

QUALITY PAYMENT PROGRAM

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KEY TOPICS:

- 1) The Quality Payment Program and HHS Secretary's Goals**
- 2) What is the Quality Payment Program?**
 - The Merit-based Incentive Payment System (MIPS)**
 - Incentives for participation in Advanced Alternative Payment Models (Advanced APMs)**
- 3) What are the next steps?**

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:

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

30% 

GOAL 2:

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

85% 



STAKEHOLDERS:

Consumers | Businesses
Payers | Providers
State Partners



Set **internal** goals for HHS



Invite **private sector** payers to match or exceed HHS goals

What is “MACRA”?

MACRA stands for the **Medicare Access and CHIP Reauthorization Act of 2015**, bipartisan legislation signed into law on April 16, 2015.

What does it do?

- **Repeals** the Sustainable Growth Rate (SGR) Formula
- **Changes the way that Medicare pays clinicians** and establishes a new framework to reward clinicians for **value** over volume
- **Streamlines** multiple quality reporting programs into 1 new system (MIPS)
- **Provides bonus payments** for participation in ***advanced alternative payment models (APMs)***

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**

Medicare Reporting under MACRA

MACRA streamlines these programs into
The **Quality Payment Program**.

Physician Quality
Reporting Program
(PQRS)

Value-Based
Payment Modifier

Medicare
Electronic Health
Records (EHR)
Incentive Program

Quality Payment Program



The Merit-based Incentive
Payment System (MIPS)

