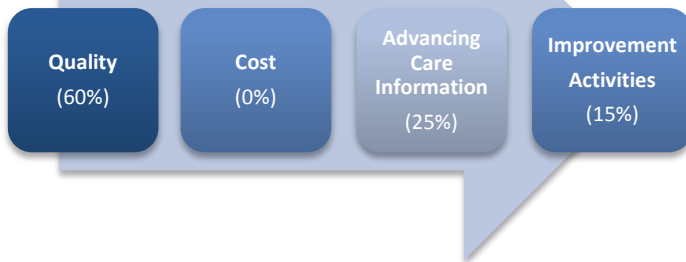


MIPS for Mohs

On October 14, 2016, the Centers for Medicare and Medicaid Services (CMS) released its long-awaited final rule implementing provisions outlined in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which repealed the Sustainable Growth Rate (SGR) reimbursement formula and replaced it with a two-track Medicare physician payment system—the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs)—collectively referred to as the Quality Payment Program (QPP). These new policies become effective January 1, 2017.

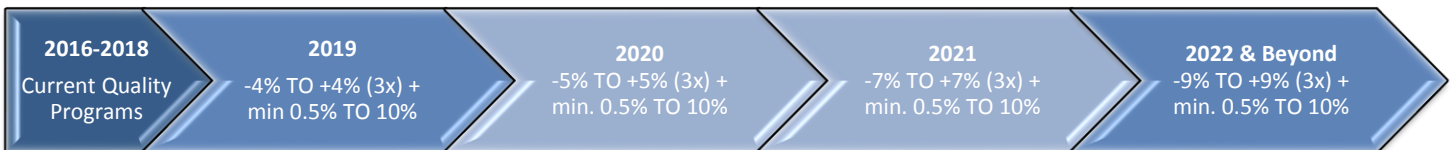
MIPS Performance Weights: Year 1



Merit-Based Incentive Payment System (MIPS)

MIPS combines elements of existing Medicare quality improvement programs and incorporates new practice-based improvement activities into a single payment update program. The result is four integrated MIPS performance categories: Quality, Cost, Advancing Care Information (ACI), and Improvement Activities, each with relative weights that contribute to an annual MIPS final score of between 0 and 100 points. The final score determines the MIPS payment adjustment, which is applied to Medicare Part B payments two years after the performance year, with 2019 being the payment adjustment year for the 2017 performance year.

MIPS Payment Adjustments by Payment Year (including Exceptional Performance Bonus)



CMS established exclusion criteria that eliminate more than half of those billing under the Medicare physician fee schedule—approximately 738,000 to 780,000 physicians and other professionals—from the MIPS program. Despite this statistic, CMS anticipates that 81.7 percent of Medicare-enrolled dermatologists will be “MIPS eligible clinicians” and subject to the program in 2017. For them, CMS has attempted to provide as much flexibility as possible. In fact, for year one, CMS set the performance threshold very low (3 points) with the goal of penalizing as few MIPS eligible clinicians as possible. CMS also set the additional performance threshold for those who do exceedingly well in the first year (70 points or more), or “exceptional performers,” who will gain access to a \$500-million-dollar “bonus” pool in addition to their positive MIPS payment adjustment.

“Pick Your Pace” in 2017

CMS has implemented a “pick your pace” reporting strategy for year one – the first “transition year” of MIPS. Providers who are subject to the program but submit no data in 2017 are assured a financial penalty of -4 percent in 2019. Avoiding this penalty can be accomplished by simply reporting as little as one quality measure for one patient, which would yield 3 points – the 2017 performance threshold. See “Avoiding the 2019 Penalty” for additional details.

To earn a positive MIPS payment adjustment, MIPS eligible clinicians should engage in 90 days of *continuous* reporting. CMS also encourages reporting for longer periods (particularly for the Quality performance category), including up to a full year, to potentially improve performance scores.

In future years, longer reporting durations are expected in order to earn incentives and avoid negative payment adjustments.

MIPS Eligibility: Who’s In? Who’s Out?

