On Your MACRA, Get Set, Go! Taking on the Quality Payment Program and MIPS

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The only constant in life is change.

Why Healthcare Reform?

- Decrease Costs
- Increase Quality

“Move from sick care to health care”
What is the Quality Payment Program?
What is Merit-Based Incentive Payment Systems (MIPS)?
Who does MIPS apply to and when?
What are the implications of reimbursement through participating in MIPS?
How do other Pay for Performance programs like MU come into play?
Are there alternatives to MIPS?
What can you do now?

**Quality Payment Program**

- Created by the "Doc Fix" legislation passed 4/15/15, Repealed Sustainable Growth Rate Model
- "Final" Rule – 10/14/2016
  - Effective 1/1/2017
- Contains two reimbursement pathways
  - Alternative Payment Models (APM)
  - MIPS
- Demonstrates shift towards value-based reimbursement, away from fee-for-service
- More information: qpp.cms.gov

Bipartisan! 92 Senators and 392 Representatives voted for MACRA.
MACRA is here to stay.
WHAT IS MIPS?

MIPS = Merit-based Incentive Payment Systems
- One part of the Quality Payment Program (QPP)
- Demonstrates shift towards value-based reimbursement, away from fee-for-service
- Composite score of quality and cost data

WHAT IS MIPS?

MIPS = Consolidation of previous Pay-for-Performance Programs
- Not exactly a stimulus program
  - Reduced payments for non-performance
  - Enhanced payments for exemplary performance

WHAT IS MIPS?

<table>
<thead>
<tr>
<th>Quality</th>
<th>New Category</th>
<th>Meaningful Use</th>
<th>Value-Based Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Replaces PQRS</td>
<td></td>
<td>Replaces</td>
<td></td>
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</tbody>
</table>
• MIPS or Alternative Payment Model
  • Example: ACO
  • All providers should report MIPS for 2017
  • “Eligible Provider” → “Eligible Clinician”
  • Medicare Part B
  • Include MD, DO, PA, NP, CRNA, and Clinical Nurse Specialist
  • 2019+: PT, OT, SLP, Audiologists, Nurse Midwives, Clinical Social Workers, Clinical Psychologists, and Dietitians
• Exemptions:
  • Newly enrolled
  • Less than or equal to $30,000 in Medicare charges, 100 Medicare patients

WHO DOES MIPS APPLY TO?
• Do you accept Medicare?
• Do you accept Commercial Insurance?

“When CMS institutes, Commercial Payers follow suit”
• Humana $93 million
• Aetna and Banner partnership = $9.9 million savings
• Anthem rewarding PCMH status
• United Healthcare “Premium”
MIPS PERFORMANCE SCORE

<table>
<thead>
<tr>
<th></th>
<th>Quality</th>
<th>Improvement</th>
<th>ACT</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>60%</td>
<td>15%</td>
<td>25%</td>
<td>0%</td>
</tr>
<tr>
<td>2018</td>
<td>50%</td>
<td>15%</td>
<td>25%</td>
<td>10%</td>
</tr>
<tr>
<td>2019+</td>
<td>30%</td>
<td>15%</td>
<td>25%</td>
<td>30%</td>
</tr>
</tbody>
</table>

MIPS makes up your Provider Report Card
Providers paid based on score

WHAT MAKES UP MIPS?
- Score published and accessible to patients
- Insurance websites
- Transparency
QUALITY REPRESENTATION

MIPS SUBMISSION

Financial Impact
- Budget Neutral
- +/- 4% to 9%

But, additional funds...
- Five Years - $500 million for exceptional performance
- Incentive: No higher than an additional 10%

Remember, “when CMS institutes…”
Advanced Alternative Payment Models (APMs)

- Next Generation ACO Model
- Medicare Shared Savings – Track 2 or 3
- Comprehensive Primary Care Plus (CPC+)
- New models could be added annually
- Exempt from MIPS payment adjustments if qualify
- Qualify for a 5% Medicare Part B incentive
- Possibility of additional incentives in future years

Fine print: All clinicians report MIPS in first year

Andy Slavitt – September 8th, 2016

2017 “Pick Your Pace” Options
- Test the Quality Payment Program
  - As long as you submit some data, avoid penalty in 2019
  - Participate for part of 2017
  - Could qualify for small positive payment adjustment
- Participate for “all” of 2017
  - “Modest” positive payment adjustment
  - Participate in an APM
  - If enough data, 5% positive adjustment
- CMS will provide resources to help practices
- Still collect MIPS data

Data collection can begin: 1/1/2017-10/2/2017

Formerly Meaningful Use
- 2017 and beyond = 25% of Composite Score
- Scored out of 100 points
- Base Score – up to 50 points – all five required
  - Protect Patient Health Information
  - eRX
  - Provide Patient Access
  - Send Summary of Care
  - Request / Accept Summary of Care

2017
- Base Score – up to 50 points – all five required
  - Protect Patient Health Information
  - eRX
  - Provide Patient Access
  - Send Summary of Care
  - Request / Accept Summary of Care

Data collection can begin: 1/1/2017-10/2/2017
• Performance Score – up to 90 points
  • Choose measures from within these categories:
    • Patient Electronic Access
    • Coordination of Care through Patient Engagement
    • Health Information Exchange
  • Bonus Score – up to 15 points
  • Beyond Immunization requirement
  • Aligning with CPIA
  • Certified EHR required