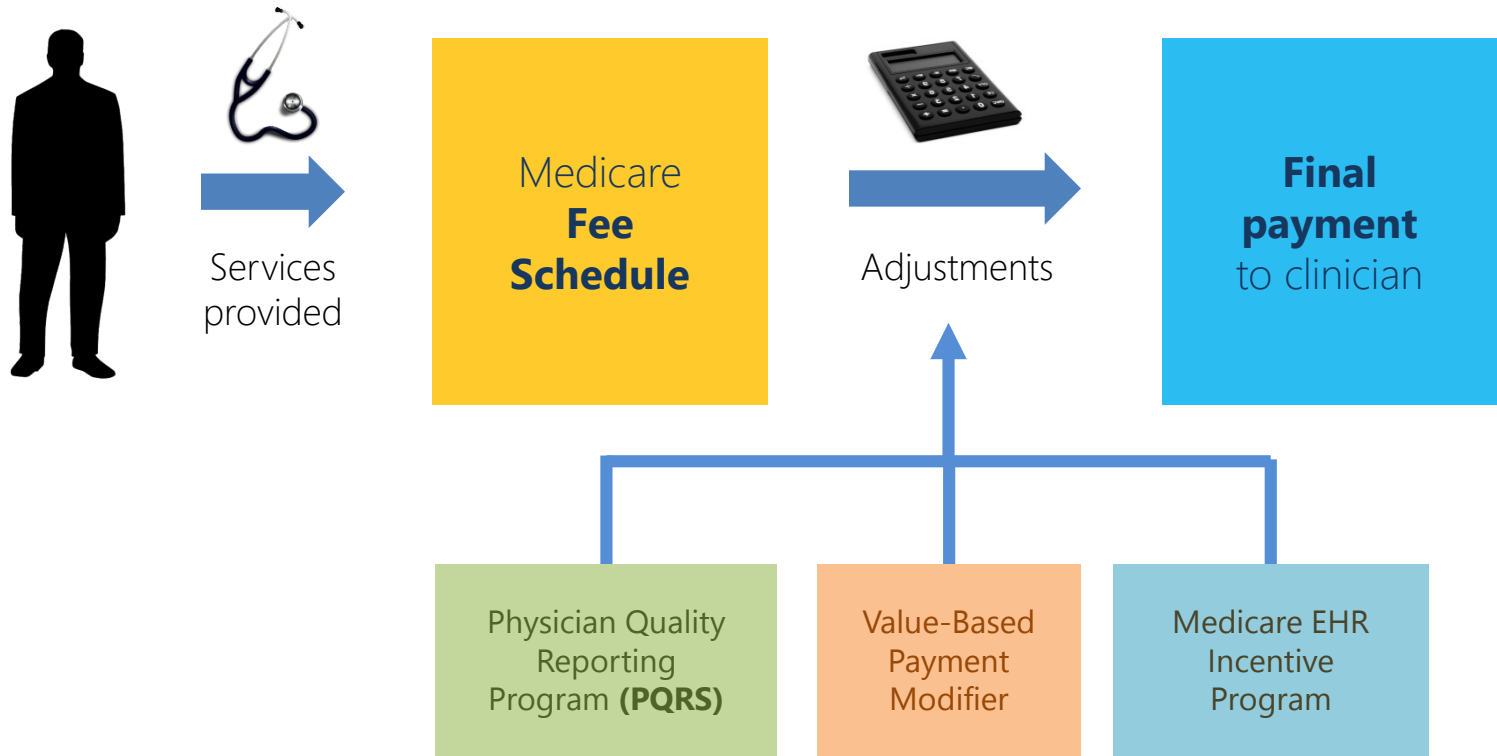
or

Advanced Alternative
Payment Models (APMs)

INTRODUCING THE