MIPS eligible clinicians* are defined as:

- ✓ Physicians (as defined in section 1861(r) of the Social Security Act)
- ✓ Physician Assistants (PAs)
- ✓ Nurse Practitioners (NPs)
- ✓ Clinical Nurse Specialists (CNSs)
- ✓ Certified Registered Nurse Anesthetists (CRNAs)

Excluded from MIPS are those who are:

- ✓ Newly-enrolled in Medicare (*Enrolled in Medicare for the first time during the performance period*)
- ✓ Below the Low-Volume Threshold (*Medicare Part B allowed charges less than or equal to \$30,000 a year or see 100 or fewer Medicare Part B patients a year*)
- ✓ Qualifying APM Participants (“QPs”)

*CMS may expand the definition of a MIPS eligible clinician to include additional eligible clinicians starting in year 3

Submitting Data to CMS

There are multiple submission mechanisms for reporting data to CMS, including the use of third party vendors. Mohs surgeons may choose to submit their quality, ACI and improvement activity data through a QCDR, such as AAD's DataDerm. DataDerm includes a more robust set of quality measures for reporting, which may be helpful for Mohs surgeons participating in MIPS in the first performance year. For example, DataDerm includes quality measures specific to Mohs surgery – measures that can not be reported through other mechanisms.

ACMS is currently developing a Mohs surgery-specific QCDR, which will include even more Mohs surgery specific quality measures. Details about the ACMS registry will be shared as they are available.

Quality Performance Category (60 percent; 60/70 points)

The Quality performance category replaces the Physician Quality Reporting System (PQRS) and accounts for 60 percent of the MIPS final score in year one. CMS will require MIPS eligible clinicians to report at least six quality measures, including one outcome measure during 2017. If an outcome measure is not available, clinicians may select another high priority measure. MIPS eligible clinicians may also choose to report a specialty-specific measure set. A specialty measure set for dermatology is available, which may be appropriate for Mohs surgery practices. Large group practices (16 or more MIPS eligible clinicians) may also be subject to additional population, claims-based quality measures if they meet certain criteria.¹

MIPS eligible clinicians that choose to submit their quality data to CMS via claims-based submission will need to report on at least 50 percent of their Medicare Part B patients. For all other submission

mechanisms, the threshold is 50 percent of *all* patients. Keep in mind, claims-based submission is only available for *individual* reporting – not *group* reporting.

For 2017, CMS is implementing a global floor of 3 points for all submitted quality measures. Otherwise, quality measures will be scored between zero and 10 points. For MIPS eligible clinicians that report greater than six measures, CMS will only count those where performance was the highest toward the quality performance score.

Bonus points will available to MIPS eligible clinicians for reporting high priority measures, including outcome (beyond the requirement) and patient experience measures, and for “end-to-end” reporting via certified EHR technology (CEHRT).

In the future, CMS intends to propose options for scoring based on improvement.

MIPS Submission Mechanisms

Improvement Activities Performance Category (15 percent; 40 points)

MIPS eligible clinicians that engage in practice-based improvement activities will earn 15 percent toward their MIPS final score. Generally, MIPS eligible clinicians must attest to completing up to four improvement activities for a minimum of 90 continuous days. Improvement activities are weighted “high” or “medium,” and worth 20 or 10 points, respectively.

For small practices, defined as 15 or fewer MIPS eligible clinicians and solo practitioners, CMS increased the value of high- and medium-weighted activities to 40 and 20 points, respectively. This means small practices and solo practitioners can meet this performance category by simply attesting to performing one high-weighted improvement activity for a continuous 90 days.

	Claims (Individual Reporting only)	Qualified Registry	Qualified Clinical Data Registry (QCDR)	Certified EHR Technology	CMS Web-based Attestation
Quality	✓	✓	✓	✓	
Improvement Activities		✓	✓	✓	✓
Advancing Care Information		✓	✓	✓	✓
Cost	Administrative claims (no submission required)				

Regardless of group size, if at least one clinician within the group is performing the improvement activity for a continuous 90 days in the performance period, the group may report on that activity. Suggested documentation expectations has been released through sub-regulatory guidance and is available on CMS' QPP website. With 94 improvement activities to choose from, including participation in an APM,² most Mohs surgeons should be confident in meeting the requirements of this performance category. In fact, CMS is proposing to count Mohs surgery fellowship as an improvement activity in 2018 and beyond. This policy is expected to be finalized in the fall of 2017 as part of the 2018 QPP Final Rule.

