Clinical Integration Educational Series

Merit-Based Incentive Payment System Reporting for Hospital-Based and Non-Patient-Facing Clinicians

Introduction

MACRA (the Medicare Access and CHIP Reauthorization Act) is a law passed by Congress in 2015 that changes how the Medicare program reimburses providers and aims to move providers toward more value-based care. The law discontinues the use of the Sustainable Growth Rate formula for determining Medicare payments to providers, and creates a new quality measurement and reimbursement framework.

MACRA's new reimbursement framework creates two payment tracks:

1. Merit-Based Incentive Payment System (MIPS) and
2. Advanced Alternative Payment Models (APMs)

Most of the clinicians in SRQCN will be reimbursed under the MIPS track. Starting in 2019, Medicare payment adjustments to clinicians will vary up to 4% based on MIPS performance in 2017.

MIPS adjusts clinician payments based on their performance across four categories: Quality, Improvement Activities, Advancing Care Information, and Cost.

The MIPS scoring and reporting process for hospital-based and non-patient-facing clinicians varies slightly from the process for clinicians not in those categories. This document will explain the MIPS reporting and scoring processes for hospital-based and non-patient-facing clinicians.

MIPS Scoring and Reporting for Hospital-Based Clinicians

Starting in 2019, Medicare payment adjustments for hospital-based clinicians will vary based on MIPS performance in 2017. However, the MIPS scoring and reporting process is slightly different for hospital-based clinicians than the process for non-hospital-based clinicians.

As defined by CMS, hospital-based clinicians are clinicians who provide 75% or more of their Medicare Part B services in inpatient hospitals, on-campus outpatient hospitals, or emergency rooms. Hospital-based clinicians typically include hospitalists, emergency room clinicians, and anesthesiologists. CMS bases the 75% calculation on claims from the year prior to the performance year.

The following table explains the MIPS category weights and reporting requirements for hospital-based clinicians in performance year 2017.

Table 1: MIPS Scoring and Reporting for Hospital-Based Clinicians

	2017 Category Weight	2017 Reporting Requirements
Quality	85%	• Clinicians report data for 6 measures including 1 outcomes-based measure • If an outcomes-based measure is not available, clinicians can report another high-priority measure (i.e., measures related to appropriate use, patient experience, patient safety, efficiency, or care coordination • Clinicians can choose measures from CMS set or Specialty subset • If fewer than 6 measures apply, clinicians report all that apply
Improvement Activities	15%	• Clinicians attest that they have completed activities related to making care more patient-centric • SRQCN will help clinicians choose activities from a CMS list • Full credit is equal to 40 points (each activity worth 10 or 20 points)
Advancing Care Information	0%	No reporting required
Cost	0%	No reporting required

MIPS Scoring and Reporting for Non-Patient-Facing Clinicians

The MIPS reporting requirements for non-patient-facing clinicians are slightly different from those of patient-facing clinicians. CMS defines non-patient-facing clinicians as those who perform fewer than 100 procedures with patient-facing codes a year. CMS released a list of these codes, available *here*. The list includes services like general office visits, outpatient visits, and surgical services.

To determine which providers qualify for non-patient-facing status, CMS will use Medicare claims from two twelve-month time periods, with the first beginning September 1 two years prior to the performance year. Providers and groups will only be deemed patient-facing if they exceed the thresholds for two consecutive assessment periods.

The following table explains the MIPS category weights and reporting requirements for non-patient-facing clinicians in performance year 2017.

Table 2: MIPS Scoring and Reporting for Non-Patient-Facing Clinicians

	2017 Category Weight	2017 Reporting Requirements
Quality	85%	• Clinicians report data for 6 measures including 1 outcomes-based measure • If an outcomes-based measure is not available, clinicians can report another high-priority measure (i.e., measures related to appropriate use, patient experience, patient safety, efficiency, or care coordination) • Clinicians can choose measures from CMS set or Specialty subset • If fewer than 6 measures apply, clinicians report all that apply
Improvement Activities	15%	• Clinicians attest that they have completed activities related to making care more patient-centric • SRQCN will recommend activities from a CMS list • Full credit is equal to 20 points (each activity worth 10 or 20 points)
Advancing Care Information	0%	No reporting required
Cost	0%	No reporting required

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