QUALITY PAYMENT PROGRAM
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

FIG

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)
INTRODUCING THE QUALITY PAYMENT PROGRAM
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
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.
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
PROPOSED RULE
MIPS: Major Provisions

- Eligibility (participants and non-participants)
- Performance categories & scoring
- Data submission
- Performance period & payment adjustments
Who Will Participate in MIPS?

Affected clinicians are called “MIPS eligible clinicians” and will participate in MIPS. The types of Medicare Part B health care clinicians affected by MIPS may expand in the first 3 years of implementation.

**Years 1 and 2**

- Physicians (MD/DO and DMD/DDS), PAs, NPs, Clinical nurse specialists, 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
Who will NOT Participate in MIPS?

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

1. **FIRST year of Medicare Part B participation**
2. **Below low patient volume threshold**
3. **Certain participants in ELIGIBLE 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
## PROPOSED RULE
### MIPS Timeline

<table>
<thead>
<tr>
<th>Year</th>
<th>2017</th>
<th>2018</th>
<th>July</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Period (Jan-Dec)</td>
<td>Reporting and Data Collection</td>
<td>2nd Feedback Report (July)</td>
<td>Targeted Review Based on 2017 MIPS Performance</td>
<td>MIPS Adjustments in Effect</td>
<td></td>
</tr>
<tr>
<td>1st Feedback Report (July)</td>
<td></td>
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</tr>
</tbody>
</table>

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**Analysis and Scoring**
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.
Note: Most clinicians will be 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:

Individual

Or

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 CATEGORIES & SCORING
A single MIPS composite performance score will factor in performance in 4 weighted performance categories on a 0-100 point scale:
Year 1 Performance Category Weights for MIPS

- Quality: 50%
- Advancing Care Information: 25%
- Clinical Practice Improvement Activities: 15%
- Cost: 10%
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%
**Summary:**

- Assessment under all available resource use measures, as applicable to the clinician
- CMS calculates based on claims so there are no reporting requirements for clinicians
- Key Changes from Current Program (Value Modifier):
  - Adding 40+ episode specific measures to address specialty concerns
  - Year 1 Weight: 10%
PROPOSED RULE
MIPS: Clinical Practice Improvement Activity Performance Category

Summary:

 ✓ To not receive a zero score, a minimum selection of one CPIA activity (from 90+ proposed activities) with additional credit for more activities

 ✓ Full credit for patient-centered medical home

 ✓ Minimum of half credit for APM participation

 ✓ Key Changes from Current Program:
   • Not applicable (new category)
   • Year 1 Weight: 15%
Who can participate?

**All MIPS Eligible Clinicians**

- Participating as an...
- Individual
- Group

Optional for 2017

- NPs, PAs, Clinical Nurse Specialists, CRNAs

Not Eligible

- Facilities (i.e. Skilled Nursing facilities)
The overall Advancing Care Information score would be made up of a base score and a performance score for a maximum score of 100 points.
PROPOSED RULE
MIPS: Advancing Care Information Performance Category

THE PERFORMANCE SCORE
The performance score accounts for up to 80 points towards the total Advancing Care Information category score

Physicians select the measures that best fit their practice from the following objectives, which emphasize patient care and information access:

- Patient Electronic Access
- Coordination of Care Through Patient Engagement
- Health Information Exchange
PROPOSED RULE

MIPS: Advancing Care Information Performance Category

Summary:

✓ Scoring based on key measures of health IT interoperability and information exchange.

✓ Flexible scoring for all measures to promote care coordination for better patient outcomes

✓ Key Changes from Current Program (EHR Incentive):
  • Dropped “all or nothing” threshold for measurement
  • Removed redundant measures to alleviate reporting burden.
  • Eliminated Clinical Provider Order Entry and Clinical Decision Support objectives
  • Reduced the number of required public health registries to which clinicians must report
  • Year 1 Weight: 25%
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

### MIPS: Performance Category Scoring

<table>
<thead>
<tr>
<th>Summary of MIPS Performance Categories</th>
<th>Maximum Possible Points per Performance Category</th>
<th>Percentage of Overall MIPS Score (Performance Year 1 - 2017)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality:</strong> 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.</td>
<td>80 to 90 points depending on group size</td>
<td>50 percent</td>
</tr>
<tr>
<td><strong>Advancing Care Information:</strong> Clinicians will report key measures of interoperability and information exchange. Clinicians are rewarded for their performance on measures that matter most to them.</td>
<td>100 points</td>
<td>25 percent</td>
</tr>
<tr>
<td><strong>Clinical Practice Improvement Activities:</strong> 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.</td>
<td>60 points</td>
<td>15 percent</td>
</tr>
<tr>
<td><strong>Cost:</strong> CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything.</td>
<td>Average score of all cost measures that can be attributed</td>
<td>10 percent</td>
</tr>
</tbody>
</table>
How do I get my data to CMS?

Data Submission for MIPS
## MIPS Data Submission Options

**Advancing Care Information and CPIA**

### Individual Reporting
- Attestation
- QCDR
- Qualified Registry
- EHR Vendor

### Group Reporting
- Attestation
- QCDR
- Qualified Registry
- EHR Vendor
- CMS Web Interface (groups of 25 or more)

Brian T. McFall, Master of Science in Public Health, Co-Founder and CEO, Navigen, Inc., introduces the concept of **Advancing Care Information** (ACI) and **Clinical Practice Improvement Arrangements** (CPIA) in systems of implementation. These initiatives aim to enhance the quality and efficiency of patient care through the integration of clinical data and information systems. Understanding the various options for submission and reporting is crucial for providers and organizations aiming to participate in these programs. By utilizing the appropriate tools and processes, practitioners can effectively measure and improve the quality of care they deliver, ensuring that patients receive the best possible outcomes.
PROPOSED RULE
MIPS PERFORMANCE PERIOD
& PAYMENT ADJUSTMENT
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).
A MIPS eligible clinician’s payment adjustment rate is based on the relationship between their CPS and the CPS performance threshold.

A CPS below the performance threshold will yield negative payment adjustment; a CPS above the performance threshold will yield neutral or positive payment adjustment.

A CPS less than or equal to 25% of the threshold will yield the maximum negative adjustment of -4%.
A CPS that falls 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 where CPS is equal to or greater than an “exceptional performance threshold,” defined as the 25th quartile of possible values above the CPS performance threshold.
How much can MIPS adjust payments?

Note: MIPS will be a budget-neutral program. Total upward and downward adjustments will be balanced so that the average change is 0%.

*Potential for 3X adjustment
When will these Quality Payment Program provisions take effect?
Putting it all together:

- **Fee Schedule**
  - 2016-2018: +0.5% each year
  - 2019-2021: No change
  - 2022-2025: +0.25% or 0.75%
  - 2026 & on: +0.25% or 0.75%

- **MIPS**
  - Max Adjustment (+/-)
  - 2016-2018: 4, 5, 7, 9, 9, 9

- **QP in Advanced APM**
  - +5% bonus (excluded from MIPS)
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