The Medicare Access & Chip Reauthorization Act of 2015

# THE MERIT-BASED INCENTIVE PAYMENT SYSTEM:

# Resource Use Performance Category

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# 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)

# 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**

# THE MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

# Who Will Participate in MIPS?

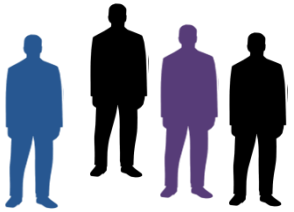
Affected clinicians are called **"MIPS eligible clinicians"** and will participate in MIPS. The types of **Medicare Part B** eligible clinicians affected by MIPS may expand in future years.

## Years 1 and 2

**Physicians, PAs, NPs, Clinical nurse specialists, Certified registered nurse anesthetists**

## Years 3+

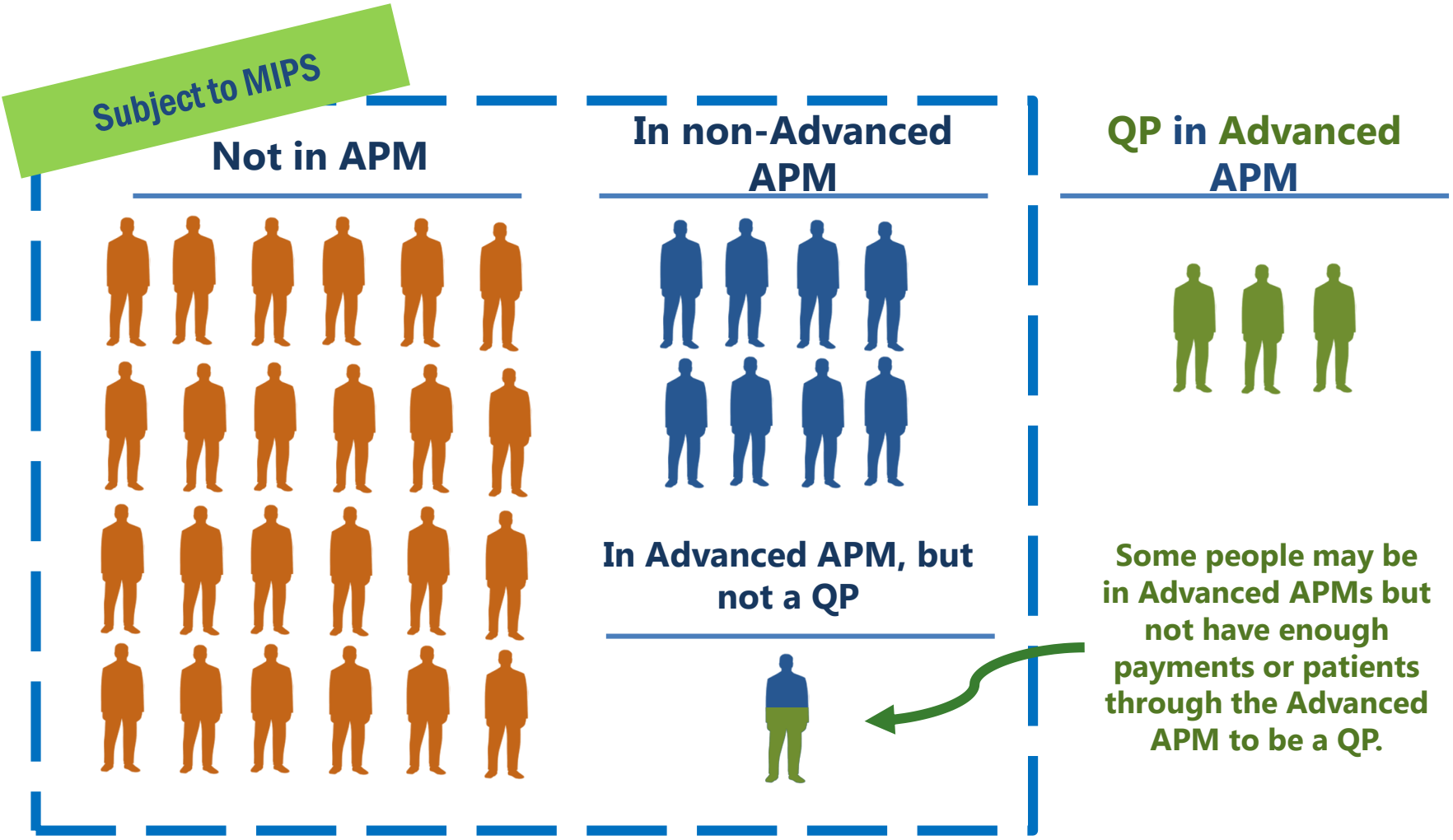
**Secretary may broaden Eligible Clinicians group to include others such as**