QUALITY PAYMENT PROGRAM

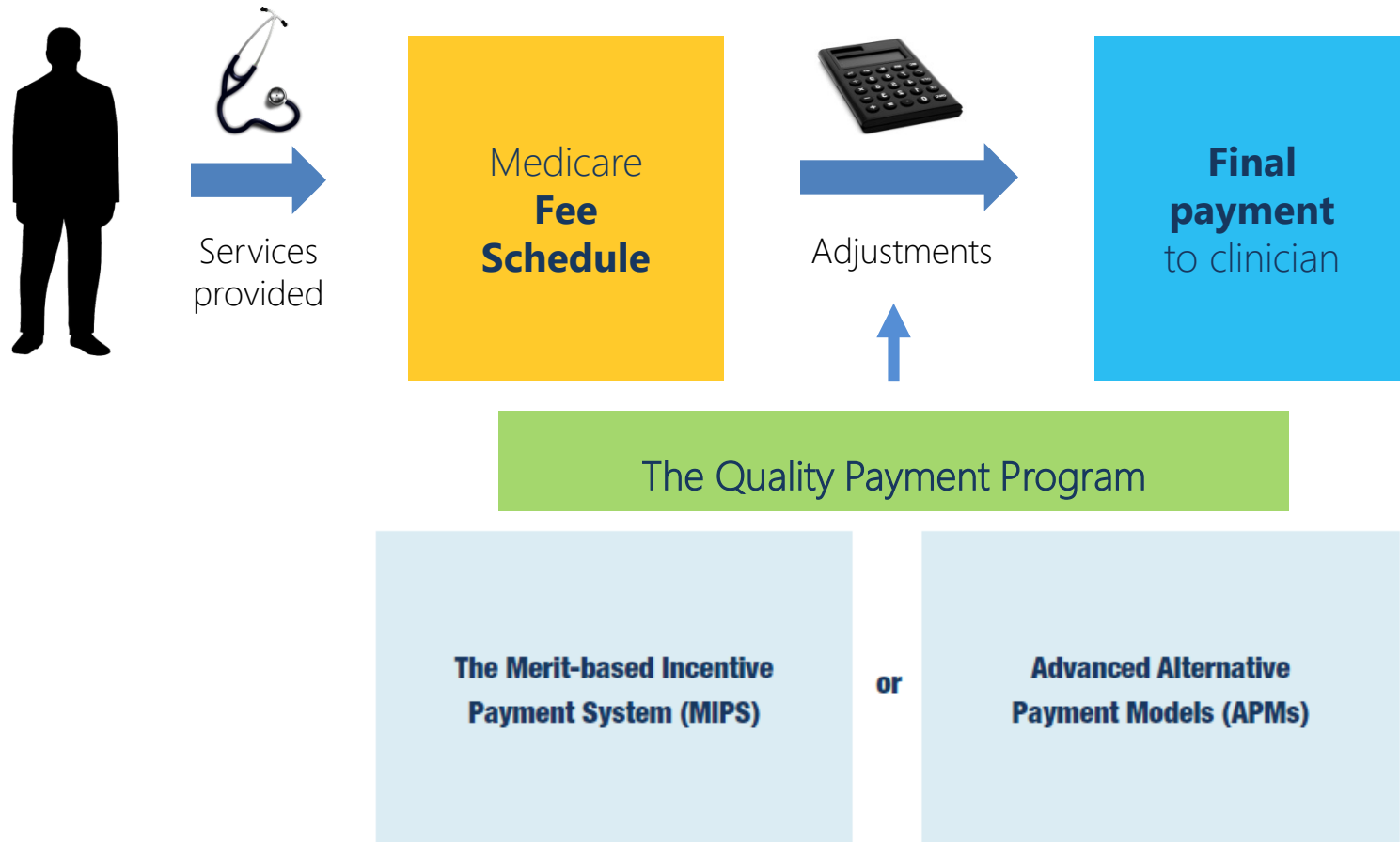
MACRA changes how Medicare pays clinicians.