¹ CMS will apply the all-cause readmissions (ACR) measure to groups of 16 or more who meet the case volume of 200 cases (the measure will not be scored if the case minimum is not met). The ACR measure in 2017 will be based on the performance period (January 1, 2017 through December 31, 2017).

² MIPS eligible clinicians and groups participating in APMs, even one that is not an Advanced APM or MIPS APM, can earn at least 50 percent (or 20 points) toward their Improvement Activities score. CMS defines participation in APMs by presence on a CMS-maintained list associated with an APM.

Cost Performance Category (0 percent; 0 points)

In the first year of the MIPS program, the Cost category will not affect eligible clinicians' MIPS final score. However, CMS will provide feedback to MIPS eligible clinicians on certain cost and resource use measures³ from CMS' predecessor program—the Value-based Payment Modifier (VM)—as well as 10 episode-based measures, where applicable. In the second year, CMS is proposing to maintain a 0 percent weighting. By the third year, however, CMS is required by law to increase the weight of the Cost performance category to 30 percent.

MIPS eligible clinicians do not need to submit data to CMS for the Cost performance category; all analysis is conducted using administrative claims data. CMS continues to develop additional episode-based cost and resource use measures for use in future years of the MIPS program. For example, CMS is in the process of developing episode-based measures specific to melanoma, which may impact Mohs surgeons.

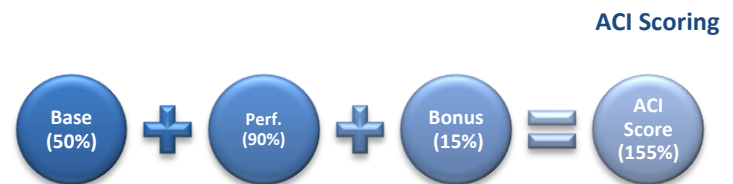
Of note, Part B drugs (physician-administered) are captured in cost measures. The Secretary has the authority to include the cost of Part D drugs, if feasible, in the future. Risk-adjustment for socio-demographic status (SDS) will also be incorporated, as feasible.

Mohs surgeons should review prior year Quality and Resource Use Report (QRURs) to better understand performance on cost and resource use measures and consider how practice patterns might impact scores.

Advancing Care Information Performance Category (25 percent; 155 points⁴)

The Advancing Care Information (ACI) performance category replaces the Medicare EHR Incentive Program, or "Meaningful Use," and is worth 25 percent of the MIPS final score in the first year. Under this performance category, MIPS eligible clinicians must fulfill a required set of measures for a minimum of 90 consecutive days to earn points toward a "base" score, which is worth half of the total ACI score. Credit toward a "performance" score is earned by submitting data on additional measures, while a "bonus" score can be earned for registry reporting and using CEHRT to completing certain improvement activities.

For 2017, MIPS eligible clinicians will need at least 2014 Edition CEHRT to report the 2017 ACI Transition Objectives and Measures (Option 2), previously referred to as Modified Stage 2. For those using 2015 Edition CEHRT, the option to report the ACI Objectives and Measures (Option 1), previously referred to as Stage 3, is available. A detailed listing of the associated measures and objectives is available on CMS' Website.⁵



Inherent to the required measure set under both Option 1 and 2 is the Security Risk Analysis – the number one measure that caused practices audited under the meaningful use program to fail and return incentives to the federal government. The Office of the National Coordinator for Health IT (ONC), in collaboration with the Office of Civil Rights (OCR) and Office of General Counsel (OGC), has developed a downloadable Security Risk Assessment (SRA) Tool⁶ to help physician practices conduct a risk assessment.

