THE MERIT-BASED INCENTIVE PAYMENT SYSTEM:

Quality Performance Category
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INTRODUCING THE 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 Fee-for-Service**

**GOAL 1:** 30%

Medicare payments are tied to quality or value through alternative payment models (categories 3-4) by the end of 2016, and 50% by the end of 2018.

**GOAL 2:** 85%

Medicare fee-for-service payments are tied to quality or value (categories 2-4) by the end of 2016, and 90% by the end of 2018.
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
**Note:** Most clinicians will be subject to **MIPS**.

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**Subject to MIPS**

- **Not in APM**
- **In non-Advanced APM**
- **In Advanced APM, but not a QP**
- **QP in Advanced APM**

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

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*Note: Figure not to scale.*
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**
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.

- **MIPS** provides clinicians the flexibility to choose the activities and measures that are most meaningful to their practice to demonstrate performance.
What will determine my MIPS Score?

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

- Quality
- Resource use
- Clinical practice improvement activities
- Advancing care information

**MIPS Composite Performance Score (CPS)**
Year 1 Performance Category Weights for MIPS

- **QUALITY**: 50%
- **ADVANCING CARE INFORMATION**: 25%
- **CLINICAL PRACTICE IMPROVEMENT ACTIVITIES**: 15%
- **Resource Use**: 10%
Calculating the Composite Performance Score (CPS) for MIPS

<table>
<thead>
<tr>
<th>Category</th>
<th>Weight</th>
<th>Scoring</th>
</tr>
</thead>
</table>
| Quality                         | 50%    | • Each measure 1-10 points compared to historical benchmark (if avail.)  
                                 |        | • 0 points for a measure that is not reported  
                                 |        | • Bonus for reporting outcomes, patient experience, appropriate use, patient safety and EHR reporting  
                                 |        | • Measures are averaged to get a score for the category  |
| Advancing care information      | 25%    | • Base score of 50 percentage points achieved by reporting at least one use case for each available measure  
                                 |        | • Performance score of up to 80 percentage points  
                                 |        | • Public Health Reporting bonus point  
                                 |        | • Total cap of 100 percentage points available  |
| CPIA                            | 15%    | • Each activity worth 10 points; double weight for “high” value activities; sum of activity points compared to a target  |
| Resource Use                    | 10%    | • Similar to quality  |

Unified scoring system:
1. Converts measures/activities to points  
2. Eligible Clinicians will know in advance what they need to do to achieve top performance  
3. Partial credit available
MIPS Incentive Payment Formula

Exceptional performers receive additional positive adjustment factor – up to $500M available each year from 2019 to 2024

- EPs above performance threshold = positive payment adjustment
- Lowest 25% = maximum reduction

**2019**
- Exceptional Performance
  - +4%

**2020**
- Exceptional Performance
  - +5%

**2021**
- Exceptional Performance
  - +7%

**2022 and onward**
- Exceptional Performance
  - +9%

*MACRA allows potential 3x upward adjustment BUT unlikely
Putting it all together:

Fee Schedule:
- 2016:
- 2017:
- 2018:
- 2019: +0.5% each year
- 2020:
- 2021:
- 2022:
- 2023:
- 2024:
- 2025:
- 2026 & on (+0.25% or 0.75%)

MIPS:
- Max Adjustment (+/-)
- 2016: 4
- 2017: 5
- 2018: 7
- 2019: 9
- 2020: 9
- 2021: 9
- 2022: 9
- 2023:
- 2024:
- 2025:
- 2026 & on:

QP in Advanced APM:
- +5% bonus
- (excluded from MIPS)
What will determine my MIPS score?

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

- Resource use
- Clinical practice improvement activities
- Advancing care information

MIPS Composite Performance Score (CPS)

*Proposed quality measures are available in the NPRM

*Clinicians will be able to choose the measures on which they’ll be evaluated
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.
Summary:

✓ Selection of 6 measures

✓ 1 cross-cutting measure and 1 outcome measure, or another high priority measure if outcome is unavailable

✓ Select from individual measures or a specialty measure set

✓ Population measures automatically calculated

✓ Key Changes from Current Program (PQRS):
  • Reduced from 9 measures to 6 measures with no domain requirement
  • Emphasis on outcome measurement
  • Year 1 Weight: 50%
## Key Changes from Current Program (PQRS)

<table>
<thead>
<tr>
<th></th>
<th>PQRS</th>
<th>Proposed MIPS Quality Performance Category</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Scoring</strong></td>
<td>Report all required measures to avoid payment adjustment</td>
<td>Report all required measures. Credit received for those measures that meet the data completeness threshold. Eligible clinicians performance will influence their score.</td>
</tr>
<tr>
<td><strong>Data Submission Criteria</strong></td>
<td>Required 9 measures across 3 National Quality Strategy (NQS) domains</td>
<td>Requires 6 measures; no NQS domain requirement</td>
</tr>
<tr>
<td><strong>Consumer Assessment of Healthcare Providers and Systems (CAHPS) Requirement</strong></td>
<td>CAHPS required for groups with 100 or more EPs.</td>
<td>CAHPS no longer required for groups of 100 or more, but clinicians can receive bonus points for electing CAHPS</td>
</tr>
</tbody>
</table>
PROPOSED RULE
MIPS Data Submission Options
Quality

