The Medicare Access & Chip Reauthorization Act of 2015

THE MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Disclaimer

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KEY TOPICS:

1) The Quality Payment Program and HHS Secretary's Goals
2) What is the Quality Payment Program?
3) How do I submit comments on the proposed rule?
4) The Merit-based Incentive Payment System (MIPS)
5) What are the next steps?

The Quality Payment Program is part of a broader push towards value and quality

In January 2015, the Department of Health and Human Services announced **new goals** for **value-based payments** and **APMs in Medicare**

Medicare Fee-for-Service

GOAL 1:

30%

Medicare payments are tied to quality or value through **alternative payment models (categories 3-4)** by the end of 2016, and 50% by the end of 2018

GOAL 2:

85%

Medicare fee-for-service payments are **tied to quality or value (categories 2-4)** by the end of 2016, and 90% by the end of 2018

STAKEHOLDERS:

Consumers | Businesses
Payers | Providers
State Partners

Set **internal goals** for HHS

Invite **private sector payers** to match or exceeed HHS goals

Medicare Payment Prior to MACRA

Fee-for-service (FFS) payment system, where clinicians are paid based on **volume** of services, not **value.**

The Sustainable Growth Rate (SGR)

- Established in 1997 to **control the cost of Medicare payments** to physicians

IF

Overall physician costs

>

Target Medicare expenditures

Physician payments cut across the board

Each year, Congress passed temporary **"doc fixes"** to avert cuts (no fix in 2015 would have meant a **21% cut** in Medicare payments to clinicians)

Medicare Payment Prior to MACRA

Fee-for-service (FFS) payment system, where clinicians are paid based on **volume** of services, not **value.**

The Sustainable Growth Rate (SGR)

Each year, Congress passed temporary **"doc fixes"** to avert cuts (no fix in 2015 would have meant a **21% cut** in Medicare payments to clinicians)

MACRA **replaces the SGR** with a **more predictable** payment method that **incentivizes value**.

INTRODUCING THE QUALITY PAYMENT PROGRAM

Quality Payment Program

- ✓ **Repeals** the Sustainable Growth Rate (SGR) Formula
- ✓ **Streamlines** multiple quality reporting programs into the new Merit-based Incentive Payment System (MIPS)
- ✓ **Provides incentive payments** for participation in **Advanced Alternative Payment Models (APMs)**

The Merit-based Incentive Payment System (MIPS) **or** **Advanced Alternative Payment Models (APMs)**

- ✓ **First step to a fresh start**
- ✓ **We're listening and help is available**
- ✓ **A better, smarter Medicare for healthier people**
- ✓ **Pay for what works to create a Medicare that is enduring**
- ✓ **Health information needs to be open, flexible, and user-centric**

When and where do I submit comments?

- The proposed rule includes proposed changes not reviewed in this presentation. We will not consider feedback during the call as formal comments on the rule. See the proposed rule for information on submitting these comments by the close of the 60-day comment period on June 27, 2016. When commenting refer to file code CMS-5517-P.

- Instructions for submitting comments can be found in the proposed rule; FAX transmissions will not be accepted. You must officially submit your comments in one of the following ways: electronically through
  - Regulations.gov
  - by regular mail
  - by express or overnight mail
  - by hand or courier

- For additional information, please go to: http://go.cms.gov/QualityPaymentProgram

Quality Payment Program

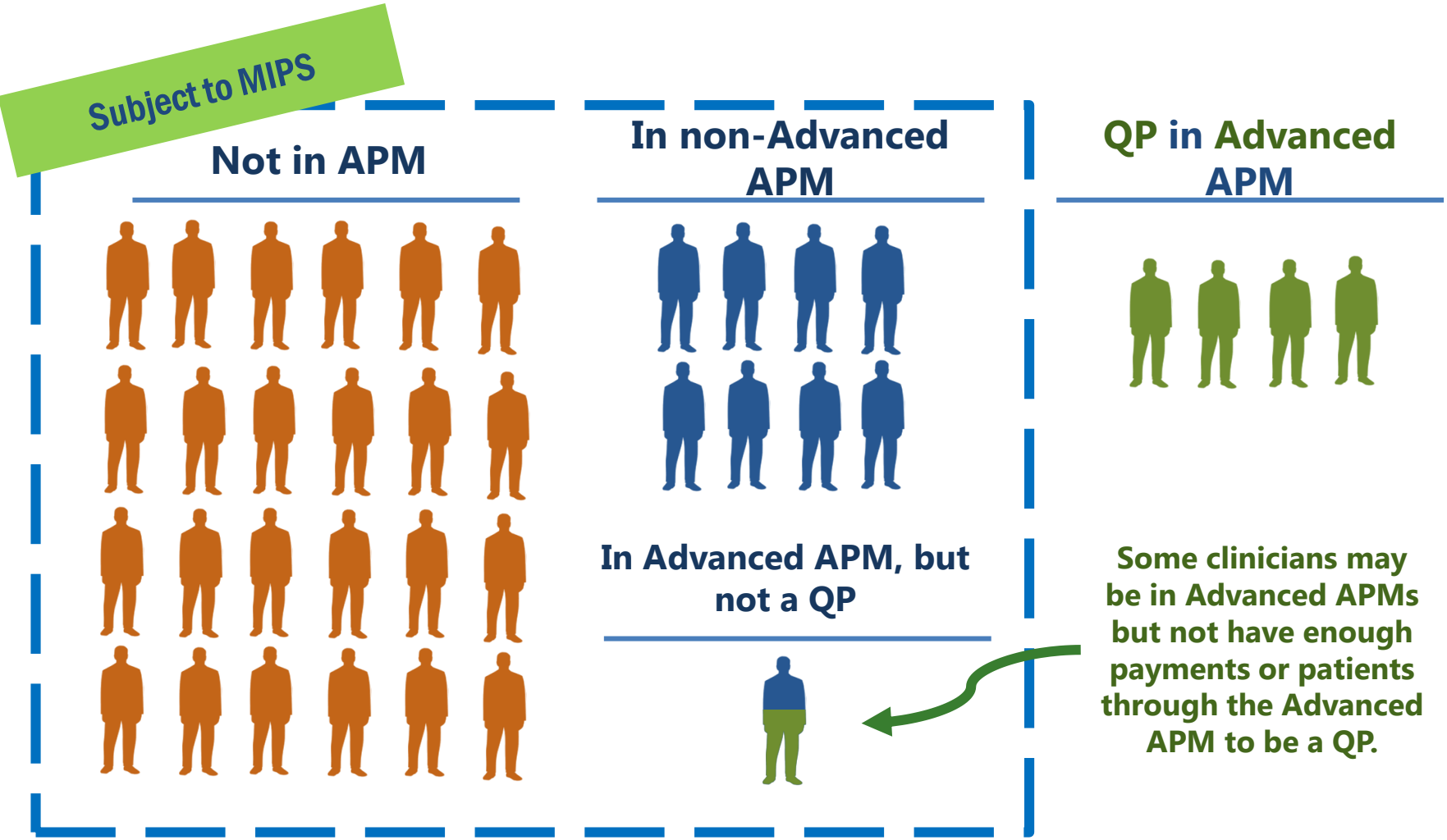
- ✓ First step to a fresh start
- ✓ We're listening and help is available
- ✓ A better, smarter Medicare for healthier people
- ✓ Pay for what works to create a Medicare that is enduring
- ✓ Health information needs to be open, flexible, and user-centric

The Merit-based Incentive Payment System (MIPS)

or

Advanced Alternative Payment Models (APMs)

Note: Most practitioners will be subject to MIPS.



