

Medicare's MIPS: The Not-So New Face of Value-Based Care

written by Dave Halpert | September 23, 2015



Rumors that PQRS and VBPM have died may be wishful thinking, but are far from true. Value-Based Care is here to stay, even as Medicare's programs evolve. You still have a chance to help shape those initiatives before they become law. So it's well worth your time now to learn all about Medicare's newest program, MIPS.

In 2019, Medicare will phase in the Merit-Based Incentive Payment System (MIPS). The 2016 reporting year will form the basis for the final Value-Based Payment Modifier (VBPM) and PQRS payment adjustments, to be applied in 2018, with MIPS to begin the following year. But don't write off VBPM or its other components, particularly the recently released 2014 Quality and Resource Use Reports (QRURs). These have a longer shelf life than you may realize.

While the information disclosed in 2014 QRURs will only directly affect your reimbursement in 2016, the underlying data—and what that reveals about your group—will be used in future Value-Based Care programs, including MIPS. As many have learned, the penalties are real. From the largest academic centers to the smallest clinics, all will be subjected to the same methodology for adjusting future payments. So MIPS is more of an evolution than a revolution, and your current VBPM efforts (and lessons learned) remain relevant.

To succeed in MIPS, first understand the underlying framework and how the program relates to today's market. CMS has created a [Strategic Vision for the future of Quality Reporting and Value-Based Care](#) to ease your transition from VBPM to MIPS. Focus on what you can do now within each component so that you can accomplish your long-term goals, rather than having to slap on short-term patches at the end of every year.

Here are six keys to understanding MIPS:

1) Input from patients, caregivers and healthcare professionals is essential.

If you feel overwhelmed by all the new rules, you're not alone. But you have an opportunity to help shape upcoming programs, including MIPS. CMS annually releases a Proposed Rule, where all aspects of the upcoming year's Fee Schedule are made public. Following the publication of this proposal, there is a comment period where stakeholders across the spectrum can weigh in.

With MIPS, CMS is going one step further, giving providers the chance to define provisions at the very core of the program, such as the payment model itself, as well as the activities that will be used for measuring and improving quality. If you want MIPS to have meaning, don't waste your opportunity to review and comment on Medicare Proposals. Be on the lookout for a Request for Information from CMS later this year, where they will be seeking additional comments on a variety of topics.

2) Feedback and data drive rapid-cycle quality improvement.

At the heart of MIPS, and all of Medicare's Value-Based Care programs, lies one central concept: demonstrable, measurable outcomes. You need to know what you are measuring—and know where you stand—in order to improve. To succeed in Value-Based Care, whether via MIPS or VBPM, you need the ability to recognize gaps in care or a failure to meet performance benchmarks.

Knowing where your group falls short is actually the easy part. The hard part is figuring out what you can do about it. The information provided in the 2014 QRUR has illustrated that poor performance (in costs, quality or both) resulted in penalties for many groups, and more groups were penalized than were able to earn incentives. In short, good performance in one aspect doesn't necessarily translate into an incentive, although it may be enough to protect you from a penalty.

So, what steps can groups take to differentiate themselves, both now and under MIPS? To drive rapid-cycle quality improvement, groups need to see the impact that their changes have had on their patients. What has worked and what has not?

Consider partnering with a Registry who has the ability to study outcomes over time and who can measure subsequent variations within the context of your group's efforts. The right partner will have the ability to identify root causes of an event, so you can understand and treat the cause, rather than simply incur a penalty based on the result.

Throughout [MACRA](#), there are frequent references to Qualified Clinical Data Registries (QCDRs) as mechanisms for truly improving care, as they facilitate the knowledge-to-improvement cycle. QCDRs are distinguished by their ability to develop and use their own "homegrown"

measures for PQRS reporting, and MIPS sets the stage for an expansion of these principles. [Check out Medicare's QCDR posting.](#)

3. Public reporting provides meaningful, transparent and actionable information.

Public reporting is another key factor in Medicare's evolving Value-Based Care programs, including MIPS. The goal of public reporting is to enable consumers (patients) to be just as informed in their health care choices as they are when buying any other product or service. Medicare's "Compare" websites are meant to give patients the information they need to make informed choices, rather than "guestimates" based on biased online reviews.

