Merit-Based Incentive Payment System
November 17, 2015

Today’s presenters:

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Agenda

- Current Health IT Landscape
- Legislative Background
- Timelines
- Merit-Based Incentive Payment System (MIPS)
- MIPS Composite Performance Score
- Alternative Payment Models (APMs)
- Physician-Focused Payment Models (PFPMs)
- CMS Request for Information (RFI)
- Technical Assistance
- How to Prepare for MIPS
- Massachusetts eHealth Institute (MeHI)
- Questions and Answers
Current Health IT Landscape
Current Health IT Landscape

- Complexity of multiple Health IT initiatives and quality reporting programs
  - Meaningful Use (MU) and Medicare/Medicaid EHR Incentive Payment Programs
  - Physician Quality Reporting System (PQRS)
  - Value-Based Modifier (VM) Payment Adjustments
  - ICD-10 and other CMS Administrative Simplification Initiatives

- Implementation of Health IT requires changes to clinical/office workflows

- CMS incentive payments and penalties (consequences of non-compliance)
Legislative Background
Legislative Background

- **Medicare Access and CHIP Reauthorization Act (MACRA)**
  - signed into law April 16, 2015
  - replaces the Sustainable Growth Rate (SGR) with a revised reimbursement model
  - contains several other provisions related to:
    - program integrity
    - fraud and abuse
    - extension of the Children’s Health Insurance Program (CHIP)

- **Bottom line:** MACRA will change how Medicare pays physicians and other health care providers
MACRA replaces the Sustainable Growth Rate (SGR) with a combination of:

- payment adjustments and incentives for providers who participate in pay-for-performance programs and Alternative Payment Models (APMs)

MACRA is designed to improve upon the SGR methodology

- more predictable than SGR, which depended on previous year’s expenditures
- increases number of physicians participating in APMs to encourage quality and efficiency
- physicians in high-quality, efficient practices may benefit financially
- designed to promote quality of care over quantity/volume

CMS is currently developing proposals to implement key elements of MACRA
MACRA Reimbursement Rates

- For 2015 through 2019, annual increase (fee schedule update) of 0.5%

- Starting in 2019, the base reimbursement rate holds steady
  - physicians can supplement their reimbursement through participation in the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models, such as Accountable Care Organizations (ACOs)
  - APM incentive payment (5% lump sum) will be available from 2019 through 2024
  - MIPS payment adjustments based on composite performance score increase from +/- 4% in 2019 to +/- 9% in 2022 and beyond

- Starting in 2026, an annual increase (fee schedule update) of 0.25% resumes
  - physicians who participate in an Alternative Payment Model (APM) are eligible for a higher annual increase of 0.75%
Timeline

**FEE**
- Fee updates as SGR ends
  - 2015 and earlier: 0.5
  - 2016: 0.5
  - 2017: 0.5
  - 2018: 0.5
  - 2019: 0
  - 2020: 0
  - 2021: 0
  - 2022: 0
  - 2023: 0
  - 2024: 0
  - 2025: 0
  - 2026 and later: 0.75 QAPMCF*
  - 2026 and later: 0.25 N-QAPMCF**

**MIPS**
- Quality
- Resource Use
- Clinical Practice Improvement Activities
- Meaningful Use of Certified EHR Technology
- PQRS, Value Modifier, EHR Incentives
- 2015 and earlier: 4%
- 2016: 5%
- 2017: 7%
- 2018: 9%
- MIPS Payment Adjustment (+/-)

**APM**
- Qualifying APM Participant
  - Medicare Payment Threshold
  - Excluded from MIPS
- 5% Incentive Payment
- Excluded from MIPS

*Qualifying APM conversion factor
**Non-qualifying APM conversion factor
Timeline: Implementation of MIPS

- Existing programs such as PQRS, Value Modifier and Meaningful Use have a 2-year delay from performance year to payment year
  - 2016 performance dictates 2018 payment adjustments, and so on
- Anticipated that 2017 will be the first MIPS performance year
  - 2017 performance would dictate 2019 payment adjustments
- CMS will further define the performance years and other details of MIPS in a Final Rule
  - Anticipated publication date – end of 2016
  - Stage 3 MU, optional in 2017 and mandatory in 2018, will be measured solely under the MIPS program (no standalone Medicare MU penalties)
  - Final Rule will also address how group performance and individual performance will affect MIPS scores
    - Components of MIPS currently vary in this regard: PQRS and VM support group measurement, while MU evaluates performance on an individual level
Merit-Based Incentive Payment System
MIPS Description and Eligibility

- Merit-Based Incentive Payment System (MIPS) consolidates three existing programs
  - Physician Quality Reporting System (PQRS)
  - Value-based Modifier (VM)
  - EHR Incentive Payment Program (Meaningful Use)

