The Medicare Access & Chip Reauthorization Act of 2015

QUALITY PAYMENT PROGRAM

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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KEY TOPICS:

1) Delivery System Reform
2) Quality Payment Program
3) Merit-based Incentive Payment System
4) Advanced Alternative Payment Model
5) Timeline and Next Steps

DELIVERY SYSTEM REFORM

Delivery System Reform: Paying for What Works

In the last few years, we've made tremendous progress to transform our nation's health care system into one that works better for everyone. Key to this effort is changing how we pay doctors, so they can focus on the quality of care they give, and not the quantity of services they order. For years, people across the health care system have agreed that we need to improve the status quo. The Affordable Care Act created new tools to encourage innovation and help us improve how we deliver care. And now, the "Quality Payment Program," the result of a bipartisan bill passed last year and supported by much of the medical community, strengthens these tools and gives us new ones.

CMS support of Health Care DSR will result in Better Care, Smarter Spending, and Healthier People

Historical State → **Evolving Future State**

Public and Private Sectors

Key Characteristics

- ✓ Producer-centered
- ✓ Incentives for volume
- ✓ Unsustainable
- ✓ Fragmented Care

Systems and Policies

- ✓ Fee-For-Service Payment Systems

Key Characteristics

- ✓ Patient-centered
- ✓ Incentives for outcomes
- ✓ Sustainable
- ✓ Coordinated care