The **current** system:



MACRA changes how Medicare pays clinicians.

The system after **MACRA**:



This change affects Medicare Part B clinicians.

Affected clinicians are called “**eligible clinicians**”. The types of **Medicare Part B** health care clinicians affected by these changes may expand in the first 3 years of implementation.

Years 1 and 2



Physicians, PAs, NPs, Clinical nurse specialists, Nurse anesthetists

Years 3+



Secretary may broaden EP group to include others such as

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



One Path to Quality:

The Merit-based Incentive Payment System (MIPS)

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 (MD/DO and DMD/DDS),
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**

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

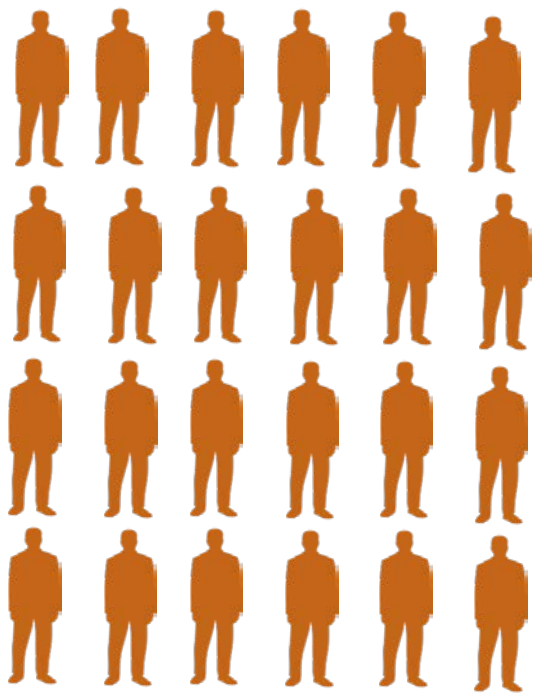
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Medicare billing charges less than or equal to \$10,000 and provides care for 100 or fewer Medicare patients in one year

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

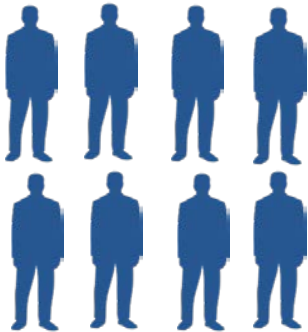
Note: Most clinicians will be subject to MIPS.

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: PERFORMANCE
CATEGORIES & SCORING**

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.**

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.