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MIPS

MIPS: First Step to a Fresh Start

- ✓ **MIPS is a new program**
  - **Streamlines 3 currently independent programs to work as one and to ease clinician burden.**
  - **Adds a fourth component to promote ongoing improvement and innovation to clinical activities.**

Quality

Resource use

Clinical practice improvement activities

Advancing care information

- ✓ **MIPS provides clinicians the flexibility to choose the activities and measures that are most meaningful to their practice to demonstrate performance.**

Medicare Reporting Prior to MACRA

Currently there are **multiple quality and value reporting programs** for Medicare clinicians:

Physician Quality Reporting Program (PQRS)

Value-Based Payment Modifier (VM)

Medicare Electronic Health Records (EHR) Incentive Program

PROPOSED RULE

MIPS: Major Provisions

- ✓ **Eligibility (participants and non-participants)**
- ✓ **Performance categories & scoring**
- ✓ **Data submission**
- ✓ **Performance period & payment adjustments**

Who Will Participate in MIPS?

Affected clinicians are called **"MIPS eligible clinicians"** and will participate in MIPS. The types of **Medicare Part B** eligible clinicians affected by MIPS may expand in future years.

Years 1 and 2

Physicians (MD/DO and DMD/DDS), PAs, NPs, Clinical nurse specialists, Certified registered nurse anesthetists

Years 3+

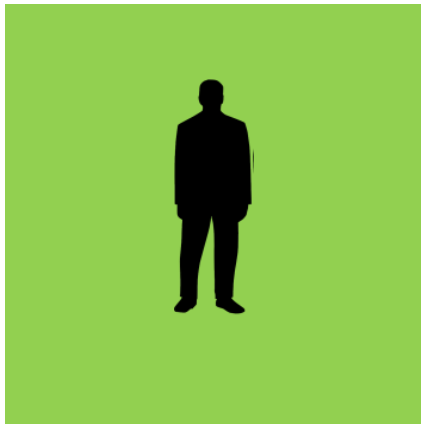
Secretary may broaden Eligible Clinicians group to include others such as

Physical or occupational therapists, Speech-language pathologists, Audiologists, Nurse midwives, Clinical social workers, Clinical psychologists, Dietitians / Nutritional professionals

Who will NOT Participate in MIPS?

There are 3 groups of clinicians who will NOT be subject to MIPS:

FIRST year of Medicare Part B participation



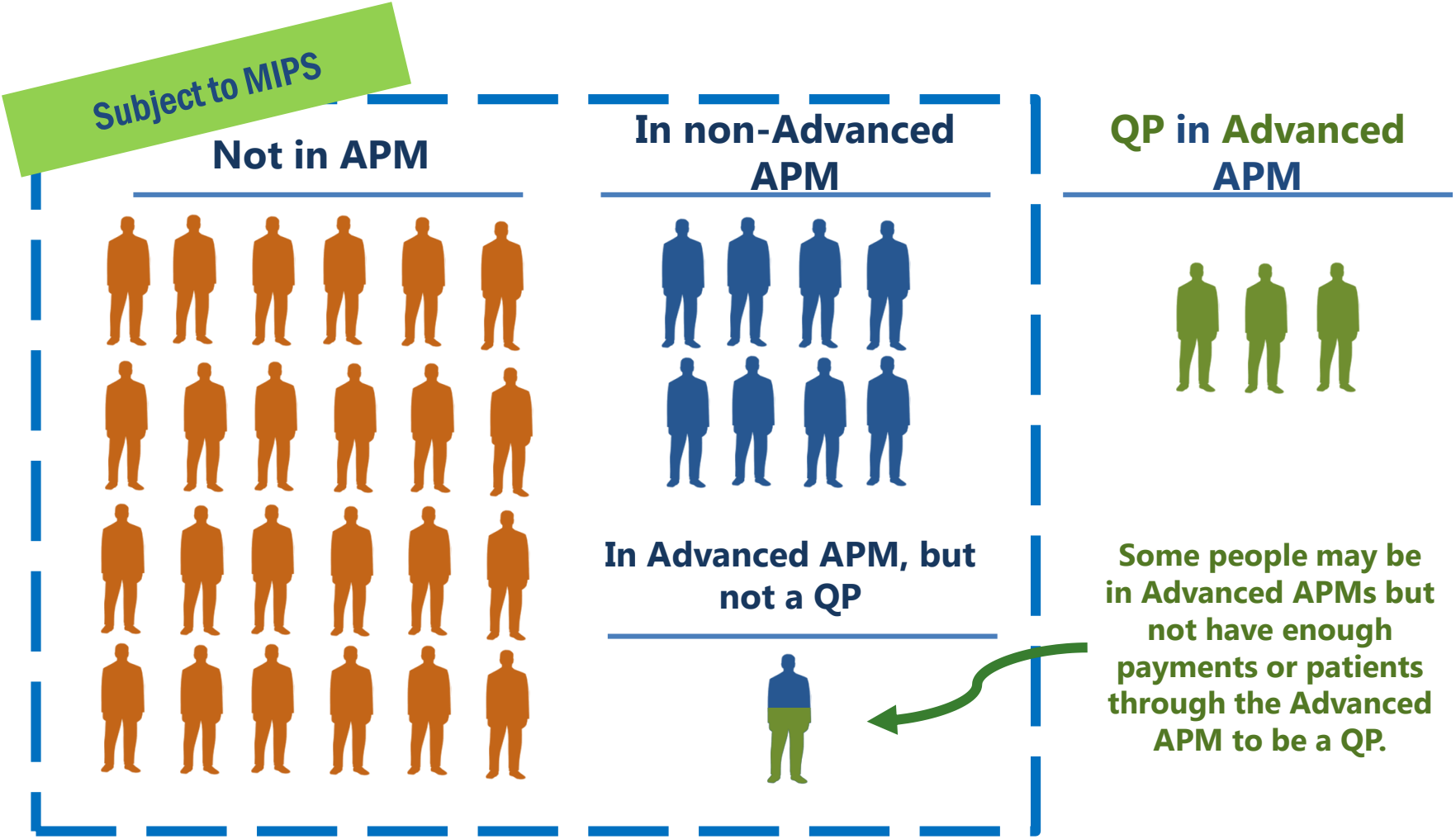
Below low patient volume threshold

Certain participants in ADVANCED Alternative Payment Models

Medicare billing charges less than or equal to $10,000 and provides care for 100 or fewer Medicare patients in one year

Note: MIPS **does not** apply to hospitals or facilities

Note: Most clinicians will be subject to MIPS.