Individual Reporting
- QCDR
- Qualified Registry
- EHR Vendors
- Administrative Claims (No submission required)
- Claims

Group Reporting
- QCDR
- Qualified Registry
- EHR Vendors
- Administrative Claims (No submission required)
- Claims
- CMS Web Interface (groups of 25 or more)
- CAHPS for MIPS Survey
Quality Reporting Model for Claims, QCDR, Qualified Registry and EHR

Select 6 Measures

Including

1 Cross-Cutting Measure

and

1 Outcomes Measure

Or

If an outcome measure is not available

1 High Priority Measure

Can’t find 6 applicable measures?

Report on all measures that ARE applicable
Individual Reporting: Claims

✓ Report at least 6 measures, including one cross-cutting measure and at least one outcome measure.
  – If an outcome measure is not available report another high priority measure
  – If fewer than 6 measures apply then report on each measure that is applicable.

✓ Select measures from either the list of all MIPS Measures or a set of specialty specific measures.

✓ Data completeness criterion: 80 percent of MIPS eligible clinician’s patients
Individual or Group Reporting: QCDR, Qualified Registry, EHR

✓ Report at least 6 measures, including one cross-cutting measure and at least one outcome measure.
  – If an outcome measure is not available report another high priority measure
  – If fewer than 6 measures apply then report on each measure that is applicable.

✓ Select measures from either the list of all MIPS Measures or a set of specialty specific measures or QCDR-approved measures.

✓ Must report on at least one measure for which there is Medicare patient data.

✓ Data completeness criterion: 90 percent of MIPS eligible clinician’s or group’s patients.
✓ Report on all measures included in the Web Interface, and populate data for first 248 consecutively ranked and assigned beneficiaries.
  – 100% of assigned beneficiaries if fewer than 248 are assigned to the group.

✓ If a group has no assigned patients, then the group (or individuals within the group) would need to select another mechanism to submit data to MIPS.

✓ Data completeness criterion: Sampling requirements for Medicare Part B patients
Registered groups of two or more MIPS eligible clinicians may voluntarily elect to participate in the CAHPS for MIPS survey.

- The CAHPS for MIPS survey would count as one cross-cutting and/or patient experience measure. Group may report any 5 measures within MIPS plus the CAHPS for MIPS survey to achieve the 6 measure threshold.

- Group must have the CAHPS for MIPS survey reported on its behalf by a CMS-approved survey vendor.

- Group will need to use another submission mechanism (e.g., qualified registry, QCDR, EHR) to complete the quality data submission.

- Data completeness criterion: Sampling requirements for Medicare Part B patients
Scoring:
Quality Performance Category

- Each measure is converted to points (1-10)
- Zero points for a measure that is not reported
- Bonus for reporting additional outcomes, patient experience, appropriate use, patient safety
- Bonus for EHR reporting

Total Points

Quality Performance Category Score
Quality Performance Category Scoring: Converting Measure to Points Based on Deciles

Each measure is converted to points (1-10)

<table>
<thead>
<tr>
<th>DECILE</th>
<th>Decile 1</th>
<th>Decile 2</th>
<th>Decile 3</th>
<th>Decile 4</th>
<th>Decile 5</th>
<th>Decile 6</th>
<th>Decile 7</th>
<th>Decile 8</th>
<th>Decile 9</th>
<th>Decile 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Points</td>
<td>1.0-1.9</td>
<td>2.0-2.9</td>
<td>3.0-3.9</td>
<td>4.0-4.9</td>
<td>5.0-5.9</td>
<td>6.0-6.9</td>
<td>7.0-7.9</td>
<td>8.0-8.9</td>
<td>9.0-9.9</td>
<td>10</td>
</tr>
</tbody>
</table>

For each measure:

- CMS publishes deciles based on national performance in a baseline period (2-years prior to the performance period).
  - Exception – Performance period is used if a baseline benchmark is not available
- Eligible clinician’s performance is compared to the published decile breaks.
- Points are assigned based on which decile range the performance data is located. All scored measures receive at least 1 point.
  - Partial points are assigned within deciles based on percentile distribution.
- Rules for special cases:
  - Eligible clinicians with performance in the top decile will receive the maximum 10 points.
  - Eligible clinicians who do not report enough measures will receive 0 points for each measure not reported, unless they could not report these measures due to insufficient applicable measures.
## Example: Assigning Points Based on Deciles

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<th>Decile 8</th>
<th>Decile 9</th>
<th>Decile 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possible POINTS</td>
<td>1.0-1.9</td>
<td>2.0-2.9</td>
<td>3.0-3.9</td>
<td>4.0-4.9</td>
<td>5.0-5.9</td>
<td>6.0-6.9</td>
<td>7.0-7.9</td>
<td>8.0-8.9</td>
<td>9.0-9.9</td>
<td>10</td>
</tr>
</tbody>
</table>

Example of decile breaks for a specific quality measure

Eligible clinician with 19% performance rate would get approximately 3.3 points (based on distribution within the decile).