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

**Note: Physician means doctor of medicine, doctor of osteopathy (including osteopathic practitioner), doctor of dental surgery, doctor of dental medicine, doctor of podiatric medicine, or doctor of optometry, and, with respect to certain specified treatment, a doctor of chiropractic legally authorized to practice by a State in which he/she performs this function.**

## Note: Most clinicians will be subject to MIPS.




*Note: Figure not to scale.*

# 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**

# 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**

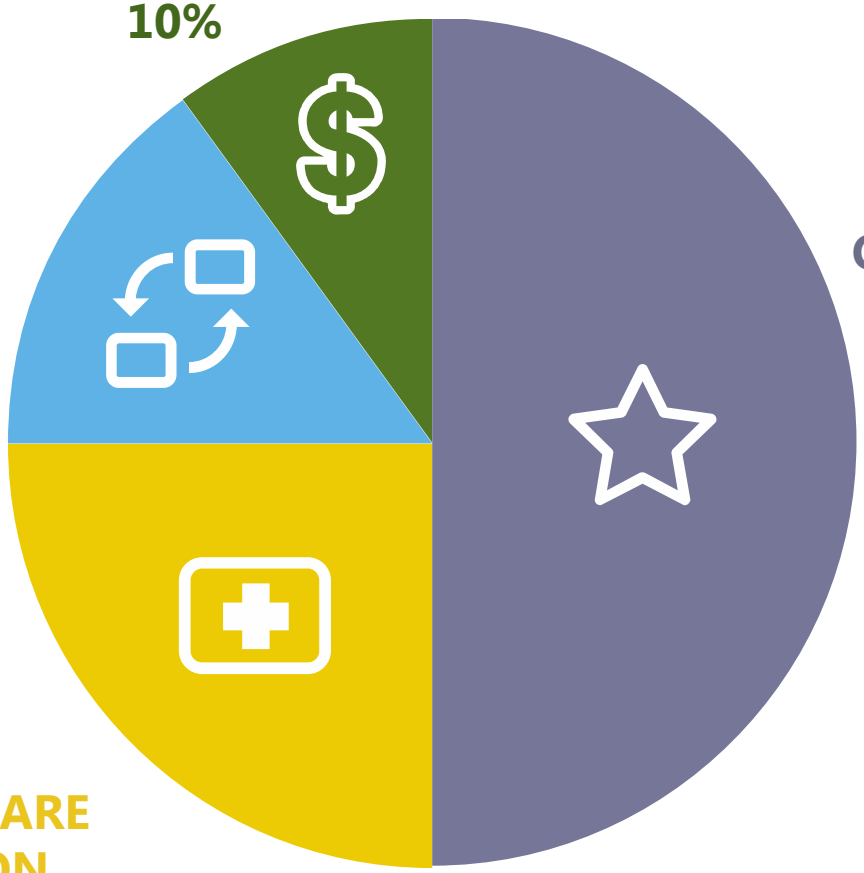
**Advancing care information**

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