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PROPOSED RULE
MIPS: Eligible Clinicians

Eligible Clinicians can participate in MIPS as an:

Or

Individual

Group

A group, as defined by taxpayer identification number (TIN), would be assessed as a group practice across all four MIPS performance categories.

Note: “Virtual groups” will not be implemented in Year 1 of MIPS.

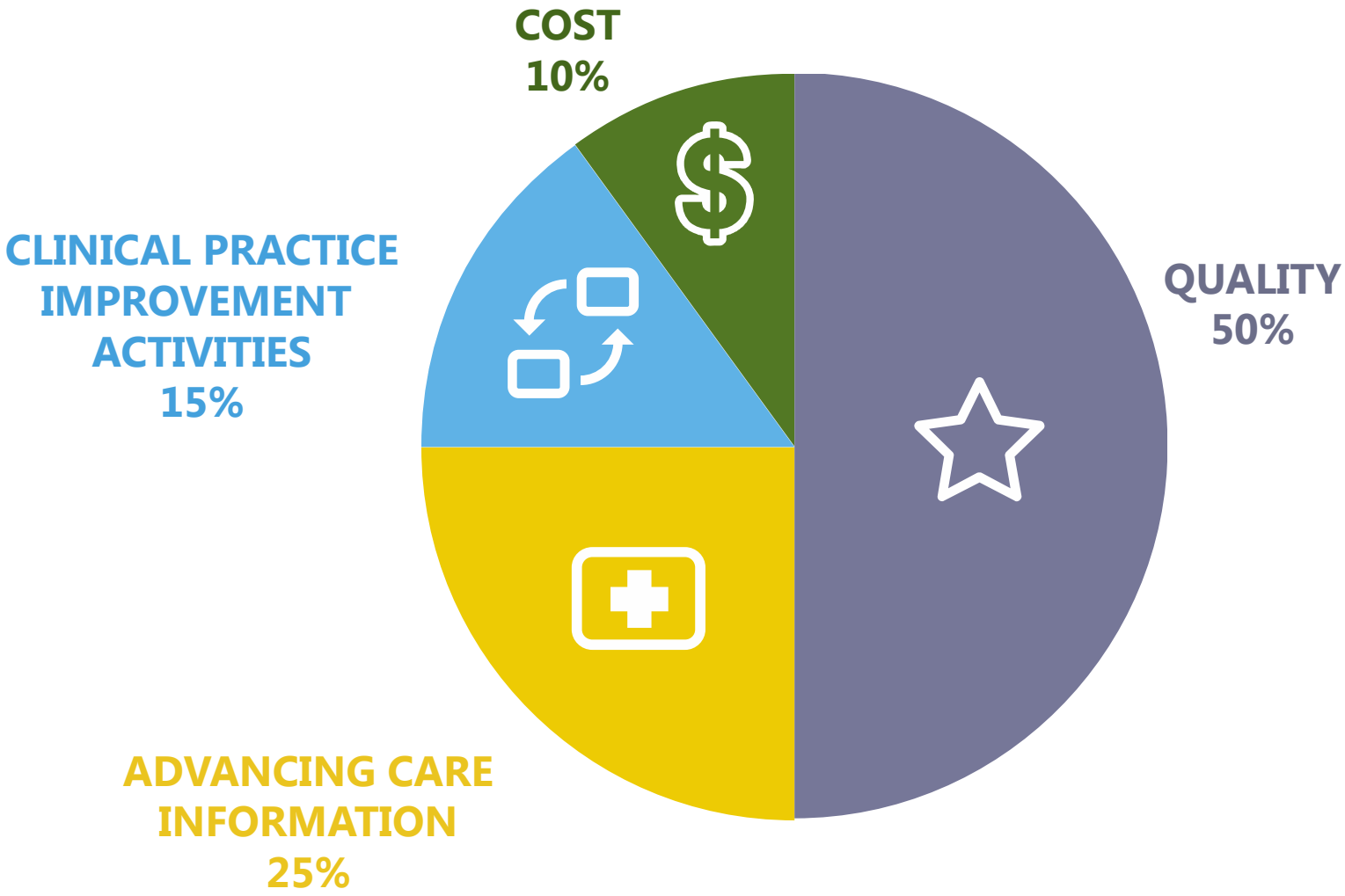
PROPOSED RULE

MIPS: PERFORMANCE CATEGORIES & SCORING

MIPS Performance Categories

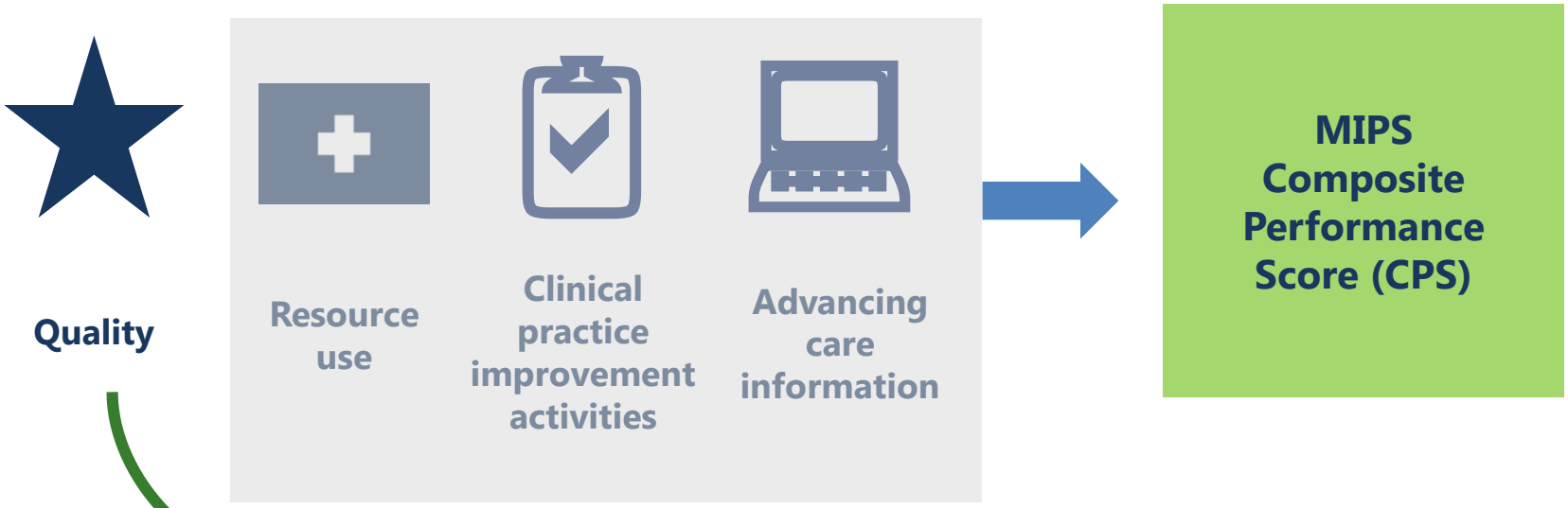
A single MIPS composite performance **score** will factor in performance in **4 weighted performance categories on a 0-100 point scale**:

Year 1 Performance Category Weights for MIPS



What will determine my MIPS score?