MIPS Performance Categories

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**

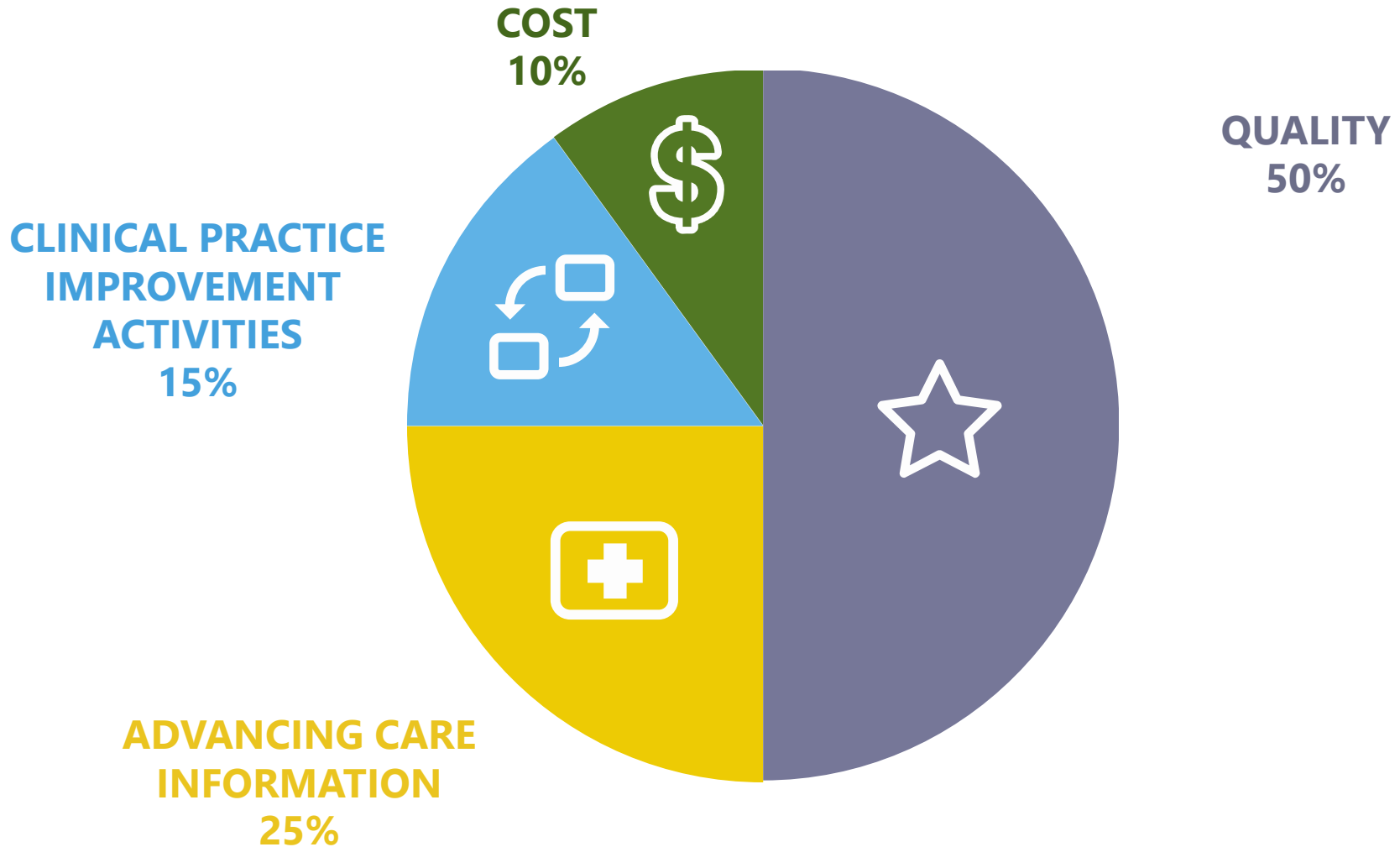


**Advancing
care
information**







**MIPS
Composite
Performance
Score (CPS)**

Year 1 Performance Category Weights for MIPS



Calculating the Composite Performance Score (CPS) for MIPS

Category	Weight	Scoring
 Quality	50%	<ul style="list-style-type: none"> 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%	<ul style="list-style-type: none"> Base score of 50 points is achieved by reporting at least one use case for each available measure Up to 10 additional performance points available per measure Total cap of 100 percentage points available
 CPIA	15%	<ul style="list-style-type: none"> Each activity worth 10 points; double weight for "high" value activities; sum of activity points compared to a target
 Resource Use	10%	<ul style="list-style-type: none"> 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

PROPOSED RULE

MIPS: Calculating the Composite Performance Score (CPS) for MIPS

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)

The CPS will be compared to the MIPS performance threshold to determine the adjustment percentage the eligible clinician will receive.

