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MIPS Update: What You Need to Know for 2019 and Beyond

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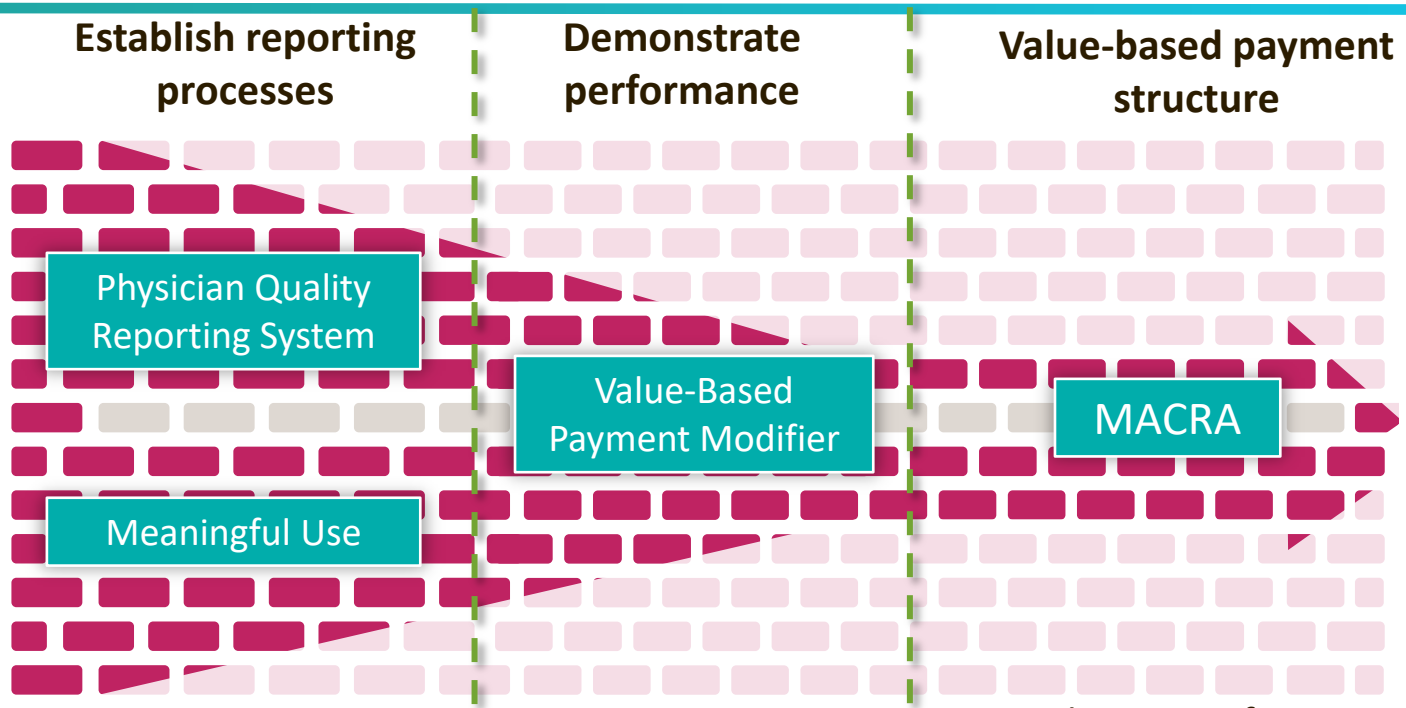
Disclosures

No financial conflicts of interest.

Learning Objectives

- Analyze policy changes between 2018 and 2019 and the potential impact for individual and group practices
- Describe each performance category's reporting requirements for successful participation
- Summarize how MIPS prepares you to transition to value-based reimbursement – what practices need to do now and in the future

The Road To Pay For Performance



- Can you effectively report on quality measures?
- Did you adopt certified EHR?

- Does your practice perform well on cost and quality compared to peers?

- How do you perform as part of a team-based approach to population health?
- How are you using your EHR to improve patient outcomes?

