

QUALITY PAYMENT PROGRAM



KEY TOPICS:

- 1) The Quality Payment Program**
- 2) The Merit-based Incentive Payment System (MIPS)**
- 3) Incentives for Participation in Advanced Alternative Payment Models (Advanced APMs)**
- 4) What are the next steps?**

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**

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>

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.**

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.

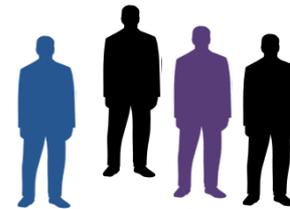
Years 1 and 2



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.

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

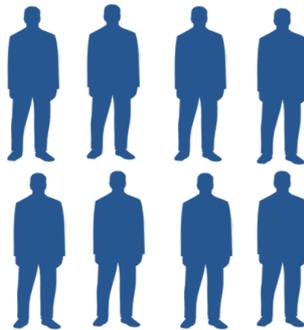
Note: Most clinicians will be subject to MIPS.

Subject to MIPS

Not in APM



In non-Advanced APM



In Advanced APM, but not a QP



QP in Advanced APM



Some people may be in Advanced APMs but not have enough payments or patients through the Advanced APM to be a QP.

Note: Figure not to scale.

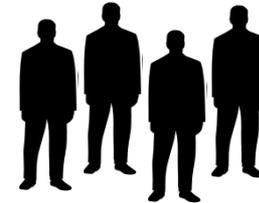
PROPOSED RULE

MIPS: Eligible Clinicians

Eligible Clinicians can participate in MIPS as an:



Or



Individual

Group

A group, as defined by taxpayer identification number (TIN), would be assessed as a group practice across all four MIPS performance categories.

Note: "Virtual groups" will not be implemented in Year 1 of MIPS.

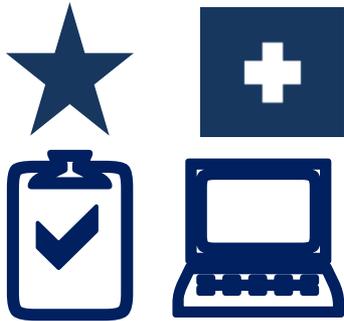
PROPOSED RULE

MIPS: Performance Category Scoring

Summary of MIPS Performance Categories		
Performance Category	Maximum Possible Points per Performance Category	Percentage of Overall MIPS Score (Performance Year 1 - 2017)
 <p>Quality: Clinicians choose six measures to report to CMS that best reflect their practice. One of these measures must be an outcome measure or a high-value measure and one must be a crosscutting measure. Clinicians also can choose to report a specialty measure set.</p>	80 to 90 points depending on group size	50 percent
 <p>Advancing Care Information: Clinicians will report key measures of interoperability and information exchange. Clinicians are rewarded for their performance on measures that matter most to them.</p>	100 points	25 percent
 <p>Clinical Practice Improvement Activities: Clinicians can choose the activities best suited for their practice; the rule proposes over 90 activities from which to choose. Clinicians participating in medical homes earn “full credit” in this category, and those participating in Advanced APMs will earn at least half credit.</p>	60 points	15 percent
 <p>Resource Use: CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything.</p>	Average score of all cost measures that can be attributed	10 percent

PROPOSED RULE

MIPS Performance Period



**MIPS Performance
Period
(Begins 2017)**

- ✓ All MIPS performance categories are aligned to a performance period of one full calendar year.
- ✓ Goes into effect in first year
(2017 performance period, 2019 payment year).

2017	2018	2019	2020	2021	2022	2023	2024	2025
								
Performance Period		Payment Year						

PROPOSED RULE

MIPS: Payment Adjustment

- ✓ A MIPS eligible clinician's payment adjustment percentage is based on the relationship between their CPS and the MIPS performance threshold.
- ✓ A CPS below the performance threshold will yield a negative payment adjustment; a CPS above the performance threshold will yield a neutral or positive payment adjustment.
- ✓ A CPS less than or equal to 25% of the threshold will yield the maximum negative adjustment of -4%.



Quality



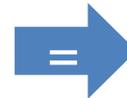
Resource
use



Clinical
practice
improvement
activities



Advancing
care
information



MIPS
Composite
Performance
Score (CPS)



PROPOSED RULE

MIPS: Payment Adjustment

- ✓ A CPS that falls at or above the threshold will yield payment adjustment of 0 to +12%, based on the degree to which the CPS exceeds the threshold and the overall CPS distribution.
- ✓ An additional bonus (not to exceed 10%) will be applied to payments to eligible clinicians with exceptional performance where CPS is equal to or greater than an “additional performance threshold,” defined as the 25th quartile of possible values above the CPS performance threshold.



