Merit-Based Incentive Payment System: Advancing Care Information Performance Category
Disclaimer

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KEY TOPICS:

1) The Quality Payment Program and HHS Secretary’s Goals
2) What is the Quality Payment Program?
3) How do I submit comments on the proposed rule?
4) The Merit-based Incentive Payment System (MIPS)
5) The Advancing Care Information Performance Category
6) What are the next steps?
In January 2015, the Department of Health and Human Services announced new goals for value-based payments and APMs in Medicare

**Medicare Fee-for-Service**

**GOAL 1:** 30%  
Medicare payments are tied to quality or value through alternative payment models (categories 3-4) by the end of 2016, and 50% by the end of 2018

**GOAL 2:** 85%  
Medicare fee-for-service payments are tied to quality or value (categories 2-4) by the end of 2016, and 90% by the end of 2018

**STAKEHOLDERS:**  
Consumers | Businesses  
Payers | Providers  
State Partners

Set internal goals for HHS  
Invite private sector payers to match or exceed HHS goals
**Medicare Payment Prior to MACRA**

**Fee-for-service** (FFS) payment system, where clinicians are paid based on **volume** of services, not **value**.

**The Sustainable Growth Rate (SGR)**

- Established in 1997 to **control the cost of Medicare payments** to physicians

**IF**

- Overall physician costs
- Target Medicare expenditures

**Physician payments cut across the board**

Each year, Congress passed temporary **“doc fixes”** to avert cuts (no fix in 2015 would have meant a **21% cut** in Medicare payments to clinicians)
INTRODUCING THE QUALITY PAYMENT PROGRAM
Quality Payment Program

- **Repeals** the Sustainable Growth Rate (SGR) Formula
- **Streamlines** multiple quality reporting programs into the new Merit-based Incentive Payment System (MIPS)
- **Provides incentive payments** for participation in Advanced Alternative Payment Models (APMs)

The Merit-based Incentive Payment System (MIPS)  
Advanced Alternative Payment Models (APMs)

- First step to a fresh start
- We’re listening and help is available
- A better, smarter Medicare for healthier people
- Pay for what works to create a Medicare that is enduring
- Health information needs to be open, flexible, and user-centric
When and where do I submit comments?

• The proposed rule includes proposed changes not reviewed in this presentation. We will not consider feedback during the call as formal comments on the rule. See the proposed rule for information on submitting these comments by the close of the 60-day comment period on June 27, 2016. When commenting, refer to file code CMS-5517-P.

• Instructions for submitting comments can be found in the proposed rule; FAX transmissions will not be accepted. You must officially submit your comments in one of the following ways: electronically through
  • Regulations.gov
  • by regular mail
  • by express or overnight mail
  • by hand or courier

• For additional information, please go to: http://go.cms.gov/QualityPaymentProgram
MIPS: First Step to a Fresh Start

✓ MIPS is a new program
  • Streamlines 3 currently independent programs to work as one and to ease clinician burden.
  • Adds a fourth component to promote ongoing improvement and innovation to clinical activities.

✓ MIPS provides clinicians the flexibility to choose the activities and measures that are most meaningful to their practice to demonstrate performance.
Currently there are **multiple quality and value reporting programs** for Medicare clinicians:

- **Physician Quality Reporting Program (PQRS)**
- **Value-Based Payment Modifier (VM)**
- **Medicare Electronic Health Records (EHR) Incentive Program**
PROPOSED RULE
MIPS: Major Provisions

✓ Eligibility (participants and non-participants)
✓ Performance categories & scoring
✓ Data submission
✓ Performance period & payment adjustments
Who Will Participate in MIPS?

Affected clinicians are called "MIPS eligible clinicians" and will participate in MIPS. The types of Medicare Part B eligible clinicians affected by MIPS may expand in future years.

Years 1 and 2

Physicians (MD/DO and DMD/DDS), PAs, NPs, Clinical nurse specialists, Certified registered nurse anesthetists

Years 3+

Secretary may broaden Eligible Clinicians group to include others such as

Physical or occupational therapists, Speech-language pathologists, Audiologists, Nurse midwives, Clinical social workers, Clinical psychologists, Dietitians / Nutritional professionals
There are 3 groups of clinicians who will NOT be subject to MIPS:

1. **FIRST year of Medicare Part B participation**
2. **Below low patient volume threshold**
3. **Certain participants in ADVANCED Alternative Payment Models**

Medicare billing charges less than or equal to $10,000 and provides care for 100 or fewer Medicare patients in one year.

Note: MIPS **does not** apply to hospitals or facilities.
Note: Most clinicians will be subject to MIPS.

Subject to MIPS

Not in APM

In non-Advanced APM

In Advanced APM, but not a QP

QP in Advanced APM

Some people may be in Advanced APMs but not have enough payments or patients through the Advanced APM to be a QP.