For the base score, worth 50 points, MIPS eligible clinicians must attest "yes" to the security risk analysis measure and submit a numerator of at least one for the remaining measures. The performance score, worth up to 90 points, builds upon the base score and is driven by a MIPS eligible clinician's performance rate for each measure reported. The performance score is calculated using either the reported numerator/denominator or points are assigned for a "yes" attestation.⁷

Bonus credits (up to 15 points) are assigned for reporting to a public health or clinical data registry or using CEHRT to report improvement activities.

Public Reporting

As required under MACRA, CMS will publicly report MIPS performance information on Physician Compare.⁸ Specifically, for each MIPS eligible clinician, CMS will publicly report the MIPS final score and performance for each performance category, as well as periodically post aggregate information of such data. CMS will also include whether a MIPS eligible clinician is a participant in an APM and will link eligible clinicians and groups to their respective APM data, where possible. CMS will maintain the 30-day preview period in advance of the publication of data on Physician Compare.

Mohs surgeons are encouraged to review their existing Physician Compare profile. If a record is not available, confirm that all information in CMS' Provider Enrollment, Chain and Ownership System (PECOS) is correct. All other questions may be directed CMS' Physician Compare

³ CMS has retained (with modification) its Total Per Capita Costs: All Beneficiaries and Medicare Spending Per Beneficiary (MSPB) cost measures. Details about these measures are available on CMS' web site.

⁴ MIPS eligible clinicians have the ability to earn an overall score for the advancing care information performance category of up to 155 percentage points, which will be capped at 100 percent when the base score, performance score and bonus score are all added together.

⁵ <https://qpp.cms.gov/measures/aci>

⁶ <https://www.healthit.gov/providers-professionals/security-risk-assessment-tool>

⁷ https://qpp.cms.gov/docs/QPP_ACI_Fact_Sheet.pdf

⁸ <https://www.medicare.gov/PhysicianCompare/search.html>

contractor at PhysicianCompare@Westat.com.

Alternative Payment Models (APMs)

MIPS eligible clinicians that significantly participate in an APM in 2017, specifically an Advanced APM, will avoid the MIPS payment adjustment and instead earn a 5 percent payment in 2019.

MACRA defines APMs at section 1833(z)(3)(c) as:

- A CMS Innovation Center Model (under section 1115A, other than a health care innovation award)
- A Medicare Shared Savings Program (section 1899)
- A demonstration under the Health Care Quality Demonstration Program (section 1866C), or
- A demonstration required by Federal law.

To be an Advanced APM, MACRA requires the APM to meet the following three criteria:

- 1) Require at least 50 percent of participants to use CEHRT;
- 2) Provide payment for covered professional services based on quality measures comparable to those used in the quality performance category of MIPS; and
- 3) Either:
 - Be a Medical Home Model expanded under CMS Center for Medicare and Medicaid Innovation (CMMI) authority; or
 - Require participating APM Entities to bear more than a nominal amount of financial risk for monetary losses.

CMS recently announced the following models as Advanced APMs for the 2017 performance year:

- Comprehensive ESRD Care Model (large dialysis organizations (LDO)/non-LDO two-sided risk)
- Comprehensive Primary Care Plus
- MSSP ACO – Tracks 2/3
- Next Generation ACO Model
- Oncology Care Model (two-sided risk)

MIPS eligible clinicians participating in these models may become “qualifying APM participants,” or QPs. CMS will make QP determinations at the level of the APM Entity (e.g. for an entire ACO). This means CMS will look at the APM entity as a whole and determine whether participating eligible clinicians and groups *collectively* meet either the payment or patient thresholds. If they do, CMS will designate all of the eligible clinicians and in the Advanced APM entity as QPs or Partial QPs.⁹

CMS estimates that between 70,000 and 120,000 clinicians (approximately 5-8 percent of all clinicians billing under the Medicare Part B) will be excluded from MIPS due to being QPs based on participation in Advanced APMs.¹⁰ This figure is even less for dermatologists, with only 1.1 percent expected to be QPs in Advanced APMs.¹¹

Physician Focused Payment Models (PFPMs)

CMS defines PFPMs as APMs (1) in which Medicare is a payer; (2) in which clinicians that are eligible professionals (EPs) as defined in section 1848(k)(3)(B) of the Act are participants and play a core role in implementing the APM’s payment methodology; and (3) which targets the quality and costs of services that eligible clinicians participating in the APM provide, order, or can significantly influence. PFPMs are not required to be Advanced APMs.