Quality



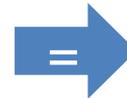
Resource
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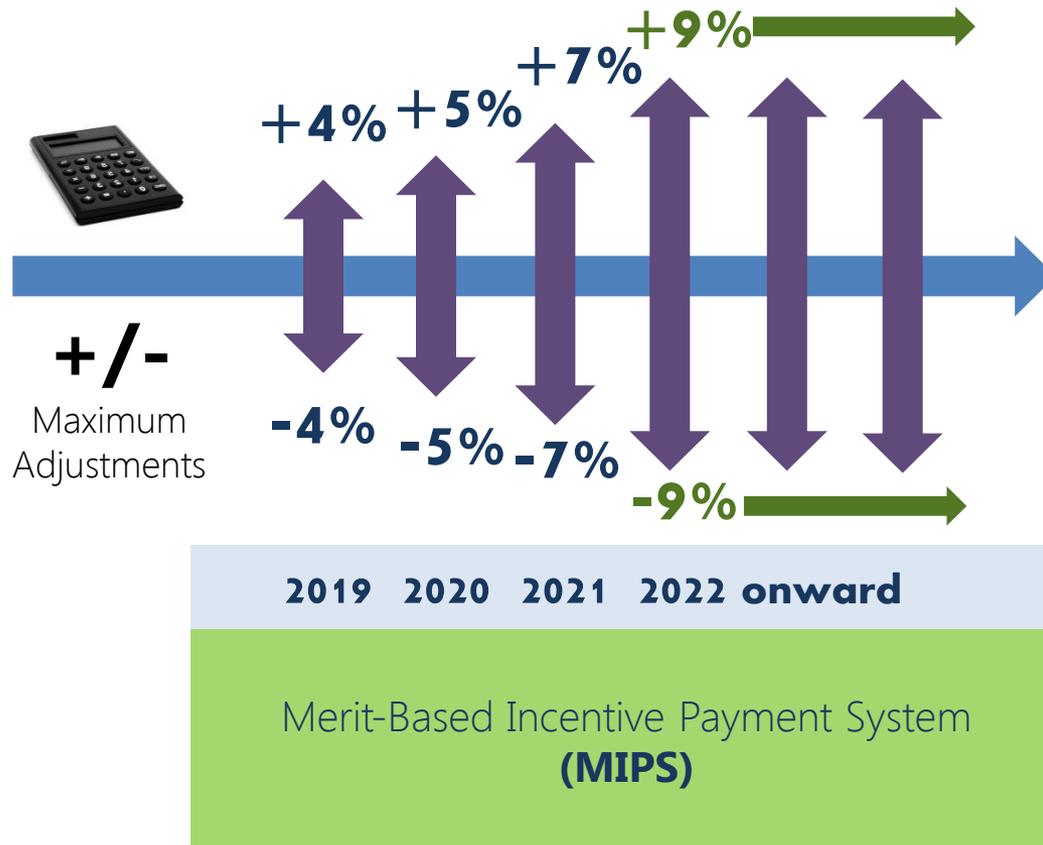
Advancing
care
information



MIPS
Composite
Performance
Score (CPS) 

How much can MIPS adjust payments?

Based on a MIPS Composite Performance Score, clinicians will receive +/- or neutral adjustments up to the percentages below.



The potential maximum adjustment % will increase each year from 2019 to 2022

INCENTIVES FOR ADVANCED APM 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.



PROPOSED RULE

Advanced APM Criterion 1:

Requires use of CEHRT

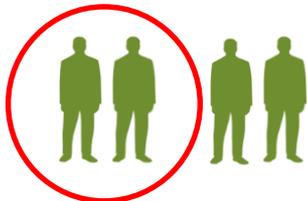


Certified
EHR use

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.



APM
Entity



Eligible
Clinicians

- ✓ 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



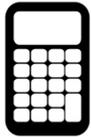
- ✓ An Advanced APM must **base payment on quality measures** comparable to those under the proposed annual list of MIPS quality performance measures;
- ✓ **No minimum** number of measures or domain requirements, **except** that an Advanced APM must have at least one **outcome measure** unless there 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

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.

