Medicare Access and CHIP Reauthorization Act Proposed Rule Summary (MIPS)

Devin Detwiler

Telligen

Devin.Detwiler@area-d.hcqis.org

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Telligen

2016

Meaningful Use

10 objectives

Full year of data/new participants is any continuous 90-day period

(4% penalty for NOT reporting)

PQRS

9 measures across 3 domains with 1 cross over measure

Full year of data OR Diagnostic Measure Group on 20 Patients

(2% penalty for NOT reporting)

(2% penalty for no data to compute VBPM)

Merit Based Incentive Payment System

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

- FIRST year of Medicare Part B participation
- Below the low patient volume threshold

  Medicare billing charges less than or equal to $10,000 AND provides care for 100 or fewer Medicare patients in one year
- Certain participants in ADVANCED Alternative Payment Models

NOT be subject to MIPS:

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

Most clinicians will be subject to MIPS.

- Clinicians not in an APM
- Clinicians In a non-advanced APM
- Clinicians may be in advanced APMs but not have enough payments or patients through the advanced APM to qualify

2017 Who is an Eligible Clinician?

- Physicians (MD/DO and DMD/DDS)
- **PAs**
- NPs
- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists

Clinicians can choose to be rated on either an individual-clinician basis or as a group of clinicians

2019 Who is an Eligible Clinician?

- Physicians (MD/DO and DMD/DDS), PAs, NPs, Clinical nurse specialists, Certified registered nurse anesthetists
- Physical or occupational therapists
- Speech-language pathologists
- Audiologists
- Nurse midwives
- Clinical social workers
- Clinical psychologists
- Dietitians / Nutritional professionals

How much can MIPS adjust payments?

Program	Performance Year	Medicare Part B Payment Adjustment Year	Maximum -% Medicare Part B Payment Adjustment	Maximum +% Medicare Part B Payment Adjustment
PQRS/VBM	2016	2018	-4% penalty	+4*X incentive
MIPS	2017	2019	-4% penalty	+4*X incentive
MIPS	2018	2020	-5% penalty	+5*X incentive
MIPS	2019	2021	-7% penalty	+7*X incentive
MIPS	2020	2022	-9% penalty	+9*X incentive

2017 Merit-Based Incentive Payment System (MIPS) A new Medicare Part B payment program for Eligible Clinicians

- Quality Performance – 50% of score in the first year
  (replaces PQRS and VBPM)
- Resource Use – 10% of score in the first year
  Will compare resources used to treat similar care episodes and clinical condition groups across practices (QRUR report)
- CPIA - Clinical Practice Improvement Activities – 15% of score in the first year
- Advancing Care Information – 25% of score in the first year
  (Replaces Meaningful Use)

2017 MIPS Performance Categories, Points, Score

Summary of MIPS Performance Categories Performance Category	Maximum Possible Points per Performance Category	Percentage of Overall MIPS Score 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.	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

2017 MIPS Performance Categories, Points, Score

Summary of MIPS Performance Categories Performance Category	Maximum Possible Points per Performance Category	Percentage of Overall MIPS Score 2017
Clinical Practice Improvement Activities: Clinicians can choose the activities best suited for their practice; the rule proposes over 90 activities from which to choose.	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

MIPS – QUALITY PERFORMANCE 50%

- Report on six rather than nine measures
- Must report on one cross-cutting measure and one outcome measure

  If an outcome measure is not available, a physician may select a "high priority" measure (e.g., appropriate use, patient safety, efficiency, patient experience or care coordination measures)
- ECs can select individual measures or specialty specific measure sets
- Report through claims, electronic health record (EHR), registry, QCDR, or group practice reporting web-interface.

MIPS - QUALITY PERFORMANCE

- If eligible, a physician could earn one bonus point per each reported measure reported through an electronic source with a cap (up to a maximum of five percent of the denominator of the quality performance category score)
  - EHR, qualified registry, QCDR or web-interface

- In addition to the six PQRS measures, CMS calculates either two (for individual clinicians and groups with less than 10 clinicians) or three (for groups with 10+ clinicians) population (claims-based) quality measures

MIPS - QUALITY PERFORMANCE

As an example, if all eight measures earned seven points each, then the total points would be 8 x 7 = 56 out of a possible 80 points, or a 56/80 = 70%. As the Quality category for the CY2017 performance year has a weight of 50%, then a quality score of 70% would result in the Quality category contributing 70% x 50% x 100 = 35 points to the clinician's overall CPS.