PFPMs will be reviewed by the Physician-Focused Payment Model Technical Advisory Committee (PTAC), an 11-member group of physicians and other experts whose role is to provide comments and recommendations to the Secretary on PFFM proposals submitted by the public.

PTAC will assess whether PFPMs meet the following criteria for PFPMs sought by the Secretary:

- Incentives: Pay for higher-value care
- Care delivery improvements: Promote better care coordination, protect patient safety, and encourage patient engagement
- Information Enhancements: Improving the availability of information to guide decision-making

Mohs surgeons have an opportunity to develop models that may be appropriate for submission to PTAC for PFFM consideration, in the future.

MIPS APMs

MIPS APMs are a subset of APMs. Generally, MIPS APMs help reduce the reporting burden for MIPS eligible clinicians. In addition to the administrative “lift,” MIPS APMs streamline scoring by aggregating eligible clinician MIPS scores to the APM entity level.

The following models are MIPS APMs for 2017:

- Most Advanced APMs
- Comprehensive ESRD Care Model (non-LDO one-sided risk)
- MSSP ACO – Track 1
- Oncology Care Model (one-sided risk)

⁹ Partial QPs meet slightly reduced APM payment/patient thresholds. While they do not receive the 5 percent APM incentive payment, they can choose whether to participate in MIPS. Partial QPs that choose not to report will avoid the MIPS payment adjustment across all Tax Identification Numbers (TINs).

¹⁰ 81 FR 77008, TABLE 57: Projected Number of Clinicians Ineligible For or Excluded From MIPS in CY 2017, By Reason

¹¹ 81 FR 77008, TABLE 58: MIPS EXCLUSIONS BY REASON AND SPECIALTY FOR MIPS TRANSITION YEAR

Avoiding the 2019 Penalty

Under CMS' "Pick Your Pace" reporting strategy, providers can "test" the MIPS program and avoid the financial penalty. Specifically, CMS states that MIPS eligible clinicians can submit a minimum amount of data in 2017 in order to avoid the -4 percent payment adjustment in 2019. The easiest, most efficient way to accomplish this is by submitting one quality measure for one patient. More specifically, an individual MIPS eligible clinician can submit one quality data code associated with one quality measure for one Medicare beneficiary on a CMS-1500 billing form before the end of the 2017 MIPS reporting period, which is December 31, 2017.

Here's how it would work according to your colleague and fellow Mohs surgeon, Mark Kaufman, MD:

1. Visit www.gpp.cms.gov/mips/quality-measures
2. Filter by "**Data Submission**" and check off "**Claims**"
3. Review the list of 74 quality measures and select the measure that is most appropriate for reporting
 - a. Dr. Kaufman suggests **Measure #130 – "Documentation of Current Medications in the Medical Record"** – as an appropriate measure for the majority of Mohs surgeons
4. Download the associated Measure Specifications, available at www.gpp.cms.gov/about/resource-library
 - a. Scroll to the file "**Quality Measure Specifications**" and download the zip file
 - b. Open the zip file and the folder Claims-Registry-Measures, then locate the document "**2017_Measure_130_Claims.pdf**"
 - c. This document provides details for reporting the measure, including measure instructions, numerator and denominator information, and the Quality Data Code (QDC) necessary for inclusion on the CMS-1500 form, which is **G8427**
 - d. **It is important to review the measure specifications carefully to ensure you appropriately apply the QDC on the CMS-1500 billing form and satisfactorily report the measure**
5. Be sure to apply a 0.01 cent charge to the QDC to ensure it is processed by your claims clearinghouse
6. Submit your claim to your Medicare Administrative Contractor (MAC)
7. In approximately 2 weeks, if transmission of your QDC was successful, you will receive Remittance Advice Remark Code (RARC) code N620 or CO 246.