The Quality Payment Program

Patrick M. Hamilton, M.P.A.

CMS Philadelphia Regional Office

November 10, 2016

What is the Quality Payment Program?

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

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)

The Quality Payment Program

- The Quality Payment Program policy will reform Medicare Part B payments for more than 600,000 clinicians across the country, and is a major step in improving care across the entire health care delivery system.
- Clinicians can choose how they want to participate in the Quality Payment Program based on their practice size, specialty, location, or patient population.

Two tracks to choose from:

Advanced Alternative Payment Models (APMs)		The Merit-based Incentive Payment System (MIPS)
If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.	or	If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Who participates?

Who participates in MIPS?

- Medicare Part B clinicians billing more than $30,000 a year **and** providing care for more than 100 Medicare patients a year.
- These clinicians include:
  - Physicians
  - Physician Assistants
  - Nurse Practitioners
  - Clinical Nurse Specialists
  - Certified Registered Nurse Anesthetists

Who is excluded from MIPS?

- Newly-enrolled Medicare clinicians
  - Clinicians who enroll in Medicare for the first time during a performance period are exempt from reporting on measures and activities for MIPS until the following performance year.
- Clinicians below the low-volume threshold
  - Medicare Part B allowed charges less than or equal to $30,000 **OR** 100 or fewer Medicare Part B patients
- Clinicians significantly participating in Advanced APMs

Easier Access for Small Practices

Small practices will be able to successfully participate in the Quality Payment Program

Why?

- Reducing the time and cost to participate
- Providing an on-ramp to participating through Pick Your Pace
- Increasing the opportunities to participate in Advanced APMs
- Including a practice-based option for participation in Advanced APMs as an alternative to total cost-based
- Conducting technical support and outreach to small practices through the forthcoming QPP Small, Rural and Underserved Support (QPP-SURS) as well as through the Transforming Clinical Practice Initiative.

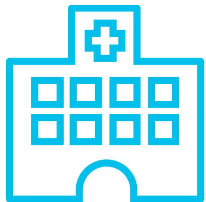
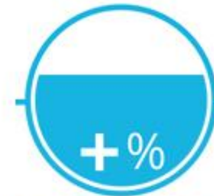
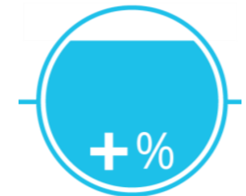
Small, Rural and Health Professional Shortage Areas (HPSAs) Exceptions

- Established low-volume threshold
  - Less than or equal to $30,000 in Medicare Part B allowed charges or less than or equal to 100 Medicare patients
- Reduced requirements for Improvement Activities performance category
  - One high-weighted activity or
  - Two medium-weighted activities
- Increased ability for clinicians practicing at Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), and Federally Qualified Health Centers (FQHCs) to qualify as a Qualifying APM Participant (QP).

How does the Quality Payment Program work?

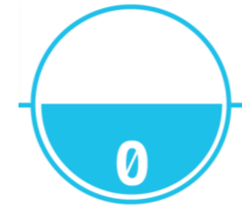
Pick Your Pace for Participation during the Transitional Year

MIPS

Participate in an Advanced Alternative Payment Model	Test Pace	Partial Year	Full Year
			
• Some practices may choose to participate in an Advanced Alternative Payment Model in 2017	• Submit **some** data after January 1, 2017 • Neutral or small payment adjustment	• Report for 90-day period after January 1, 2017 • Small positive payment adjustment	• Fully participate starting January 1, 2017 • Modest positive payment adjustment

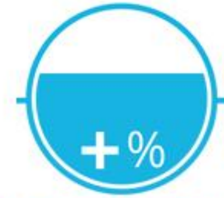
Not participating in the Quality Payment Program for the transition year will result in a negative 4% payment adjustment.

MIPS: Choosing to Test for 2017



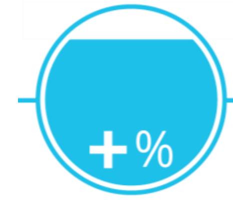
- If you submit a minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity), you can avoid a downward adjustment

MIPS: Partial Participation for 2017



- If you submit 90 days of 2017 data to Medicare, you may earn a neutral or small positive payment adjustment.
- That means if you’re not ready on January 1, you can choose to start anytime between January 1 and October 2, 2017. Whenever you choose to start, you'll need to send in performance data by March 31, 2018.