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

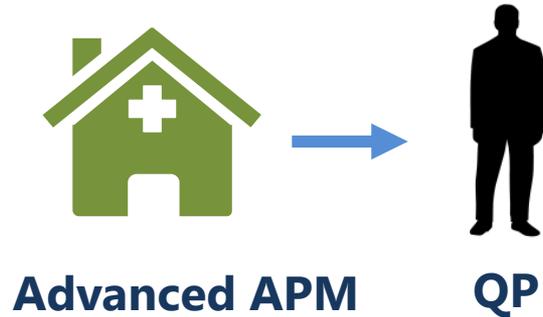
- ✓ The Advanced APM financial risk criterion is **completely met** if the APM is a **Medical Home Model** that is **expanded under CMS Innovation Center Authority**
- ✓ Medical Home Models that **have not been expanded** will have **different financial risk and nominal amount standards** than those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

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)

How do I become a **Qualifying APM Participant (QP)**?



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

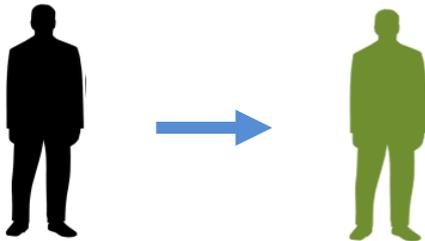


Bonus applies in 2019-2024; then QPs receive higher fee schedule updates starting in 2026

PROPOSED RULE

How do Eligible Clinicians become QPs?

Eligible Clinicians to QP in 4 STEPS



Eligible Clinicians

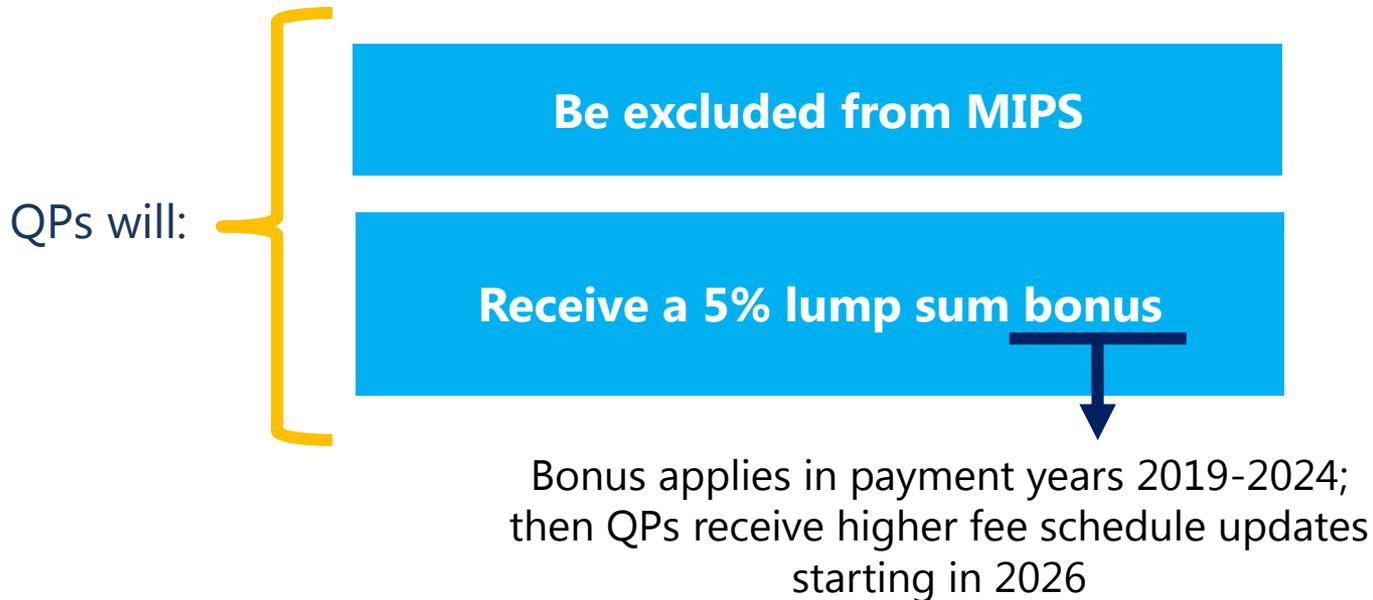
QP

1. QP determinations are made at the **Advanced APM Entity level**.
2. CMS calculates a **“Threshold Score”** for each Advanced APM Entity.
3. The Threshold Score for each method is compared to the corresponding **QP threshold**.
4. All the eligible clinicians in the Advanced APM Entity **become QPs** for the payment year.

- ✓ The period of assessment (QP Performance Period) for each payment year will be **the full calendar year that is two years prior to the payment year** (e.g., 2017 performance for 2019 payment).
- ✓ Aligns with the MIPS performance period.