Note: Figure not to scale.
Eligible Clinicians can participate in MIPS as an:

- Individual

- Group

A group, as defined by taxpayer identification number (TIN), would be assessed as a group practice across all four MIPS performance categories.

Note: “Virtual groups” will not be implemented in Year 1 of MIPS.
A single MIPS composite performance score will factor in performance in **4 weighted performance categories** on a 0-100 point scale:

- **Quality**
- **Resource use**
- Clinical practice improvement activities
- Advancing care information

**MIPS Composite Performance Score (CPS)**
Year 1 Performance Category Weights for MIPS

- **QUALITY**: 50%
- **ADVANCING CARE INFORMATION**: 25%
- **CLINICAL PRACTICE IMPROVEMENT ACTIVITIES**: 15%
- **COST**: 10%

The diagram shows the distribution of weights for each category.
PROPOSED RULE
MIPS: ADVANCING CARE INFORMATION PERFORMANCE CATEGORY
## Changes from EHR Incentive Program to Advancing Care Information

<table>
<thead>
<tr>
<th>Past Requirements for the Medicare EHR Incentive Program</th>
<th>New Proposal for Advancing Care Information Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>One-size-fits-all – every objective reported and weighed equally</td>
<td>Customizable – clinicians can choose which categories to emphasize in their scoring</td>
</tr>
<tr>
<td>Requires across-the-board levels of achievement or “thresholds,” regardless of practice or experience</td>
<td>Flexible. Allows for diverse reporting that matches clinician’s practice and experience.</td>
</tr>
<tr>
<td>Measurement emphasizing process</td>
<td>Measurement emphasizing patient engagement and interoperability</td>
</tr>
<tr>
<td>Disjointed and redundant with other Medicare reporting programs</td>
<td>Aligned with other Medicare reporting programs. No need to report redundant quality measures.</td>
</tr>
</tbody>
</table>
| No exemptions for reporting | Exemptions for reporting for clinicians in:  
  - Advanced alternative payment models  
  - First year with Medicare  
  - Have low Medicare volumes |
What will determine my MIPS score?

The MIPS composite performance score will factor in performance in 4 weighted performance categories on a 0-100 point scale:

- **Quality**
- **Resource use**
- **Clinical practice improvement activities**
- **Advancing care information**

*% weight of this may decrease as more users adopt EHR*
Who can participate?

All MIPS Eligible Clinicians

Participating as an...

Individual

Group

Optional for 2017

NPs, PAs, Clinical Nurse Specialists, CRNAs

Not Eligible

Facilities (i.e. Skilled Nursing facilities)
PROPOSED RULE
MIPS: Advancing Care Information Performance Category

The overall Advancing Care Information score would be made up of a base score and a performance score for a maximum score of 100 percentage points.
PROPOSED RULE
MIPS: Advancing Care Information Performance Category

Base Score
Accounts for 50 percentage points of the total Advancing Care Information category score.

To receive the base score, physicians must simply provide the numerator/denominator or yes/no for each objective and measure.
CMS proposes six objectives and their measures that would require reporting for the base score:

- **Protect Patient Health Information** (yes required)
- **Electronic Prescribing** (numerator/denominator)
- **Patient Electronic Access** (numerator/denominator)
- **Coordination of Care Through Patient Engagement** (numerator/denominator)
- **Health Information Exchange** (numerator/denominator)
- **Public Health and Clinical Data Registry Reporting** (yes required)
PROPOSED RULE
MIPS: Advancing Care Information
Performance Category

THE PERFORMANCE SCORE
The performance score accounts for up to 80 percentage points towards the total Advancing Care Information category score.

Physicians select the measures that best fit their practice from the following objectives, which emphasize patient care and information access:

- Patient Electronic Access
- Coordination of Care Through Patient Engagement
- Health Information Exchange
Summary:

✓ Scoring based on key measures of patient engagement and information exchange.

✓ Flexible scoring for all measures to promote care coordination for better patient outcomes

✓ Key Changes from Current Program (EHR Incentive):
  • Dropped “all or nothing” threshold for measurement
  • Removed redundant measures to alleviate reporting burden.
  • Eliminated Clinical Provider Order Entry and Clinical Decision Support objectives
  • Reduced the number of required public health registries to which clinicians must report
  • Year 1 Weight: 25%
PROPOSED RULE
MIPS COMPOSITE SCORE
## Proposed Rule
### MIPS: Performance Category Scoring