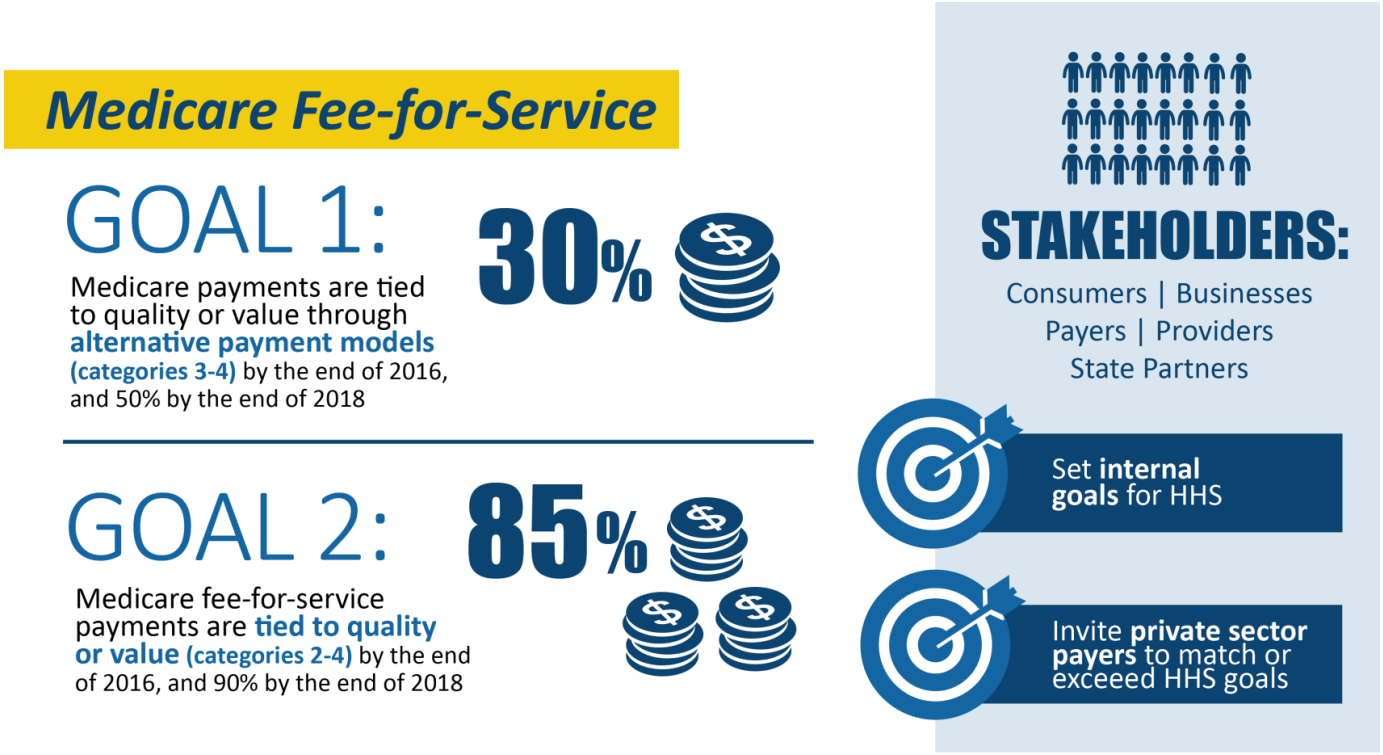
Systems and Policies

- ✓ Value-based purchasing
- ✓ Accountable Care Organizations
- ✓ Episode-based payments
- ✓ Medical Homes
- ✓ Quality/cost transparency

QUALITY PAYMENT PROGRAM

The Quality Payment Program is part of a broader push towards value and quality

In January 2015, the Department of Health and Human Services announced **new goals** for **value-based payments** and **APMs in Medicare**



Medicare Payment Prior to MACRA

Fee-for-service (FFS) payment system, where clinicians are paid based on **volume** of services, not **value.**

The Sustainable Growth Rate (SGR)

- Established in 1997 to **control the cost of Medicare payments** to physicians

IF

Overall physician costs

>

Target Medicare expenditures

Physician payments cut across the board

Each year, Congress passed temporary **"doc fixes"** to avert cuts (no fix in 2015 would have meant a **21% cut** in Medicare payments to clinicians)

Quality Payment Program

- ✓ **Repeals** the Sustainable Growth Rate (SGR) Formula
- ✓ **Streamlines** multiple quality reporting programs into the new Merit-based Incentive Payment System (MIPS)
- ✓ **Provides incentive payments** for participation in **Advanced Alternative Payment Models (APMs)**

The Merit-based Incentive Payment System (MIPS) **or** **Advanced Alternative Payment Models (APMs)**

- ✓ **First step to a fresh start**
- ✓ **We're listening and help is available**
- ✓ **A better, smarter Medicare for healthier people**
- ✓ **Pay for what works to create a Medicare that is enduring**
- ✓ **Health information needs to be open, flexible, and user-centric**

PROPOSED RULE
MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

MIPS: First Step to a Fresh Start

- ✓ **MIPS is a new program**
  - **Streamlines 3 currently independent programs to work as one and to ease clinician burden.**
  - **Adds a fourth component to promote ongoing improvement and innovation to clinical activities.**

Quality

Resource use

Clinical practice improvement activities

Advancing care information

- ✓ **MIPS provides clinicians the flexibility to choose the activities and measures that are most meaningful to their practice to demonstrate performance.**

Medicare Reporting Prior to MACRA

Currently there are **multiple quality and value reporting programs** for Medicare clinicians:

Physician Quality Reporting Program (PQRS)

Value-Based Payment Modifier (VM)

Medicare Electronic Health Records (EHR) Incentive Program

Who Will Participate in MIPS?

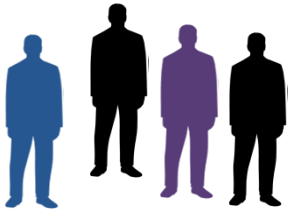
Affected clinicians are called **"MIPS eligible clinicians"** and will participate in MIPS. The types of **Medicare Part B** eligible clinicians affected by MIPS may expand in future years.