Eligible clinician with 95% performance rate would get 10 points.
If performance on a measure is clustered together, then decile scoring could result in different scoring for similar performance.

Proposed scoring for topped out measures:
- Assign points based on middle of cluster
**Topped Out: Mid-Cluster Approach**

**Decile Breaks for a Quality Measure**

<table>
<thead>
<tr>
<th>DECILE</th>
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<th>Decile 8</th>
<th>Decile 9</th>
<th>Decile 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>POINTS</td>
<td>1.0-1.9</td>
<td>2.0-2.9</td>
<td>3.0-3.9</td>
<td>4.0-4.9</td>
<td>5.0-5.9</td>
<td></td>
<td></td>
<td>8.5 points</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0%</td>
<td>75%</td>
<td>80%</td>
<td>85%</td>
<td>95%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Example of Proposed Approach**

- Half of eligible clinicians reporting measure score 100%.
- Middle of the cluster is the middle of Decile 8, or 8.5 points.
- Assign all performance rates in the cluster 8.5.
Quality Performance Category Score: Bonus Points

- Minimum case volume required
- Bonus points:
  - Up to 10% “extra credit” total in bonus points
  - Additional high priority measures (up to 5% of possible total)
    - 2 bonus points awarded for additional outcome/patient experience
    - 1 bonus point for other high priority measures
  - CEHRT Bonus (up to 5% of possible total)
    - 1 bonus point for each measure reported using CEHRT for end-to-end electronic reporting
    - Not available for claims
Scoring Example:
Dr. Joy Smith Submitted the following:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Measure Type</th>
<th>Number of Cases</th>
<th>Points Based on Performance</th>
<th>Total Possible Points (10 x Weight)</th>
<th>Quality Bonus Points For High Priority</th>
<th>Quality Bonus Points for EHR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure 1</td>
<td>Outcome Measure using CEHRT</td>
<td>20</td>
<td>4.1</td>
<td>10</td>
<td>0 (required)</td>
<td>1</td>
</tr>
<tr>
<td>Measure 2</td>
<td>Process using CEHRT</td>
<td>21</td>
<td>9.3</td>
<td>10</td>
<td>N/A</td>
<td>1</td>
</tr>
<tr>
<td>Measure 3</td>
<td>Process using CEHRT</td>
<td>22</td>
<td>10</td>
<td>10</td>
<td>N/A</td>
<td>1</td>
</tr>
<tr>
<td>Measure 4</td>
<td>Process</td>
<td>50</td>
<td>10</td>
<td>10</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Measure 5</td>
<td>High Priority- Patient Safety</td>
<td>43</td>
<td>8.5</td>
<td>10</td>
<td>1</td>
<td>N/A</td>
</tr>
<tr>
<td>Measure 6 (Missing)</td>
<td>Cross-Cutting</td>
<td>N/A</td>
<td>0</td>
<td>10</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Acute Composite</td>
<td>Admin. Claims</td>
<td>10</td>
<td>Not scored: below minimum sample size</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Chronic Composite</td>
<td>Admin. Claims</td>
<td>20</td>
<td>6.3</td>
<td>10</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>All-Cause Hospital Readmission</td>
<td>Admin. Claims</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Total Points</td>
<td>All Measures</td>
<td>N/A</td>
<td>48.2</td>
<td>70</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>
Dr. Smith has 48.2 points based on performance. She qualifies for 1 bonus point for reporting an additional high priority measure. She gets 3 bonus points for using their EHR to report quality measures. She gets 52.2 Total Points. The Total Possible points are 70. The Quality Performance Category Score is 74.6%.
TAKE-AWAY POINTS

1) The Quality Payment Program changes the way Medicare pays clinicians and offers financial incentives for providing high value care.

2) Medicare Part B clinicians will participate in the MIPS, unless they are in their 1st year of Part B participation, become QPs through participation in Advanced APMs, or have a low volume of patients.

3) Payment adjustments and bonuses will begin in 2019.
THANK YOU!

More Ways to Learn To learn more about the Quality Payment Programs including MIPS program information, watch the [http://go.cms.gov/QualityPaymentProgram](http://go.cms.gov/QualityPaymentProgram) to learn of Open Door Forums, webinars, and more.
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
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