The MIPS composite performance **score** will factor in performance in
4 weighted performance categories on a 0-100 point scale :



*Proposed quality measures are available in the NPRM

*clinicians will be **able to choose** the measures on which they'll be evaluated

PROPOSED RULE

MIPS: Quality Performance Category

Summary:

- ✓ **Selection of 6 measures**
- ✓ **1 cross-cutting measure and 1 outcome measure, or another high priority measure if outcome is unavailable**
- ✓ **Select from individual measures or a specialty measure set**
- ✓ **Population measures automatically calculated**
- ✓ **Key Changes from Current Program (PQRS):**
  - **Reduced from 9 measures to 6 measures with no domain requirement**
  - **Emphasis on outcome measurement**
  - **Year 1 Weight: 50%**

What will determine my MIPS score?

The MIPS composite performance **score** will factor in performance in
4 weighted performance categories on a 0-100 point scale :

*Will compare resources used to treat similar **care episodes** and **clinical condition groups** across practices

*Can be **risk-adjusted** to reflect external factors

PROPOSED RULE

MIPS: Resource Use Performance Category

Summary:

- ✓ **Assessment under all available resource use measures, as applicable to the clinician**
- ✓ **CMS calculates based on claims so there are no reporting requirements for clinicians**
- ✓ **Key Changes from Current Program (Value Modifier):**
  - **Adding 40+ episode specific measures to address specialty concerns**
  - **Year 1 Weight: 10%**

What will determine my MIPS score?

The MIPS composite performance **score** will factor in performance in
4 weighted performance categories on a 0-100 point scale :

*Examples include care coordination, shared decision-making, safety checklists, expanding practice access

PROPOSED RULE

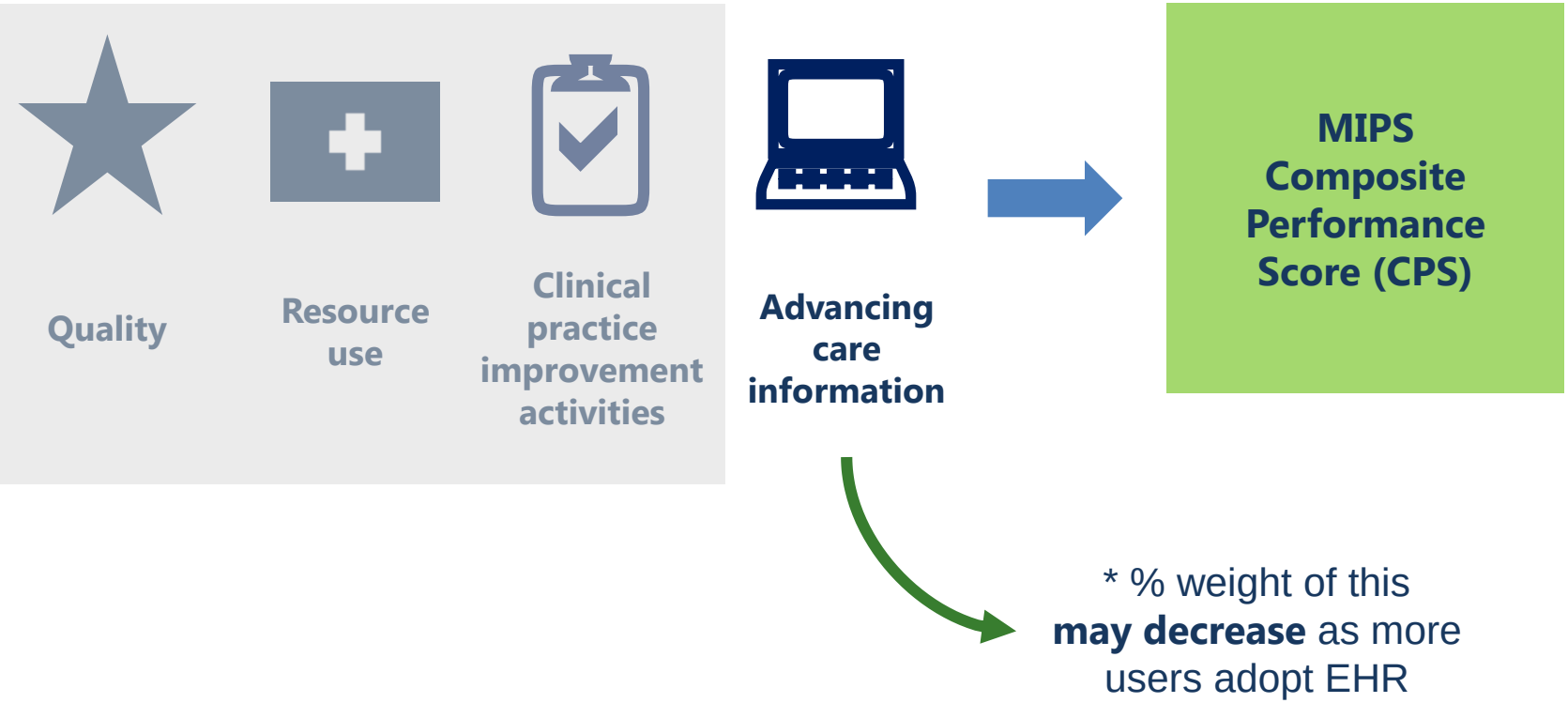
MIPS: Clinical Practice Improvement Activity Performance Category

Summary:

- ✓ **Minimum selection of one CPIA activity (from 90+ proposed activities) with additional credit for more activities**
- ✓ **Full credit for patient-centered medical home**
- ✓ **Minimum of half credit for APM participation**
- ✓ **Key Changes from Current Program:**
  - **Not applicable (new category)**
  - **Year 1 Weight: 15%**

What will determine my MIPS score?

The MIPS composite performance **score** will factor in performance in
4 weighted performance categories on a 0-100 point scale :



PROPOSED RULE

MIPS: Advancing Care Information Performance Category

Who can participate?

