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

Establish reporting processes

Physician Quality Reporting System

Meaningful Use

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

Demonstrate performance

Value-Based Payment Modifier

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

Value-based payment structure

MACRA

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

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.

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

* Multiple variations of ACOs exist, allowing each to establish a leadership and administrative infrastructure and to include gainssharing 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
A single MIPS composite performance score factors into overall performance in 4 weighted categories.

**2017 reporting**
- Advancing Care Info (25 points)
- Quality (60 points)
- Resource use - VBM (0 points)
- Clinical practice improvement (15 points)

**2018 reporting**
- Advancing Care Info (25 points)
- Quality (50 points)
- Resource use - VBM (10 points)
- Clinical practice improvement (15 points)

**2019 and beyond reporting**
- Advancing Care Info (25 points)
- Quality (45 points)
- Resource use - VBM (15 points)
- Clinical practice improvement (15 points)

Total points: 100 points
# Macranomics: Payment Year Timeline

<table>
<thead>
<tr>
<th>Year</th>
<th>Physician Fee Schedule Updates</th>
<th>MIPS</th>
<th>Eligible APMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>0.5%</td>
<td>±4%</td>
<td>Qualifying APM participant</td>
</tr>
<tr>
<td>2016</td>
<td>0.5%</td>
<td>±5%</td>
<td>5% Incentive Payment</td>
</tr>
<tr>
<td>2017</td>
<td>0.5%</td>
<td>±7%</td>
<td>5% Incentive Payment</td>
</tr>
<tr>
<td>2018</td>
<td>0.5%</td>
<td>±9%</td>
<td>5% Incentive Payment</td>
</tr>
<tr>
<td>2019</td>
<td>0.5%</td>
<td>±9%</td>
<td>5% Incentive Payment</td>
</tr>
<tr>
<td>2020</td>
<td>0</td>
<td>±9%</td>
<td>5% Incentive Payment</td>
</tr>
<tr>
<td>2021</td>
<td>0</td>
<td>±9%</td>
<td>5% Incentive Payment</td>
</tr>
<tr>
<td>2022</td>
<td>0</td>
<td>±9%</td>
<td>5% Incentive Payment</td>
</tr>
<tr>
<td>2023</td>
<td>0</td>
<td>±9%</td>
<td>5% Incentive Payment</td>
</tr>
<tr>
<td>2024</td>
<td>0</td>
<td>±9%</td>
<td>5% Incentive Payment</td>
</tr>
<tr>
<td>2025</td>
<td>0.75 N-QAPMCF²</td>
<td>±9%</td>
<td>5% Incentive Payment</td>
</tr>
<tr>
<td>2026</td>
<td>0.25 N-QAPMCF²</td>
<td>±9%</td>
<td>5% Incentive Payment</td>
</tr>
</tbody>
</table>

- **Physician Fee Schedule Updates**: 0.5%, 0.5%, 0.5%, 0.5%, 0, 0, 0, 0, 0, 0, 0.75 N-QAPMCF², 0.25 N-QAPMCF²
- **MIPS**: ±4%, ±5%, ±7%, ±9%
- **Eligible APMs**: Qualifying APM participant, 5% Incentive Payment

1. Qualifying APM conversion factor
2. Non-Qualifying APM conversion factor
3. Physician Quality Reporting System
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