MIPS: Full Participation for 2017



- If you submit a full year of 2017 data to Medicare, you may earn a moderate positive payment adjustment. The best way to earn the largest positive adjustment is to participate fully in the program by submitting information in all the MIPS performance categories.

Key Takeaway:

- Positive adjustments are based on the performance data on the performance information submitted, not the **amount** of information or **length of time submitted.**

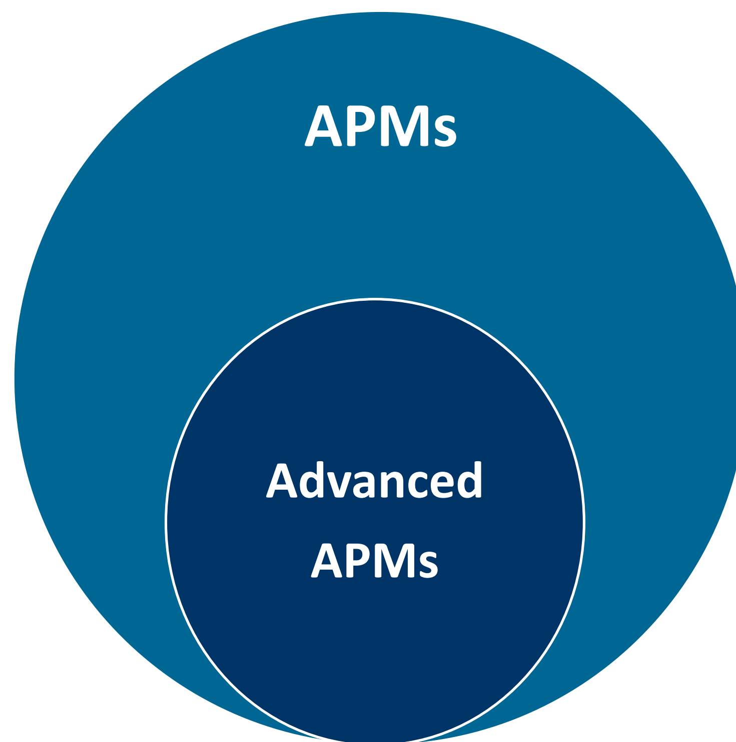
Bonus Payments and Reporting Periods

- MIPS payment adjustment is based on data submitted.
- Best way to get the max adjustment is to participate for a full year.
- A full year gives you the most measures to pick from. **BUT** if you report for 90 days, you could still earn the max adjustment.
- We're encouraging clinicians to pick what's best for their practice. A full year report will prepare you most for the future of the program.

Alternative Payment Models

- An Alternative Payment Model (APM) is a payment approach, developed in partnership with the clinician community, that provides added incentives to clinicians to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.
- APMs may offer significant opportunities to eligible clinicians who are not immediately able or prepared to take on the additional risk and requirements of Advanced APMs.