PROPOSED RULE

MIPS Data Submission Options

Quality and Resource Use

Individual Reporting



Group Reporting



Quality

- ✓ QCDR
- ✓ Qualified Registry
- ✓ EHR
- ✓ Administrative Claims (No submission required)
- ✓ Claims

- ✓ QCDR
- ✓ Qualified Registry
- ✓ EHR
- ✓ Administrative Claims (No submission required)
- ✓ CMS Web Interface (groups of 25 or more)
- ✓ CAHPS for MIPS Survey



Resource use

- ✓ Administrative Claims (No submission required)

- ✓ Administrative Claims (No submission required)

PROPOSED RULE

MIPS Data Submission Options

Advancing Care Information and CPIA

Individual Reporting



Group Reporting



Advancing
care
information

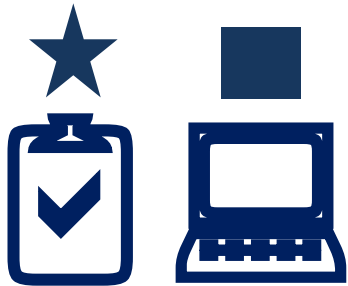


CPIA

<ul style="list-style-type: none"> ✓ Attestation ✓ QCDR ✓ Qualified Registry ✓ EHR 	<ul style="list-style-type: none"> ✓ Attestation ✓ QCDR ✓ Qualified Registry ✓ EHR ✓ CMS Web Interface (groups of 25 or more)
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PROPOSED RULE

MIPS Performance Period



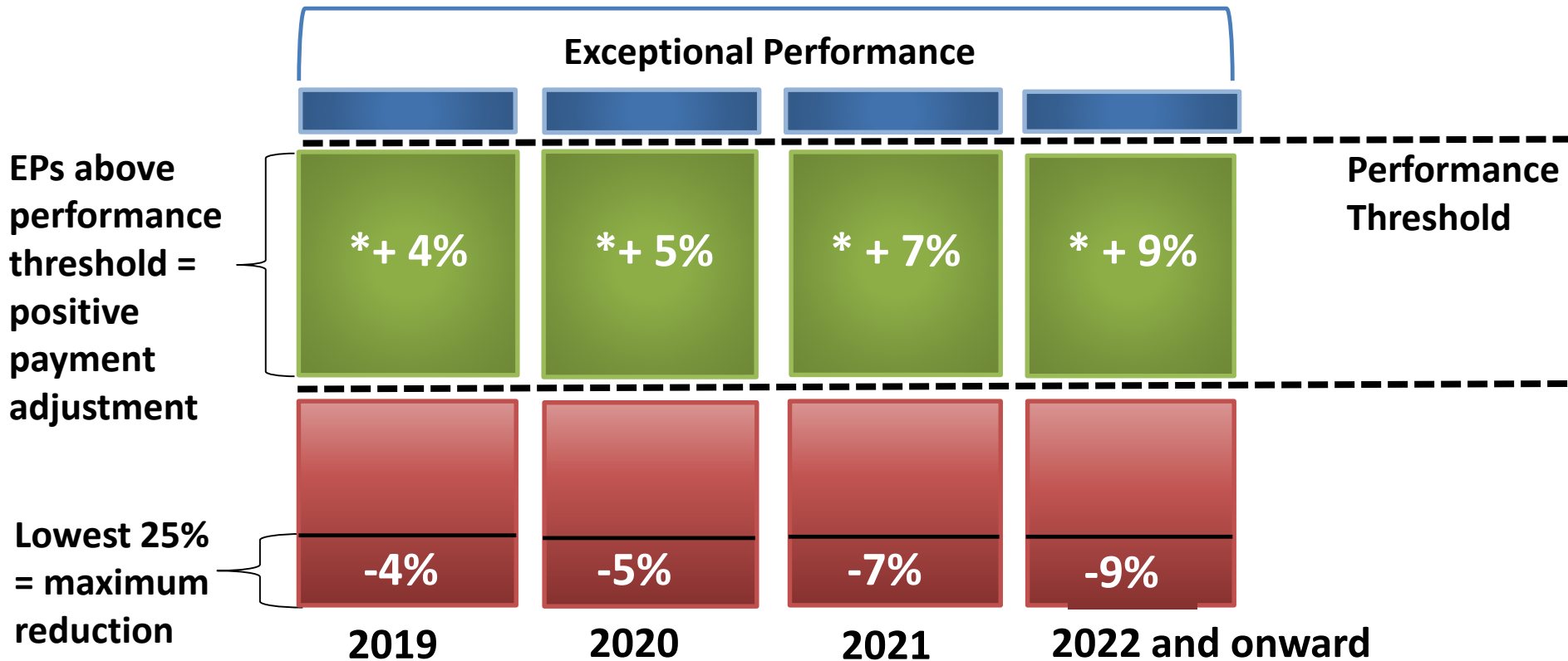
**MIPS Performance
Period
(Begins 2017)**

