry other than an immunization registry, and one for using CEHRT to accomplish specific objectives in a subset of the improvement activities.

Meeting the base measure reporting requirements, regardless of which EHR edition is being used, will earn the practice 50 percentage points toward their ACI score (meaningful use). The optional performance measures and bonus measures can total as high as 115 additional points, but the maximum ACI point total cannot exceed 100 points. The base measures require either "yes/no" attestation or a minimum of one patient that meets the denominator and numerator requirements for each of the measures. For example, to meet the minimum requirement for the "Sent Summary of Care" base measure, a patient care summary has to be sent for a single patient during a transition of care or referral.

This represents a significant change from the "pass/fail" reporting requirements based on meeting minimal thresholds under the meaningful use program. HIM professionals will play an important role in helping their organizations transform into a true performance environment. Further, understanding the weightings for performance categories each year will allow HIM professionals to set goals and to focus attention on areas that will yield the best outcomes for their organizations.

Cost Scores in MIPS APMs

Cost is weighted at zero percent for the 2017 performance year for MIPS APMs and will likely continue at this level. However, cost reduction remains a central goal of every MIPS APM ACO as it can result in either shared savings or, for the Track 2-3 MSSP and Next Generation ACOs, shared losses. ACO cost scores are determined in part by risk adjusted scores, which in turn depend on accurate documentation and coding of comorbid conditions. Accurate ICD-10-CM coding is of utmost importance for reporting resource use. Medicare expenditures attributed to a patient are risk-adjusted based on disease history and other factors. Practices will need to ensure disease and condition coding and documentation—including comorbid conditions—is as specific, accurate, and complete as possible.

Performance Periods

For the 2019 payment year, CMS will look to 2017 performance. During the 2017 "transition year," participation in a MIPS APM will allow practices to avoid negative reimbursement adjustments from Medicare by exceeding the minimum of reporting one quality measure or one improvement activity. For the most common type of ACO, MSSP Track 1, quality data is submitted for a full year by the ACO for every Taxpayer Identification Number (TIN) in the ACO. Practices need to report ACI data independently. The ACI performance period has a minimum of 90 continuous days. For an MSSP Track 1 ACO organization, all MIPS-eligible clinicians who bill through the TIN of an ACO MSSP participant are considered to be participating in the APM Entity.

Focus on Performance

The emphasis of MACRA is a shift to a reimbursement model tied to improvement in the quality and efficiency of healthcare. In addition, it is a significantly more competitive reimbursement model. Practices will experience adjustments in reimbursement for Medicare services based on their performance compared to other practices on a national scale. Practices, therefore, have an incentive, and in future years will have a requirement, to achieve higher performance rates for this and all other measures in order to receive higher level reimbursements from Medicare. Since high levels of performance can only be achieved through accurate data capture, reporting, and creation of supporting documentation, HIM professionals will be required to monitor performance trends throughout the reporting period and intervene as needed when measure performance is suboptimal.

HIM's Role in MACRA Success

HIM professionals will play a central role in organizations as they strive to perform at levels that would make them eligible for additional positive payment adjustments, as well as achieve the highest levels of performance under MACRA. Given their role as stewards of healthcare information, HIM professionals are also poised to assume an even bigger role in the areas of change management, information governance, patient data analytics, and quality reporting. HIM professionals have a unique opportunity in MACRA's early years to help establish data management protocols in physician practices and medical groups embarking on Quality Payment Program adoption. A high percentage of MIPS-eligible clinicians will likely find themselves in a MIPS APM. An understanding of the many facets of MACRA, including considerations related to MIPS APMs, will allow HIM professionals to provide value to their organizations.

Notes

[1] Marron-Stearns, Michael. "How MACRA Changes HIM." *Journal of AHIMA* 88, no. 3 (March 2017): 22-25.

[2] Muhlestein, David; Robert Saunders; and Mark McClellan. "Growth Of ACOs And Alternative Payment Models In 2017." June 28, 2017.

[3] Centers for Medicare and Medicaid Services. "Fast Facts: All Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organizations (ACOs)." January 2017.

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