All MIPS Eligible Clinicians

Participating as an…

Individual

or

Groups

Those Not Eligible → **Include: NPs, PAs, Hospitals, Facilities & Medicaid**

PROPOSED RULE

MIPS: Advancing Care Information Performance Category

BASE SCORE	+	PERFORMANCE SCORE	+	BONUS POINT	=	COMPOSITE SCORE
Account for **50 points** of the total **Advancing Care Information Performance** Category Score		Account for **80 points** of the total **Advancing Care Information Performance** Category Score		Up to **1 point** of the total **Advancing Care Information Performance** Category Score		Earn 100 or more points and receive **FULL 25 points** in the **Advancing Care Information Category** of MIPS Composite Score

The overall Advancing Care Information score would be made up of a base score and a performance score for a maximum score of 100 points

PROPOSED RULE

MIPS: Advancing Care Information Performance Category

BASE SCORE

BASE SCORE

Accounts for

50 points

of the total Advancing Care Information category score.

To receive the base score, physicians and other clinicians must simply provide the numerator/denominator or yes/no for each objective and measure

PROPOSED RULE

MIPS: Advancing Care Information Performance Category

CMS proposes six objectives and their measures that would require reporting for the base score:

Protect Patient Health Information (yes required)

Electronic Prescribing (numerator/denominator)

Patient Electronic Access (numerator/denominator)

Coordination of Care Through Patient Engagement (numerator/denominator)

Health Information Exchange (numerator/denominator)

Public Health and Clinical Data Registry Reporting (yes required)

PROPOSED RULE

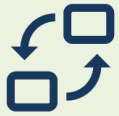
MIPS: Advancing Care Information Performance Category

The Performance Score

The performance score accounts for up to 80 points towards the total Advancing Care Information category score

Patient Electronic Access

Coordination of Care Through Patient Engagement



Health Information Exchange

Physicians and other clinicians select the measures that best fit their practice from the following objectives, which emphasize patient care and information access:

PROPOSED RULE

MIPS: Advancing Care Information Performance Category

Summary:

- ✓ **Scoring based on key measures of health IT interoperability and information exchange.**
- ✓ **Flexible scoring for all measures to promote care coordination for better patient outcomes**
- ✓ **Key Changes from Current Program (EHR Incentive):**
  - **Dropped "all or nothing" threshold for measurement**
  - **Removed redundant measures to alleviate reporting burden**
  - **Eliminated Clinical Provider Order Entry and Clinical Decision Support objectives**
  - **Reduced the number of required public health registries to which clinicians must report**
  - **Year 1 Weight: 25%**

PROPOSED RULE

MIPS: Performance Category Scoring

Summary of MIPS Performance Categories		
Performance Category	**Maximum Possible Points per Performance Category**	**Percentage of Overall MIPS Score (Performance Year 1 - 2017)**
Quality: Clinicians choose six measures to report to CMS that best reflect their practice. One of these measures must be an outcome measure or a high-value measure and one must be a crosscutting measure. Clinicians also can choose to report a specialty measure set.	80 to 90 points depending on group size	50 percent
Advancing Care Information: Clinicians will report key measures of interoperability and information exchange. Clinicians are rewarded for their performance on measures that matter most to them.	100 points	25 percent
Clinical Practice Improvement Activities: Clinicians can choose the activities best suited for their practice; the rule proposes over 90 activities from which to choose. Clinicians participating in medical homes earn "full credit" in this category, and those participating in Advanced APMs will earn at least half credit.	60 points	15 percent
Cost: CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything.	Average score of all cost measures that can be attributed	10 percent

PROPOSED RULE

MIPS: Calculating the Composite Performance Score (CPS) for MIPS

A single MIPS composite performance **score** will factor in performance in
4 weighted performance categories on a 0-100 point scale :

The CPS will be compared to the MIPS performance threshold to determine the adjustment percentage the eligible clinician will receive.

PROPOSED RULE

MIPS: Calculating the Composite Performance Score (CPS) for MIPS

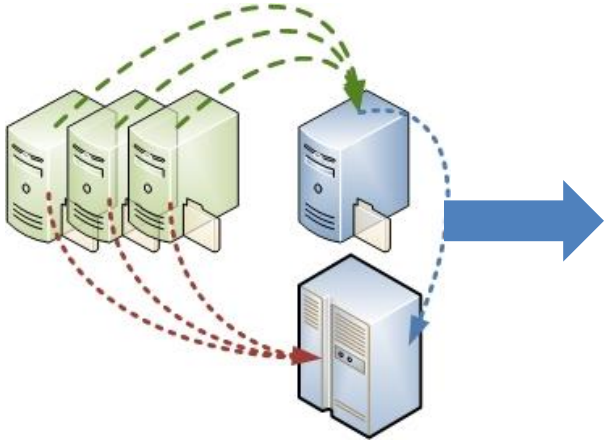
- ✓ **MIPS composite performance scoring method that accounts for:**
  - **Weights of each performance category**
  - **Exceptional performance factors**
  - **Availability and applicability of measures for different categories of clinicians**
  - **Group performance**
  - **The special circumstances of small practices, practices located in rural areas, and non-patient- facing MIPS eligible clinicians**

Calculating the Composite Performance Score (CPS) for MIPS

Category	Weight	Scoring
Quality	50%	• Each measure 1-10 points compared to historical benchmark (if avail.) • 0 points for a measure that is not reported • Bonus for reporting outcomes, patient experience, appropriate use, patient safety and EHR reporting • Measures are averaged to get a score for the category
Advancing care information	25%	• Base score of 60 points is achieved by reporting at least one use case for each available measure • Up to 10 additional performance points available per measure • Total cap of 100 percentage points available
CPIA	15%	• Each activity worth 10 points; double weight for "high" value activities; sum of activity points compared to a target
Resource Use	10%	• Similar to quality

✓ Unified scoring system:
1. Converts measures/activities to points
2. Eligible Clinicians will know in advance what they need to do to achieve top performance
3. Partial credit available

HOW DO I GET MY DATA TO CMS?
DATA SUBMISSION FOR MIPS



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

PROPOSED RULE

MIPS Data Submission Options
Quality and Resource Use

	Individual Reporting	Group Reporting
Quality	✓ Claims ✓ QCDR ✓ Qualified Registry ✓ EHR Vendors ✓ Administrative Claims (No submission required)	✓ QCDR ✓ Qualified Registry ✓ EHR Vendors ✓ CMS Web Interface (groups of 25 or more) ✓ CAHPS for MIPS Survey ✓ Administrative Claims (No submission required)
Resource use	✓ Administrative Claims (No submission required)	✓ Administrative Claims (No submission required)