MIPS - QUALITY PERFORMANCE

- Two bonus points for reporting each extra outcome measure beyond the one required
- Two bonus points for reporting the patient experience measure (CAHPS for MIPS survey counts as one patient experience measure)
- One bonus point for reporting each extra high priority measure

4 max bonus points can be applied

MIPS – RESOURCE USE 10%

- CMS calculates based on claims so there are no reporting requirements for clinicians
- Adding 40+ episode specific measures to address specialty concerns
- CMS plans on making refinements to its attribution methodology starting in 2018, which will impact the 2019 payment adjustment.

MIPS – RESOURCE USE

- QRUR- Quality and Resource Use Reports
  - Available for full year of 2014
  - Available for 6 mos. of 2015
  - Full year 2015 available this fall

- Can be risk-adjusted to reflect external factors
  - (i.e. high risk populations)

MIPS – RESOURCE USE

- For instance, say a clinician earns six and eight points respectively on two included cost measures. Then the category contributes (6+8)/20 x 10% x 100 = 7 CPS points.

MIPS –Clinical Practice Improvement Activities 15%

- To not receive a zero score, a minimum selection of one CPIA activity with additional credit for more activities
- Full credit for accredited patient-centered medical home
- Minimum of half credit for APM participation

MIPS –Clinical Practice Improvement Activities

See handout of current proposed list

If a clinician is in certain medical home models, the clinician automatically earns the full 60 points

MIPS –Clinical Practice Improvement Activities

- Examples Expanded Access
  - Evening, weekend, 24/7 urgent/ER Care
  - Collection of patient experience and satisfaction data regarding access
  - Work with QIN/QIO to expand DSME
- Examples Population Health
  - Systematic anticoagulation program with patients self management education and reporting
  - Use of a Qualified Clinical Data Registry to generate regular feedback reports
  - Empanelment of total population

MIPS –Clinical Practice Improvement Activities

- Examples Care Coordination
  - Close the referral loop by providing reports to referring provider
  - Timely identification and communication of abnormal test results with timely follow up
  - Participation in TCPI
- Examples Beneficiary Engagement
  - Improve patient input - home monitoring, patient reported data
  - Work with your QIO/QIN to offer DSME
  - Maximizing patient portal for bi-directional exchanges
  - Use of shared decision making tools and resources
  - Use of the PAM tool/How's My Health

MIPS –Clinical Practice Improvement Activities

- Other categories are
  - Patient Safety
  - Health Equity
  - Emergency Response and Preparedness
  - Integrated Behavioral and Mental Health (SIM)

MIPS –Clinical Practice Improvement Activities

- Medium-weight activities (worth 10 points each)
- High-weight activities (worth 20 points)

If a clinician is non-patient-facing, a small practice with 15 or fewer professionals, a practice in a rural area, or a practice in a geographic Health Professional Shortage Area (HPSA), then all activities are worth 30 points each

MIPS –Clinical Practice Improvement Activities

- The CPIA percentage score is calculated by dividing the total CPIA points by 60. For example, 40 points would yield a 40/60 = 67.7% CPIA performance score, which in turn would deliver 67.7% x (15% CPIA category weighting) x 100 = 10 CPS points.

MIPS – Advancing Care Information 25%

- % weight of this may decrease as more users adopt EHRs
- To receive the base score, physicians must simply provide the numerator/denominator or yes/no for each objective and measure
  - Protect Patient Information
  - Electronic Prescribing
  - Patient Electronic Access
  - Coordination of Care/Patient Engagement
  - Health Information Exchange
  - Public Health/Clinical Data Registry

MIPS – Advancing Care Information

- **Bonus Point:** Up to 1 bonus point for reporting to an additional public health registry

MIPS - Composite Performance Score

Unified scoring system:

- Converts measures/activities to points
- Eligible Clinicians will know in advance what they need to do to achieve top performance
- Partial credit available
- Permits physicians to submit data for the first time through QCDRs.

MIPS - Composite Performance Score

- 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

MIPS - Composite Performance Score

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 50 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 Each measure compared to historical benchmark (if avail.)

Questions?

