

Merit Based Incentive Payment System (MIPS) Mobile Challenge Bootcamp



May 8th, 2016

Boot camp Agenda

- 2:00 – 2:15 – Challenge Introduction – Mindy Hangsleben, CMS
- 2:15 – 2:45 - Overview of Medicare Access & CHIP Reauthorization Act of 2015 (MACRA)/MIPS and Current State Education & Outreach Research Findings – Dr. Pierre Yong, Director Quality Measure Value- Based Incentive Group, CMS
- 2:45 – 3:15 - Customer Insight
- 3:15 – 5:00 – Q & A/Working Time with experts in the room

The Challenge

- CMS recently issued a proposed rule that will change the way Medicare physicians are paid for giving quality care through the Quality Payment Program (QPP)
- This challenge will focus on solving the problem that many of the 1.2 Million Clinicians and their staff will face – the ability to easily access information that is relevant to enable successful reporting in the new Merit Based Incentive Payment System (MIPS) program.

Why this Challenge?

- Many small practice and solo clinicians along with their staff may be unaware of the program, what it means for them, key dates, or how to successfully participate
- Clinicians that are aware of the program still need to know and understand when things are changing
- The Quality Payment Program offers many options that clinicians will need to successfully navigate
- Different clinicians may have different needs and motivations for their involvement

Our Goal

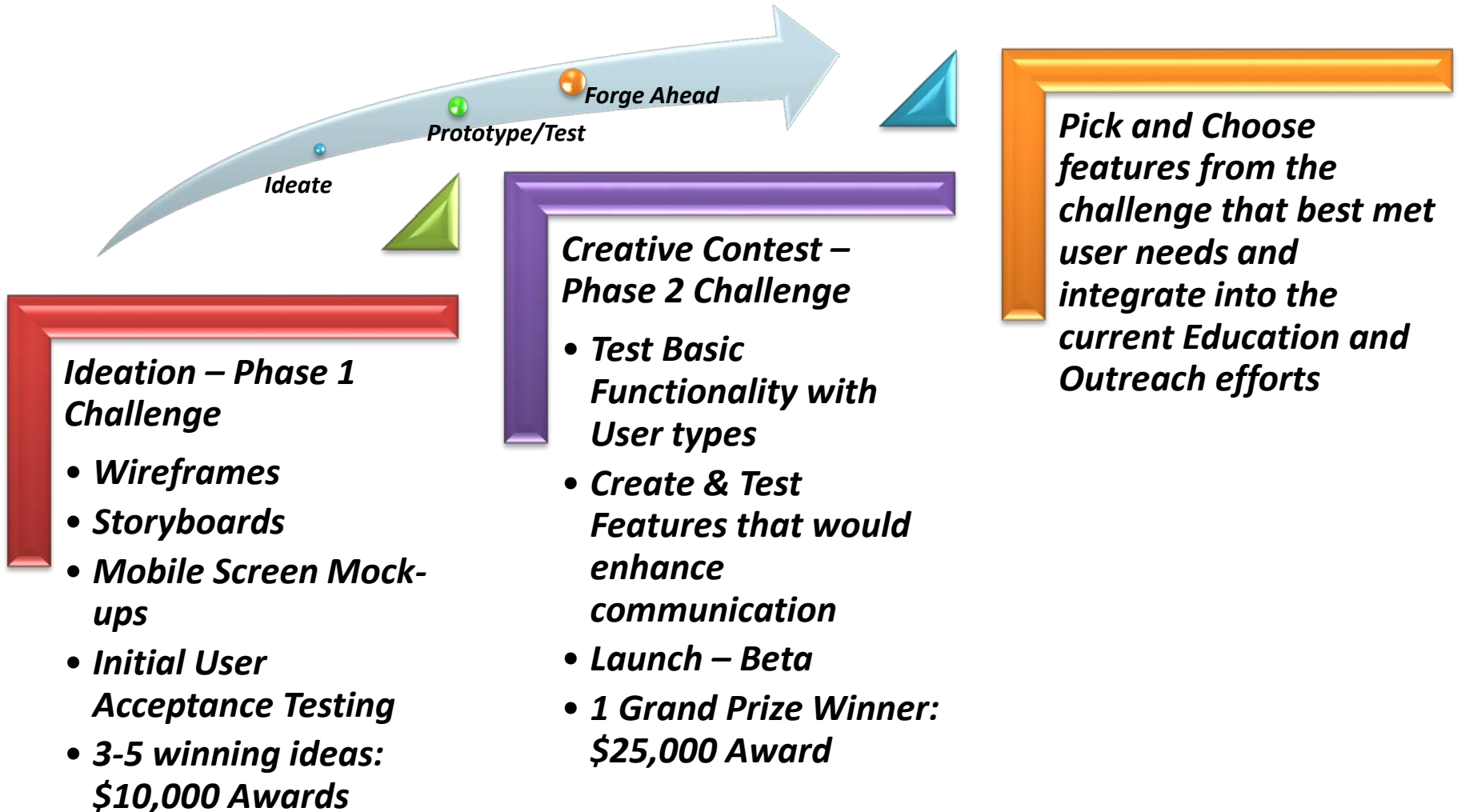
Engagement & Education

- To help clinicians and their support teams **understand** the Merit-Based Incentive Payment System (MIPS), the **benefits** of participation, and how they can **move their** practice toward quality based care.

What's a Challenge?

- The solutions are up to you!
- Allows the government to collect great ideas and a wide variety of perspectives to solve a particular problem
- Submissions could be interesting suggestions, approaches, plans, proposals, designs, or other proposed solutions in written, graphic, or video form

Challenge Phases



Prizes

- Phase 1: Top 3-5 will receive \$10,000/winning submission
- Phase 2: Winner will receive \$25,000

Dates & Timing

- July 15: Deadline for Phase I Submissions
- July 30: HHS announces top three to five challenge applicants and launches Phase II
 - Applicants that did not win in Phase I will be permitted to compete for Phase II
- September 30: Deadline for Phase II Submissions
- October 15: HHS announces grand prize winner

Judging Criteria – Phase 1

- Ease with which a user can navigate Usability and Design
- Evidence of design incorporating User feedback
- Innovation in Design
- Look and Feel

Phase I Submission Requirements

Submissions could take many forms, including but not limited to:

- Mockups/Wireframes
- Storyboards
- Flowcharts
- Videos/animations
- User Feedback Incorporation

List of users and the lessons learned from co-design around the problem statement

Judging Criteria – Phase 2

- Are a majority of clinicians able to easily use the solution from start to finish
- Do a majority of clinicians understand the requirements of MIPS after using the solution?
- Are a majority of clinicians able to identify if they are qualified to participate in MIPS after using the solution?