As patients become knowledgeable about where to find this information and how to use it, they will migrate from providers who cannot demonstrate good performance to those who can. Public reporting will improve clinical performance through attrition.

Already, there have been some [startling revelations from Medicare's Physician Compare website](#). Later this year, the public can expect to see even more:

- All 2014 PQRS GPRO measures for groups with more than 25 providers who submitted through the GPRO Web Interface;

- A subset of measures for any group practice who submitted PQRS through a Registry or EHR in 2014;

- 2014 CAHPS for PQRS survey results (the survey was required for groups with 100 or more providers and optional for groups with 25-99 providers);

- ACO Public Reporting Results for the 2014 program year.

Plan on seeing more comprehensive sets of measures posted each year, as well as additional information on the results of other programs. As in other aspects of MIPS, CMS is inviting anyone (patients, professionals or providers) to suggest, comment and evaluate public reporting practices. The new face of public reporting will be drawn by those who actively participate in its development.

4. Quality reporting programs rely on an aligned measure portfolio.

MIPS will mark the official end of PQRS, VBPM and Meaningful Use, but the programs will be ending in name only. Each will be rolled up into MIPS, with the goal of establishing one set of measurement criteria, rather than several. Similar but separate rules, particularly between PQRS and Meaningful Use, have caused a great deal of consternation among practices, and [have even led to financial penalties](#).

So, although those programs will be—technically speaking—retired, they are not going away. In fact, they will provide the infrastructure of MIPS, and will be weighted as follows:

- Quality Reporting (like PQRS): 30 percent
- Value-Based Care (Quality and Resources): 30 percent
- Meaningfully Using EHR Technology: 25 percent
- Clinical Practice Improvement: 15 percent

MIPS will also provide a mechanism for those who are using these principles, but are doing so via an Alternative Payment Model (APM), such as a Patient-Centered Medical Home or a Bundled Payment Initiative. Remember, even if you are able to opt out of MIPS through APM participation, you are not opting out of Value-Based Care. If you are not improving outcomes through efficient and coordinated care, you can expect to face penalties under MIPS.

5. Quality reporting and value-based purchasing program policies are aligned.

MIPS will continue a two-step process for measuring quality. The first step is reporting—without information, there is nothing to measure. PQRS quality data is key. The second step involves comparison, which is at the heart of the VBPM. Performance of PQRS measures, CMS claims-based outcome measures and patient costs attributed to your TIN are combined to compare your results to your peers’.

MIPS will utilize information gleaned from quality reporting to differentiate quality from one provider to the next. The best way to set the stage for MIPS success is to start today, focusing on PQRS and VBPM. Look for a Registry partner that is able to report the measures that are appropriate for your practice and can help you determine which measures are right for you, or that has the technological muscle and industry experience to help you succeed in an Alternative Payment Model.

6. Penalties and incentives increase over time.

Each component in Medicare’s Strategic Vision is present in today’s market; we are not in for a complete overhaul, but a program alignment. The similarities between the future (MIPS) and the present (PQRS, VBPM, MU) include the familiar methodology of bonuses and penalties.

As with PQRS and VBPM, penalties will be levied on poorly performing groups (based on cost and quality composites), and then distributed to those who perform well. Similar to the VBPM, MIPS will phase in the magnitude of penalties and incentives. The timeline is as follows:

2019: Maximum penalty of 4 percent; maximum incentives of 4 percent x the Adjustment

Factor (AF) required to keep the program budget neutral

2020: Maximum penalty of 5 percent; maximum incentives of 5 percent x AF

2021: Maximum penalty of 7 percent; maximum incentives of 7 percent x AF

2022: Maximum penalty of 9 percent; maximum incentives of 9 percent x AF

Value-Based Care is not a passing fad. In order to repeal the Sustainable Growth Rate (and an automatic, across-the-board 21 percent cut in reimbursements), CMS needs a mechanism to curb excessive spending without sacrificing patients' health and well-being. That is the purpose of MIPS. The details have yet to be determined, but the starting gun has fired. Take the time to understand MIPS and contribute your insights to the public comment process. Position yourself for success in 2019 by contextualizing MIPS within Medicare's Strategic Vision and adopting a performance-based strategy under Value-Based Care.

[Download your free copy of the ICLOPS Insider's Guide to PQRS 2015 Reporting: How to Succeed in the Value-Based Health Care Environment.](#)

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