Michigan Spine Surgery Improvement Collaborative
MIPS/QCDR Information Sheet

For those with questions regarding MIPS and QCDR, Dr. David Nerenz has put together some information points that may help. Dr. Nerenz is happy to come do a presentation and/or have a discussion as to specific questions that this overview might not address.

1. The MACRA legislation of 2015 creates the "Quality Payment Program" (QPP) that links Medicare reimbursement to a set of performance measures.

2. The QPP involves two distinct tracks - the Alternative Payment Model (APM) track for physicians who are involved in financial risk programs like the Next Generation ACO program, and the Merit-Based Incentive Payment Program (MIPS) for everybody else. We're guessing that about 95% of the physicians in the US (and probably therefore among our MSSIC surgeons) will be in MIPS.

3. MIPS involves annual reporting of measures in four domains - quality, information technology, practice improvement, and cost. An overall performance score is calculated based on measures in the four domains, and that score is linked to dollars with a two-year lag (performance in 2017 affects payment in 2019).

4. There are a number of ways to report data in the domains other than cost, and one of those ways is an approved registry. One key feature of registry reporting is that a physician can report "non-MIPS" measures that are in the registry but not on the standard, national, approved list of MIPS quality measures.

5. Scoring is based on six measures - either the six that a physician chooses to report, or the six from some larger set that give the physician the best score (as determined by CMS).

6. The financial consequences are real – although the potential financial rewards are small in the first year (data from 2017; payment in 2019), Medicare payments will move as much as up or down 9% relative to a base payment once the program is in its fifth year and beyond.

7. We have applied for, and received, approval from CMS to use the MSSIC registry for MIPS reporting for any surgeon or surgeon group that wants to do their reporting that way. This is not mandatory for surgeons in MSSIC - surgeons can use other options - but it's available.

8. Most physicians in the US will have more than six quality measures to choose from, so they will naturally report the ones that they do best on. In the standard MIPS measure set, it's hard to find six measures relevant to spine surgery. That puts spine surgeons (and other specialists) at a major disadvantage in MIPS. We are concerned that spine surgeons across the country will get payment penalties in MIPS if they do standard reporting.

9. We have 16 measures approved for MIPS reporting - about half are process measures (e.g., collecting functional status data at baseline and followup) and half are outcome measures (e.g. percent achieving

significant improvement in back or leg pain scores). Surgeon Champions were provided the list of measures as an attachment earlier this week.

10. We will be happy to work with surgeons or surgeon groups who want to use the MSSIC registry for reporting to make sure that what we have is accurate and complete, and that the information actually sent to CMS matches what we think we see either in the dashboard or in separate analysis that the coordinating center statisticians can do.

11. Some of the measures involve data elements that are typically abstracted from surgeons' clinic records rather than from hospital records. For those measures, we can only report to CMS if we have the data. Surgeons who haven't allowed abstractor access to their clinic records and who therefore have large amounts of missing data in the MSSIC registry will not be able to report MIPS measures involving those data elements. That doesn't mean that they cannot use MSSIC as their reporting option, but it does mean that they may only have 6 measures to report (at best) and have to take their chances in the national MIPS scoring competition with their scores on those six measures.

For additional information, please contact:

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