PROPOSED RULE

APM Incentive Payment



- ✓ The “APM Incentive Payment” will be based on the estimated aggregate payments for professional services furnished the year prior to the payment year.
- ✓ E.g., the 2019 APM Incentive Payment will be based on 2018 services.

PROPOSED RULE

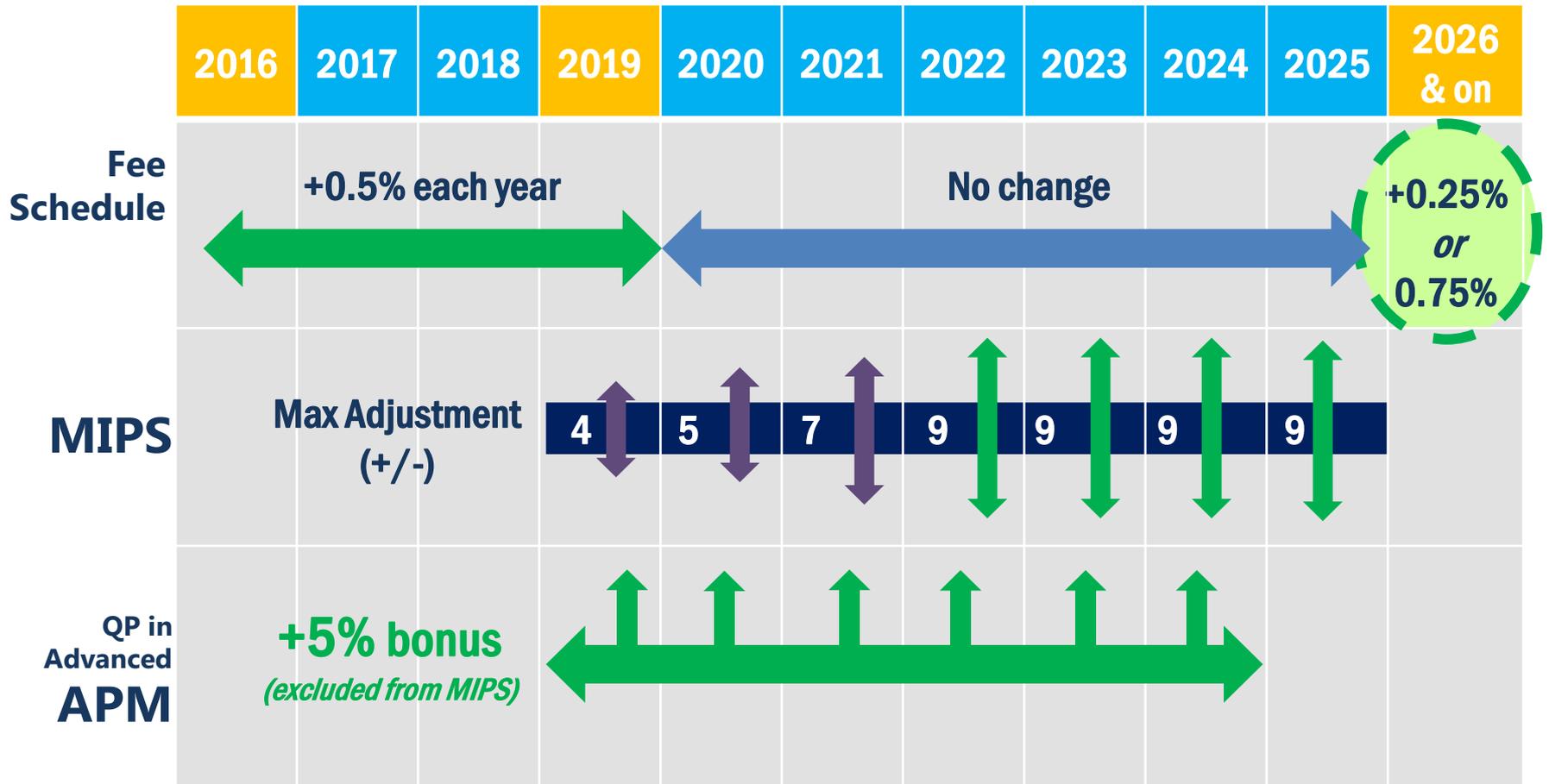
QP Determination and APM Incentive Payment Timeline

2017	2018	2019
QP Performance Period	Incentive Payment Base Period	Payment Year
QP status based on Advanced APM participation here.	Add up payments for a QP's services here.	+5% lump sum payment made here. (and excluded from MIPS adjustments)

2018	2019	2020
QP Performance Period	Incentive Payment Base Period	Payment Year

Repeat the cycle each year...

Putting it all together:



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

<http://go.cms.gov/QualityPaymentProgram>

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