- For the 2015 and 2016 performance years (and the respective 2017 and 2018 payment years), the PQRS, Value-based Modifier and MU programs will continue as separate and distinct programs

MIPS Eligible Professionals

First two years
- Physicians
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Nurse Anesthetists

Third year and beyond
- All of the above, plus:
  - Physical Therapists
  - Occupational Therapists
  - Speech-language Pathologists
  - Audiologists
  - Nurse Midwives
  - Clinical Social Workers
  - Clinical Psychologists
  - Dietitians
MIPS Payment Adjustments

- EPs can either participate in MIPS or be a Qualifying Participant (QP) in an Alternative Payment Model (APM)
  - EPs who participate in MIPS receive payment adjustments (positive, negative or neutral) based on their composite performance score
  - Providers with a high composite score will be eligible for incentives, while providers with a low composite score will be subject to payment penalties
  - On a yearly basis, QPs will be excluded from MIPS and receive a 5% lump sum incentive payment for that year

- Composite performance score is based on four categories
  1. Quality (related to PQRS and VM)
  2. Resource Use (cost)
  3. Clinical Practice Improvement Activities
  4. Meaningful Use (MU) of Certified EHR Technology (CEHRT)

- MIPS payment adjustments based on composite performance score increase from +/- 4% in 2019 to +/- 9% in 2022 and beyond*
MIPS Composite Performance Score
MIPS Performance Category: Quality

30% of an EP’s MIPS composite performance score is determined by performance in the Quality category

- Measures will include:
  - Quality measures currently used in existing (PQRS and VM);
  - Clinical Quality Measures (CQMs) currently used for Meaningful Use;
  - Measures currently used by Qualified Clinical Data Registries (QCDR) may also be included; and
  - Additional measures to be solicited by CMS from professional organizations and others in the health care community.

- National Quality Strategy (NQS) Domains:
  - Clinical Processes/Effectiveness
  - Patient Safety
  - Care Coordination
  - Patient and Family Engagement
  - Population/Public Health
  - Efficient Use of Healthcare Resources
30% of an EP’s MIPS composite performance score is determined by performance in the Resource Use category

Resource Use measures:
- Are enhanced through public input;
- Directly engage professionals;
- Allow professionals to report their specific role in treating the beneficiary (e.g., primary care or specialist);
- Allow professionals to report the type of treatment (e.g., chronic condition, acute episode);
- Are designed to not penalize providers for serving sicker or more costly patients
MIPS Performance Category: Clinical Practice Improvement

15% of an EP’s MIPS composite performance score is determined by performance in the Clinical Practice Improvement category

- Clinical Practice Improvement includes the following categories:
  - Expanded practice access
  - Population management
  - Care coordination
  - Beneficiary engagement
  - Patient safety
  - Practice assessment

- EPs who work in a certified Patient-Centered Medical Home (PCMH) or "comparable specialty practice" will receive the maximum score of 15 in this category

- EPs who participate in an APM will receive a minimum score of 7.5 in this category
25% of an EP’s MIPS composite performance score is determined by performance in the Meaningful Use of CEHRT category

- Measures and activities are the same as current MU requirements
- CMS may reduce the weight for this performance category
  - Not below 15%
  - Any year in which the proportion of EPs who are Meaningful Users is estimated to be 75% or greater
  - Result: An increase in the percentage weights for the other categories
Alternative Payment Models (APMs)
Alternative Payment Models (APMs)

- An eligible APM entity:
  - requires participants to use certified EHR technology
  - provides payment for covered professional services based on quality measures “comparable to” MIPS quality measures, AND
  - either requires participants to bear financial risk for monetary losses under the APM that are in excess of a nominal amount, OR is a medical home model

- Example: Medicare Shared Savings Program ACO

- CMS predicts that only a small minority of providers will qualify for the APM incentive payment in the early years
Incentive payments for participation in eligible APMs under two options:

<table>
<thead>
<tr>
<th>Medicare Thresholds:</th>
<th>All-Payer Thresholds:</th>
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<tbody>
<tr>
<td>Certain % of Medicare payments attributable to services furnished through an eligible APM</td>
<td>Certain % of All-Payer and Medicare payments attributable to services furnished through an eligible APM</td>
</tr>
</tbody>
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| If a provider exceeds Medicare payment thresholds, they receive a 5% Bonus | If a provider exceeds All-Payer and Medicare payment thresholds, they receive a 5% Bonus |
| If a provider exceeds MIPS payment threshold, but is below Medicare payment thresholds, participation in MIPS is optional (Partially Qualifying APM Participant) | If a provider exceeds MIPS threshold, but is below All-Payer and Medicare payment thresholds, participation in MIPS is optional (Partially Qualifying APM Participant) |
Physician Focused Payment Models
Development of PFPMs

