



MIPS 101:

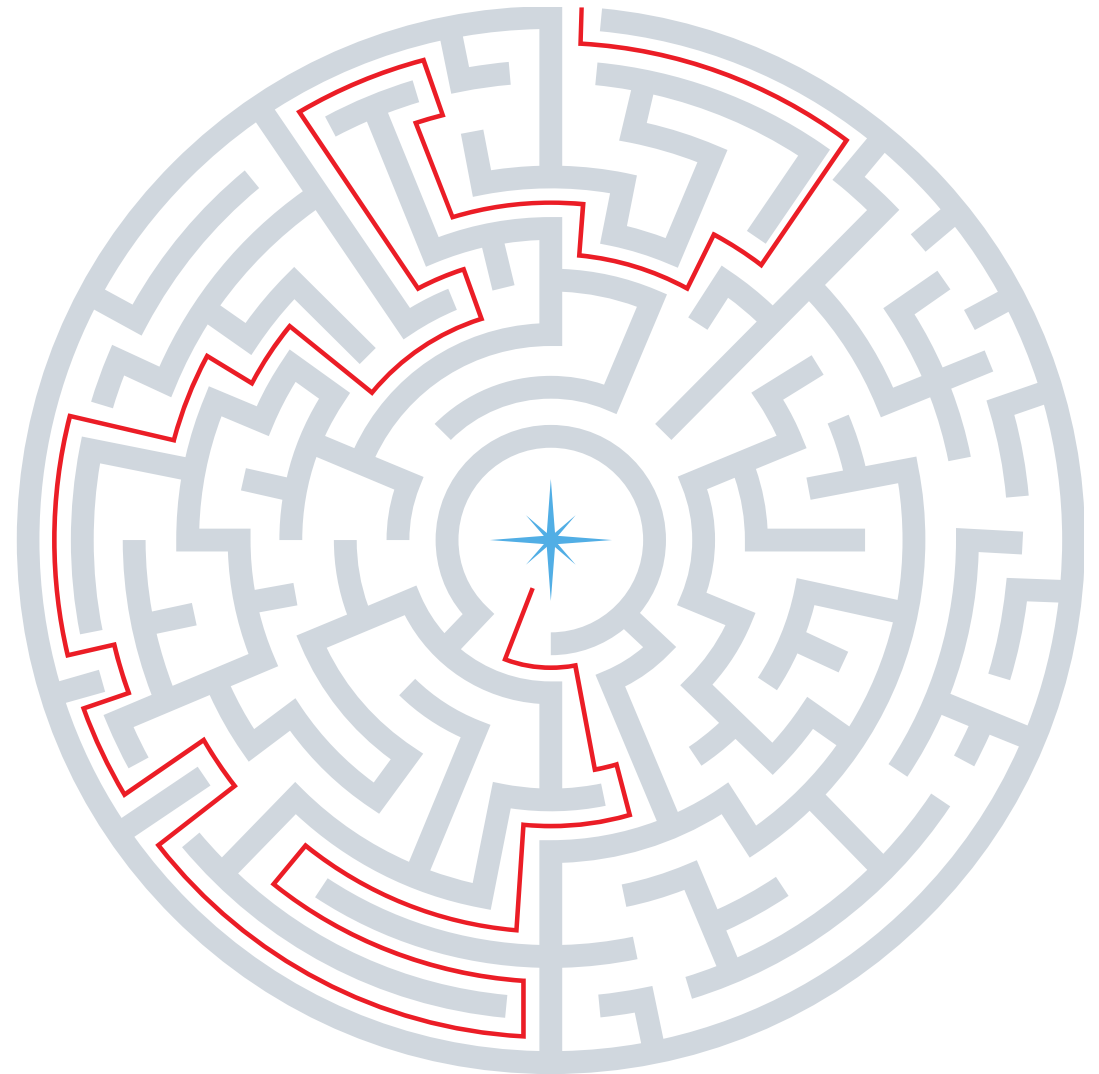
Introduction to the Merit-Based Payment System







AUGUST 2016



MIPS is the new Medicare payment system for physicians. This document is designed to guide you through the basics of this new system. It will help you answer:

- What is MIPS?
- Does MIPS apply to your practice?
- How does MIPS change your Medicare payments and reporting requirements?
- What does MIPS mean for your practice?