Advanced APMs are a Subset of APMs



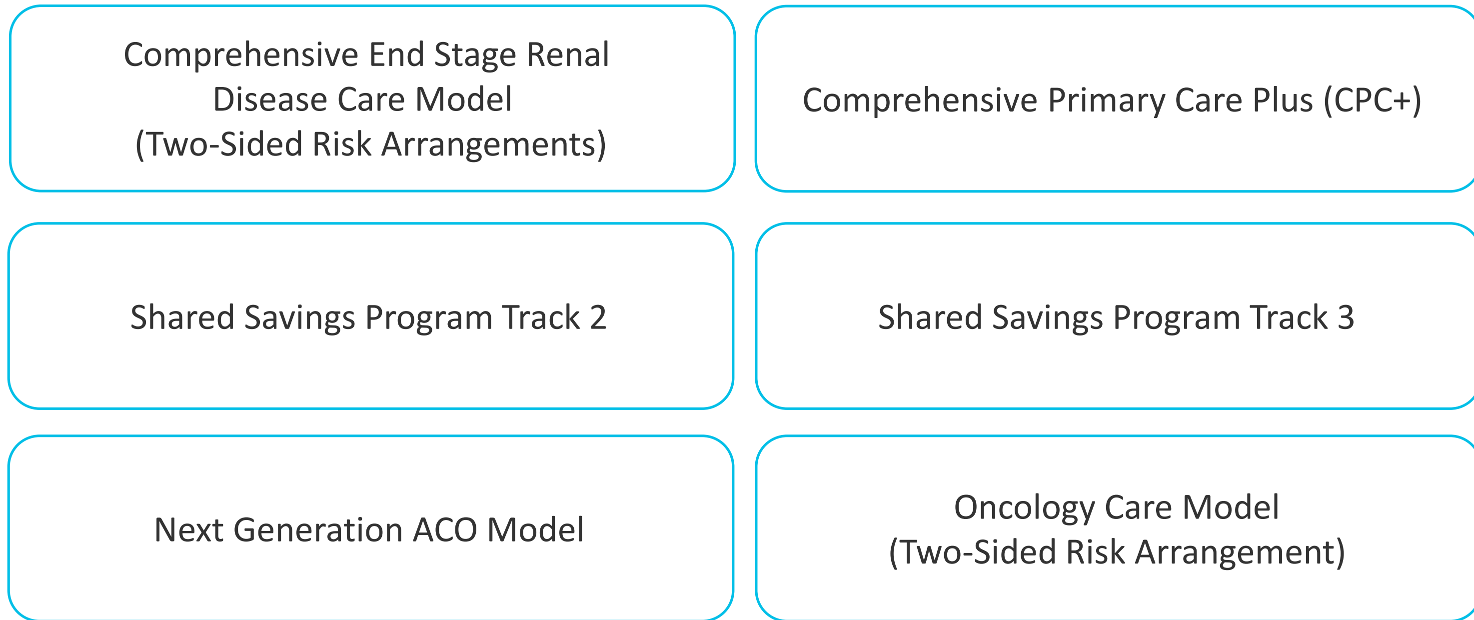
Advanced Alternative Payment Models

- Advanced Alternative Payment Models (Advanced APMs) enable clinicians and practices to earn greater rewards for taking on some risk related to their patients' outcomes.
- It is important to understand that the Quality Payment Program does not change the design of any particular APM. Instead, it creates **extra incentives** for a sufficient degree of participation in Advanced APMs.

Advanced APMs
Advanced APM-specific rewards + 5% lump sum incentive

Advanced APMs in 2017

For the **2017 performance year**, the following models are Advanced APMs:



The list of Advanced APMs is posted at QPP.CMS.GOV and will be updated with new announcements on an ad hoc basis.

Future Advanced APM Opportunities

- MACRA established the **Physician-Focused Payment Model Technical Advisory Committee (PTAC)** to review and assess Physician-Focused Payment Models based on proposals submitted by stakeholders to the committee.
- **In future performance years**, we anticipate that the following models will be Advanced APMs:

Comprehensive Care for Joint Replacement (CJR) Payment Model (CEHRT)

New Voluntary Bundled Payment Model

Advancing Care Coordination through Episode Payment Models Track 1 (CEHRT)

Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)

ACO Track 1+

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Advancing Care Information/Hospital & CAH Meaningful Use 2017

MIPS Performance Category: Advancing Care Information

- Promotes patient engagement and interoperability using certified EHR technology
- Replaces the Medicare EHR Incentive Program
- Greater flexibility in choosing measures
- In 2017, there are 2 measure sets for reporting based on EHR edition:
  1. Advancing Care Information Objectives and Measures
  2. 2017 Advancing Care Information Transition Objectives and Measures

MIPS Performance Category: Advancing Care Information — Reporting

Clinicians must use certified EHR technology to report

For those using EHR Certified to the 2015 Edition:	**For those using 2014 Certified EHR Technology:**
Option 1: Advancing Care Information Objectives and Measures	**Option 1:** 2017 Advancing Care Information Transition Objectives and Measures
Option 2: Combination of the two measure sets	**Option 2:** Combination of the two measure sets

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

MIPS Performance Category: Advancing Care Information

- Earn up to 155% maximum score, which will be capped at 100%
- Advancing Care Information category score includes:
  - Base score (worth 50%)
  - Performance score (up to 90%)
  - Bonus score (up to 15%)