<table>
<thead>
<tr>
<th>Category</th>
<th>Individual</th>
<th>Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>• Claims&lt;br&gt;• Qualified Registry, QCDR &lt;br&gt;• EHR</td>
<td>• Web Interface &gt;25&lt;br&gt;• Qualified Registry, QCDR&lt;br&gt;• EHR&lt;br&gt;• CAHPS Survey for MIPS</td>
</tr>
<tr>
<td>Improvement Activity (IA)</td>
<td>• Attestation&lt;br&gt;• Qualified registry, QCDR &lt;br&gt;• EHR</td>
<td>• Attestation&lt;br&gt;• Qualified registry, QCDR&lt;br&gt;• EHR&lt;br&gt;• Web Interface &gt; 25</td>
</tr>
<tr>
<td>Promoting Interoperability (Now PI, formerly ACI)</td>
<td>• Attestation&lt;br&gt;• Qualified registry, QCDR &lt;br&gt;• EHR</td>
<td>• Attestation&lt;br&gt;• Qualified registry, QCDR&lt;br&gt;• EHR&lt;br&gt;• Web Interface &gt; 25</td>
</tr>
<tr>
<td>Cost</td>
<td>• Administrative claims</td>
<td>• Administrative claims</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>Measures</th>
<th>Bonus Points</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Outcome or Patient Experience Measure</td>
<td>2 points each</td>
<td>6 point max</td>
</tr>
<tr>
<td>Additional High Priority Measure</td>
<td>1 point each</td>
<td></td>
</tr>
<tr>
<td>eCQM Submission using CEHRT</td>
<td>1 point each</td>
<td>6 point max</td>
</tr>
<tr>
<td>Improvement</td>
<td></td>
<td>Up to 10 percentage points</td>
</tr>
</tbody>
</table>
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)

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

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)

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

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)**

<table>
<thead>
<tr>
<th>Elective Outpatient PCI</th>
<th>Knee Arthroplasty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Cataract Removal with IOL Implantation</td>
<td>Screening/Surveillance Colonoscopy</td>
</tr>
<tr>
<td>Intracranial Hemorrhage or Cerebral Infarction</td>
<td>Simple Pneumonia with Hospitalization</td>
</tr>
<tr>
<td>STEMI with PCI</td>
<td>Revascularization for Lower Extremity Chronic Critical Limb Ischemia</td>
</tr>
</tbody>
</table>

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?

- Decrease ALOS
- HCC – accurate coding and documentation by physicians
- Decrease unnecessary utilization
- Decrease HACs and Complications
- Avoidable Admissions
- Unnecessary Readmissions

The Usual Suspects

Decrease unnecessary utilization

Accurate coding and documentation by physicians

Unnecessary Readmissions
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)

Many large practice organizations are focused on the day to day:

- Scheduling
- Throughput
- Documentation/EHR
- Revenue cycle
- Staffing
- Rx renewal
- Referral management
What We Have Learned From TCPI

What transformation will add:

- Data collection, review and PI based on it. Time for this work.
- Collection of REAL data and identification of disparities
- Patient and Family Advisors
- Improved Access
- Team based care delivery
- Risk stratification
- Preventive care/education
- Chronic condition management/case management review
- Care Coordination and referral management process
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 arrangements
  • 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

<table>
<thead>
<tr>
<th></th>
<th>CPC</th>
<th>CPC+ Track 1</th>
<th>CPC+ Track 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Size</strong></td>
<td>7 Regions; ~500 practices</td>
<td>≤20 Regions; ≤2500 practices</td>
<td>≤20 Regions; ≤2500 practices</td>
</tr>
<tr>
<td><strong>Duration</strong></td>
<td>4 y (2012-2016)</td>
<td>5 y (2017-2021)</td>
<td>5 y (2017-2021)</td>
</tr>
<tr>
<td><strong>Medicare care management fee</strong></td>
<td>$20 PBPM PY1-2; $15 PBPM PY3-4; average across 4 risk tiers</td>
<td>$15 PBPM average across 4 risk tiers</td>
<td>$27 PBPM average across 5 risk tiers; $100 for highest-risk tier</td>
</tr>
<tr>
<td><strong>Medicare payment for office visits</strong></td>
<td>100% FFS</td>
<td>100% FFS</td>
<td>100% FFS for non-evaluation and management; reduced FFS + up-front payment for evaluation and management</td>
</tr>
<tr>
<td><strong>Medicare incentive payment</strong></td>
<td>Shared savings based on quality metrics and TCOC³</td>
<td>$2.50 PBPM based on quality and utilization metrics</td>
<td>$4 PBPM based on quality and utilization metrics</td>
</tr>
<tr>
<td><strong>HIT partners</strong></td>
<td>Not required</td>
<td>Not required</td>
<td>Required</td>
</tr>
</tbody>
</table>
Contact Information

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Thank You!