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Maximum Possible Points per Performance Category</th>
<th>Percentage of Overall MIPS Score (Performance Year 1 - 2017)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality:</strong> 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. Clinicians also can choose to report a specialty measure set.</td>
<td>80 to 90 points depending on group size</td>
<td>50 percent</td>
</tr>
<tr>
<td><strong>Advancing Care Information:</strong> Clinicians will report key measures of patient engagement and information exchange. Clinicians are rewarded for their performance on measures that matter most to them.</td>
<td>100 points</td>
<td>25 percent</td>
</tr>
<tr>
<td><strong>Clinical Practice Improvement Activities:</strong> Clinicians can choose the activities best suited for their practice; the rule proposes over 90 activities from which to choose. Clinicians participating in medical homes earn “full credit” in this category, and those participating in Advanced APMs will earn at least half credit.</td>
<td>60 points</td>
<td>15 percent</td>
</tr>
<tr>
<td><strong>Cost:</strong> CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything.</td>
<td>Average score of all cost measures that can be attributed</td>
<td>10 percent</td>
</tr>
</tbody>
</table>
PROPOSED RULE

MIPS: Calculating the Composite Performance Score (CPS) for MIPS

A single MIPS composite performance score will factor in performance in 4 weighted performance categories on a 0-100 point scale:

1. Quality
2. Resource use
3. Clinical practice improvement activities
4. Advancing care information

MIPS Composite Performance Score (CPS)

The CPS will be compared to the MIPS performance threshold to determine the adjustment percentage the eligible clinician will receive.
MIPS composite performance scoring method that accounts for:

- 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
Calculating the Composite Performance Score (CPS) for MIPS

<table>
<thead>
<tr>
<th>Category</th>
<th>Weight</th>
<th>Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>50%</td>
<td>• Each measure 1-10 points compared to historical benchmark (if avail.)&lt;br&gt;• 0 points for a measure that is not reported&lt;br&gt;• Bonus for reporting outcomes, patient experience, appropriate use, patient safety and EHR reporting&lt;br&gt;• Measures are averaged to get a score for the category</td>
</tr>
<tr>
<td>Advancing care information</td>
<td>25%</td>
<td>• Base score of 50 percentage points achieved by reporting at least one use case for each available measure&lt;br&gt;• Performance score of up to 80 percentage points&lt;br&gt;• Public Health Reporting bonus point&lt;br&gt;• Total cap of 100 percentage points available</td>
</tr>
<tr>
<td>CPIA</td>
<td>15%</td>
<td>• Each activity worth 10 points; double weight for “high” value activities; sum of activity points compared to a target</td>
</tr>
<tr>
<td>Resource Use</td>
<td>10%</td>
<td>• Similar to quality</td>
</tr>
</tbody>
</table>

Unified scoring system:
1. Converts measures/activities to points
2. Eligible Clinicians will know in advance what they need to do to achieve top performance
3. Partial credit available
HOW DO I GET MY DATA TO CMS?
DATA SUBMISSION FOR MIPS
PROPOSED RULE
MIPS Data Submission Options
Advancing Care Information

Individual Reporting
- Attestation
- QCDR
- Qualified Registry
- EHR

Group Reporting
- Attestation
- QCDR
- Qualified Registry
- EHR
- CMS Web Interface (groups of 25 or more)
PROPOSED RULE
MIPS PERFORMANCE PERIOD
& PAYMENT ADJUSTMENT
All MIPS performance categories are aligned to a performance period of one full calendar year. 
Goes into effect in first year (2017 performance period, 2019 payment year).
A MIPS eligible clinician’s payment adjustment percentage is based on the relationship between their CPS and the MIPS performance threshold.

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.

A CPS less than or equal to 25% of the threshold will yield the maximum negative adjustment of -4%.
A CPS that falls at or above the threshold will yield payment adjustment of 0 to +12%, based on the degree to which the CPS exceeds the threshold and the overall CPS distribution.

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.
How much can MIPS adjust payments?

Based on a CPS, clinicians will receive +/- or neutral adjustments up to the percentages below.

- The potential maximum adjustment % will increase each year from 2019 to 2022.
How much can MIPS adjust payments?

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

*Potential for 3X adjustment

Merit-Based Incentive Payment System (MIPS)
Dr. Joy Smith, who receives the +4% adjustment for MIPS, could receive up to +12% in 2019. For exceptional performance she could earn an additional adjustment factor of up to +10%.

**Note:** This scaling process will only apply to positive adjustments, not negative ones.
# PROPOSED RULE
## MIPS Timeline

<table>
<thead>
<tr>
<th>2017</th>
<th>2018</th>
<th>July</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Period (Jan-Dec)</td>
<td>Reporting and Data Collection</td>
<td>2nd Feedback Report (July)</td>
<td>Targeted Review Based on 2017 MIPS Performance</td>
<td>MIPS Adjustments in Effect</td>
</tr>
<tr>
<td>1st Feedback Report (July)</td>
<td></td>
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**Analysis and Scoring**
More Ways to Learn To learn more about the Quality Payment Programs including MIPS program information, watch the [http://go.cms.gov/QualityPaymentProgram](http://go.cms.gov/QualityPaymentProgram) to learn of Open Door Forums, webinars, and more.