Years 1 and 2

Physicians, PAs, NPs, Clinical nurse specialists, Certified registered nurse anesthetists

Years 3+

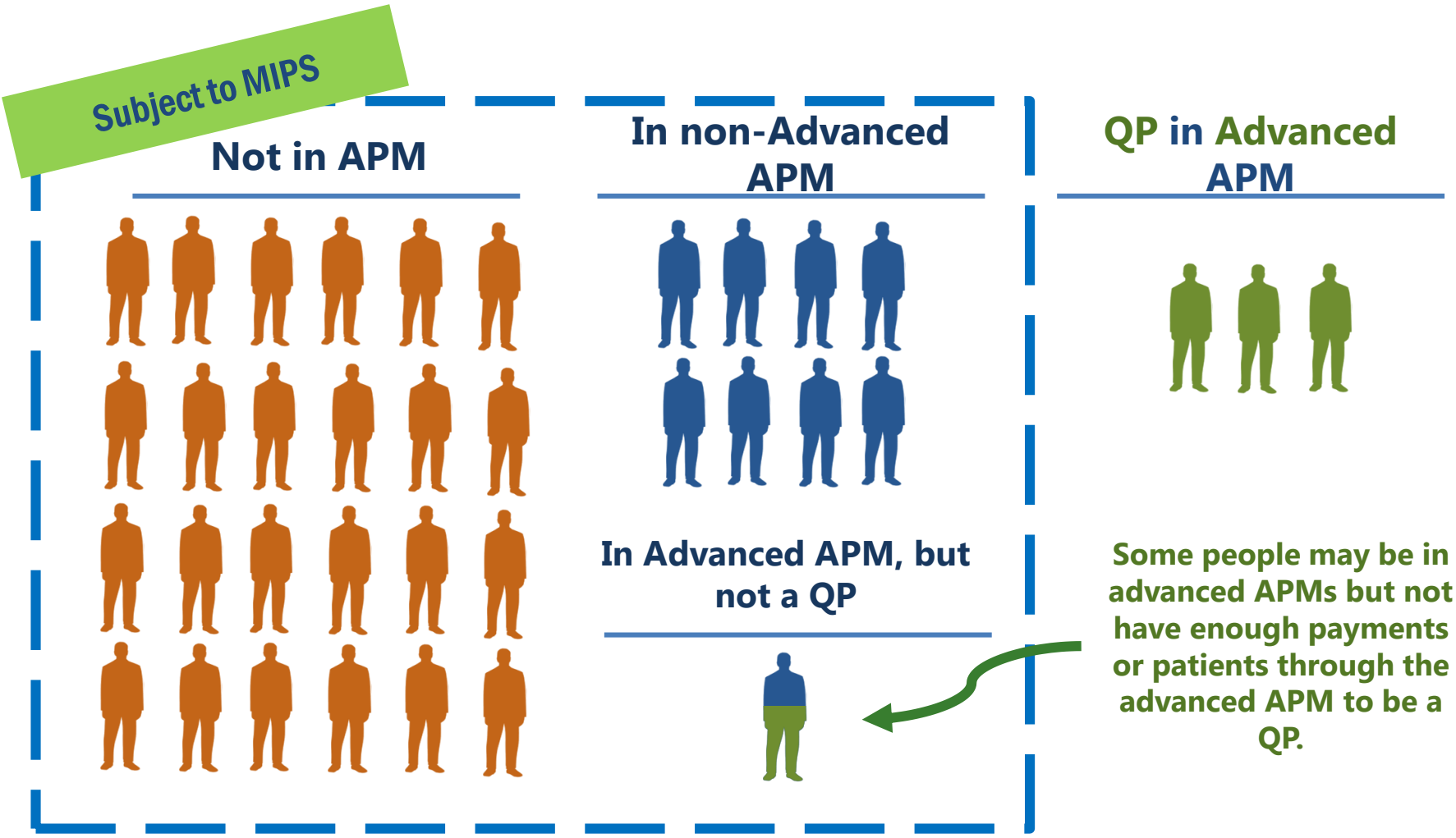
Secretary may broaden Eligible Clinicians group to include others such as



Physical or occupational therapists, Speech-language pathologists, Audiologists, Nurse midwives, Clinical social workers, Clinical psychologists, Dietitians / Nutritional professionals

Note: Physician means doctor of medicine, doctor of osteopathy (including osteopathic practitioner), doctor of dental surgery, doctor of dental medicine, doctor of podiatric medicine, or doctor of optometry, and, with respect to certain specified treatment, a doctor of chiropractic legally authorized to practice by a State in which he/she performs this function.