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

MIPS Performance Category: Advancing Care Information

Advancing Care Information Objectives and Measures:

Base Score Required Measures

Objective	Measure
Protect Patient Health Information	Security Risk Analysis
Electronic Prescribing	e-Prescribing
Patient Electronic Access	Provide Patient Access
Health Information Exchange	Send a Summary of Care
	Request/Accept a Summary of Care

2017 Advancing Care Information Transition Objectives and Measures:

Base Score Required Measures

Objective	Measure
Protect Patient Health Information	Security Risk Analysis
Electronic Prescribing	e-Prescribing
Patient Electronic Access	Provide Patient Access
Health Information Exchange	Health Information Exchange

MIPS Performance Category: Advancing Care Information

Advancing Care Information Objectives and Measures

Objective	Measure
Patient Electronic Access	Provide Patient Access*
	Patient-Specific Education
Coordination of Care through Patient Engagement	View, Download and Transmit (VDT)
	Secure Messaging
	Patient-Generated Health Data
Health Information Exchange	Send a Summary of Care*
	Request/Accept a Summary of Care*
	Clinical Information Reconciliation
Public Health and Clinical Data Registry Reporting	Immunization Registry Reporting

2017 Advancing Care Information Transition Objectives and Measures

Objective	Measure
Patient Electronic Access	Provide Patient Access*
	View, Download and Transmit (VDT)
Patient-Specific Education	Patient-Specific Education
Secure Messaging	Secure Messaging
Health Information Exchange	Health Information Exchange*
Medication Reconciliation	Medication Reconciliation
Public Health Reporting	Immunization Registry Reporting

CY 2017 OPPS Final Rule

- Finalized the EHR reporting periods in 2016 and 2017 to any continuous 90-day period in CY 2016 and 2017 for all returning EPs, hospitals and CAHs that have previously attested
  - New participants must attest to Modified Stage 2 MU no later than October 1, 2017 to avoid the 2018 payment adjustment
- One-time significant hardship exception from the 2018 payment adjustment for certain EPs who are new participants in the EHR Incentive Program in 2017 and are transitioning to MIPS in 2017
- Meaningful use requirements for eligible hospitals and CAHs, and the MIPS advancing care information performance category requirements for eligible clinicians, now more closely aligned

CY 2017 OPPS Final Rule

- Eliminated the CDS and CPOE objectives and associated measures for eligible hospitals and CAHs attesting under the Medicare EHR Incentive Program beginning with the EHR reporting period in CY 2017
- Reduced a subset of the thresholds for eligible hospitals and CAHs attesting under the Medicare EHR Incentive Program for EHR reporting periods in CY 2017 for Modified Stage 2 and in CY 2017 and 2018 for Stage 3
  - Updated the measures for EPs, eligible hospitals and CAHs with a new naming convention to align with the measure nomenclature proposed for the MIPS

CY 2017 OPPS Final Rule

- **Changes to the Objectives and Measures for Modified Stage 2:**
  - Reduced the threshold for the Patient Electronic Access, View Download Transmit (VDT) Measure from more than 5 percent to at least one patient
- With the elimination of the CDS and CPOE objectives and measures, there is a final list of 7 objectives and 10 measures for Modified Stage 2
- Modifications to the meaningful use objectives and measures would be applicable only to eligible hospitals and CAHs attesting under the Medicare EHR Incentive Program for an EHR reporting period in CY 2017 (also applies to "dual-eligible hospitals")
  - These proposed changes would not apply to eligible hospitals and CAHs that attest to meaningful use under their State's Medicaid EHR Incentive Program.
  - These eligible hospitals and CAHs would continue to attest to their State Medicaid agencies on the measures and objectives finalized in the 2015 EHR Incentive Programs Final Rule

Modified Stage 2 Objectives and Measures in 2017 for Eligible Hospitals and CAHs Attesting Under the Medicare EHR Incentive Program