-  Introduction to MIPS
-  Your Practice's Eligibility
-  Key Payment Changes from MIPS
-  New Proposed Reporting Requirements
-  Timeline of Changes
-  Implications for Your Practice

With the passage of MACRA, MIPS is Medicare's default payment track for physicians:

Focus of this Document



Track 1: Merit-Based Incentive Payment System (MIPS)

- Medicare's default payment track, starting in 2019 (performance period begins 2017)
- Practices are scored across quality, cost, EHR, and practice improvement metrics
- A composite performance score (CPS) sets annual incentives / penalties*
- Exceptional performers can receive up to 10% in bonus payments from 2019 to 2024*




Track 2: Advanced Alternative Payment Models (AAPMs)

- Practices in an Advanced APM are exempt from MIPS incentives / penalties
- These practices are also exempt from MIPS reporting requirements
- Practices receive a 5% annual payment bonus from 2019 to 2024

MIPS will replace 3 current Medicare reporting and incentive programs:

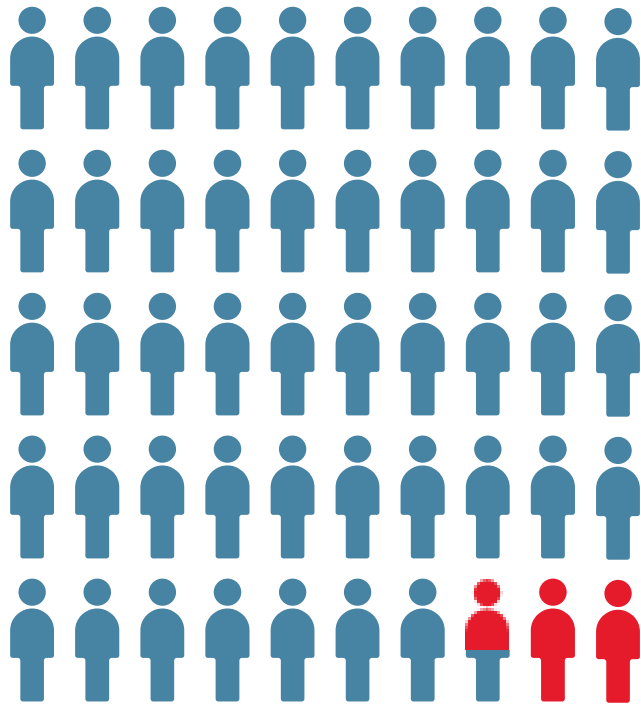
1. Meaningful Use (MU)
2. Physician Quality Reporting System (PQRS)
3. Value Based Payment Modifier (VM)

A large blue right-facing curly bracket that groups the three items in the list above it.

For more information on these programs, see the Appendix

Your practice is subject to MIPS unless you fall into one of 3 exemption categories:

MIPS applies to ~95% of the physicians in the U.S.*



Physician Exemptions from MIPS+

1. **New Medicare Physicians:** this is your first year receiving payments from Medicare
2. **Low Volume Medicare Physicians:** you have Medicare billing charges of <\$10,000 per year and you provide care for 100 or fewer Medicare patients per year
3. **Qualified Participants in Advanced APMs:** you participate in an Advanced Alternative Payment Model, such as:
 - Medicare Shared Savings Program – two-sided risk
 - Comprehensive Primary Care Plus
 - Next Generation ACO Model

*Percentage of physicians in MIPS estimated by CMS

+Criteria for physician exemptions are subject to change in final CMS rule

Under MIPS, your practice faces 3 changes to Medicare payments:

- ### 1 Fee Schedule Increases

 - Baseline increases of 0.5% per year to your Medicare payments from 2016 to 2019
 - Baseline increases of 0.25% per year to your Medicare payments, starting in 2026*
- ### 2 MIPS Incentives / Penalties

 - Annual positive/negative adjustments to your Medicare payments, based on your MIPS composite performance score (new scoring index, starting in 2017)
 - Scheduled increases in incentives / penalties over time:

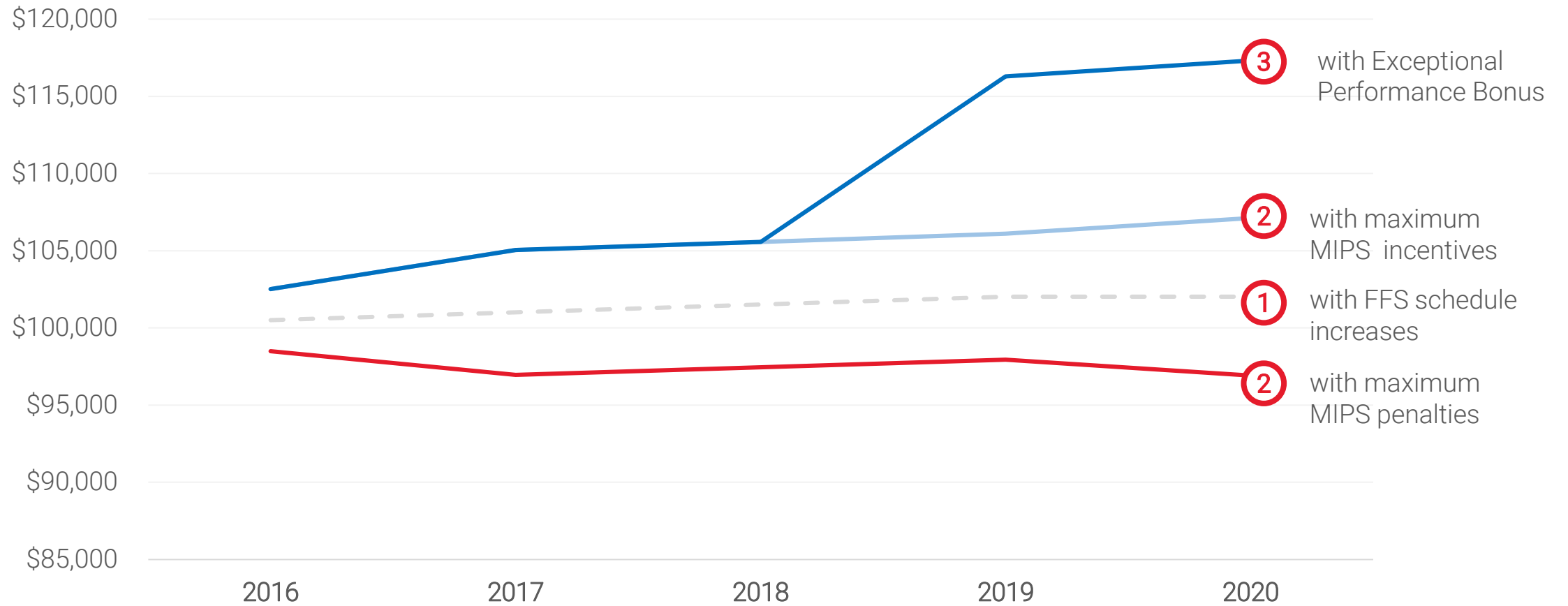
2019: +/- 4% of Medicare payments	2021: +/- 7% of Medicare payments
2020: +/- 5% of Medicare payments	2022: +/- 9% of Medicare payments
- ### 3 MIPS Exceptional Performance Bonus

 - Applies if your practice scores above the “exceptional performance” threshold on the MIPS scoring index (threshold to be determined)
 - Potential bonus of 10% of Medicare payments per year from 2019-2024⁺





Confidential & Proprietary *Assumes no participation in an Advanced Alternative Payment Model (APM)
+Amount for exceptional performance bonus subject to change in final CMS rule

These changes will create wide variation in revenue for the same set of Medicare services:

Example: Projected Medicare Payments on \$100K Business Today



Your practice's penalties / incentives will be based on a new composite performance score:

MIPS Composite Performance Score (CPS) Category	Score Weighting	
	2017*	MSSP**
 Quality <i>(PQRS Style Measures)</i>	50%	50%
 Clinical Practice Improvement Activities <i>(Practice Processes)</i>	15%	20%
 Advancing Care Information <i>(Rebranded Meaningful Use)</i>	25%	30%
 Resource Use <i>(Total Patient Costs)</i>	10%	N/A ⁺





- First year of MIPS scoring emphasizes quality metrics*
- Practices in non-Advanced APMs (e.g., Medicare Shared Savings – Track 1) are not scored on costs
- Performance period begins in 2017 and sets your incentives/penalties for 2019**
- Failure to report = maximum penalties

*Weighting will shift over time, with Quality and Resource Use both weighted at 30% by 2019

+Participants in the Medicare Shared Savings Program – Track 1 are exempt from cost scoring in the proposed rule





**Start date of performance period and weighting of MSSP are subject to change in final CMS rule

Starting next year, your practice must submit detailed reporting measures for this score:

CPS Category	Reporting Requirements for Practices*	Submission Method*
 <p>Quality</p>	<ul style="list-style-type: none"> Pick 6 out of 100 measures to report (PQRS/MU eQuality) Must report 1+ outcome measure (e.g., HbA1c poor control) 	<ul style="list-style-type: none"> Claims GPRO Registries (Bonus Points) EHR Submission (Bonus Points)
 <p>Clinical Practice Improvement Activities</p>	<ul style="list-style-type: none"> Pick from menu of 90+ activities with different weights All activities weighted 10 points or 20 points Need 60 points for full credit 	<ul style="list-style-type: none"> Attestation Exploring EHR and Registry Submission Can be reported at group level
 <p>Advancing Care Information</p>	<p>12 Total Measures in 3 Categories (11 Required)</p> <ul style="list-style-type: none"> Need 100 out of 131 possible points 50 points for reporting all 11 measures 80 possible points for performance on 8 measures 1 bonus point for reporting the 12th measure 	<ul style="list-style-type: none"> Same as Clinical Practice Improvement Activities
 <p>Resource Use</p>	<ul style="list-style-type: none"> No practice reporting required (calculated from claims) 	<p>N/A</p>

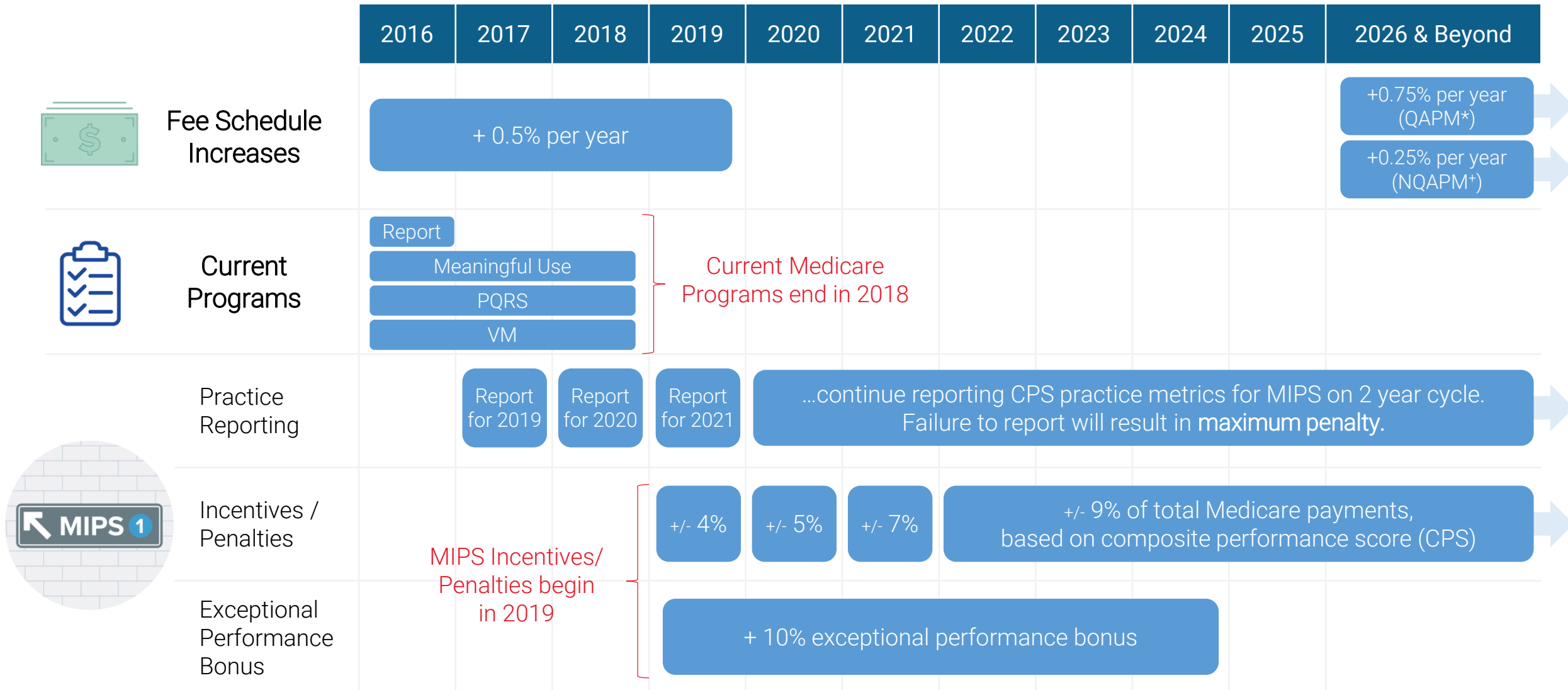
Details subject to change in final CMS rule (published Nov 2016)