# What will determine my MIPS Score?

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



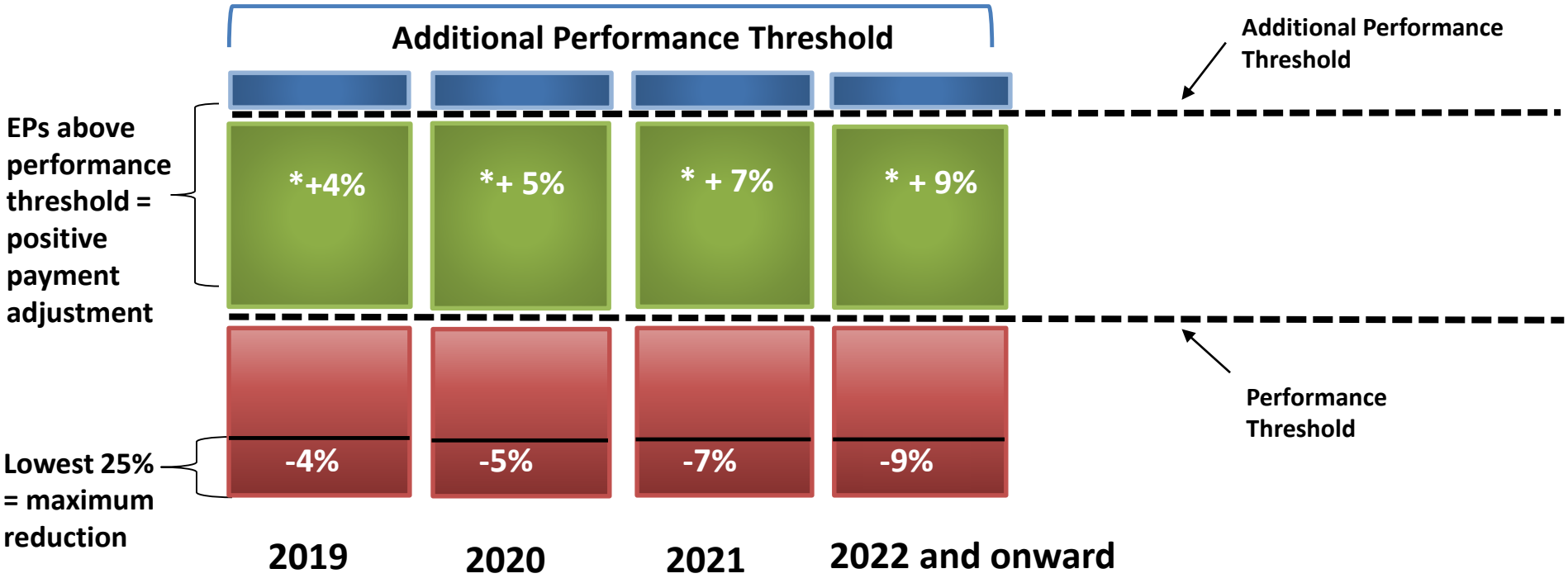
# Calculating the Composite Performance Score (CPS) for MIPS

| Category | Weight | Scoring |
|---|---|---|
| **Quality** | 50% | • Each measure 1-10 points compared to historical benchmark (if avail.)<br>• 0 points for a measure that is not reported<br>• Bonus for reporting outcomes, patient experience, appropriate use, patient safety and EHR reporting<br>• 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<br>• Performance score of up to 80 percentage points<br>• Public Health Reporting bonus point<br>• 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

