Medicare’s new Merit-based Incentive Payment System, (MIPS) combines three existing physician payment programs that may be familiar to you—PQRS, VBPM, and Meaningful Use of Electronic Health Records (MU)—into a single performance program and adds one brand new component: Clinical Practice Improvement Activities. Under MIPS, each provider (or group) will receive a single composite performance score (CPS) based on achievements in these four areas. Each area is weighted differently, and the weights change over time.

Since payment adjustments are made two years after the reporting period, implementation of MIPS begins in 2017 when data is being collected, with resulting payment adjustments starting in 2019.

### Composite Performance Score Weighting Over Time

<table>
<thead>
<tr>
<th>MIPS Category</th>
<th>2019*</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality (formerly Physician Quality Reporting System or PQRS)</td>
<td>50%</td>
<td>45%</td>
<td>30%</td>
</tr>
<tr>
<td>Resource Use (formerly Value-based Payment Modifier or VBPM)</td>
<td>10%</td>
<td>15%</td>
<td>30%</td>
</tr>
<tr>
<td>Advancing Care Information (formerly Meaningful Use of EHR or MU)</td>
<td>25%</td>
<td>25%**</td>
<td>25%**</td>
</tr>
<tr>
<td>Clinical Practice Improvement Activities (new)</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td><strong>Total Composite Performance Score</strong></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

* Data collection occurs two years prior (e.g., data collection for 2019 program is in 2017).
** ACI weight can drop to 15% if more than 75% of EPs are successful.

As you can see, there is an increasing emphasis on resource use (costs) over time. Note that the proportion of the CPS for quality measurement decreases in proportion to the increase of the values for costs.

### MIPS Payment Adjustments (2019-2022)

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Bonus</td>
<td>+4%*</td>
<td>+5%*</td>
<td>+7%*</td>
<td>+9%*</td>
</tr>
<tr>
<td>Maximum Penalty</td>
<td>-4%</td>
<td>-5%</td>
<td>-7%</td>
<td>-9%</td>
</tr>
</tbody>
</table>

MIPS payments are budget neutral, meaning that penalty payments must be offset by bonus payments under the MIPS program. Therefore, exceptional performers may be eligible for an additional 3x bonus in order to maintain budget neutrality. There will never be scaling factors applied to penalty payments, so the maximums listed are, in fact, the maximum penalty potentials.

### Three Exemptions from the MIPS Program

1. The physician is in the first year of participating in the Part B Medicare program.
2. The physician provides care for 100 or fewer Medicare beneficiaries and has $10K or less in Medicare charges during the calendar year.
3. The physician is a qualifying participant in an eligible advanced alternative payment model (APM).
Neurology Practice Checklist:
Preparing for the Merit-based Incentive Payment System

This list of questions outlines steps you can take today—based on a self-assessment around your current Medicare quality program participation—to help you prepare for the MIPS. The first data collection year for MIPS is 2017, which will affect payment bonuses and penalties in 2019. Answer the questions below to help ensure that you and your practice are ready.

Initial General Considerations

• Contact the AAN about signing up for the wait list to participate in the Axon Registry. Clinical data registries can streamline MIPS reporting and assist with performance scoring.
• If you are in a practice with more than one eligible clinician, decide whether to report individually or as a group.
• Determine whether your practice meets the requirements for small or rural accommodations.

1. Did you attest to Meaningful Use of your Electronic Health Record (EHR)?

   If “yes”:
   - Ensure that your EHR is a certified EHR technology, referred to as CEHRT. Determine whether it is 2014- or 2015-edition certified. The version will determine the measures on which you report.
   - Speak with your vendor about how their product supports new payment model adoption (e.g., how does their product support Medicare quality reporting?).
   - Consider how to ensure that you can report at least one unique patient for each measure of the MIPS base score’s 6 objectives.
   - Conduct a security risk analysis that complies with HIPAA Security Rule Requirements in early 2017. Failure to do so will result in a score of zero for this category.
   - Determine whether there is an additional public health registry to which you can report to receive an additional point towards the total score under MIPS.
   - Review Modified Meaningful Use requirements for 2016.
   - Incorporate data collection into workflows.
   - Consider preparing for Meaningful Use in 2017.