If you participate in an ACO (e.g., MSSP – Track 1*), your practice has several advantages:

CPS Category	Advantages for Practices in MSSP - Track 1*
 <p>Quality</p>	<ul style="list-style-type: none"> • No reporting required from practices (ACO submits on behalf of practices through GPRO) • ACO's quality measures replace MIPS measures
 <p>Clinical Practice Improvement Activities</p>	<ul style="list-style-type: none"> • Same overall requirements (60 points = full credit) • Practice gets 30 points automatically for being in MSSP
 <p>Advancing Care Information</p>	<ul style="list-style-type: none"> • None (same requirements and submission method)
 <p>Resource Use</p>	<ul style="list-style-type: none"> • Shared savings from MSSP replaces this category • Practices not assessed on cost performance for MIPS

MSSP advantages will be impacted by changes to final CMS rule (published Nov 2016)

Timeline of Changes



*Physicians in Qualifying APMs (QAPM) receive a fee schedule increase of 0.75% per year, starting in 2026

+Physicians not in Qualifying APMs (NQAPM) receive a fee schedule increase of 0.25% per year, starting in 2026

**Timing of reporting requirements subject to change in final CMS rule

MIPS impacts your practice in several ways:



Medicare Payments at Risk

- A growing share of your Medicare payments are at risk
- Your cost and quality performance will lead to penalties or incentives



New Reporting Requirements

- Under MIPS, your practice must report quality, EHR use, and practice improvement information
- Failing to report leads to maximum penalties
- Joining an APM can help relieve the reporting burden and improve performance



Key Decision on Joining APMs

- MACRA encourages practices to join Alternative Payment Models (APMs)
- You should decide whether APMs offer a better future for your practice



Preparing for Value Based Care

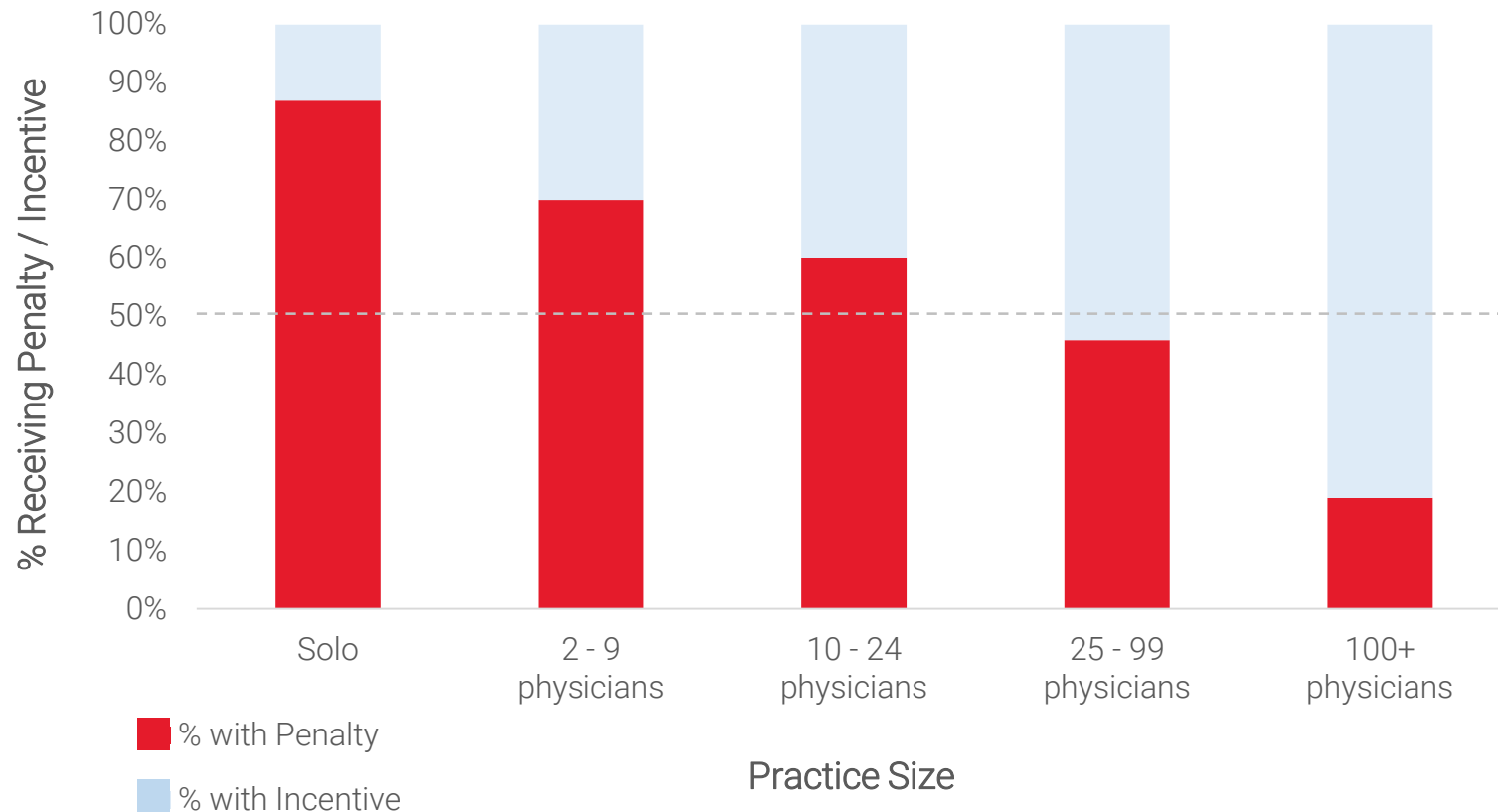
- Your practice will be penalized / rewarded based on cost and quality performance
- To survive, you need strategic, technological, and operational capabilities to successfully deliver value based care