The HHS Payment Taxonomy Framework

Only Category 4 Changes Utilization

Table 1. Department of Health and Human Services Payment Taxonomy Framework

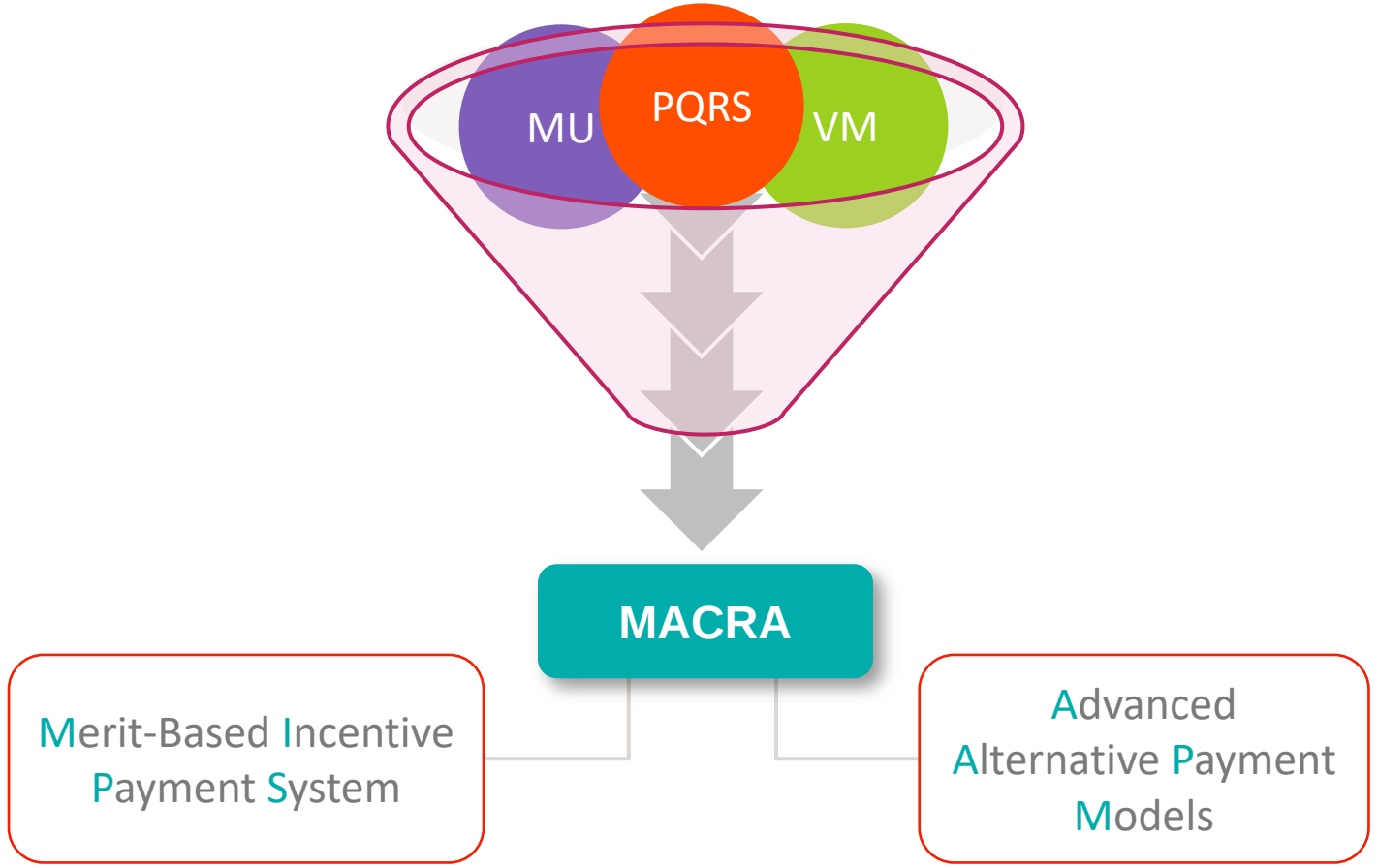
Characteristic	Category 1: FFS Without Links to Quality	Category 2: FFS With Links to Quality	Category 3: APMs Built on FFS Architecture	Category 4: Population and Personal Payments
Description	Service-based reimbursement	A portion of reimbursement tied to quality and efficiency outcomes	Payments remain tied to individual service volume; increased accountability for quality and efficiency; incentives for population health management	Reimbursement based on attributed patient population over a defined period; accountability for cost and quality
Examples	FFS	PQRS; value-based payment modifier; hospital readmissions penalty; MIPS	Medicare Shared Savings ACOs (tracks 1, 2[a], and 3[a])[b]; BPCI, CCJR bundled payments; AMI EPM[a]; medical homes; Next Generation ACO[a,b]; Comprehensive Primary Care Plus[a]	Pioneer ACO (years 3-5)[b]

Abbreviations: ACOs, accountable care organizations; AMI EPM, Acute Myocardial Infarction Episode Payment Model; APMs, alternative payment models; BPCI, Bundled Payments for Care Improvement; CCJR, Comprehensive Care for Joint Replacement; FFS, fee-for-service; MIPS, Merit-Based Incentive Payment System; PQRS, Physician Quality Reporting System.

[a] These models qualify for the APM pathway in the Medicare Access and Children's Health Insurance Program Reauthorization Act proposed rule.

[b] Multiple variations of ACOs exist, allowing each to establish a leadership and administrative infrastructure and to include gainsharing only or may have downside risk.