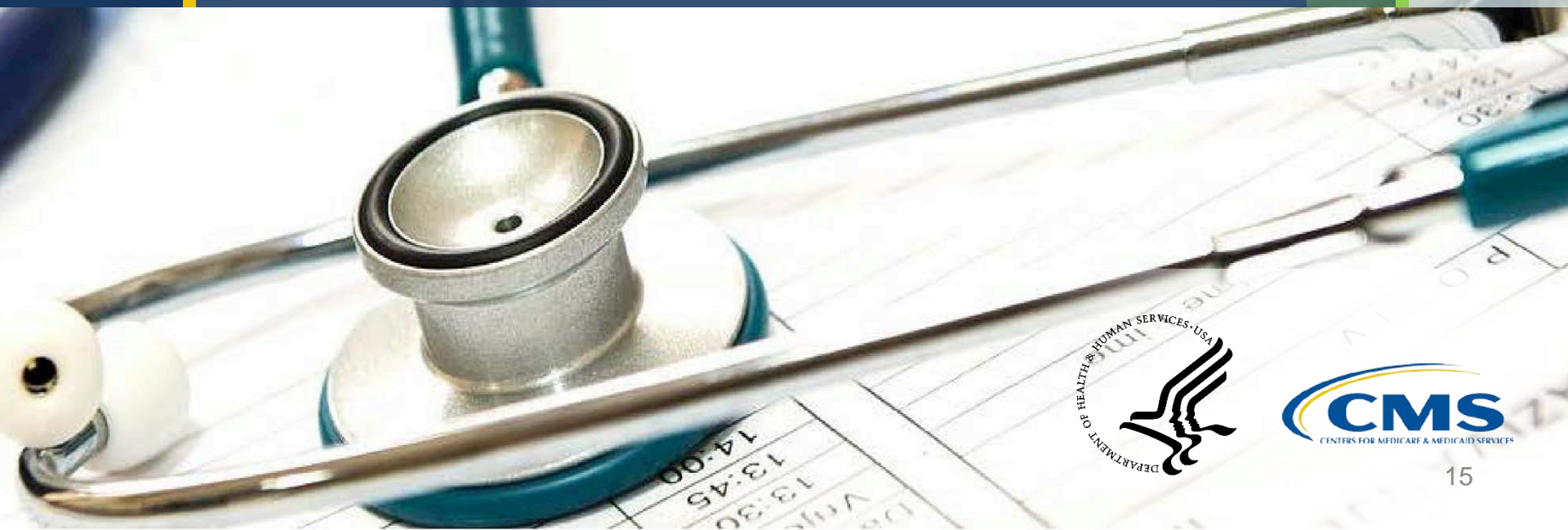
Phase II Submission Requirements

- Working prototype of the mobile solution
- Video demonstrating the use of the mobile solution (maximum of 5 minutes, on YouTube or Vimeo)
 - Provide clear sense of look, feel, and interactions
- Presentation describing solution
- User research summary
 - List of users
 - Lessons learned from usability testing and updates made to the solution

Eligibility & Registration

- Eligibility details can be found on the challenge.gov website

THE MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)



Disclaimer

This presentation was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This presentation was prepared as a service to the public and is not intended to grant rights or impose obligations. This presentation may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.


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) What are the next steps?**

The Quality Payment Program is part of a broader push towards value and quality

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)

Medicare Payment Prior to MACRA

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The Sustainable Growth Rate (SGR)



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)

MACRA **replaces the SGR** with a **more predictable** payment method that **incentivizes value**.

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)**

or

**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](http://www.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>

Quality Payment Program

- ✓ **First step to a fresh start**
- ✓ **We're listening and help is available**
- ✓ **A better, smarter Medicare for healthier people**
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**The Merit-based
Incentive
Payment System
(MIPS)**

or

**Advanced
Alternative
Payment Models
(APMs)**

Note: Most practitioners 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 clinicians may be in Advanced APMs but not have enough payments or patients through the Advanced APM to be a QP.



MIPS

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.**



Quality



Resource use



**Clinical practice
improvement
activities**



**Advancing care
information**

- ✓ **MIPS provides clinicians the flexibility to choose the activities and measures that are most meaningful to their practice to demonstrate performance.**

Medicare Reporting Prior to MACRA

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



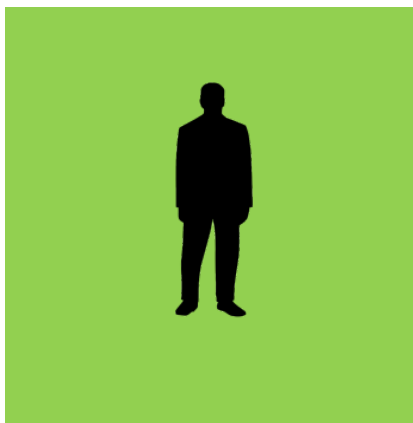
Physical or occupational therapists,
Speech-language pathologists,
Audiologists, Nurse midwives,
Clinical social workers, Clinical
psychologists, Dietitians /
Nutritional professionals

Who will NOT Participate in MIPS?

There are 3 groups of clinicians who will NOT be subject to MIPS:



FIRST year of Medicare
Part B participation



Below **low patient**
volume threshold



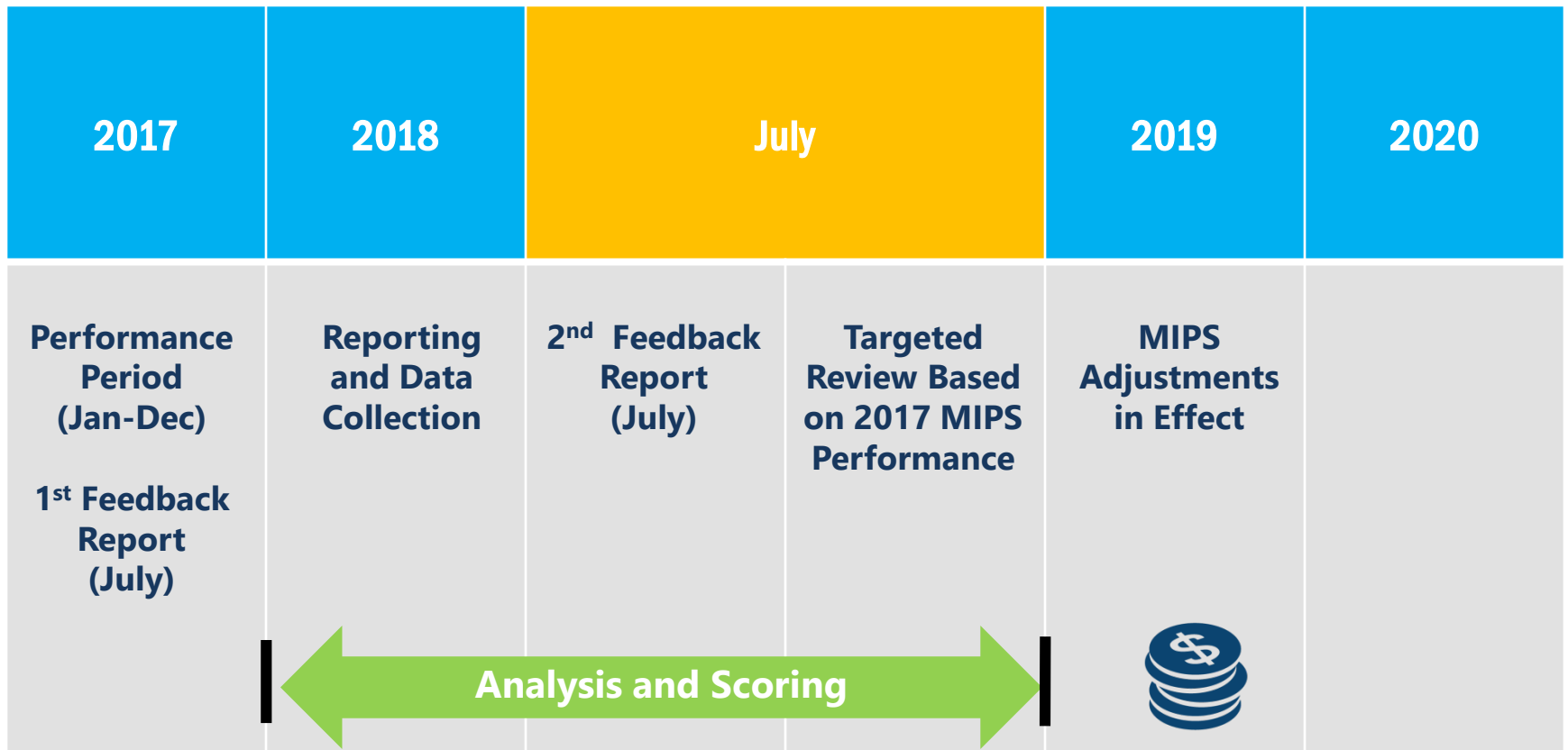
Certain participants in
ADVANCED Alternative
Payment Models