PROPOSED RULE

MIPS Data Submission Options
Advancing Care Information and CPIA

	Individual Reporting	Group Reporting
Advancing care information	✓ Attestation ✓ QCDR ✓ Qualified Registry ✓ EHR Vendor	✓ Attestation ✓ QCDR ✓ Qualified Registry ✓ EHR Vendor ✓ CMS Web Interface (groups of 25 or more)
CPIA	✓ Attestation ✓ QCDR ✓ Qualified Registry ✓ EHR Vendor ✓ Administrative Claims (No submission required)	✓ Attestation ✓ QCDR ✓ Qualified Registry ✓ EHR Vendor ✓ CMS Web Interface (groups of 25 or more)

PROPOSED RULE
MIPS PERFORMANCE PERIOD & PAYMENT ADJUSTMENT

PROPOSED RULE

MIPS Performance Period

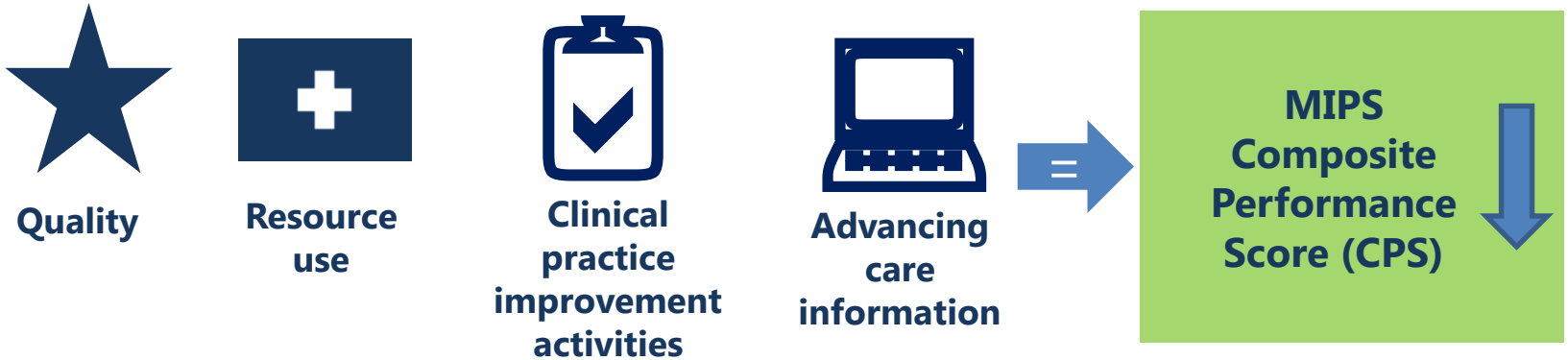
MIPS Performance Period (Begins 2017)

- ✓ **All MIPS performance categories are aligned to a performance period of one full calendar year.**
- ✓ **Goes into effect in first year (2017 performance period, 2019 payment year).**

2017	2018	2019	2020	2021	2022	2023	2024	2025
Performance Period		Payment Year						

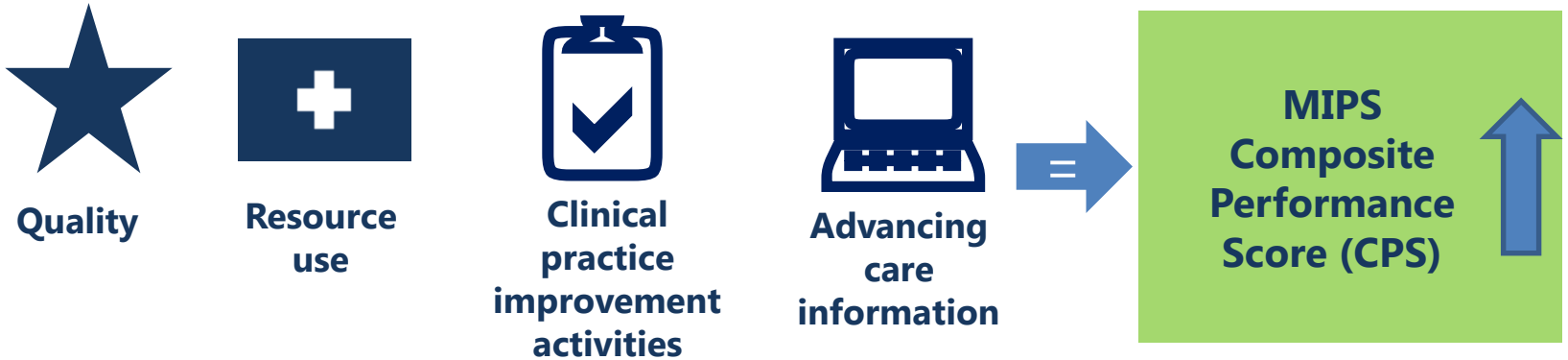
PROPOSED RULE
MIPS: Payment Adjustment

- ✓ A MIPS eligible clinician's payment adjustment percentage is based on the relationship between their CPS and the MIPS performance threshold.
- ✓ A CPS below the performance threshold will yield a negative payment adjustment; a CPS above the performance threshold will yield a neutral or positive payment adjustment.
- ✓ A CPS less than or equal to 25% of the threshold will yield the maximum negative adjustment of -4%.