MACRA's Quality Payment Program Establishes Two Avenues For Clinicians



MU = meaningful use; PQRS = Physician Quality Reporting System; VM = Value-Based Payment Modifier. **Sources:** CMS. Medicare Programs: CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for Transition Year (PDF). November 11, 2017; Sg2 Analysis, 2017.

Use MIPS To Develop 4 Core Competencies Of Value-based Care Delivery

#1: Achieve quality and implement processes to drive improvement

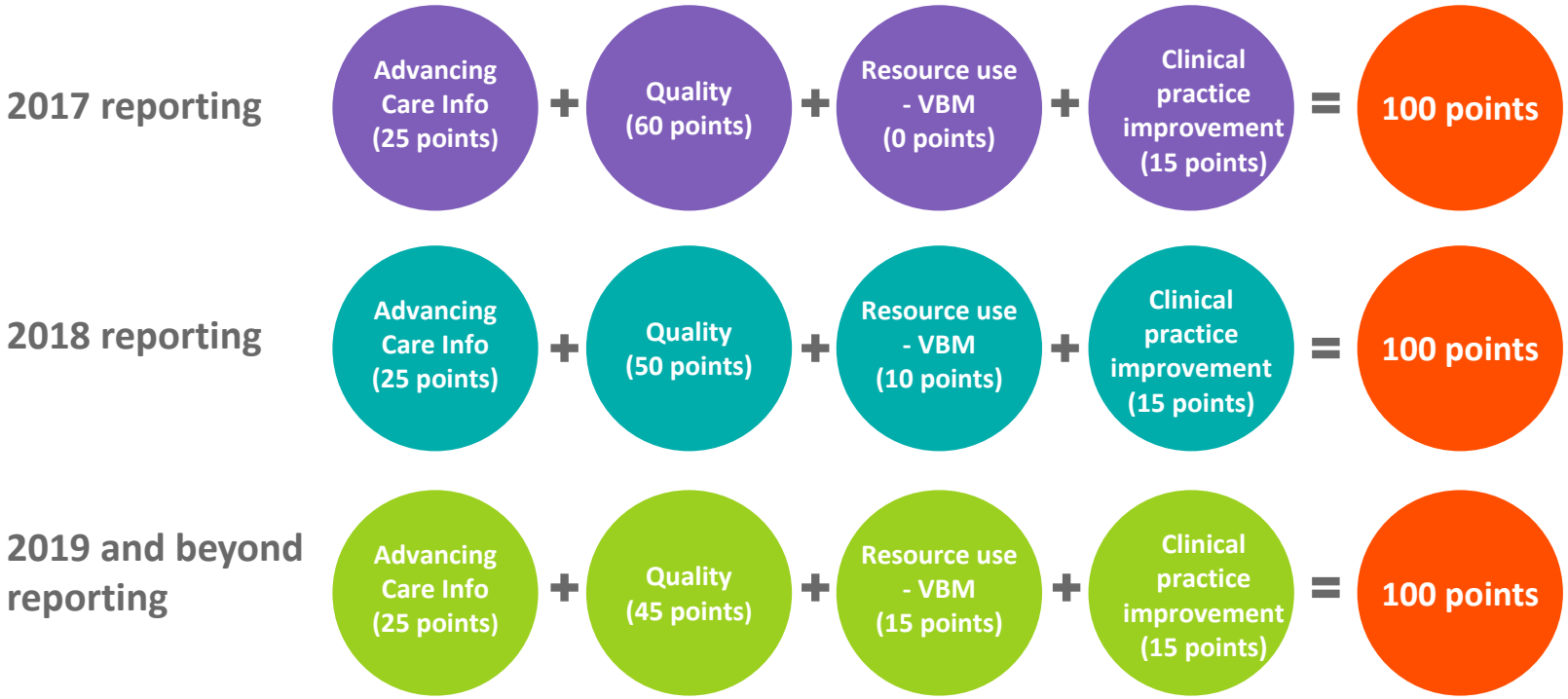
#2: Effectively manage resources while delivering high-value care to patients