- ✓ 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						

MIPS Incentive Payment Formula

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



**MACRA allows potential 3x upward adjustment BUT unlikely*

Another Path to Quality:



Advanced Alternative Payment Models (APMs)

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.

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

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)**?



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

What about private payer or Medicaid APMs? Can they help me qualify to be a QP?

Starting in **2021**, **some** arrangements with other non-Medicare payers can **count toward** becoming a QP.

**“All-Payer
Combination
Option”**

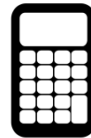
IF the “Other Payer APMs” meet criteria similar to those for Advanced APMs, CMS will consider them “Other Payer Advanced APMs”:



**Certified
EHR use**

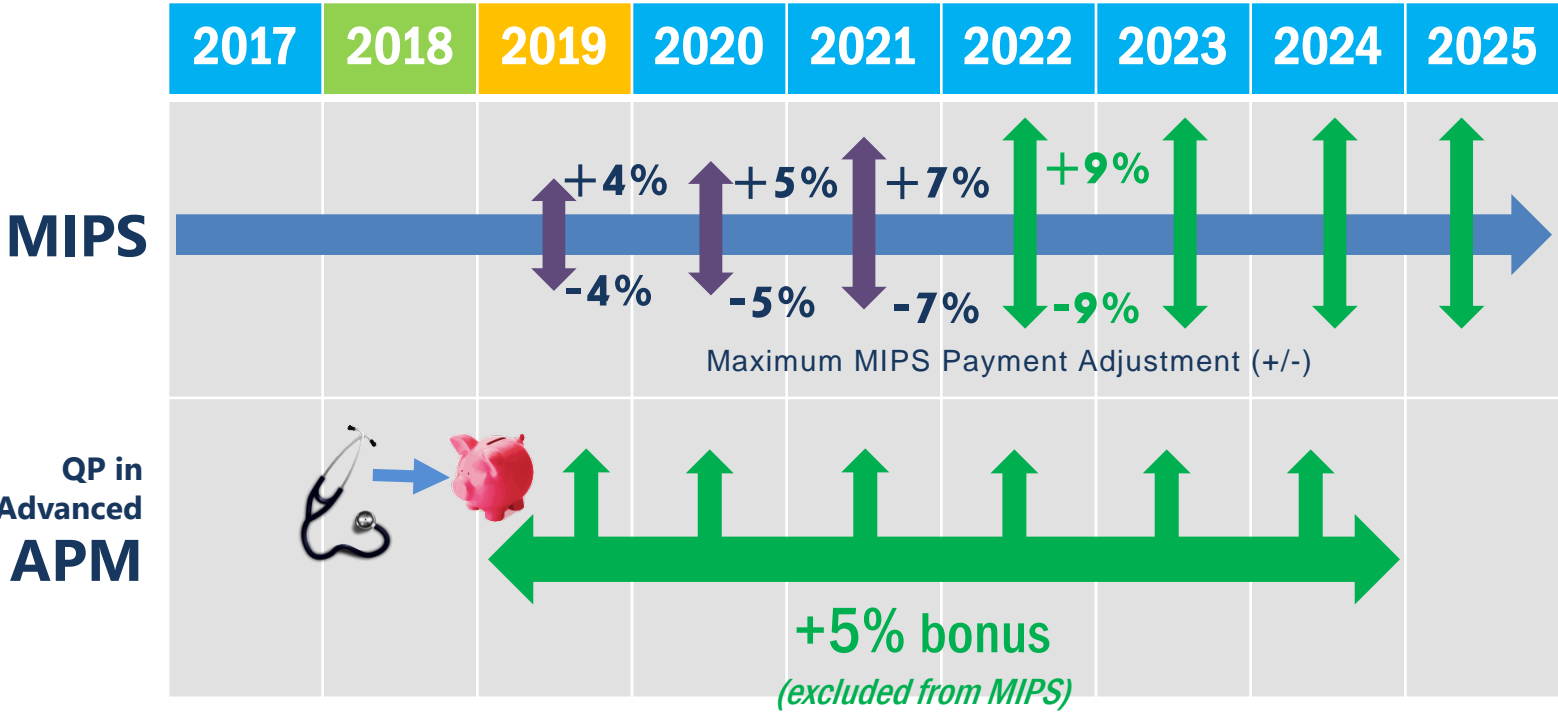


**Quality
Measures**

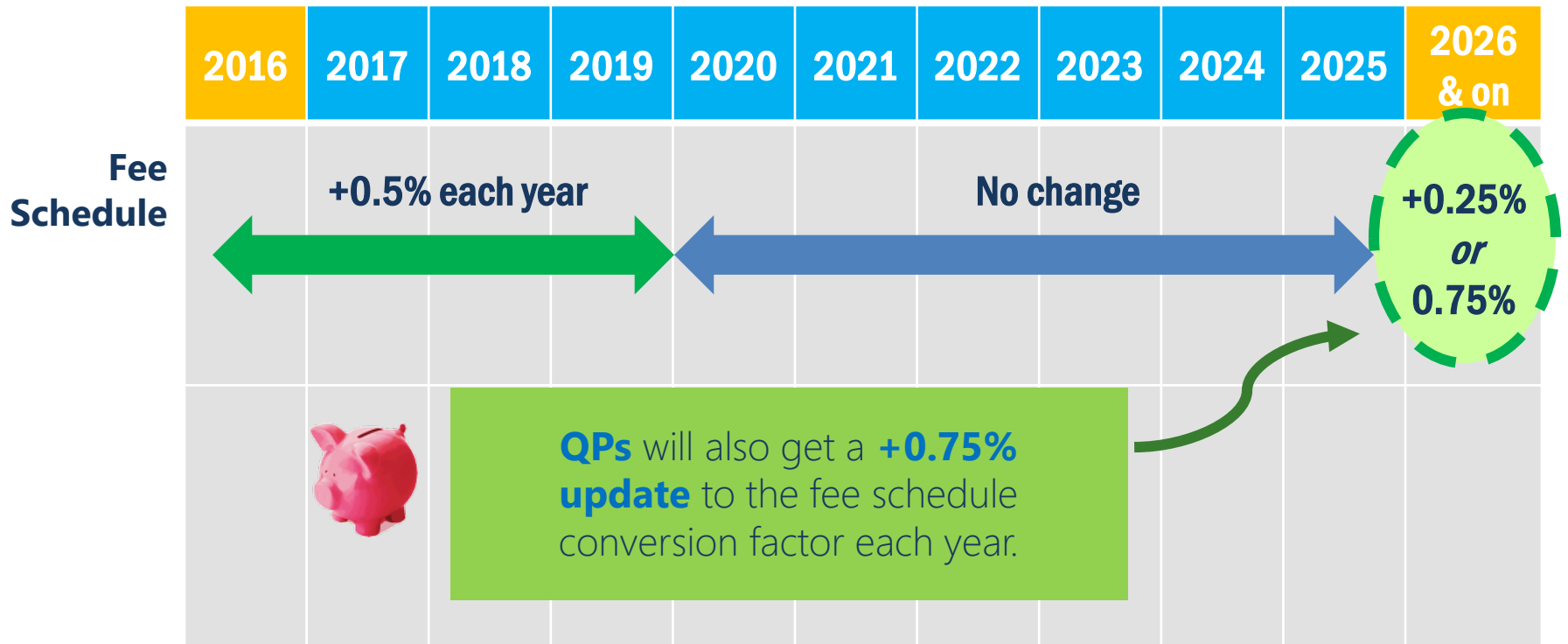


**Financial
Risk**

MIPS adjustments and APM Incentive Payment will begin in 2019.