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

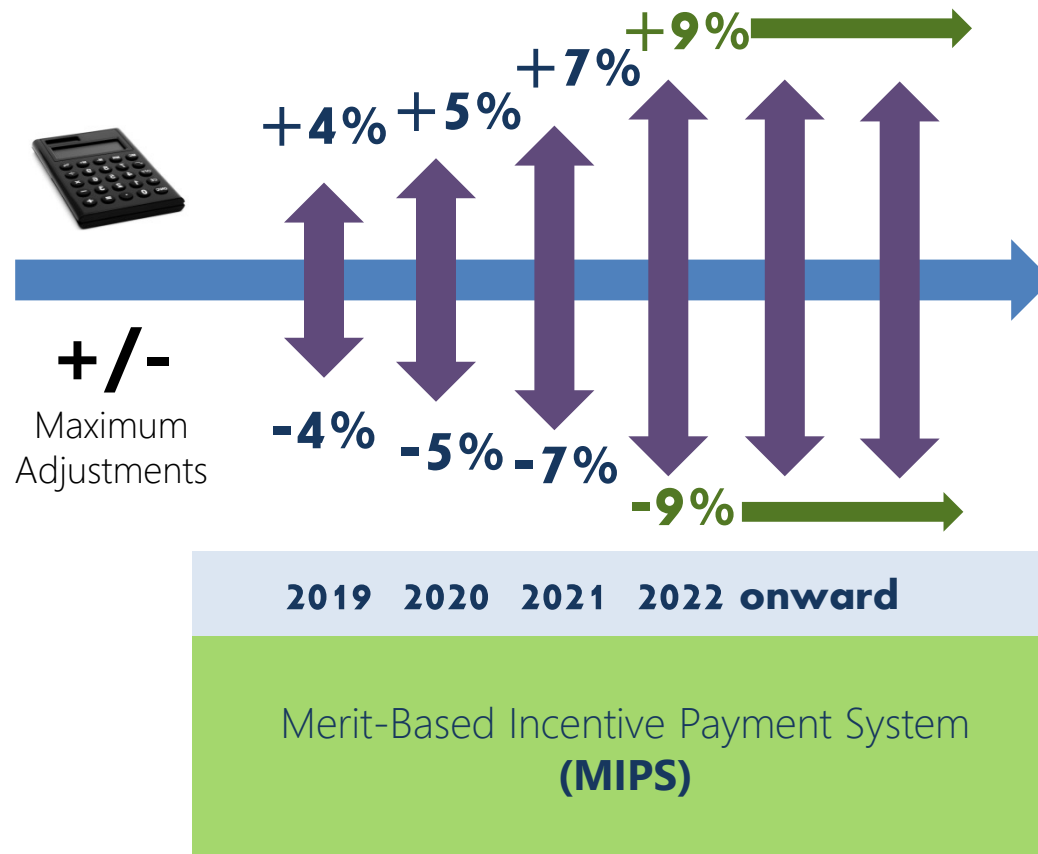
Note: MIPS **does not** apply to hospitals or facilities

PROPOSED RULE MIPS Timeline



How much can MIPS adjust payments?

Based on a MIPS Composite Performance Score, clinicians will receive **+/- or neutral** adjustments up to the percentages below.



The potential maximum adjustment % will increase each year from 2019 to 2022

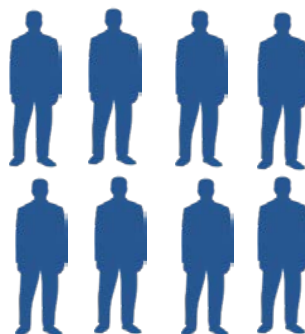
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Subject to MIPS

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QP in Advanced APM



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PROPOSED RULE

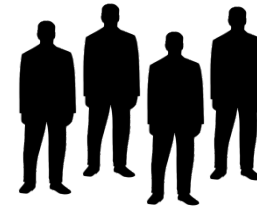
MIPS: Eligible Clinicians

Eligible Clinicians can participate in MIPS as an:



Individual

Or



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.