Note: Most clinicians will be subject to MIPS.

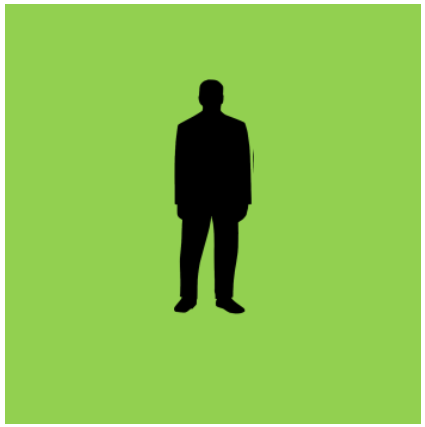


Note: Figure not to scale.

Who will NOT Participate in MIPS?

There are 3 groups of clinicians who will NOT be subject to MIPS:

FIRST year of Medicare Part B participation



Below low patient volume threshold

Certain participants in ADVANCED Alternative Payment Models

Medicare billing charges less than or equal to $10,000 and provides care for 100 or fewer Medicare patients in one year

Note: MIPS **does not** apply to hospitals or facilities

MIPS Performance Categories

A single MIPS composite performance **score** will factor in performance in **4 weighted performance categories on a 0-100 point scale**:

What will determine a MIPS score?

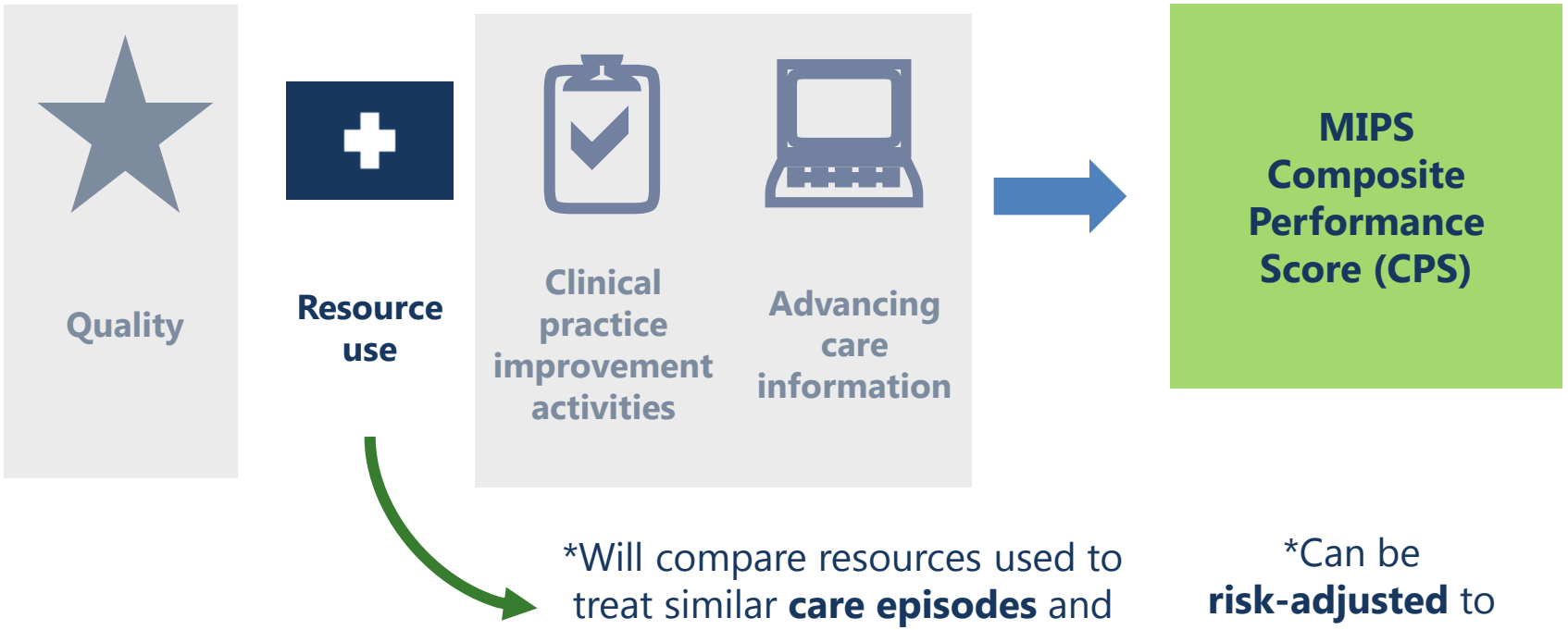
The MIPS composite performance **score** will factor in performance in **4 weighted performance categories on a 0-100 point scale** :