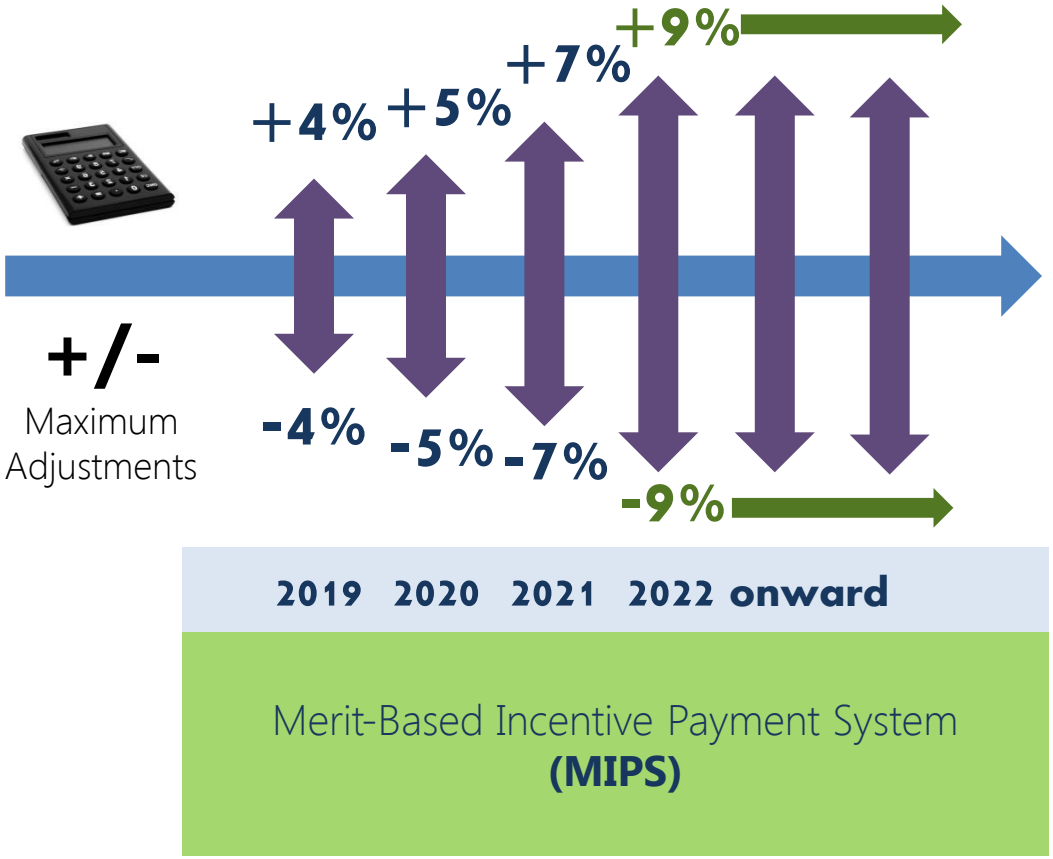
PROPOSED RULE
MIPS: Payment Adjustment

- ✓ A CPS that falls at or above the threshold will yield payment adjustment of 0 to +12%, based on the degree to which the CPS exceeds the threshold and the overall CPS distribution.
- ✓ An additional bonus (not to exceed 10%) will be applied to payments to eligible clinicians with exceptional performance where CPS is equal to or greater than an "additional performance threshold," defined as the 25th percentile of possible values above the CPS performance threshold.



How much can MIPS adjust payments?

Based on a CPS, clinicians will receive **+/- or neutral** adjustments **up to** the percentages below.

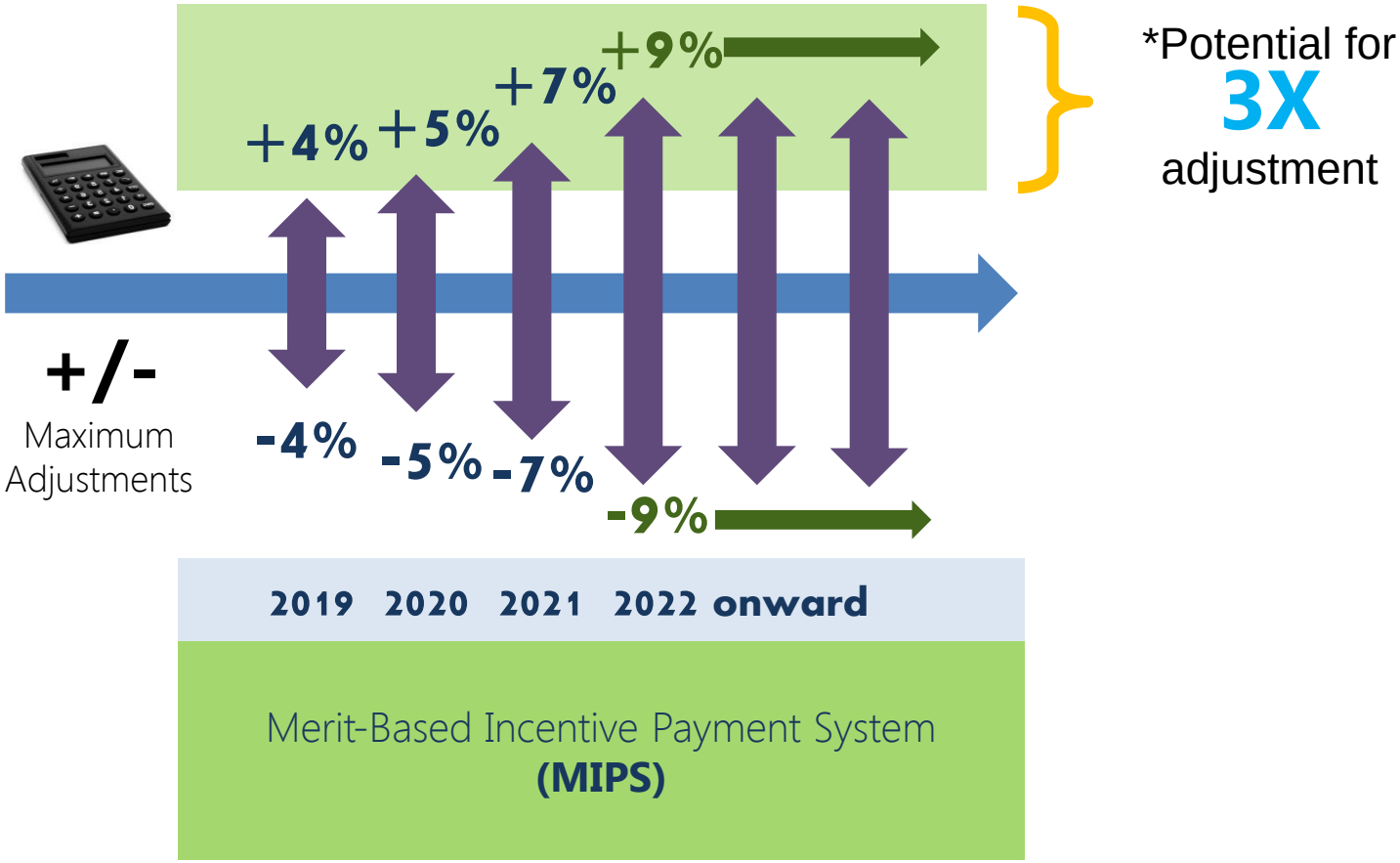


Adjusted Medicare Part B **payment** to clinician

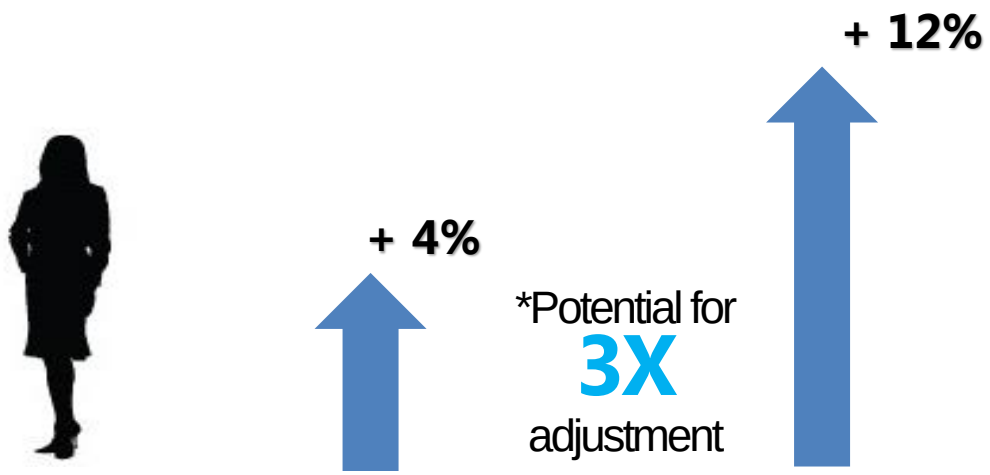
The potential maximum adjustment % will increase each year from 2019 to 2022

How much can MIPS adjust payments?