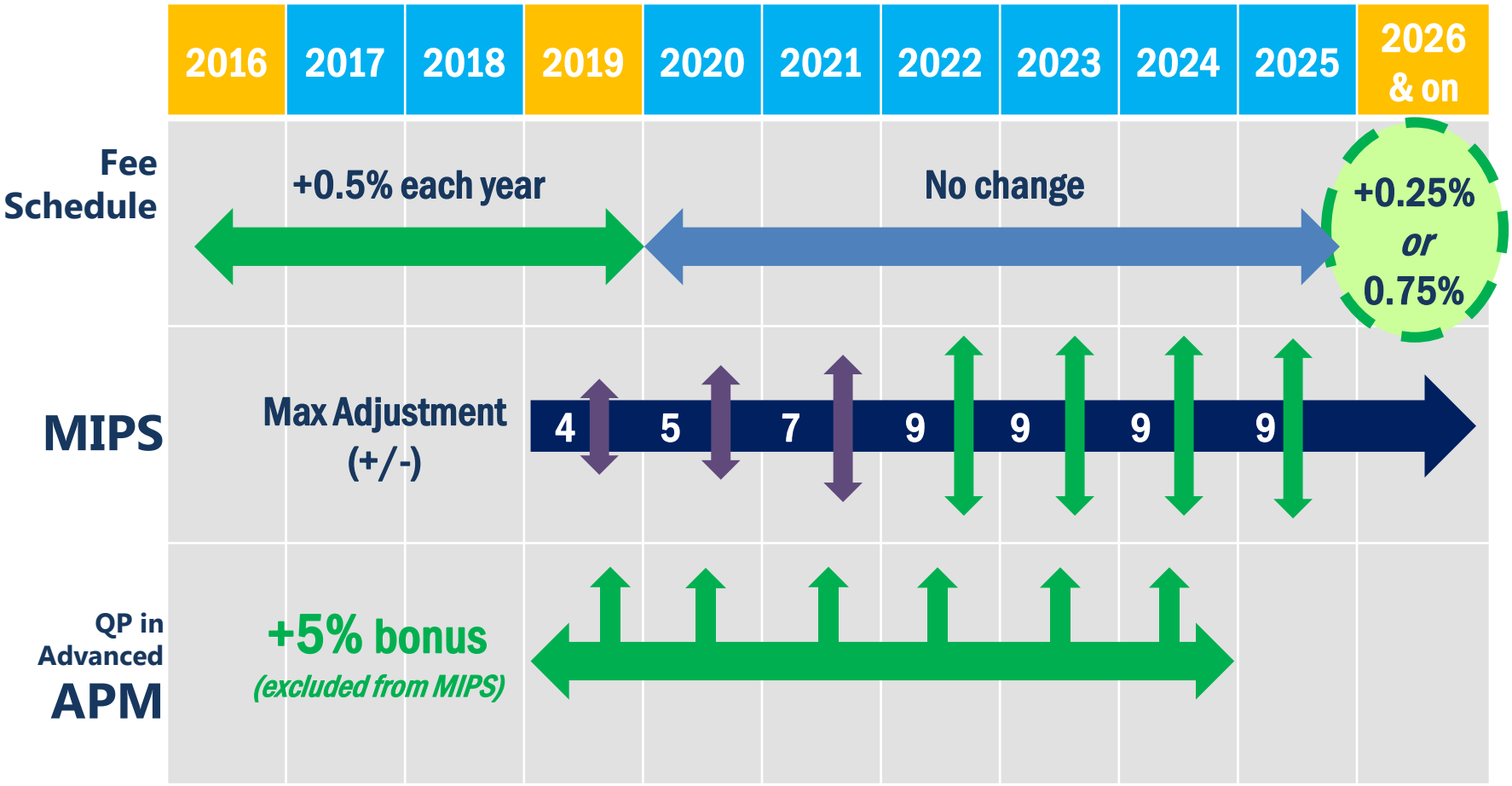
# MIPS Incentive Payment Formula

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




**MACRA allows potential 3x upward adjustment BUT unlikely*

# Putting it all together:



# RESOURCE USE PERFORMANCE CATEGORY

# Focusing on Resource Use

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%**

# Key Changes from Current Program Value Modifier

| Value Modifier | Proposed MIPS Resource Use Category |
|---|---|
| 6 measures:<br>Total per capita costs for all attributed beneficiaries,<br><br>Medicare Spending per Beneficiary (MSPB),<br><br>Total per capita cost measures for the four condition-specific groups (chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, and diabetes mellitus).<br><br>Attribution to the group practice (TIN) | 2 of the 6 VM measures:<br>Total per capita costs for all attributed beneficiaries,<br><br>Medicare Spending per Beneficiary (MSPB),<br><br>Removes total per capita cost measures for the four condition-specific groups.<br><br>Proposes up to 41 other episode based measures<br><br>Attribution to group (TIN) or individual (TIN/NPI) |

# Key Changes from Current Program
# -Total Per Capita Cost-

| Value Modifier | Proposed MIPS Resource Use Category |
|---|---|
| Total per capita costs for all attributed beneficiaries (or cases) include payments under both Part A and Part B, but do not include Medicare payments under Part D for drug expenses | Similar to VM.<br><br>Propose minor changes to the definition of primary care services used for the 2-step attribution process. |

# Key Changes from Current Program
# -Attribution for Total Per Capita-

| Value Modifier | Proposed MIPS Resource Use Category |
|---|---|
| Two-step attribution process for the claims-based measures. | Expansion of primary care services inclusion to align with Medicare Shared Savings Program as follows:<br><br>Inclusion of the new care coordination codes for chronic care management (CCM) and<br>transitional care management (TCM)<br><br>Exclusion of nursing visits that occur in a skilled nursing facility. |