#3: Leverage technology investments to enhance patient engagement and safety

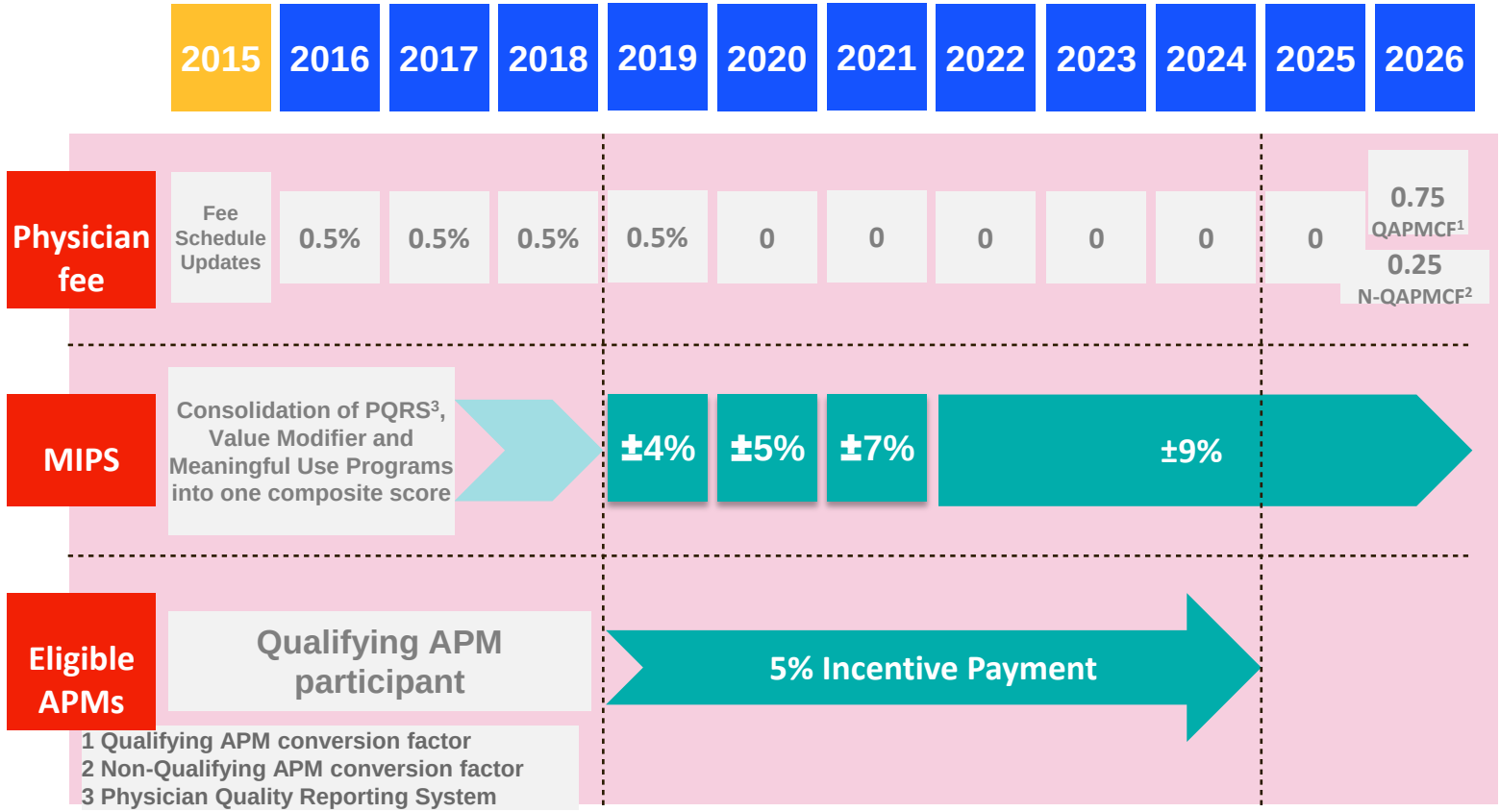
#4: Establish culture of care coordination and commitment to continuous improvement

MIPS Category Weights

A single MIPS composite performance score factors into overall performance in 4 weighted categories