PROPOSED RULE MIPS: PERFORMANCE CATEGORIES & SCORING

MIPS Performance Categories

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**

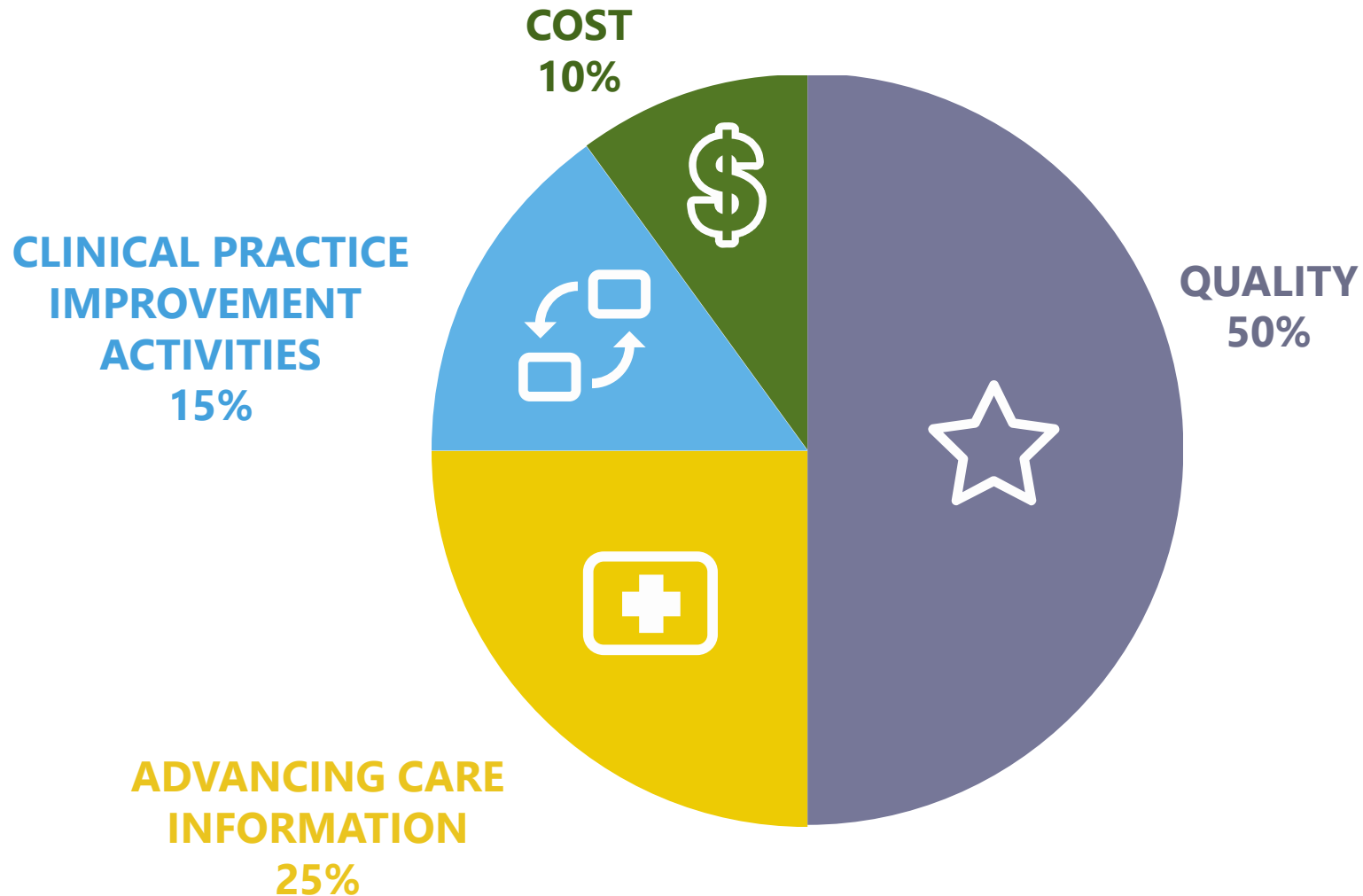


**Advancing
care
information**



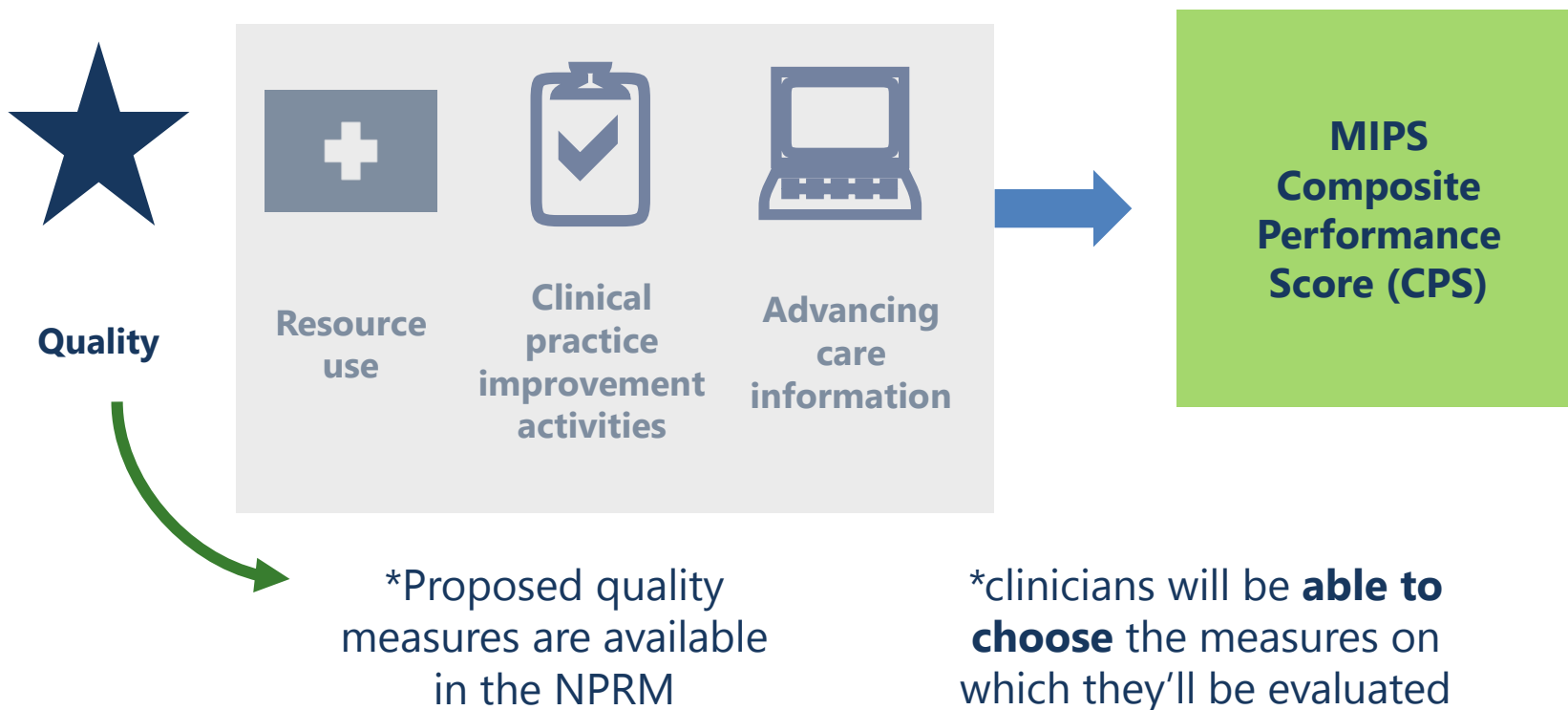
**MIPS
Composite
Performance
Score (CPS)**

Year 1 Performance Category Weights for MIPS



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** :



PROPOSED RULE

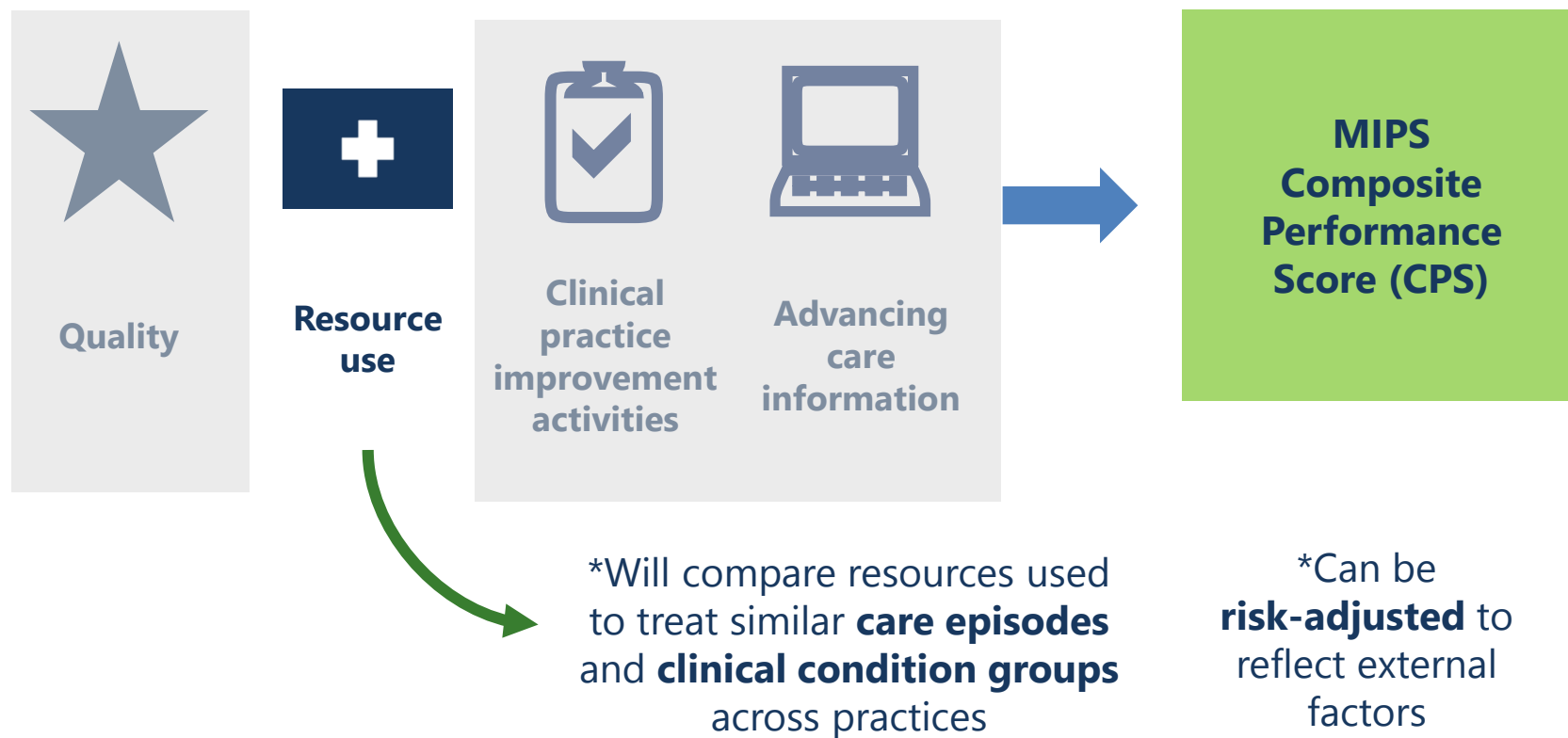
MIPS: Quality Performance Category

Summary:

- ✓ **Selection of 6 measures**
- ✓ **1 cross-cutting measure and 1 outcome measure, or another high priority measure if outcome is unavailable**
- ✓ **Select from individual measures or a specialty measure set**
- ✓ **Population measures automatically calculated**
- ✓ **Key Changes from Current Program (PQRS):**
 - **Reduced from 9 measures to 6 measures with no domain requirement**
 - **Emphasis on outcome measurement**
 - **Year 1 Weight: 50%**

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** :



PROPOSED RULE

MIPS: Resource Use Performance Category

Summary:

- ✓ **Assessment under all available resource use measures, as applicable to the clinician**
- ✓ **CMS calculates based on claims so there are no reporting requirements for clinicians**
- ✓ **Key Changes from Current Program (Value Modifier):**
 - **Adding 40+ episode specific measures to address specialty concerns**
 - **Year 1 Weight: 10%**

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** :



*Examples include care coordination, shared decision-making, safety checklists, expanding practice access

PROPOSED RULE

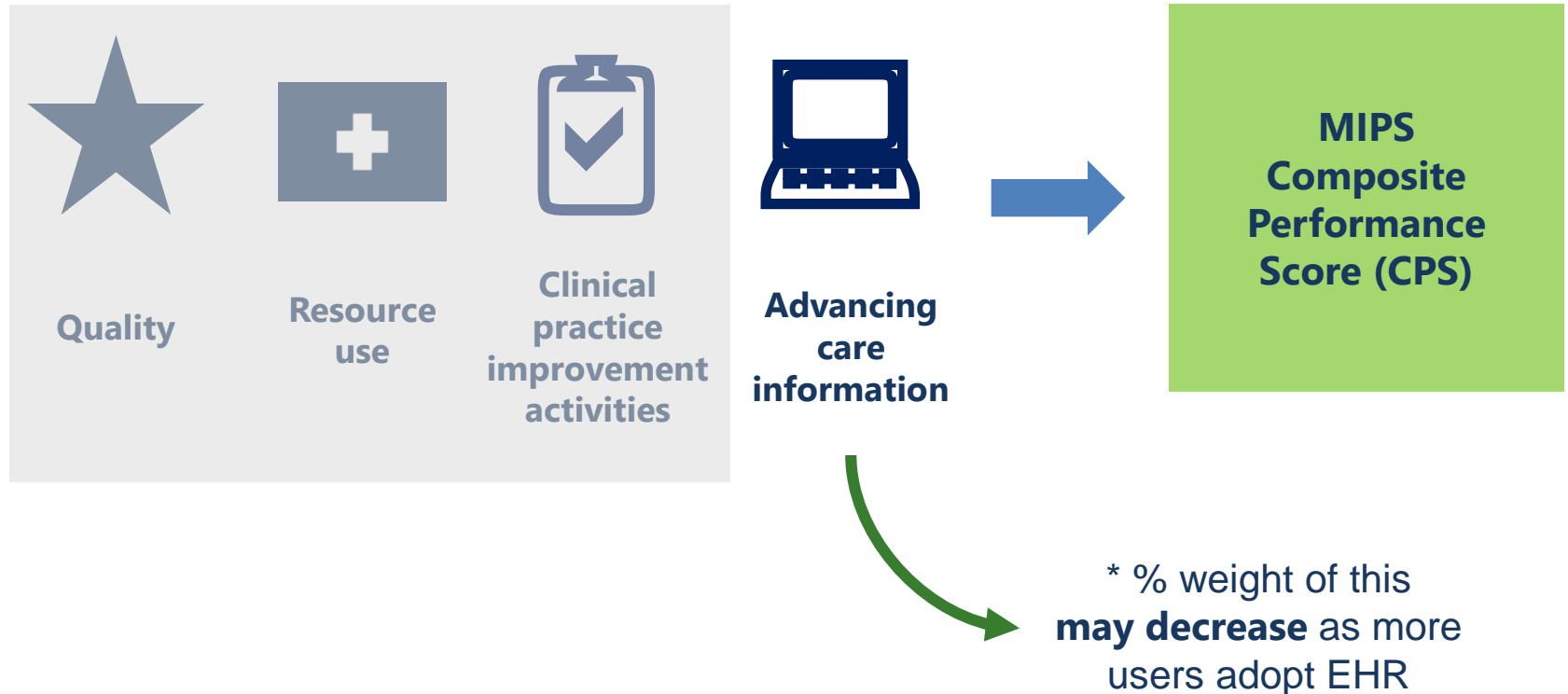
MIPS: Clinical Practice Improvement Activity Performance Category

Summary:

- ✓ **Minimum selection of one CPIA activity (from 90+ proposed activities) with additional credit for more activities**
- ✓ **Full credit for patient-centered medical home**
- ✓ **Minimum of half credit for APM participation**
- ✓ **Key Changes from Current Program:**
 - **Not applicable (new category)**
 - **Year 1 Weight: 15%**

What will determine my MIPS score?

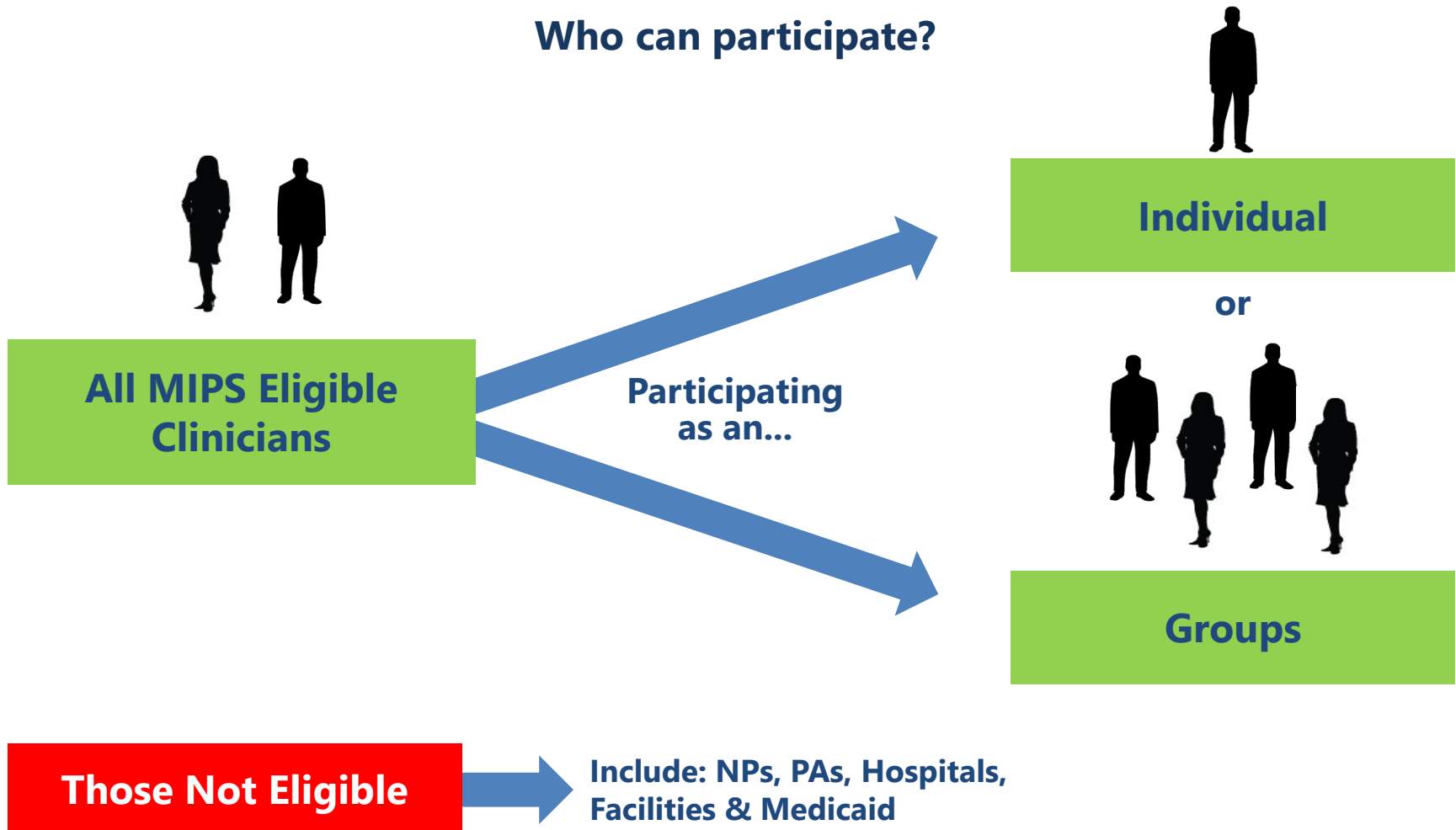
The MIPS composite performance **score** will factor in performance in **4 weighted performance categories on a 0-100 point scale** :