Objective	Previous Measure Name/Reference	Measure Name	Threshold Requirement
Protect Patient Health Information	Measure	Security Risk Analysis	Yes/No attestation
Electronic prescribing	Measure	e-Prescribing	>10%
Health Information Exchange	Measure	Health Information Exchange	>10%
Patient Specific Education	Eligible Hospital/CAH Measure	Patient-Specific Education	>10%
Medication Reconciliation	Measure	Medication Reconciliation	>50%
Patient Electronic Access	Eligible Hospital/CAH Measure 1	Provide Patient Access	>50%
	Eligible Hospital/CAH Measure 2	View, Download Transmit (VDT)	At least 1 patient
Public Health Reporting	Immunization Reporting	Immunization Registry Reporting	Public Health Reporting to 3 Registries
	Syndromic Surveillance Reporting	Syndromic Surveillance Reporting	
	Specialized Registry Reporting	Specialized Registry Reporting	
	Electronic Reportable Laboratory Result Reporting	Electronic Reportable Laboratory Result Reporting	

CY 2017 OPPS Proposed Rule

- Changes to the Objectives and Measures for Stage 3 in 2017 and 2018:
  - For the Patient Electronic Access to Health Information objective, CMS is reducing the thresholds:
    - For the Provide Patient Access measure from more than 80 percent to more than 50 percent.
    - For the Patient-Specific Education measure from more than 35 percent to more 10 percent

CY 2017 OPPS Proposed Rule

- Changes to the Objectives and Measures for Stage 3 in 2017 and 2018:
  - For the Coordination of Care Through Patient Engagement objective, CMS finalizes its proposal to:
    - Maintain that providers must attest to the numerator and denominator for all three measures, but would only be required to successfully meet the threshold for two of the three measures
    - Reduce the threshold of the View, Download Transmit (VDT) measure from more than 5 percent to at least one patient
    - Reduce the threshold of the Secure Messaging measure from more than 25 percent to more than 5 percent

CY 2017 OPPS Proposed Rule

- Changes to the Objectives and Measures for Stage 3 in 2017 and 2018:
  - For the Health Information Exchange (HIE) objective, CMS is finalizing its proposal to:
    - Maintain that providers must attest to the numerator and denominator for all three measures, but would only be required to successfully meet the threshold for two of the three measures
    - Reduce the threshold for the Send a Summary of Care measure from more than 50 percent to more than 10 percent
    - Reduce the threshold for the Request/Accept Summary of Care measure from more than 40 percent to more than 10 percent
    - Reduce the threshold for the Clinical Information Reconciliation measure from more than 80 percent to more than 50 percent

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CY 2017 OPPS Proposed Rule

- **Changes to the Objectives and Measures for Stage 3 in 2017 and 2018:**
  - For the Public Health and Clinical Data Registry Reporting objective, CMS is finalizing its proposal to:
    - Reduce the reporting requirement for Public Health and Clinical Data Registry Reporting from any combination of six measures to align with the Modified Stage 2 requirement of any combination of **three** measures

- With the proposed elimination of the CDS and CPOE objectives and measures, there is a proposed list of 6 objectives and 13 measures for Stage 3

CY 2017 OPPS Proposed Rule

- Proposed Changes to the Objectives and Measures for Stage 3 in 2017 and 2018:
  - For the Public Health and Clinical Data Registry Reporting objective, CMS is proposing to:
    - Reduce the reporting requirement for Public Health and Clinical Data Registry Reporting from any combination of six measures to align with the Modified Stage 2 requirement of any combination of **three** measures

- With the proposed elimination of the CDS and CPOE objectives and measures, there is a proposed list of 6 objectives and 13 measures for Stage 3

Stage 3 Objectives and Measures for 2017 and 2018 for Eligible Hospitals and CAHs Attesting Under the Medicare EHR Incentive Program

Objective	Previous Measure Name/Reference	Measure Name	Threshold Requirement
Protect Patient Health Information	Measure	Security Risk Analysis Measure	Yes/No attestation
Electronic prescribing	Eligible hospital/CAH Measure	e-Prescribing	>25%
Patient Electronic Access to Health Information	Measure 1	Provide Patient Access	>50%
	Measure 2	Patient- Specific Education	>10%
Coordination of Care through Patient Engagement	Measure 1	View, Download Transmit (VDT)	>At least 1 patient
	Measure 2	Secure Messaging	>5%
	Measure 3	Patient Generated Health Data	>5%
Health Information Exchange	Measure 1	Send a Summary of Care	>10%
	Measure 2	Request/Accept Summary of Care	>10%
	Measure 3	Clinical Information Reconciliation	>50%
Public Health and Clinical Data Registry Reporting	1) Immunization Registry Reporting 2) Syndromic Surveillance Reporting 3) Case Reporting 3) Public Health Registry Reporting 4) Clinical Data Registry Reporting 5) Electronic Reportable Laboratory Result Reporting	1) Immunization Registry Reporting 2) Syndromic Surveillance Reporting 3) Electronic Case Reporting 4) Public Health Registry Reporting 4) Clinical Data Registry Reporting 5) Electronic Reportable Laboratory Result Reporting	Report to 3 Registries or claim exclusions