*Proposed quality measures are available in the NPRM

*clinicians will be **able to choose** the measures on which they'll be evaluated

What will determine a MIPS score?

The MIPS composite performance **score** will factor in performance in **4 weighted performance categories on a 0-100 point scale** :



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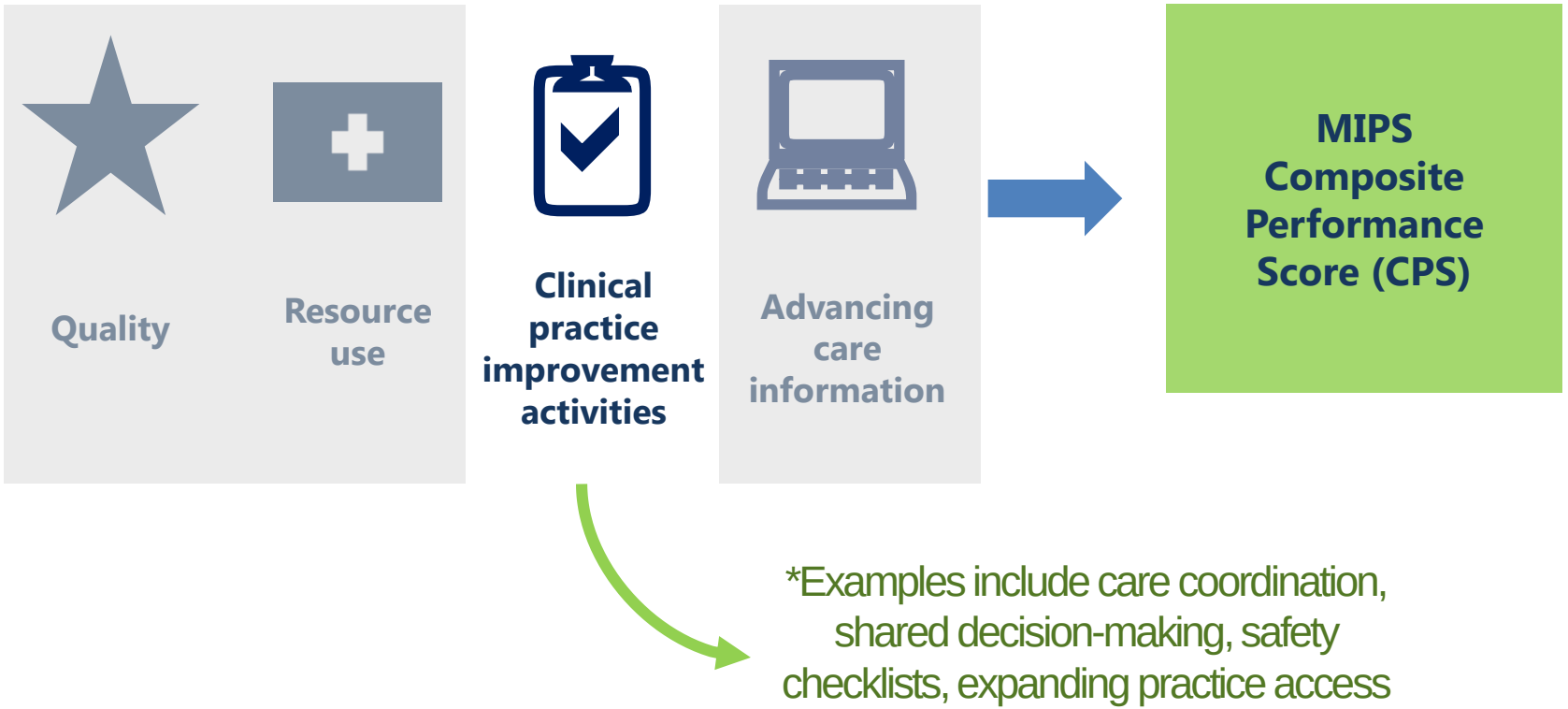