Note: MIPS will be a **budget-neutral** program. Total upward and downward adjustments will be balanced so that the average change is 0%.



MIPS: Scaling Factor Example



Dr. Joy Smith, who receives the +4% adjustment for MIPS, could receive up to +12% in 2019. For exceptional performance she could earn an additional adjustment factor of up to +10%.

Note: This scaling process will only apply to positive adjustments, not negative ones.

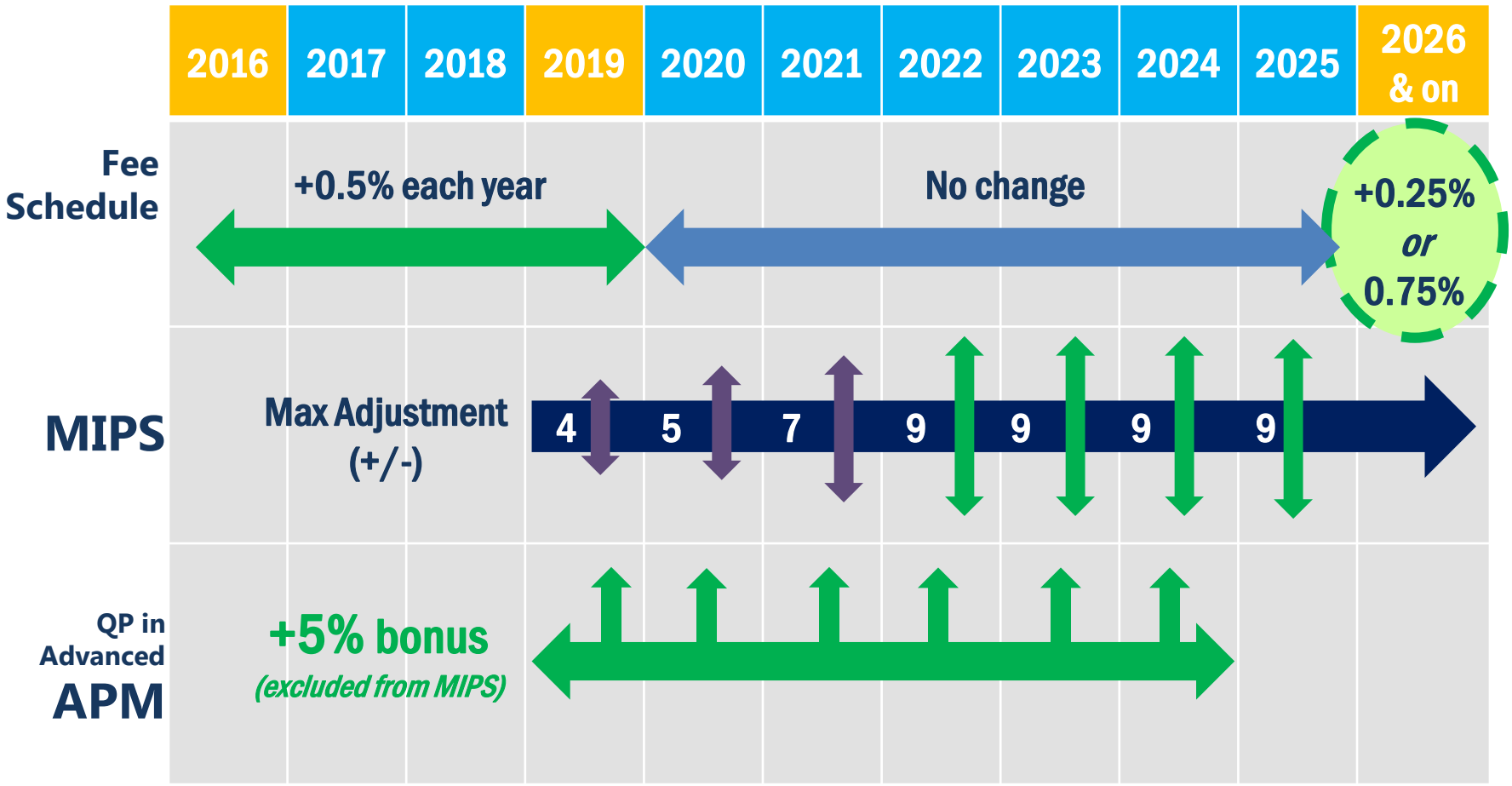
PROPOSED RULE
MIPS Timeline

2017	2018	July		2019	2020
Performance Period (Jan-Dec) 1st Feedback Report (July)	Reporting and Data Collection	2nd Feedback Report (July)	Targeted Review Based on 2017 MIPS Performance	MIPS Adjustments in Effect	

Analysis and Scoring

When will these Quality Payment Program provisions take effect?

Putting it all together:



TAKE-AWAY POINTS

1) The Quality Payment Program **changes the way Medicare pays clinicians** and offers financial **incentives** for providing high **value** care.

2) Medicare **Part B clinicians** will participate in the **MIPS**, unless they are in their 1st year of Part B participation, become QPs through participation in **Advanced APMs**, or have a low volume of patients.

3) Payment adjustments and bonuses will begin in **2019**.

THANK YOU!

More Ways to Learn To learn more about the Quality Payment Programs including MIPS program information, watch the http://go.cms.gov/QualityPaymentProgram to learn of Open Door Forums, webinars, and more.

APPENDIX

How will the Quality Payment Program affect me?

Am I in an **APM**?

- **Yes** → Am I in an **Advanced** APM?
  - **Yes** → Do I have **enough payments or patients** through my Advanced APM?
    - **Yes** → **Qualifying APM Participant (QP)**
    - **No** → **Favorable** MIPS scoring & APM-specific **rewards**
  - **No** → **Favorable** MIPS scoring & APM-specific **rewards**
- **No** → Is this my **first year** in Medicare OR am I below the **low-volume threshold**?
  - **Yes** → **Not** subject to **MIPS**
  - **No** → Subject to **MIPS**

Qualifying APM Participant (QP)

- **Excluded** from MIPS
- 5% lump sum **bonus payment** (2019-2024), higher **fee schedule updates (**2026+)
- APM-specific **rewards**

Bottom line: There will be **financial incentives for participating in an APM**, even if you don't become a **QP.**