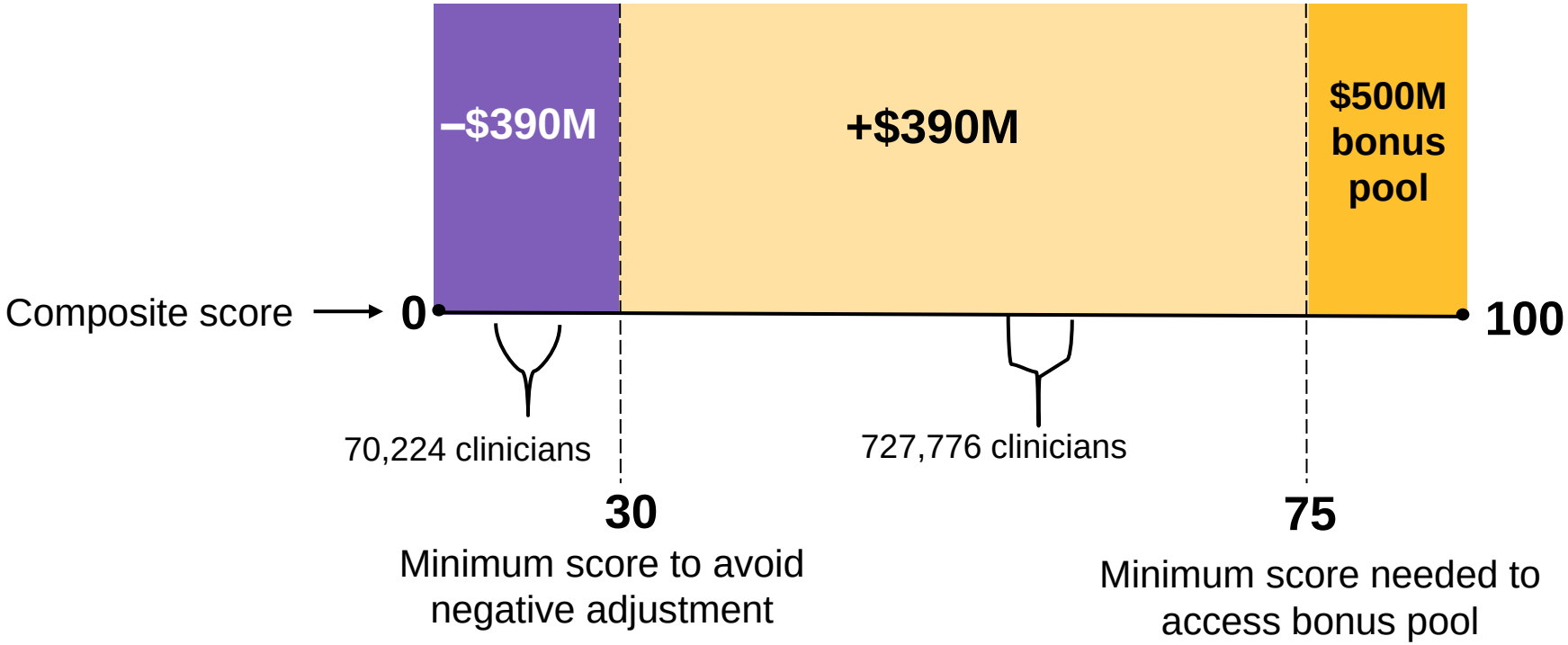


Macranomics: Payment Year Timeline



Estimated 2019 Performance Year Payment Distribution

- Payments designed to be **budget neutral**
- MIPS is a zero-sum game



Estimated number of MIPS participants will increase 148K to 798K

MIPS Reporting Options

Category	Individual	Group
Quality	• Claims • Qualified Registry, QCDR • EHR	• Web Interface >25 • Qualified Registry, QCDR • EHR • CAHPS Survey for MIPS
Improvement Activity (IA)	• Attestation • Qualified registry, QCDR • EHR	• Attestation • Qualified registry, QCDR • EHR • Web Interface ≥ 25
Promoting Interoperability (Now PI, formerly ACI)	• Attestation • Qualified registry, QCDR • EHR	• Attestation • Qualified registry, QCDR • EHR • Web Interface ≥ 25
Cost	• Administrative claims	• Administrative claims

Quality Category Reporting Options

- Claims – Individuals only
- Qualified Registry – 6 Measures or Specialty Measure Set
- QCDR – Choose 6 from Available QCDR Measures
- CMS Web Interface – 25+ ECs, 15 Quality measures *
- CEHRT – Choose 6 of 54 eCQMs
- One measure must be outcome measure or a high priority measure if outcome not available

Quality Related Bonus Points

Measures	Bonus Points	Maximum
Additional Outcome or Patient Experience Measure	2 points each	6 point max
Additional High Priority Measure	1 point each	
eCQM Submission using CEHRT	1 point each	6 point max
Improvement		Up to 10 percentage points

Health It For Practice Transformation

- Near-real time quality measurement and improvement
  - Outcome measures – clinical and financial
  - Process measures linked to clinical decision support
- Population health management
  - Empanelment – internal and external
  - Risk stratification – clinical, socio-economic and demographic
  - Risk management – Identify and close gaps in care
    - Preventive care
    - Rising risk intervention
    - Hospital care – admissions and readmissions
    - Referral leakage
    - Care coordination and patient engagement

MACRA 2017 Compared To 2018 (Final)

	2017	2018
Low-Volume Threshold	≤$30,000 Part B allowed charges OR ≤100 Part B beneficiaries	≤$90,000 Part B allowed charges OR ≤200 Part B beneficiaries
MIPS Payment Adjustment	+/- 4x%	+/- 5x%
Minimum Score to Avoid Penalty	3 points (out of 100)	15 points (out of 100)
Pillar Weights	Quality – 60% Improvement Activities – 15% Advancing Care Information – 25% Cost – 0%	Quality – 50% Improvement Activities – 15% Advancing Care Information – 25% Cost – 10%
Data Completeness Criteria	90 days for Quality, IA and ACI*; 50% of all eligible patients reported	365 days for Cost and Quality, 90 days for IA, ACI*; 60% of all eligible patients reported
Complex Patient Bonus	No	Yes – up to 5 points as measured by HCC risk score and number of dual eligible.
Small Practice Bonus	No	Yes – up to 5 points for groups ≤15
Virtual Groups	No	Yes, solo practitioners and groups ≤10 can form virtual groups; sign-up by 12/31/17
Facility-based Measurement Option for Cost and Quality	No	No, but CMS has stated their intent to include this in the 2019 performance rules.