What will determine a MIPS score?

The MIPS composite performance **score** will factor in performance in **4 weighted performance categories on a 0-100 point scale** :

* % weight of this **may decrease** as more users adopt EHR

PROPOSED RULE
MIPS: Advancing Care Information Performance Category

CMS proposes six objectives and their measures that would require reporting for the base score:

Protect Patient Health Information (yes required)

Electronic Prescribing (numerator/denominator)

Patient Electronic Access (numerator/denominator)

Coordination of Care Through Patient Engagement (numerator/denominator)

Health Information Exchange (numerator/denominator)

Public Health and Clinical Data Registry Reporting (yes required)

PROPOSED RULE
INCENTIVES FOR ADVANCED ALTERNATIVE PAYMENT MODEL PARTICIPATION

What is an Alternative Payment Model (APM)?

APMs are **new approaches to paying** for medical care through Medicare that **incentivize quality and value.**

As defined by MACRA, **APMs include:**

- ✓ **CMS Innovation Center model** (under section 1115A, other than a Health Care Innovation Award)
- ✓ **MSSP** (Medicare Shared Savings Program)
- ✓ **Demonstration** under the Health Care Quality Demonstration Program
- ✓ **Demonstration** required by federal law

Advanced APMs meet certain criteria.

As defined by MACRA, Advanced APMs **must meet the following criteria**:

- ✓ The APM requires participants to use **certified EHR technology**.
- ✓ The APM **bases payment on quality** measures comparable to those in the MIPS quality performance category.
- ✓ The APM either: **(1)** requires APM Entities to bear more than nominal **financial risk** for monetary losses; **OR (2)** is a **Medical Home Model expanded** under CMMI authority.

PROPOSED RULE
Medical Home Models

Medical Home Models:

- ✓ Have a **unique financial risk criterion** for becoming an Advanced APM.
- ✓ Enable participants (who are not excluded from MIPS) to receive the **maximum score in the MIPS CPIA category.**

A **Medical Home Model is an APM** that has the following features:

- ✓ Participants include **primary care practices** or multispecialty practices that include primary care physicians and practitioners and offer primary care services.
- ✓ **Empanelment of each patient** to a primary clinician; and
- ✓ **At least four** of the following:
  - Planned coordination of chronic and preventive care.
  - Patient access and continuity of care.
  - Risk-stratified care management.
  - Coordination of care across the medical neighborhood.
  - Patient and caregiver engagement.
  - Shared decision-making.
  - Payment arrangements in addition to, or substituting for, fee-for-service payments.

NOTE: MACRA **does NOT** change how any particular APM functions or rewards value. Instead, it **creates extra incentives** for APM participation.

PROPOSED RULE

Advanced APM Criterion 1:

Requires use of CEHRT

Certified EHR use

Example: An Advanced APM has a provision in its participation agreement that at least 50% of an APM Entity's eligible clinicians must use CEHRT.