   If “no”:
   - Adopt Certified Electronic Health Record Technology.
   - See “yes” above.

   Resources to help with Meaningful Use of your EHR:
   AAN webpage, CMS EHR Incentive Programs webpage

2. Do you report to the Physician Quality Reporting System (PQRS)?

   “Yes” means that your practice has successfully reported as a group or you have successfully reported as an individual with individual quality measures or a quality measures group.

   If “yes”:
   - Consider whether you plan to report through claims, EHR, clinical registry, qualified clinical data registry (QCDR), or group practice reporting option (GPRO)*. *GPRO Web-interface is only available for physicians in practices of 25+ eligible clinicians.
   - Determine which quality measures you plan to report on; there are individual measures and specialty-specific measures sets.
   - Monitor your measure performance throughout the performance year as part of your quality improvement plan.

   If “no”:
   - Select a method (claims, registry, or EHR) of reporting your quality of care to CMS.
   - Resource: Use AAN PQRSwizard (when available).
   - For your report, review measure specifications and select measures based on the patients you see.
   - Consider qualifying AAN PQRS measures.
   - Consider clinical conditions most often treated, type(s) of care typically provided, setting where care is provided, quality improvement goals, and other quality reporting programs already used (e.g., Meaningful Use of your EHR).
3. Have you obtained and reviewed your Quality and Resource Use Reports (QRURs) from CMS?

“Yes” means that you have reviewed your 2014 mid-year and 2014 annual QRUR and are aware of how your practice will fare under the 2016 Value-based Payment Modifier (VBPM) program.

If “yes,” your next steps are:
- Review QRUR reports for accuracy and, if necessary, file an informal review.
- Develop a Quality Improvement (QI) plan.
- Use mid-year and annual QRURs to identify potential opportunities for improvement.
- Incorporate improvement opportunities into your QI plan.
- Identify your most costly patient population conditions and diagnoses. Identify targeted care delivery plans for these conditions.
- Articulate internal workflow changes that can be made to support care delivery plans.
- Consider potential partners outside of your practice to advance a coordinated care plan (e.g., other specialists to whom you refer patients).

If “no” (you have not obtained your mid-year and annual QRURs and/or are unaware of how your practice will fare under the VBPM), your next steps are:

- Obtain Enterprise Identity Management (EIDM) system account.
- Download mid-year and annual QRURs and review data for accuracy. If necessary, file an informal review.
- Identify potential opportunities for improvement based on the information provided in the QRUR.
- Develop QI plan and incorporate data from QRURs into QI plan.
- Understand implications of non-participation in CMS’ Quality Programs.

Resources to help with QRUR:
AAN VBPM webpage, CMS VBPM webpage, AAN video series, Lessons for Neurologists from QRURs, Obtain your QRUR from CMS

4. Have you heard of Clinical Practice Improvement Activities?

If “yes” OR if “no”:

- Review the proposed rule list of 90+ activities to evaluate which activities your practice is already doing and what adjustments need to be made to complete needed activities.
- Consider which 90 days in 2017 would work best for your practice to report on CPIA activities.
- The maximum score in the CPIA category is 60 points, unless you are in a qualifying small or rural practice. Select activities that add to a minimum of 60 total CPIA points.
Consider accessing these resources to help get properly reimbursed for work that you already are performing.

- Bill reimbursable Chronic Care Management codes
- Resource: FAQ: CCM Codes
- Bill reimbursable Advanced Care Planning codes
- Resource: CMS’s FAQ: ACP Codes
- Bill Transitional Care Management codes
- Resource: FAQ: TCM Codes
- Resource: AAFP’s Transitional Care Management 30-Day Worksheet
- Resource: Neurology Compensation and Productivity Report
- Access the AAN Financial Impact Calculator to see how participation in Medicare programs could impact your practice