Notes: *Except when reported through CMS Web Interface, CAHPS, and the readmission measures are for 12 months. Hospital-based clinicians exempt from ACI reporting for 2018. Sources: CMS. Fed Regist. 2017;82:30010–30500; CMS. Final Rule With Comment Period: Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models (PDF). October 14, 2016 Sg2 Analysis, 2017.

MACRA 2018 Compared To 2019 (Proposed)

	2018	2019
Low-Volume Threshold	≤$90,000 Part B allowed charges OR ≤200 Part B beneficiaries	≤$90,000 Part B allowed charges OR ≤200 Part B beneficiaries OR ≤200 Covered Professional Services
MIPS Payment Adjustment	+/- 5x% (will include Part B drugs)	+/- 7x% (will include Part B drugs)
Minimum Score to Avoid Penalty	15 points (out of 100)	30 points (out of 100)
Eligible for Exceptional Performance Bonus	≥70 points (out of 100)	≥75 points (out of 100)
Category Weights	**Quality:** 50% **Improvement Activities:** 15% **Advancing Care Information:** 25% **Cost:** 10%	**Quality:** 45% **Improvement Activities:** 15% **Advancing Care Information:** 25% **Cost:** 15%
Data Completeness Criteria	365 days for Cost and Quality, 90 days for IA, ACI*	365 days for Cost and Quality, 90 days for IA, ACI*
Complex Patient Bonus	Yes—up to 5 points as measured by HCC risk score and number of dual eligible.	Yes—up to 5 points as measured by HCC risk score and number of dual eligible.
Small Practice Bonus	Yes—up to 5 points for groups ≥15 if you report one category	Yes—up to 5 points for groups ≥15 if you report one category
Improvement Bonus	Yes—up to 10 points in Quality and 1 for Cost	Yes—up to 10 points in Quality and 1 for Cost

HHS. *Final Rule: Medicare Program; Revisions to Payment Policies Under the Physician Fee schedule and Other Revisions to Part B for CY 2019. Federal Register.* November 23, 2018; Sg2 Analysis, 2018.

Cost Score Changes For 2019

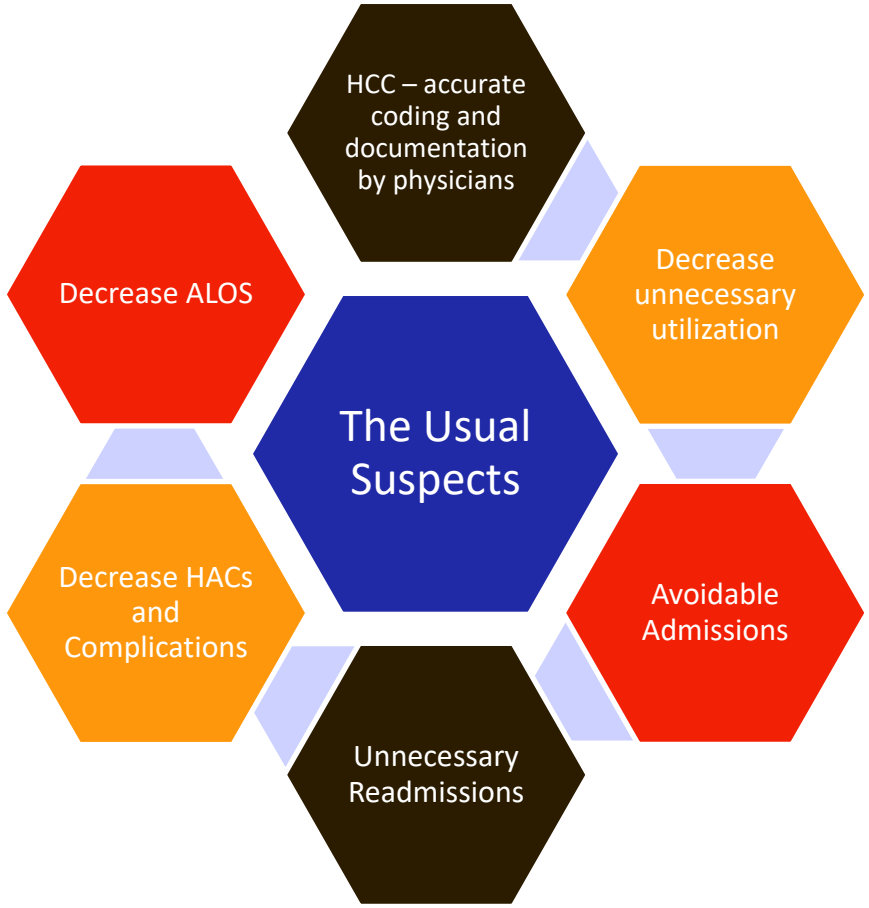
- **Increased to 15% weighting for 2019**
- **Two types of measures Currently:**
  - Total Per Capita Cost (all attributed beneficiaries)
  - Medicare Spend per Beneficiary (MSPB)