- ✓ An Advanced APM must **require at least 50% of the eligible clinicians in each APM Entity to use CEHRT** to document and communicate clinical care. The threshold will **increase to 75%** after the first year.
- ✓ For the **Shared Savings Program only**, the APM may apply a **penalty or reward** to APM entities based on the degree of CEHRT use among its eligible clinicians.

PROPOSED RULE

Advanced APM Criterion 2:

Requires MIPS-Comparable Quality Measures

Quality Measures

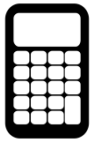
- ✓ An Advanced APM must **base payment on quality measures** comparable to those under the proposed annual list of MIPS quality performance measures;
- ✓ **No minimum** number of measures or domain requirements, **except** that an Advanced APM must have at least one **outcome measure** unless there is not an appropriate outcome measure available under MIPS.

- ✓ **Comparable** means any actual MIPS measures or other measures that are **evidence-based, reliable, and valid**. For example:
  - Quality measures that are endorsed by a consensus-based entity; or
  - Quality measures submitted in response to the MIPS Call for Quality Measures; or
  - **Any other quality measures that CMS determines to have an evidence-based focus to be reliable and valid.**

PROPOSED RULE

Advanced APM Criterion 3:

Requires APM Entities to Bear More than Nominal Financial Risk



Financial Risk

An Advanced APM must meet **two standards**:

Financial Risk Standard

APM Entities must bear risk for monetary losses.

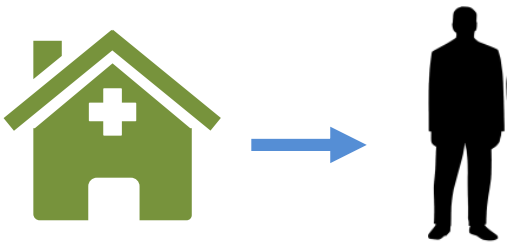
&

Nominal Amount Standard

The risk APM Entities bear must be of a certain magnitude.

- ✓ The Advanced APM financial risk criterion is **completely met** if the APM is a **Medical Home Model** that is **expanded under CMS Innovation Center Authority**
- ✓ Medical Home Models that **have not been expanded** will have **different financial risk and nominal amount standards** than those for other APMs.

How does a clinician become a Qualifying APM Participant (QP)?



Advanced APM **QP**

You must have a **certain %** of your patients or payments through an **Advanced APM**.

QPs will:

- **Be excluded from MIPS**
- **Receive a 5% lump sum bonus**

Bonus applies in 2019-2024; then QPs receive higher fee schedule updates starting in 2026

