Common QPP Pitfalls: MIPS

FEBRUARY 16, 2017

About Tom Lee, Ph.D.
Founder & CEO of SA Ignite

Tom is a serial entrepreneur and leading expert in healthcare value-based programs such as MIPS, MACRA, Meaningful Use, and PQRS. He is the father of two small children and after a frightening personal healthcare experience, his concern for their future in the world inspired him to create a company that matched his personal passion: driving innovation in the public healthcare system. Leveraging its cloud-based physician performance analytics and reporting platform, SA Ignite has grown to serve 15,000+ providers in 80+ healthcare organizations. Tom is a member of the Young Presidents' Organization and earned a B.S. with Distinction in Physics from Stanford, a Ph.D in Physics from U.C. Berkeley where he was a National Science Foundation Fellow, and an M.B.A. with Distinction from the Kellogg School of Management at Northwestern University.

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Today's agenda

- Happenings in Washington, D.C.
  - Feb 10 - Rep. Tom Price, MD confirmed as new HHS Secretary
  - Rep. Price helped architect and voted for MACRA QPP
  - 2 Republican senators expressed support for CMS Innovation Center (CMMI)
- HIMSS (Feb 19-23)
  - See our blog "What to look for at HIMSS 2017"
- **Part 1 of Common QPP Pitfalls: MIPS**

6 common MIPS pitfalls

1. There is no downside to doing the minimum to avoid a penalty.
2. There is no need to re-examine how we monitor and report quality.
3. We will report all quality measures for which we have data.
4. There is no need to re-examine how we monitor and report MU.
5. Our MSSP ACO will handle all our MIPS reporting needs.
6. Since we are in an Advanced APM, there is no need to track MIPS.

1. There is no downside to doing the minimum to avoid a penalty

- Low MIPS scores will be viewable by consumers
  - Even for clinicians reporting as a group
  - Data will be available via Physician Compare and consumer sites like Yelp, Angie's List, and Consumer Reports
- Reporting only 1 measure could yield a MIPS score of only 3 out of 100
- Risk of falling behind competition and being penalized in the future
  - 74% of CIOs polled will report beyond the minimum requirements
  - In 2018 or 2019, performance threshold set equal to national average thereafter

The "MIPS Accelerating Treadmill"

MIPS score and payment adjustment attached to clinicians for 2 years

	2017	2018	2019	2020
Performance Year Worksite	Org A	Org B	Org C	
Reporting	Individual's Score	Group's Score		
Payment Year Worksite			Org C is paid based on Org A score	Org C is paid based on Org B score

Credentialing & Contracting

Compensation

M&A

2. There is no need to re-examine how we monitor and report quality

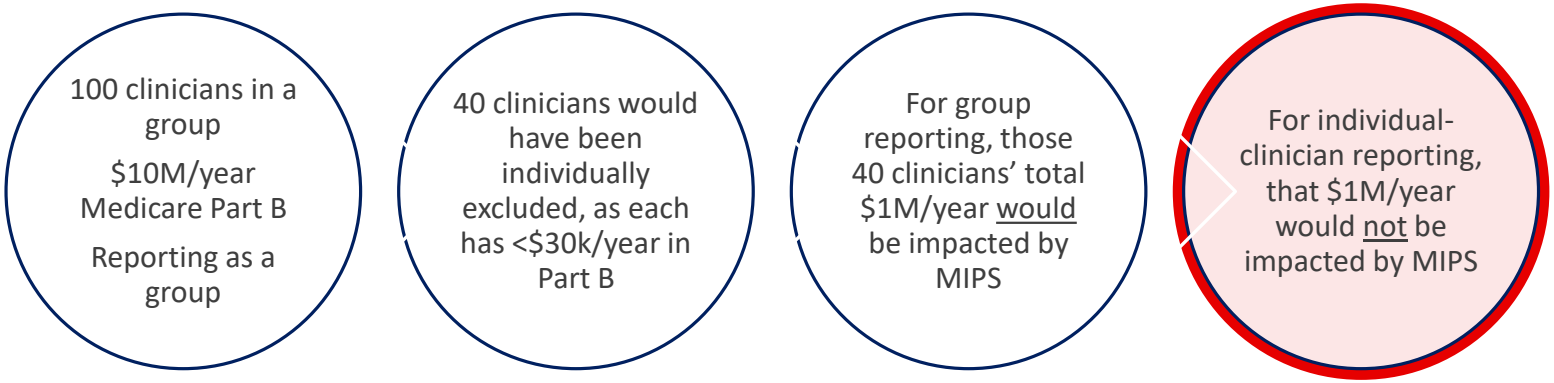
- Past penalty avoidance is no guarantee of MIPS success
  - MIPS quality benchmarks vary based on reporting method
  - New scoring methodology is pay-for-performance, not pay-for-reporting
- "Measures group" individual-provider method is gone
- CAHPS patient satisfaction survey is no longer required for groups
- For reporting across multiple EHRs in one TIN, re-consider GPRO EHR Direct
- The end-to-end reporting bonus effectively helps subsidize electronic reporting methods