Episode-based measures (the third type of measurement)

Elective Outpatient PCI	**Knee Arthroplasty**
Routine Cataract Removal with IOL Implantation	**Screening/Surveillance Colonoscopy**
Intracranial Hemorrhage or Cerebral Infarction	**Simple Pneumonia with Hospitalization**
STEMI with PCI	**Revascularization for Lower Extremity Chronic Critical Limb Ischemia**

Acronyms: PCI = percutaneous coronary intervention; IOL = intraocular lens; STEMI = ST-elevation myocardial infarction
Note: The MACRA 2018 proposed rule indicates the cost category weighting = 0% but is subject to change pending the final rule. CHF = chronic heart failure. Sources: CMS. *Final Rule With Comment Period: Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models*. October 14, 2016; Sg2 Analysis, 2018.

How To Impact The Resource Use Pillar?



Practice Improvement Data
8 Categories, 92 Different Activities

- Achieving Health Equity
- Behavioral and Mental Health
- Beneficiary Engagement
- Care Coordination
- Emergency Preparedness and Response
- Expanded Patient Access
- Patient Safety and Practice Assessment
- Population Management

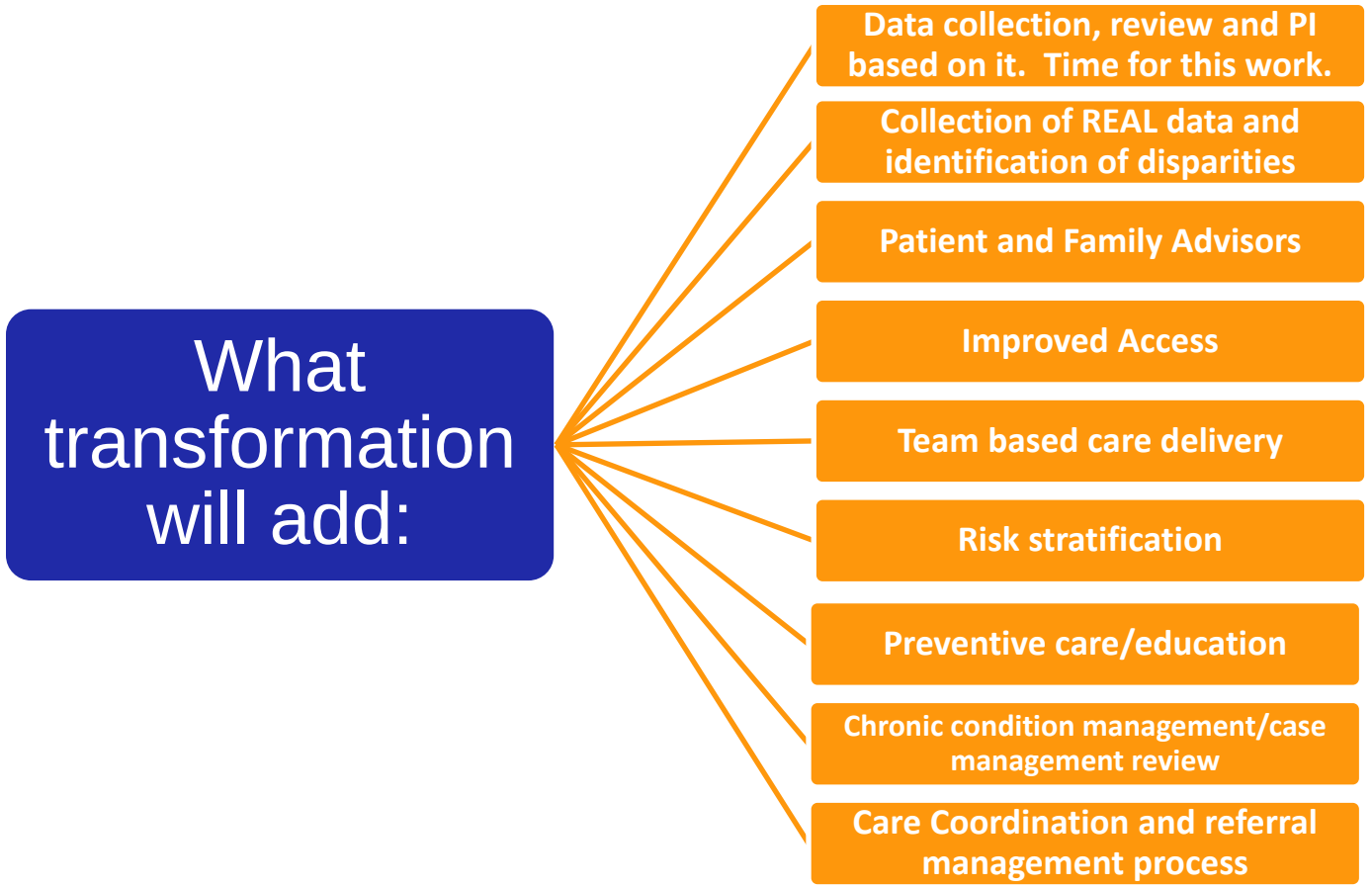
- Participants in certified patient-centered medical homes, comparable specialty practices, or an APM designated as a Medical Home Model: You will automatically earn full credit