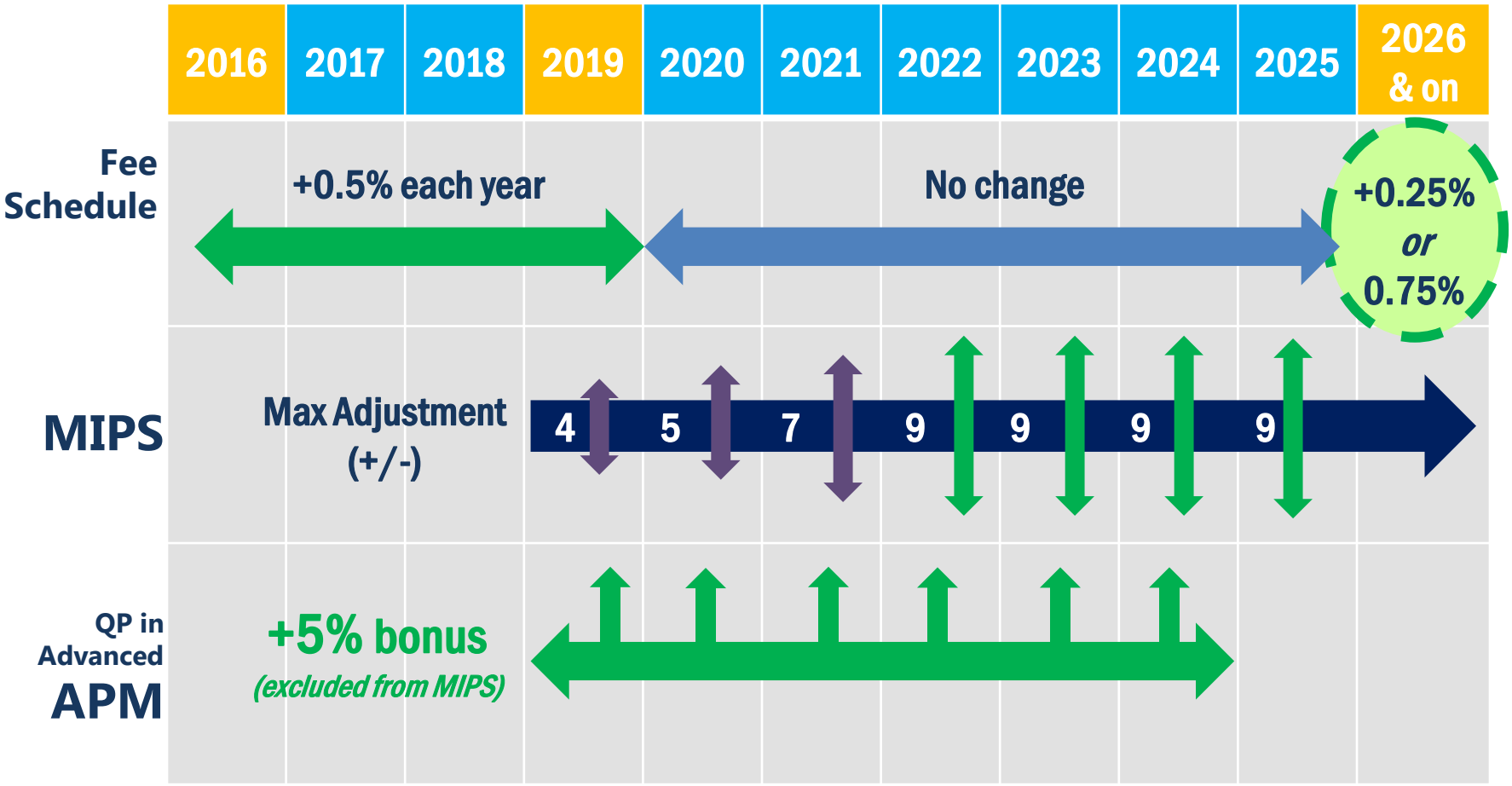
Proposed Rule
Advanced APMs

Based on the proposed criteria, which current APMs will be Advanced APMs in 2017?

- ✓ **Shared Savings Program** (Tracks 2 and 3)
- ✓ **Next Generation ACO Model**
- ✓ **Comprehensive ESRD Care (CEC)** (large dialysis organization arrangement)
- ✓ **Comprehensive Primary Care Plus (CPC+)**
- ✓ **Oncology Care Model (OCM)** (two-sided risk track available in 2018)

When will these Quality Payment Program provisions take effect?

Putting it all together:



When and where do I submit comments?

- The proposed rule includes proposed changes not reviewed in this presentation. We will not consider feedback during the call as formal comments on the rule. See the proposed rule for information on submitting these comments by the close of the 60-day comment period on June 27, 2016. When commenting refer to file code CMS-5517-P.

- Instructions for submitting comments can be found in the proposed rule; FAX transmissions will not be accepted. You must officially submit your comments in one of the following ways: electronically through
  - Regulations.gov
  - by regular mail
  - by express or overnight mail
  - by hand or courier

- For additional information, please go to: http://go.cms.gov/QualityPaymentProgram

Find additional information about the Quality Payment Program, including fact sheets and more at:

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