# Key Changes from Current Program (MSPB)

| Value Modifier | Proposed MIPS Resource Use Category |
| --- | --- |
| • MSBP measures care around a hospitalization<br>• Measure is adjusted for inpatient DRG and other factors. A separate adjustment is also applied based on specialty composition of the group practice<br>• Minimum 125 cases to be reliably measured | • Measure for individual cases is still the same<br>• Two technical adjustments for MIPS<br>  • Modified the way individual cases are aggregated for a single score<br>  • Removed specialty adjustment<br>• Two adjustments make MSPB more at the smaller case volume.<br>• Proposed to reduce the number of cases to 20 |

# Key Changes from Current Program (Clinical Episode Groups)

| Value Modifier | Proposed MIPS Resource Use Category |
| --- | --- |
| No episodes used for payment | • 41 episodes proposed representing a large portion of Medicare charges. Examples include:<br><br>Examples on Next Slide<br><br>(See tables 4 and 5 in the proposed rule for full list) |

# Key Changes from Current Program (Proposed Clinical Episode Groups)

| | |
|---|---|
| • Heart Failure, Chronic (represents 4.6% of Medicare spend)<br>• Ischemic Heart Disease (IHD), Chronic (4%)<br>• Asthma/Chronic Obstructive Pulmonary Disease (COPD), Chronic (4%)<br>• Atrial Fibrillation (AFib)/Flutter, Chronic (3.1%)<br>• Heart Failure, Acute Exacerbation (2.1%)<br>• Hip/Femur Fracture or Dislocation Treatment, Inpatient (IP)-Based (2.1%) | • Knee Arthroplasty (Replacement) (1.9%)<br>• Spinal Fusion (1.7%)<br>• Pneumonia, Community Acquired, Inpatient (IP)-Based (1.5%)<br>• Acute Myocardial Infarction (AMI) without PCI/CABG (1.4%)<br>• Percutaneous Cardiovascular Intervention (PCI) (1.4%)<br>• Ischemic Stroke (1.4%)<br>• Knee Arthroplasty (Replacement) (1.4%)<br><br>***(See Tables 4 and 5 in the Resource Use Performance Category Proposed Rule for Full List)*** |

# Individual vs. Group Attribution

| Assessed in Other MIPS Performance Categories as: | Resource Use Attribution | Rationale |
|---|---|---|
| Individual Eligible Clinician | TIN/NPI<br>(rather than TIN) | Measured based on cases specific to their practice, rather than all the cases attributed to the group TIN |
| Group | TIN<br>(group TIN under which they report) | Attribution matches assessment level for other MIPS categories |

# Scoring:
# Resource Use Performance Category
# Dr Joy Smith

**Each measure is converted to points (1-10)**

**+**

**Minimum Case Volume**

**(20 including for MSPB)**

**=**

**Total Points**

22.3 points

4 measures with minimum case volume

22.3 points

**Total Points**

**÷**

**Total Possible points**

**=**

**Resource Use Performance Category Score**

22.3 points

40 possible points

55.8%

# Scoring Example:
# Dr. Joy Smith Submitted the following:

| [A] RU | [B] Type of Measure | Number of Cases | Performance | [D] Measure Perf. Threshold | [E] Points Based on Decile | [H] Total Possible Points (10 points x [F]) |
|---|---|---|---|---|---|---|
| M1 | MSPB | 20 | 15,000 | 13,000 | 4.0 | 10 |
| M2 | Total Per Capita | 21 | 12,000 | 10,000 | 4.2 | 10 |
| M3 | Episode 1 | 22 | 15,000 | 18,000 | 5.8 | 10 |
| M4 | Episode 2 | 10 | 11,000 | 9,000 | Below Case Threshold | N/A |
| M5 | Episode 3 | 0 | N/A | N/A | No Attributed Cases | N/A |
| M36 | Episode 4 | 45 | 7,000 | 10,000 | 8.3 | 10 |
| TOTAL | | | | | 22.3 | 40 |

Resource use performance category score = (22.3/40) or 55.8%

# ADDITIONAL INFORMATION

# 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.

# 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

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