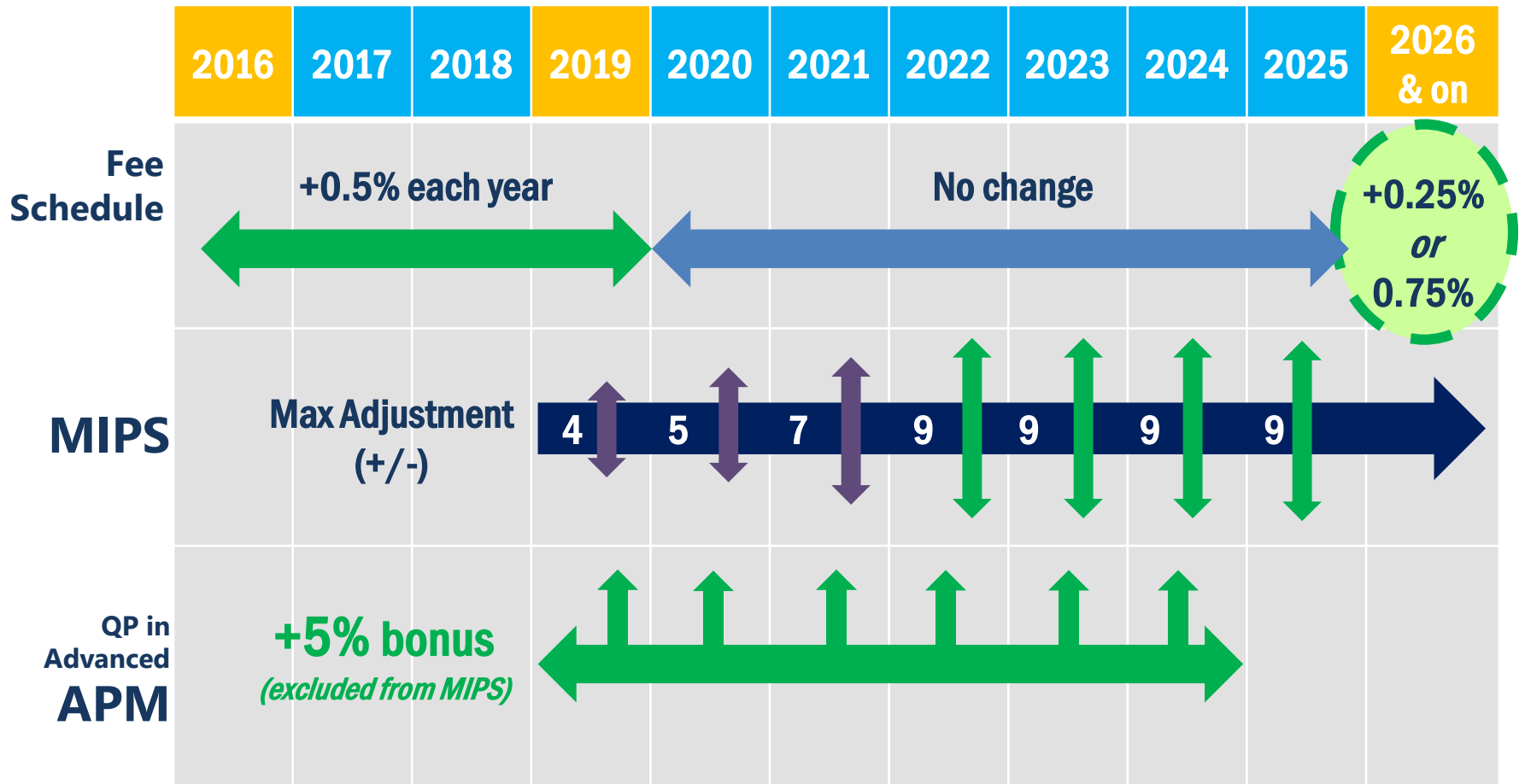


Fee schedule updates begin in 2016.



Everyone else will get a +0.25% update.

Putting it all together:



What should I do to prepare for MACRA?

- Look for future educational activities
- Review fact sheets and the proposed rule on these changes released April 27th
- <http://go.cms.gov/QualityPaymentProgram>
- Final rule targeted for early fall 2016
- Consider collaborating with one of the TCPI Practice Transformation Networks or Support and Alignment Networks.

QUESTIONS?