ACI Score = Base + Performance + Bonus

For Base, one patient in numerator, receive 10 points for measure
• 50 Base + 90 Performance + 15 Bonus = 155 points
• Maximum points possible of 100
• 25% total weight against Composite Score

QUALITY

• 2017 = 60%; 2018 = 50%; 2019+ = 30% of Composite
• Replaces PQRS and VBM Quality portion
  • PQRS – Report 9 measures
  • Quality – Report 6 measures (200+ to pick from)
    • Each 10 points
  • Population
    • 16+ clinicians – one population health measure
  • Total points – 60-70 based on size
  • 2017: Report up to 6 quality measures,
    • including an outcome measure
Single measure scoring metric example:

<table>
<thead>
<tr>
<th>Decile</th>
<th>Lowest Quality Measure Benchmarks</th>
<th>Possible Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decile</td>
<td>1</td>
<td>0.0 - 6.9</td>
</tr>
<tr>
<td>Decile</td>
<td>2</td>
<td>7.0 - 15.9</td>
</tr>
<tr>
<td>Decile</td>
<td>3</td>
<td>16.0 - 22.9</td>
</tr>
<tr>
<td>Decile</td>
<td>4</td>
<td>23.0 - 29.9</td>
</tr>
<tr>
<td>Decile</td>
<td>5</td>
<td>30.0 - 40.0</td>
</tr>
<tr>
<td>Decile</td>
<td>6</td>
<td>41.0 - 50.0</td>
</tr>
<tr>
<td>Decile</td>
<td>7</td>
<td>51.0 - 60.0</td>
</tr>
<tr>
<td>Decile</td>
<td>8</td>
<td>61.0 - 70.0</td>
</tr>
<tr>
<td>Decile</td>
<td>9</td>
<td>71.0 - 80.0</td>
</tr>
<tr>
<td>Decile</td>
<td>10</td>
<td>81.0 - 100.0</td>
</tr>
</tbody>
</table>

For more information on specific measures, visit qpp.cms.gov, download 2017 Quality Benchmarks.
• 2017: Report 4 improvement activities
• Measures within the following categories
  • Expanded Patient Access
  • Population Management
  • Care Coordination
  • Beneficiary Engagement
  • Patient Safety and Practice Assessment
  • Achieving Health Equity
  • Emergency Preparedness and Response
  • Integrated Behavioral and Mental Health
• Maximum score: 20-40 points
• Weighting of activities different – 10 to 20 points

WHAT IS CPIA?

<table>
<thead>
<tr>
<th>2017 Action</th>
<th>2017 Payment Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report nothing</td>
<td>-4% payment adjustment</td>
</tr>
<tr>
<td>Submit one quality measure</td>
<td>No payment adjustment</td>
</tr>
<tr>
<td>Submit one CPA</td>
<td>No payment adjustment</td>
</tr>
<tr>
<td>Submit Required ACI measures for 90 days</td>
<td>No payment adjustment</td>
</tr>
<tr>
<td>Report on data for 90+ days</td>
<td>Small + payment adjustment</td>
</tr>
<tr>
<td>Report on data for all of 2017</td>
<td>+4% payment adjustment</td>
</tr>
</tbody>
</table>

• 2017 Threshold = 3 points / 100
• “Full Year” participation
• Positive adjustments based on performance data submitted, not the amount of information or length of time
• 70+ points – “Exceptional Performers”
• Gain access to $500 million additional
Example Composite Score: 65.8 out of 100

**2017 FINAL SCORE CALCULATION EXAMPLE**

- **Quality**
  - (42 of 60 points) x 60% weight x 100 = 42 points
- **ACI**
  - (50 of 100 points) x 25% weight x 100 = 12.5 points
- **CPIA**
  - (30 of 40 points) x 15% weight x 100 = 11.3 points (rounded up from 11.25)
- **Resource Use / Cost**
  - (14 of 20 points) x 0% weight x 100 = 0 CPS points

**Total CPS points = 42 + 12.5 + 11.3 + 0 = 65.8 / 100**

**HOW CAN YOU MAXIMIZE YOUR SCORE?**

**Individual**
- Payment adjustment based on individual NPI number performance (tied to single tax ID)
- Submit through:
  - EHR
  - Registry
  - Qualified Clinical Data Registry
  - Medicare Claims

**Group**
- One payment adjustment per a group of clinicians based on group performance (tied to single tax ID)
- Submit through:
  - EHR
  - Registry
  - QCDR
  - CMS Web Interface
  - Registration by 6/30/17

**REPORTING**

**Reporting Differences**
Shift towards Value-Based Reimbursement is happening right now!

- Transparency!
- Details published, but additional details to follow

"CMS institutes & commercial payers follow suit"

WHAT ARE THE IMPLICATIONS?

1) Understand Financial Implications to the Practice
   - Estimate your MIPS score using current data
2) Talk with your Eligible Clinicians & Decision-makers
   - Help them understand the program
   - Decide on individual or group reporting
3) Obtain QRUR (Quality Resource and Use) Report
   - Accessed through CMS Enterprise Portal
4) Participate!
   - Prior participation in programs like MU should allow ease into QPP
5) Stay in the Loop and Prepare for More Change!
   - Additional rules to come

STEPS TO PREPARE

The only constant in life is change.