PROPOSED RULE

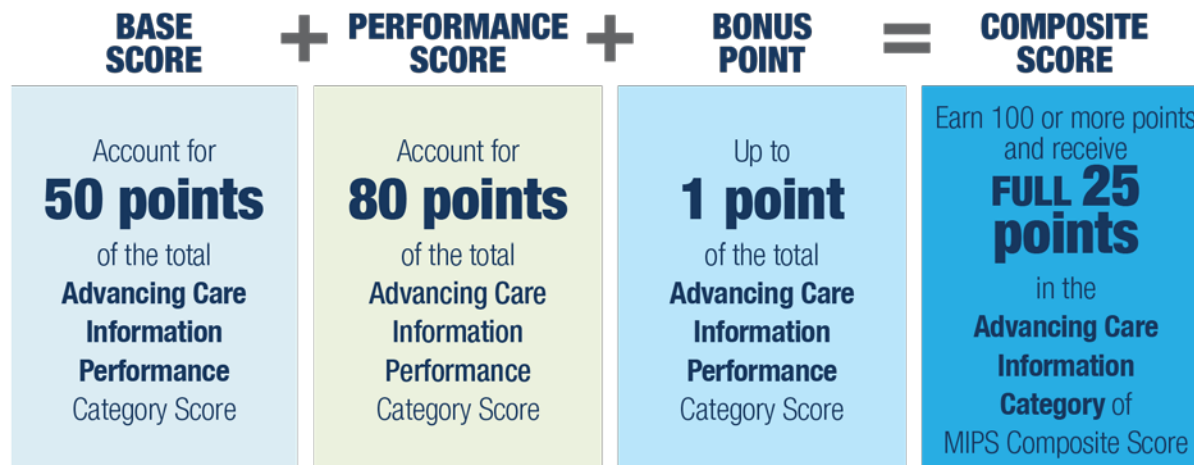
MIPS: Advancing Care Information Performance Category

Who can participate?



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 points

PROPOSED RULE

MIPS: Advancing Care Information Performance Category

**BASE
SCORE**

BASE SCORE

**Accounts for
50 points
of the total
Advancing Care
Information
category score.**

To receive the base score, physicians and other clinicians must simply provide the numerator/denominator or yes/no for each objective and measure

PROPOSED RULE

MIPS: Advancing Care Information Performance Category

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

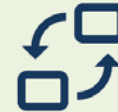
The performance score accounts for up to 80 points towards the total Advancing Care Information category score



**Patient Electronic
Access**



**Coordination of Care Through
Patient Engagement**



**Health Information
Exchange**

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

PROPOSED RULE





MIPS: Advancing Care Information Performance Category

Summary:

- ✓ **Scoring based on key measures of health IT interoperability 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: Performance Category Scoring

Summary of MIPS Performance Categories		
Performance Category	Maximum Possible Points per Performance Category	Percentage of Overall MIPS Score (Performance Year 1 - 2017)
 Quality: 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.	80 to 90 points depending on group size	50 percent
 Advancing Care Information: Clinicians will report key measures of interoperability and information exchange. Clinicians are rewarded for their performance on measures that matter most to them.	100 points	25 percent
 Clinical Practice Improvement Activities: 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.	60 points	15 percent
 Cost: CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything.	Average score of all cost measures that can be attributed	10 percent

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**:







The CPS will be compared to the MIPS performance threshold to determine the adjustment percentage the eligible clinician will receive.

PROPOSED RULE

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

- ✓ **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**

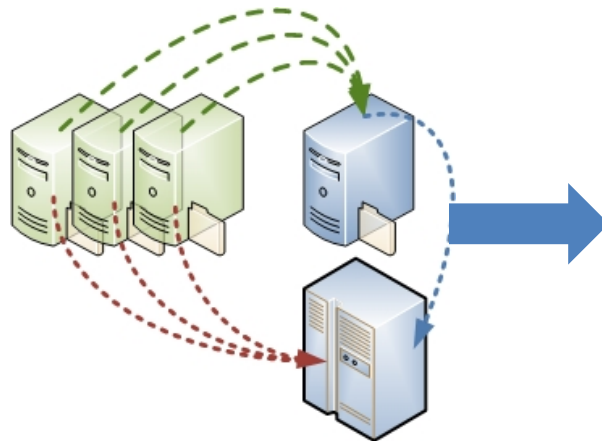
Calculating the Composite Performance Score (CPS) for MIPS

Category	Weight	Scoring
 Quality	50%	<ul style="list-style-type: none"> Each measure 1-10 points compared to historical benchmark (if avail.) 0 points for a measure that is not reported Bonus for reporting outcomes, patient experience, appropriate use, patient safety and EHR reporting Measures are averaged to get a score for the category
 Advancing care information	25%	<ul style="list-style-type: none"> Base score of 60 points is achieved by reporting at least one use case for each available measure Up to 10 additional performance points available per measure Total cap of 100 percentage points available
 CPIA	15%	<ul style="list-style-type: none"> Each activity worth 10 points; double weight for "high" value activities; sum of activity points compared to a target
 Resource Use	10%	<ul style="list-style-type: none"> Similar to quality

- ✓ 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

Quality and Resource Use

Individual Reporting



Group Reporting



Quality

- ✓ QCDR
- ✓ Qualified Registry
- ✓ EHR Vendors
- ✓ Administrative Claims (No submission required)
- ✓ Claims

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- ✓ Qualified Registry
- ✓ EHR Vendors
- ✓ Administrative Claims (No submission required)
- ✓ CMS Web Interface (groups of 25 or more)
- ✓ CAHPS for MIPS Survey



Resource use

- ✓ Administrative Claims (No submission required)

- ✓ Administrative Claims (No submission required)

PROPOSED RULE

MIPS Data Submission Options

Advancing Care Information and CPIA

Individual Reporting



Group Reporting



**Advancing
care
information**



CPIA

- ✓ Attestation
- ✓ QCDR
- ✓ Qualified Registry
- ✓ EHR Vendor

- ✓ Attestation
- ✓ QCDR
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- ✓ EHR Vendor
- ✓ Administrative Claims (No submission required)

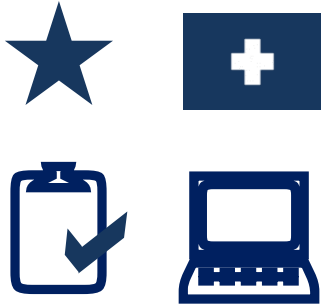
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PROPOSED RULE MIPS PERFORMANCE PERIOD & PAYMENT ADJUSTMENT


PROPOSED RULE

MIPS Performance Period



**MIPS Performance
Period
(Begins 2017)**

- ✓ 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).

2017	2018	2019	2020	2021	2022	2023	2024	2025
								
Performance Period		Payment Year						

PROPOSED RULE

MIPS: Payment Adjustment

- ✓ 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%.