MIPS low-volume exclusion amplifies importance of the individual vs. group reporting decision

Example 1:

MIPS low-volume exclusion amplifies importance of the individual vs. group reporting decision

Example 2:

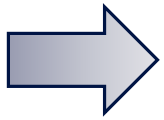


3. We will report all quality measures for which we have data

- All reported measure values, whether good or bad, will be considered for public reporting to consumers
- Clinicians may not agree with CMS' selection of the "top six" measures to count towards the quality score
- Submitting measures beyond those that will maximize the quality score unnecessarily expands audit risk

CMS confirmation:
All measure values will be publicly reported

If a clinician reports more than six measures, will only the six measures be publicly reported or all submitted measures?



"If a clinician or group submits individual measures and they meet the public reporting standards, they may be publicly reported. So, the assumption is if submitted, measures will be available for public reporting even if the number of measures are above the reporting requirement."

- The CMS Quality Payment Program Support Team

4. There is no need to re-examine how we monitor and report MU

- New group reporting option may increase the ACI score
  - Caveat: EHRs may not support group reporting natively
- Conversion from all-or-nothing to continuous scoring system can cause lower-than-expected ACI scores

Advancing Care Information (ACI) scoring

BASE SCORE	+	PERFORMANCE SCORE	+	BONUS POINTS	=	ACI SCORE

50 points (required)	**Max 90 points**	**Max 15 points**	Earn 100 or exceed 100 and receive full **25 points** in the **ACI Category** of MIPS Final Score
• 5 required measures • 2017: Only 4 measures • All numerators >0 or "yes," otherwise *entire* ACI score is 0	• 9 measures each scored on decile scale, e.g. 71% to 80% earns 8 points • 2017 only 7 measures, same total max points	• At least one additional public health reporting (5 points) • Cross-category bonus: Report improvement activity via CEHRT (10 points)	

Takeaway: Past high MU compliance does not assure a high ACI score.
Real Example: 97% past MU compliance but ACI score only 78%

5. Our MSSP ACO will handle all our MIPS reporting needs

- **MSSP Track 1:** ACI must be reported by each participating TIN
  - CMS calculates weighted average based on each TIN's # of MIPS ECs (next slide)
- All clinicians inherit the ACO's MIPS score – What's the estimate?
- How will performance be monitored across all TINs, MIPS categories, and at the clinician level to enable improvement?
- If a TIN separately reports MIPS, then the ACO's MIPS score will always override the TIN's separately acquired MIPS score (slide after next)
- **Takeaway:** Each TIN's "MIPS fate" is tied to the ACO, but each TIN has obligations to fulfill in order to maximize the shared MIPS score

MSSP ACO: MIPS scoring standard

All MSSP ECs will receive the ACO MIPS score and equivalent payment adjustment

50
POINTS

Quality

Submitted via CMS Web Interface for the ACO

30
POINTS

Advancing Care Information

Submitted via ACO participant TINs

20
POINTS

Improvement Activities

ACO receives full credit, no action required

0
POINTS

Cost

The ACO's MIPS score always overrides

(Not True for Non-APM Clinicians)

Example: MSSP ACO

2017 1H | **2017 2H** | **2018** | **2019**

Clinician Switches TIN

ACO TIN A: MIPS Score A

TIN B: MIPS Score B

ACO's MIPS Score A Adjusts TIN B $

Clinician With 2 MIPS Scores

ACO TIN: MIPS Score 1

TIN: MIPS Score 2

ACO's MIPS Score 1 Adjusts TIN A $

6. Since we are in an Advanced APM, there is no need to track MIPS

- Clinicians joining an Advanced APM entity after Aug 31 are subject to MIPS for one year
- What is the risk your Advanced APM entity will not meet the “PQP” threshold to gain a MIPS exemption?
- Track your MIPS baseline to see how much MIPS money you would otherwise have earned and in case you decide to leave the Advanced APM and participate in MIPS
- MIPS will be the most pervasive physician scoring mechanism in the industry
  - Applicable to credentialing, contracting, compensation, and other areas of operations

Educational Resources

New! SA Ignite's relaunched website + HIMSS 2017 - Booth #3375

10 FAQs About MIPS (Google "mips")

- www.saignite.com/MIPS-FAQs

10 FAQs About APMs

- www.saignite.com/APM-FAQs

Free MIPS Financial Calculator (Google "mips calculator")

- www.saignite.com/resources

Recorded MIPS monthly webinars and downloads:

- www.saignite.com/the-abcs-of-mips-webinars

LinkedIn Group "Merit-Based Incentive Payment System"

Thank you for joining us

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