Where can I go to learn more?

Help Is Available

qpp.cms.gov

CMS has organizations on the ground to provide help to clinicians who are eligible for the Quality Payment Program:

Transforming Clinical Practice Initiative (TCPI): TCPI is designed to support more than 140,000 clinician practices over the next 4 years in sharing, adapting, and further developing their comprehensive quality improvement strategies. Clinicians participating in TCPI will have the advantage of learning about MIPS and how to move toward participating in Advanced APMs. Click here to find help in your area.

Quality Innovation Network (QIN)-Quality Improvement Organizations (QIOs): The QIO Program's 14 QIN-QIOs bring Medicare beneficiaries, providers, and communities together in data-driven initiatives that increase patient safety, make communities healthier, better coordinate post-hospital care, and improve clinical quality. More information about QIN-QIOs can be found here.

If you're in an APM: The Innovation Center's Learning Systems can help you find specialized information about what you need to do to be successful in the Advanced APM track. If you're in an APM that is not an Advanced APM, then the Learning Systems can help you understand the special benefits you have through your APM that will help you be successful in MIPS. More information about the Learning Systems is available through your model's support inbox.

When and where do I submit comments?

- The **final rule with comment** includes 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 **December 19, 2016**. When commenting refer to file code **CMS-5517-FC**.
- 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: QPP.CMS.GOV**

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Do you need technical assistance to help you participate in the Quality Payment Program? The Centers for Medicare & Medicaid Services has specialized programs and resources for eligible clinicians across the country.

PRIMARY CARE & SPECIALIST PHYSICIANS

Transforming Clinical Practice Initiative

- Supports more than 140,000 clinician practices through active, collaborative and peer-based learning networks over 4 years.
- **Practice Transformation Networks (PTNs) and Support Alignment Networks (SANs)** are located in all 50 states to provide comprehensive technical assistance, as well as tools, data, and resources to improve quality of care and reduce costs.
- The goal is to help practices transform over time and move toward Advanced Alternative Payment Models.

Locate the PTN(s) and SAN(s) in your state

SMALL & SOLO PRACTICES

Small, Underserved Rural Support Technical Assistance

- Provides outreach, guidance, and direct technical assistance to clinicians in solo or small practices (15 or fewer), particularly those in rural and underserved areas, to promote successful health IT adoption, optimization, and delivery system reform activities.
  - Assistance will be tailored to the needs of the clinicians.
  - Organizations selected to provide this technical assistance will be available in late 2016.

LARGE PRACTICES

Quality Innovation Network-Quality Improvement Organizations (QIN-QIO) Education and Support

- Supports clinicians in **large practices (more than 15 clinicians)** in meeting Merit- Based Incentive Payment System requirements through customized technical assistance.
- Includes one-on-one assistance when needed.
- There are 14 QIN-QIOs that serve all 50 states, the District of Columbia, Guam, Puerto Rico, and Virgin Islands.

Locate the QIN-QIO that serves your state

Quality Innovation Network (QIN) Directory

TECHNICAL SUPPORT

All Eligible Clinicians Are Supported By:

Quality Payment Program Website: qpp.cms.gov
Serves as a starting point for information on the Quality Payment Program.

Quality Payment Program Service Center
Assists with all Quality Payment Program questions.
1-866-288-8292 TTY: 1-877-715-6222 QPP@cms.hhs.gov

Advanced Alternative Payment Model (APM) Learning Networks
Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Contact Info

Patrick Hamilton, M.P.A.

Health Insurance Specialist

CMS Philadelphia Regional Office

215-861-4097

Patrick.hamilton@cms.hhs.gov