Quality



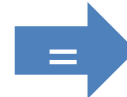
Resource
use



Clinical
practice
improvement
activities



Advancing
care
information



MIPS
Composite
Performance
Score (CPS)



PROPOSED RULE

MIPS: Payment Adjustment

- ✓ 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 percentile of possible values above the CPS performance threshold.



Quality



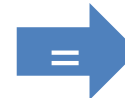
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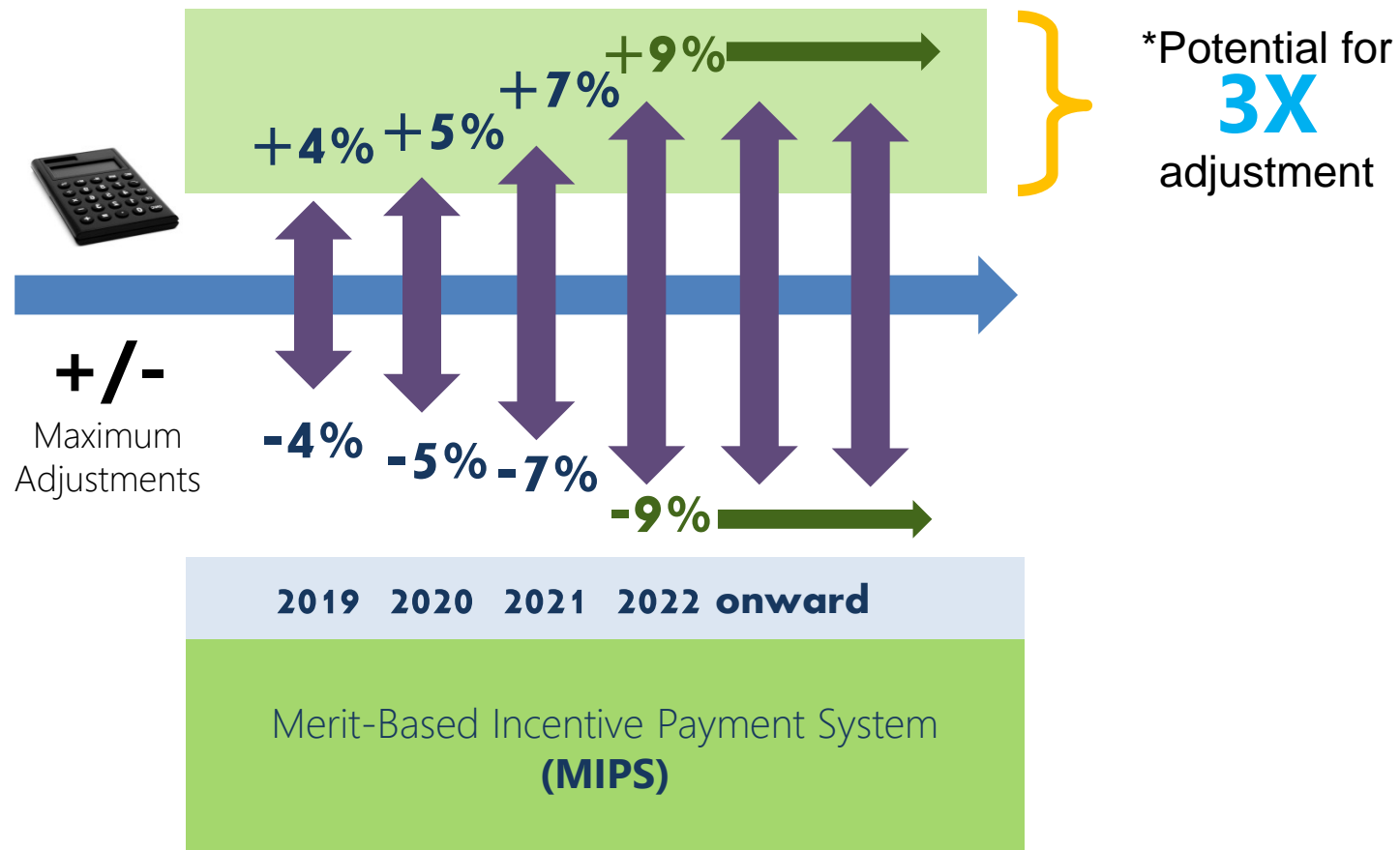


MIPS
Composite
Performance
Score (CPS)

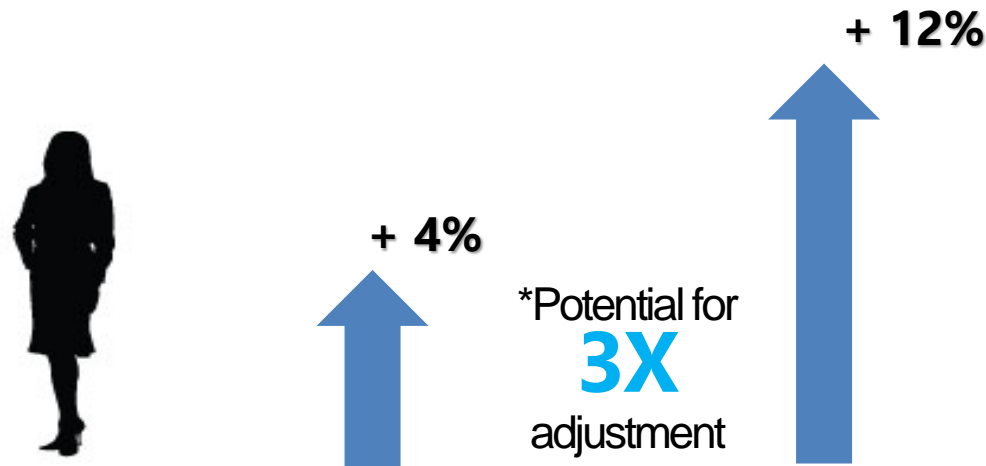


How much can MIPS adjust payments?

