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?
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:**

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:**

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 exceed HHS goals

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

<table>
<thead>
<tr>
<th>Overall physician costs</th>
<th>Target Medicare expenditures</th>
</tr>
</thead>
</table>

**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)
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)

- **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.

Subject to MIPS

Not in APM

In non-Advanced APM

In Advanced APM, but not a QP

QP in Advanced APM

Some clinicians may be in Advanced APMs but not have enough payments or patients through the Advanced APM to be a QP.

Note: Figure not to scale.
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.

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

1. **FIRST year of Medicare Part B participation**
2. **Below low patient volume threshold**
3. **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
## PROPOSED RULE
### MIPS Timeline

<table>
<thead>
<tr>
<th>Year</th>
<th>2017</th>
<th>2018</th>
<th>July</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Performance Period (Jan-Dec)</strong></td>
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<tr>
<td><strong>1st Feedback Report (July)</strong></td>
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<tr>
<td><strong>Reporting and Data Collection</strong></td>
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<td><strong>2nd Feedback Report (July)</strong></td>
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<tr>
<td><strong>Targeted Review Based on 2017 MIPS Performance</strong></td>
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<tr>
<td><strong>MIPS Adjustments in Effect</strong></td>
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</tbody>
</table>

**Analysis and Scoring**
How much can MIPS adjust payments?

Based on a MIPS Composite Performance Score, clinicians will receive +/- or neutral adjustments up to the percentages below.

<table>
<thead>
<tr>
<th>Year</th>
<th>Adjustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>+/- 4%</td>
</tr>
<tr>
<td>2020</td>
<td>+/- 5%</td>
</tr>
<tr>
<td>2021</td>
<td>+/- 7%</td>
</tr>
<tr>
<td>2022</td>
<td>+/- 9%</td>
</tr>
<tr>
<td>2023 and onward</td>
<td>+/- 9%</td>
</tr>
</tbody>
</table>

Adjusted Medicare Part B payment to clinician

The potential maximum adjustment % will increase each year from 2019 to 2022.
Note: Most clinicians will be subject to MIPS.

Subject to MIPS

Not in APM

In non-Advanced APM

In Advanced APM, but not a QP

QP in Advanced APM

Some people may be in Advanced APMs but not have enough payments or patients through the Advanced APM to be a QP.

Note: Figure not to scale.
Eligible Clinicians can participate in MIPS as an:

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

- Quality
- Resource use
- Clinical practice improvement activities
- Advancing care information

MIPS Composite Performance Score (CPS)
Year 1 Performance Category Weights for MIPS

- **Quality** (50%)
- **Advancing Care Information** (25%)
- **Clinical Practice Improvement Activities** (15%)
- **Cost** (10%)

The pie chart visually represents the weight distribution among the four performance categories.
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:

- Resource use
- Clinical practice improvement activities
- Advancing care information

MIPS Composite Performance Score (CPS)

*Proposed quality measures are available in the NPRM

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

- Quality
- Resource use
- Clinical practice improvement activities
- Advancing care information

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

What will determine my MIPS score?

Quality

Resource use

Clinical practice improvement activities

Advancing care information

MIPS Composite Performance Score (CPS)

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

- **Quality**
- **Resource use**
- **Clinical practice improvement activities**
- **Advancing care information**

*MIPS Composite Performance Score (CPS)*

* % weight of this may decrease as more users adopt EHR*
PROPOSED RULE
MIPS: Advancing Care Information Performance Category

Who can participate?

- All MIPS Eligible Clinicians
- Participating as an Individual or Groups
- Not eligible Facilities (i.e. Skilled Nursing facilities)
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**: Account for 50 points of the total Advancing Care Information Performance Category Score
- **Performance Score**: Account for 80 points of the total Advancing Care Information Performance Category Score
- **Bonus Point**: Up to 1 point of the total Advancing Care Information Performance Category Score

**Composite Score**: Earn 100 or more points and receive full 25 points in the Advancing Care Information Category of MIPS Composite Score.
To receive the base score, physicians and other clinicians must simply provide the numerator/denominator or yes/no for each objective and measure.
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)
The Performance Score

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

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

✓ Scoring based on key measures of patient engagement 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**

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Maximum Possible Points per Performance Category</th>
<th>Percentage of Overall MIPS Score (Performance Year 1 - 2017)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality:</strong> 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.</td>
<td>80 to 90 points depending on group size</td>
<td>50 percent</td>
</tr>
<tr>
<td><strong>Advancing Care Information:</strong> Clinicians will report key measures of patient engagement and information exchange. Clinicians are rewarded for their performance on measures that matter most to them.</td>
<td>100 points</td>
<td>25 percent</td>
</tr>
<tr>
<td><strong>Clinical Practice Improvement Activities:</strong> 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.</td>
<td>60 points</td>
<td>15 percent</td>
</tr>
<tr>
<td><strong>Cost:</strong> CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything.</td>
<td>Average score of all cost measures that can be attributed</td>
<td>10 percent</td>
</tr>
</tbody>
</table>
A single MIPS composite performance score will factor in performance in 4 weighted performance categories on a 0-100 point scale:

- Quality
- Resource use
- Clinical practice improvement activities
- Advancing care information

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

<table>
<thead>
<tr>
<th>Category</th>
<th>Weight</th>
<th>Scoring</th>
</tr>
</thead>
</table>
| **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 50 percentage points achieved by reporting at least one use case for each available measure  
                              |        | • Performance score of up to 80 percentage points  
                              |        | • Public Health Reporting bonus point  
                              |        | • 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
PROPOSED RULE
MIPS Data Submission Options
Quality and Resource Use

<table>
<thead>
<tr>
<th>Individual Reporting</th>
<th>Group Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ QCDR</td>
<td>✓ QCDR</td>
</tr>
<tr>
<td>✓ Qualified Registry</td>
<td>✓ Qualified Registry</td>
</tr>
<tr>
<td>✓ EHR</td>
<td>✓ EHR</td>
</tr>
<tr>
<td>✓ Administrative Claims (No submission required)</td>
<td>✓ Administrative Claims (No submission required)</td>
</tr>
<tr>
<td>✓ Claims</td>
<td>✓ CMS Web Interface (groups of 25 or more)</td>
</tr>
<tr>
<td></td>
<td>✓ CAHPS for MIPS Survey</td>
</tr>
<tr>
<td>✓ Administrative Claims (No submission required)</td>
<td>✓ Administrative Claims (No submission required)</td>
</tr>
</tbody>
</table>
## Proposed Rule

### MIPS Data Submission Options

#### Advancing Care Information and CPIA

<table>
<thead>
<tr>
<th>Individual Reporting</th>
<th>Group Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Attestation</td>
<td>✓ Attestation</td>
</tr>
<tr>
<td>✓ QCDR</td>
<td>✓ QCDR</td>
</tr>
<tr>
<td>✓ Qualified Registry</td>
<td>✓ Qualified Registry</td>
</tr>
<tr>
<td>✓ EHR Vendor</td>
<td>✓ EHR Vendor</td>
</tr>
<tr>
<td>✓ Administrative Claims (No submission required)</td>
<td>✓ CMS Web Interface (groups of 25 or more)</td>
</tr>
</tbody>
</table>
PROPOSED RULE
MIPS PERFORMANCE
PERIOD & PAYMENT
ADJUSTMENT
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).

<table>
<thead>
<tr>
<th>MIPS Performance Period (Begins 2017)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Period</td>
</tr>
</tbody>
</table>
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%.
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.
Note: MIPS will be a budget-neutral program. Total upward and downward adjustments will be balanced so that the average change is 0%.

*Potential for 3X adjustment
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.
MIPS Incentive Payment Formula

Exceptional performers receive additional positive adjustment factor – up to $500M available each year from 2019 to 2024

EPs above performance threshold = positive payment adjustment

Lowest 25% = maximum reduction

2019 2020 2021 2022 and onward

* + 4% * + 5% * + 7% * + 9%

* MACRA allows potential 3x upward adjustment BUT unlikely
When will these Quality Payment Program provisions take effect?
### Putting it all together:

<table>
<thead>
<tr>
<th>Year</th>
<th>Fee Schedule</th>
<th>MIPS</th>
<th>QP in Advanced APM</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>+0.5% each year</td>
<td>4</td>
<td>+5% bonus (excluded from MIPS)</td>
</tr>
<tr>
<td>2017</td>
<td>+0.5% each year</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>+0.5% each year</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>2019</td>
<td>+0.5% each year</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>2020</td>
<td>+0.5% each year</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>2021</td>
<td>No change</td>
<td>9</td>
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<td>2022</td>
<td>No change</td>
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<td>2023</td>
<td>No change</td>
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<td>2024</td>
<td>No change</td>
<td>9</td>
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<tr>
<td>2025</td>
<td>No change</td>
<td>9</td>
<td></td>
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<tr>
<td>2026 &amp; on</td>
<td>+0.25% or 0.75%</td>
<td>9</td>
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</table>
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](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 Advanced APM?
- Yes
- No

Do I have enough payments or patients through my Advanced APM?
- Yes
- No

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

Favorable MIPS scoring & APM-specific rewards

Is this my first year in Medicare OR am I below the low-volume threshold?
- Yes
- No

Not subject to MIPS
- Subject to MIPS

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