- Physician-Focused Payment Models (PFPMs) are newly proposed payment and service delivery models
  - Not specifically defined in MACRA
  - MACRA tasks CMS with establishing the criteria for PFPMs
- A Technical Advisory Committee (TAC) will be named to allow stakeholders to propose PFPMs
  - The TAC will review and provide recommendations based on criteria established through rulemaking
  - HHS/CMS will review and prioritize recommendations against existing factors
  - Factors can be found here: [http://innovation.cms.gov/Files/x/rfi-websitepreamble.pdf](http://innovation.cms.gov/Files/x/rfi-websitepreamble.pdf)
- Accepted recommendations can take 12-24 months to go from concept to model; not all recommendations will be accepted
- Bottom line: CMS will continue to develop APMs
CMS Request for Information
Public Comment: MACRA Provisions

Deadline is 5:00pm today – November 17th

Stakeholder input on the following topics:

- MIPS EP Identifier and Exclusions
- Virtual Groups
- Quality Performance Category
- Resource Use Performance Category
- Clinical Practice Improvement Activities Performance Category
- Meaningful Use of Certified EHR Technology Performance Category
- Development of Performance Standards
- Flexibility in Weighting Performance Categories
- MIPS Composite Performance Score and Performance Threshold
- Public Reporting
- Feedback Reports
CMS also requests public comment on the following questions related to Meaningful Use:

- Should the performance score for this category be based solely on full achievement of Meaningful Use?
- Should CMS use a tiered methodology for determining levels of achievement that would allow EPs to receive a higher or lower score based on their performance relative to the thresholds established in the MU program’s objectives and measures?
- What alternate methodologies should CMS consider for this performance category?
- How should hardship exemptions be treated?
Technical Assistance
Technical Assistance

- RFI also asked for public comment on technical assistance to MIPS EPs in small practices and practices in Health Professional Shortage Areas (HPSAs)
  - Small practices: 15 or fewer EPs
- MACRA requires the HHS Secretary to enter into contracts or agreements with appropriate entities, such as:
  - Quality Improvement Organizations (QIOs)
  - Regional Extension Centers (RECs)
  - Regional Health Collaboratives
- These entities will offer guidance and assistance to MIPS EPs with respect to the MIPS performance categories, or with implementing or participating in an APM
- Priority given to practices in rural areas, HPSAs, and medically underserved areas, and practices with low composite scores
How to Prepare for MIPS
Four Steps to Prepare for MIPS

1. Start the conversation
   - Convene a group of technical, administrative and clinical staff to discuss MIPS and how it will impact your practice

2. Expand your knowledge base beyond MU, PQRS and VM
   - MIPS composite score also includes Clinical Practice Improvement – What activities can you implement now?
   - APM participation – What does it involve? Would it work for your practice?

3. Maintain or expand efforts with PQRS, VM and MU

4. Contact MeHI
   - Meaningful Use guidance and support
   - PQRS Registry and Services
   - Stay informed about MIPS as CMS seeks additional stakeholder input and releases proposed/final rules
How to Prepare for MIPS

- Together, Quality and Resource Use make up 60% of your MIPS composite score
  - The Quality category roughly corresponds to current PQRS requirements
  - The Resource Use category reflects current requirements for the Value Modifier (VM) program

- Prepare Now!
  1. Select measures
  2. Perform a “dry run”
  3. Improve provider performance
How to Prepare for MIPS

- Meaningful Use makes up 25% of your MIPS composite score

- Prepare for Meaningful Use attestation
  - Review CMS Final Rule: Modifications to MU for 2015-2017 & Stage 3
  - Resolve registration issues early; ensure EPs registration information is kept up-to-date
  - Be prepared for potential audits; keep all supporting documentation for a minimum of 6 years post-attestation
  - Expand the MU knowledge base within your organization: “MU is a program, not a person”
  - Embrace the stability – 2 full years of stable objectives & measures
  - Maintain Patient Engagement efforts and initiatives
MeHI’s Role

Provide a broad range of services to help providers

- Navigate the Health IT landscape
- Capitalize on the shift toward performance-based reimbursement
- Leverage Health IT and achieve the **Triple Aim +1**
  - Improving patient care
  - Improving population health
  - Reducing the cost of care
  - + Provider Satisfaction
MeHI’s Role

Support healthcare providers in achieving Meaningful Use of EHR technology

- Meaningful Use Gap Analysis
- Registration and Attestation support
- Secure document storage and audit preparation

Support providers with Physician Quality Reporting System (PQRS) reporting

- Qualified registry for submitting PQRS measures

Collaborate with external partners to offer

- Patient engagement resources
- Privacy and security tools – BluePrint SecurityConnect™
- Other Health IT resources

Engage in thought leadership

- Educational outreach, informational webinars and training courses
- Subject matter expertise on topics of interest to provider organizations
Questions?
Contact Us

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