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



MIPS: Scaling Factor Example

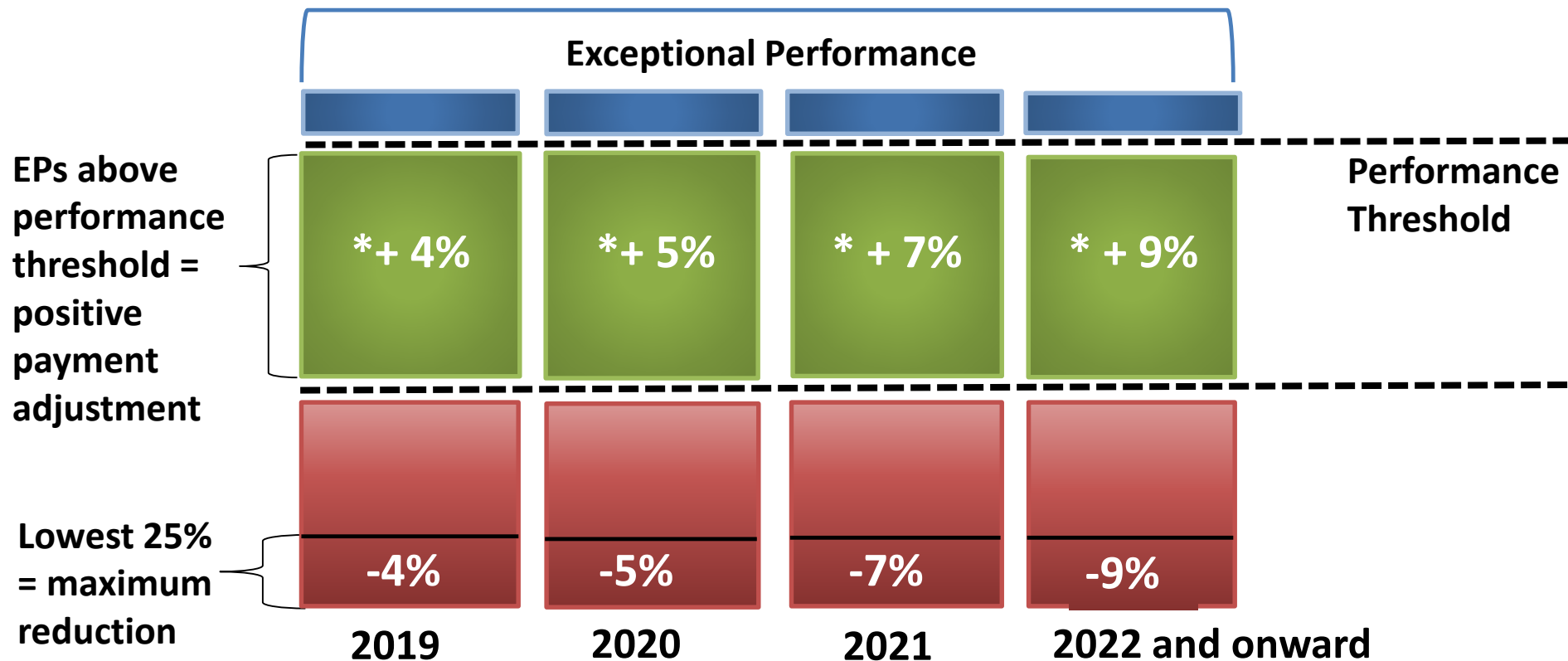


Dr. Joy Smith, who receives the +4% adjustment for MIPS, could receive up to +12% in 2019. For exceptional performance she could earn an additional adjustment factor of up to +10%.

Note: This scaling process will only apply to positive adjustments, not negative ones.

MIPS Incentive Payment Formula

Exceptional performers receive additional positive adjustment factor – up to \$500M available each year from 2019 to 2024

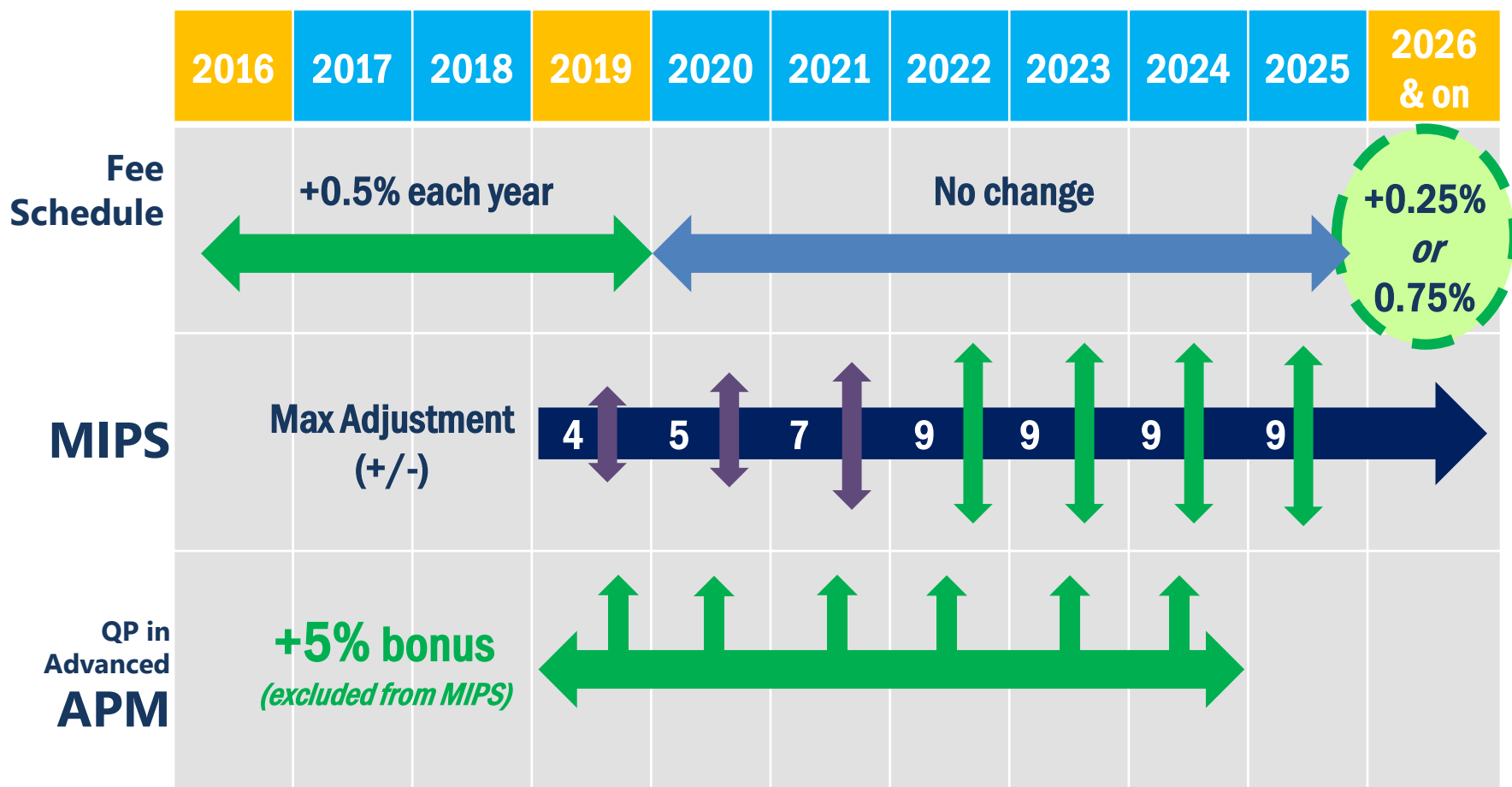


**MACRA allows potential 3x upward adjustment BUT unlikely*

A vintage brass alarm clock with two bells and a winding handle, resting on a wooden surface. The clock face is visible, showing numbers 1 through 12 and some smaller numbers like 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24. The clock is positioned on the right side of the frame. A semi-transparent green rectangular box is overlaid on the left side of the clock, containing the text.

When will these Quality Payment Program provisions take effect?

Putting it all together:



TAKE-AWAY POINTS

- 1) The Quality Payment Program **changes the way Medicare pays clinicians** and offers financial **incentives** for providing high **value** care.
- 2) Medicare **Part B clinicians** will participate in the **MIPS**, unless they are in their 1st year of Part B participation, become QPs through participation in **Advanced APMs**, or have a low volume of patients.
- 3) Payment adjustments and bonuses will begin in **2019**.

Current State of Education & Outreach

- Users are unaware of key dates or opportunities to learn more about the program until it's too late
 - Ex. A practice found out that in order to qualify for an incentive payment for the current year they would have had to submit data one year beforehand, therefore missing out on incentive for the year
- Hard to navigate cms.gov
- Many sources of information that don't align which is problematic since CMS is a trusted source by users
 - Current sources being used, CMS.gov, listservs, Quality Improvement Organizations (QIOs), Quality Improvement Networks (QINs), Regional Extension Centers (RECs), Consultant websites, specialty societies, Electronic Health Record Vendors (EHR), Data Registries, Qualified Clinical Data Registries (QCDRs), etc.

Current State of Education & Outreach

- Complex program creating lots of time wasted trying to find out who has the right answer
- Multiple users with very different needs
- Large volume of communication hinders keeping track of what to pay attention and what is relevant to the user

Customer Insights

Imagine CMS was a grocery store. Can you describe what it's like to shop there?



Potential Types of Users/Customers

- Physicians, Nurse Practitioners, Physician Assistants
 - Broad and diverse practice setting and specialty focus
- APM Entities
- Non-clinical staff (e.g. Office Managers/Practice Managers/Administrators)
- Registries
- EHR Vendors
- Quality Analysts

Clinician & Practice Quotes

“If I have to choose between what’s best for the patient or the checkbox, I will choose the patient every time”.

“Our savviest policy physicians were overwhelmed after 15 minutes of a MACRA overview”

“Give me information specific to a Radiologist”

Q & A



Co-design Time