Equity In Healthcare

- Healthcare disparities in disease prevalence and care delivery
- REAL data
- Socioeconomic Data (Zip Codes)
- Sexual Orientation and Gender Identity (SOGI) Data

What We Have Learned From TCPI
(Transformation Of Clinical Practice Initiative)

What We Have Learned From TCPI



The Need For Data

Physicians Need Data

- Improving Productivity – requires analysis to identify potential areas of improvement Physicians need access to multiple data sets to make decisions
- Decrease Cost – Decrease the cost of running your practice, decrease the cost of patient care
- Regulatory Changes – Data required to optimize value based reimbursement

The Data Challenge

Challenges include:

- Measuring performance scores, analyzing clinical outcomes, and applying risk stratification algorithms to patients in a given population
- Tracking, aggregating and analyzing clinical and financial data
- Addressing care delivery team challenges (on the ability of care givers to population data to make informed decisions while in the process of seeing patients.)
- Building collaborative processes across the care continuum
- Getting the data in one place

Using Data For Practice Improvement

- Identify opportunities
- Daily measurement and benchmarks
- Visual Management
- Leading Indicators
- Lagging Indicators

Creating The Structure And Processes For Practice Pi

- Who collects, aggregates and analyzes the data
- How is it presented
- When do you meet, with whom and what do you do with the data.
- Using a process improvement methodology like PDSA or LEAN

Strategy Deployment Board – Clinic

Comprehensive Primary Care +

- **CPC+ is a Payment *and* Delivery reform model**
- *Commercial and Public payers partner to:*
- Make similar payment arraignments
- Provide claims data feedback to practices
- Alignment of Quality Measures

CPC+, 5 Comprehensive Primary Care – Ambulatory Functions

- Access and continuity
- Risk-stratified management
- Planned care for chronic conditions and preventive care
- Patient and caregiver engagement
- Comprehensiveness and coordination of care

A Lack Of Structure And Process For These Functions

- Access and continuity – existing panels vs. new patient access
- Risk-stratified care management – using multiple chronic conditions and socioeconomic criteria to stratify the panel. Appropriate assignment within the team for care
- Planned care for chronic conditions and preventive care – utilizing MAs and RNs for education, counseling and referral to CBOs
- Patient and caregiver engagement – many organizations have PFACs on the in patient side but not in the practice or ambulatory side
- Comprehensiveness and coordination of care – major opportunities for most organizations. One organization has one CC for 1200 clinicians
- Provider compensation models – poor alignment between how clinicians are paid and how they are reimbursed or aligned with organizational goals

CPC+ Track 1 & 2 Payment Models

	CPC	CPC+ Track 1	CPC+ Track 2
Size	7 Regions; ≈500 practices	≤20 Regions; ≤2500 practices	≤20 Regions; ≤2500 practices
Duration	4 y (2012-2016)	5 y (2017-2021)	5 y (2017-2021)
Medicare care management fee[a]	$20 PBPM PY1-2; $15 PBPM PY3-4; average across 4 risk tiers	$15 PBPM average across 4 risk tiers	$27 PBPM average across 5 risk tiers; $100 for highest-risk tier
Medicare payment for office visits	100% FFS	100% FFS	100% FFS for non–evaluation and management; reduced FFS + up-front payment for evaluation and management
Medicare incentive payment	Shared savings based on quality metrics and TCOC[b]	$2.50 PBPM based on quality and utilization metrics	$4 PBPM based on quality and utilization metrics
HIT partners	Not required	Not required	Required

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Thank You!

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