MIPS Data Submission Options
Quality

- QCDR
- Qualified Registry
- EHR
- Administrative Claims (No submission required)
- CMS Web Interface(groups of 25 or more)
- CAHPS for MIPS Survey

(Just like PQRS)

MIPS Data Submission Options
Advancing Care Information and CPIA

- Attestation
- QCDR
- Qualified Registry
- EHR
- CMS Web Interface(groups of 25 or more)

MIPS: Payment Adjustment

- A CPS less than or equal to 25% of the threshold will yield the maximum negative adjustment of -4%.
- 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

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

MIPS: Payment Adjustment

- Exceptional performers receive additional positive adjustment factor –up to $500M available each year from 2019 to 2024
- 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 quartile of possible values above the CPS performance threshold

Questions?

What is an Alternative Payment Model (APM)?

- CMS Innovation Center model (undersection 1115A, other than a Health Care Innovation Award)
- MSSP(Medicare Shared Savings Program)
- Demonstration under the Health Care Quality Demonstration Program

Advanced APMs Criteria

- Financial Risk Standard

  APM Entities must bear risk for monetary losses.

- Nominal Amount Standard

  The risk APM Entities bear must be of a certain magnitude.

Advanced APMs Criteria

- The APM requires participants to use certified EHR technology.
- The APM bases payment on quality measures comparable to those in the MIPS quality performance category.
- The APM requires APM Entities to bear more than nominal financial risk for monetary losses;

OR

- Is a Medical Home Model expanded under CMMI authority

Medical Home Models

- Have a unique financial risk criterion for becoming an Advanced APM

OR

- Enable participants (who are not excluded from MIPS) to receive the maximum score in the MIPS CPIA category

Medical Home Models

- Medical Home Model is an APM that has the following features:

  Participants include primary care practices or multispecialty practices that include primary care physicians and practitioners and offer primary care services

- 100% Empanelment of each patient to a primary clinician

AND

Medical Home Models

At least four of the following:

- Planned coordination of chronic and preventive care.
- Patient access and continuity of care.
- Risk-stratified care management.
- Coordination of care across neighborhood.
- Patient and caregiver engagement.
- Shared decision-making.
- Payment arrangements in addition to, or substituting for, fee-for-service payments.

Advanced APMs

- Medicare Shared Savings Program (Tracks 2 and 3)
- Next Generation ACO Model
- Comprehensive ESRD Care(CEC) (large dialysis organization arrangement)
- Comprehensive Primary Care Plus (CPC+)
- Oncology Care Model (OCM) (two-sided risk track available in 2018)

How do Eligible Clinicians become QPs?

- CMS will calculate a percentage "Threshold Score" for each Advanced APM Entity using two methods (payment amount and patient count)
- Methods are based on Medicare Part B professional services and beneficiaries attributed to Advanced APM Entities
- CMS will use the method that results in a more favorable QP determination for each Advanced APM Entity

MACRA supports care delivery and promotes innovation

Allocates $20 million / yr. from 2016-2020 to small practices to provide technical assistance regarding MIPS performance criteria or transitioning to an APM

Creates an advisory committee to help promote development of **Physician-Focused Payment Models**

APM Scoring Standard

	Performance Weight	Percentage
Quality	N/A	0
Resource Use	N/A	0
Clinic Practice Improvement Activities - CPIA	APM Entity participant individual scores will be aggregated, weighted and averaged to yield one APM Entity level score	25%
Advancing Care Information	APM Entity participant individual scores will be aggregated, weighted and averaged to yield one APM Entity level score	75%

MIPS – Public Disclosure

- MIPS will publish each eligible clinician's annual Composite Performance Score (CPS) and scores for each MIPS performance category within approximately 12 months after the end of the relevant performance year. For the first time, consumers will be able to see their providers rated on a scale of 0 to 100 and how their providers compare to peers nationally.
- Physician Compare will also continue to publish cost utilization data for all Medicare Part B clinicians

RESOURCES

TCPI

https://redcap.ucdenver.edu/surveys/?s=KNXXTJ98ET

SIM

https://www.colorado.gov/healthinnovation

ENSW

http://www.practiceinnovationco.org/ensw/

Thank you for your time!

Devin Detwiler

303-875-9131

Devin.Detwiler@area-d.hcqis.org

This material was prepared by Telligen, the Medicare Quality Innovation Network Quality Improvement Organization, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 11SOW-CO-B4 and D1-6/2016-11669

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Telligen