Medicare Payments at Risk

Most small practices will likely be penalized by CMS in 2019*:

Estimated Impact to Practices from MIPS (2019)*



- Due to the burden of new reporting requirements, most small practices are expected to be penalized by CMS in 2019*:
 - 87% of solo practices
 - 70% of practices with 2 - 9 physicians
- In contrast, the majority of large practices (25+ physicians) are expected to receive incentives

Appendix



Acronym	Program	Description
MU	Meaningful Use	<p>Part of the EHR Incentives & Certification program, Meaningful Use defines the ways in which healthcare providers are required to use certified electronic health records to improve quality/safety /efficiency, engage patients and family, improve care coordination and population health, and maintain privacy and security of patient health information.</p> <p>Meaningful Use guidelines are staggered into 3 stages, with requirements gradually expanding from 2011 to 2016. Failure to attest to Meaningful Use results in annual penalties of up to 3% of Medicare payments by 2017.</p> <p><i>Note: Penalties and incentives levered under Meaningful Use will expire in 2018</i></p> <p>For more information, see guidelines published by the Office of the National Coordinator.</p>
PQRS	Physician Quality Reporting System	<p>The Physician Quality Reporting System is a program overseen by CMS that requires physicians and group practices to report specified quality metrics. Failure to report the specified quality data face penalties of 2% of Medicare payments by 2017.</p> <p><i>Note: Penalties and incentives levered under PQRS will expire in 2018</i></p> <p>For more information, see the guidelines published on the CMS website.</p>

Acronym	Program	Description
SGR	Sustainable Growth Rate	<p>Established in 1997 to control Medicare payments to physicians, the sustainable growth rate (SGR) determined a target maximum growth rate in total Medicare physician payments. If the actual growth rate exceeded the target maximum, Medicare would cut all physician payments indiscriminately to meet the target growth rate.</p> <p>Since 2002, Congress passed temporary “doc fixes” each year to avoid cutting physician payments.</p> <p>Note: The passage of MACRA in 2015 repealed the SGR in favor of a new value-based payment system.</p>
VM	Value Based Payment Modifier	<p>The Value-Based Payment Modifier (VM) is a physician payment program designed to incentivize or penalize physicians according to their performance along several quality and cost metrics.</p> <p>The VM program was the precursor to MIPS, with physician practices facing gradual introduction of penalties and incentives up to +/-2% of Medicare payments from 2016 to 2018.</p> <p><i>Note: All eligible professionals (i.e., all currently practicing physicians) in the U.S. face penalties and incentives determined by the VM program through 2018.</i></p> <p>For more information, see the guidelines published on the CMS website.</p>

- <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program.html>
- <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/NPRM-QPP-Fact-Sheet.pdf>
- <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-MIPS-NPRM-Slides.pdf>