APMs Are Here and MIPS Is Coming Sooner Than You Think: How to Plan for the Unknown

written by Dave Halpert | March 9, 2016

How do you prepare for a program with yet-to-be-defined rules that will involve larger potential penalties (or incentives)—but requires long term planning? It's a real quandary, but the time is now to begin thinking strategically about the upcoming Merit-Based Incentive Payment System, or MIPS.

MIPS Fundamentals

MIPS was created from the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The Act succeeded in expunging the looming but flawed "Sustainable Growth Rate" formula, replacing impending cuts with reimbursement tied to Value-Based Health Care. MIPS details may be lacking, but the overall MIPS framework is taking shape. Scheduled to begin on January 1, 2019, MIPS will absorb three existing initiatives:

The Physician Quality Reporting System (PQRS)
The Value-Based Payment Modifier (VBPM)
Meaningful Use (MU)

Rather than having separate programs for reporting, scoring and quantifying clinical information, MIPS will streamline this administrative burden by creating an overall score, based on four components:

Quality
Resource Use
Clinical Practice Improvement

Meaningful Use of Certified EHR Technology (CEHRT)

MIPS forges the path toward two goals developed by the Department of Health and Human Services: Expand available Alternate Payment Models (APMs) and tie Medicare payments to their results; and link the vast majority of remaining Fee-for-Service (FFS) payments to quality and value.

As with PQRS, VBPM and MU, MIPS eligibility is far-reaching—nearly universal. The only groups who will not be MIPS-eligible will be those who are either new to Medicare (first year accepting Medicare patients) or those who have a patient volume that is below a minimum threshold. Providers will have options on how they choose to participate (e.g. traditional quality reporting or APMs), but regardless of method, incentive payments will come to those who are able to demonstrate high quality care and improved outcomes, while those who cannot are at risk of financial penalties.

Rising Incentive and Penalty Rates

Incentive and penalty rates have been defined, and they will progressively increase. In 2019, the range is four percent either way, or an eight percent possible swing for all Medicare Part B reimbursements. That may sound modest in comparison to the total possible PQRS+VBPM+MU penalty, but that is just the MIPS opening bid. By 2022, bonuses and penalties will hit nine percent each way, meaning that there will be an 18 percent variation in reimbursements for the same services billed under Medicare Part B.

In practice, the difference may be even greater. As with PQRS and VBPM, MIPS must remain budget-neutral. To ensure that the scales are balanced, Medicare may apply a scaling adjustment factor to the incentives to ensure that the end-of-year balance is zero. Take note—the adjustment would only be applied to the incentive, and not the penalty. In other words, sanding down the penalty is most assuredly NOT a part of the MIPS plan, and reinforces the second DHS goal of linking FFS payments to quality.

Everyone else is in, although participation methods will vary. The key distinction is whether you, as a provider, participate in an Alternate Payment Model.

How Alternate Payment Models Fit Into MIPS

APMs are perhaps the clearest window for viewing the inner-workings of the MIPS development process. They've been identified as one of two overarching goals from the Department of Health and Human Services—at least 30 percent of Medicare payments will be tied to quality and/or value by 2018. It's not surprising to see APMs in MIPS, but the depth to which they've been integrated is telling.

MIPS will incorporate APMs into the MIPS composite, even though Alternative Payment Models do not operate in the standard FFS environment. This distinction reflects the fact that MIPS is structured to account for diversity in practice and actually rewards providers who are proactively engaged in programs designed to lower costs while improving quality of care. These providers will receive a "favorable" score in the "Clinical Practice Improvement" component of their MIPS composite. In other words, providers may be able to devote more energy to, for example, a Bundled Payment program, rather than spreading their efforts too thin over multiple quality initiatives.

Emphasis on Performance Improvement

Favorable scoring through APM participation makes it clear that providers are being steered toward performance improvement. In fact, MIPS is so accommodating of APMs that some providers will have the opportunity to bypass MIPS altogether. Rather than simply earning a "favorable" score in the Clinical Practice Improvement areas, those with enough at stake can participate exclusively through a program of their choice.

However, not all APMs merit this distinction. For example, a Next Generation ACO may achieve the right criteria, but a traditional Medicare Shared Savings Program (MSSP) ACO will not. While both are designed to improve outcomes, factor quality and cost, and bear financial risk, the MSSP model does not fulfill all requirements of a "Qualified" APM. To be considered a Qualified APM Participant, or QP, providers must fulfill all of the following requirements:

> Payment based on quality metrics, similar to what is defined in MIPS;
> Certified EHR Technology (CEHRT);
> The financial risk in the Qualified APM must be greater than nominal, although how this is determined is not defined, or it must be a Medical Home.
> Patient volume will also be factored, but the extent is yet to be determined. Of course, the meaning is clear—you will not get to call yourself a Qualified APM Participant, or a QP, by merely incorporating a small (and easily cherry-picked) group of patients. However, if you meet all of these requirements, not only will you bypass MIPS, but you'll earn a five percent lump sum incentive payment.

How to Prepare for MIPS Without Knowing All the Rules

There are definitive steps that you can take now to prepare for MIPS.

> Work with a Specialized Registry or Clinical Data Registry (CDR) that is capable of tracking outcomes over time. Only through longitudinal study will you be able to identify areas for improvement, act on those findings and measure the results. A CDR will also be able to integrate multiple sources of data, ensuring that your APM is effectively

coordinating care through multiple settings. By so doing, in addition to improving care, you will also enhance your MIPS cost, quality and clinical resource improvement composite scores.

Learn from your VBPM by opting for VBPM consultative services now, while that program is still separate. The Value-Based Payment Modifier is not truly going away—it's just getting a makeover. MIPS will tie incentives and penalties to reimbursement, based on a combination of cost and quality factors, so by learning from your experience now, you will be better prepared for the future. A VBPM consultation can help you identify potential pitfalls by addressing areas with higher comparative costs, including both the costs and the total impact across the system. A comprehensive VPBM analysis will also factor services that may occur off your watch, but on your dime, and will help you ask the right questions and address the real issue—and do it before you're on the wrong side of an 18 percent swing.

Watch for the Proposed Rule, scheduled for release within the next several weeks (Spring 2016, according to CMS). While the overall structure will likely reflect these themes, the specifics are still to be determined. This will be followed by a comment period, meaning that you should review the Rule and consider whether the specifics defined will work in your real world of practice.

This is your chance to speak up! CMS is legally obligated to read comments and address them. In the past, CMS has overturned elements of its Proposed Rules in the Final Version based on comments. It may seem like an empty gesture, but it isn't—a new program is being defined and will become the standard until the mid 2020s, if not longer. While you won't have to "forever hold your peace," speaking now increases the chances of a better, more manageable and effective MIPS than if you stay silent.

Download your free copy of our new eBook, *ICLOPS Value-Based Payment Modifier Primer: How NOT to Forfeit Your Medicare Revenues.*

Founded in 2002, ICLOPS has pioneered data registry solutions for improving patient health. Our industry experts provide comprehensive Value-Based Payment Modifier, ACO Services, ICLOPS Clinical Data Registry and Performance Improvement Technology and Services Solutions that help you both report and improve your performance. ICLOPS is a CMS Qualified Clinical Data Registry.

Contact ICLOPS for a Discovery Session.

Image Credit: Ned Horton