The Quality Payment Program: Year 2 (2018) Overview

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Important Note: Sections of this presentation were developed in collaboration with Centers for Medicare & Medicaid Services (CMS).

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Some slides are courtesy of CMS from various CMS webinars and presentations about the Quality Payment Program.

Objectives

1. Identify the background and purpose of the Quality Payment Program (QPP): Medicare Access and CHIP Reauthorization Act (MACRA) of 2015.
2. Identify framework paths: Merit Based Incentive Payment Systems (MIPS) and Advanced Alternative Payment Models (APMs).
3. Discuss payment adjustments and bonuses related to MIPS and APMs.
4. Discuss **Final Rule with comments Year 2 (Performance Year 2018).**
5. Identify steps to prepare for the QPP within the IHS.

Quality Payment Program Overview

Origin of the Quality Payment Program (QPP)

- ✓ Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).
- ✓ Bipartisan Legislation
- ✓ **Repeals** the Sustainable Growth Rate (SGR) Formula
- ✓ Increases focus on quality of care and value of care delivered
- ✓ Moving towards patient- centric health care system
  - Delivers better care
  - Smarter spending
  - Healthier People
- ✓ **Offers two tracks of participation**

Final Rule with Comment Period: Comments Due January 1, 2018

Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year

CMS is issuing an interim final rule with comment period (IFC) that addresses extreme and uncontrollable circumstances MIPS eligible clinicians may face as a result of widespread catastrophic events affecting a region or locale in CY 2017, such as Hurricanes Irma, Harvey and Maria.

See the Final Rule for information on submitting these comments by the close of the 60-day comment period on January 1, 2018 no later than 5 p.m. ET. When commenting refer to file code **CMS 5522-FC.**

DATES : *Effective Date*: These provisions of this final rule with comment period and interim final rule with comment period are effective on January 1, 2018.

Resource: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/QPP-Year-2-Executive-Summary.pdf

Quality Payment Program: Two Participation Tracks

Health care providers to take part in CMS' quality programs in one of two ways:

1. Merit-Based Incentive Payment System (MIPS)
2. Advanced Alternative Payment Models (Advanced APMs)

The Merit-based Incentive Payment System (MIPS)

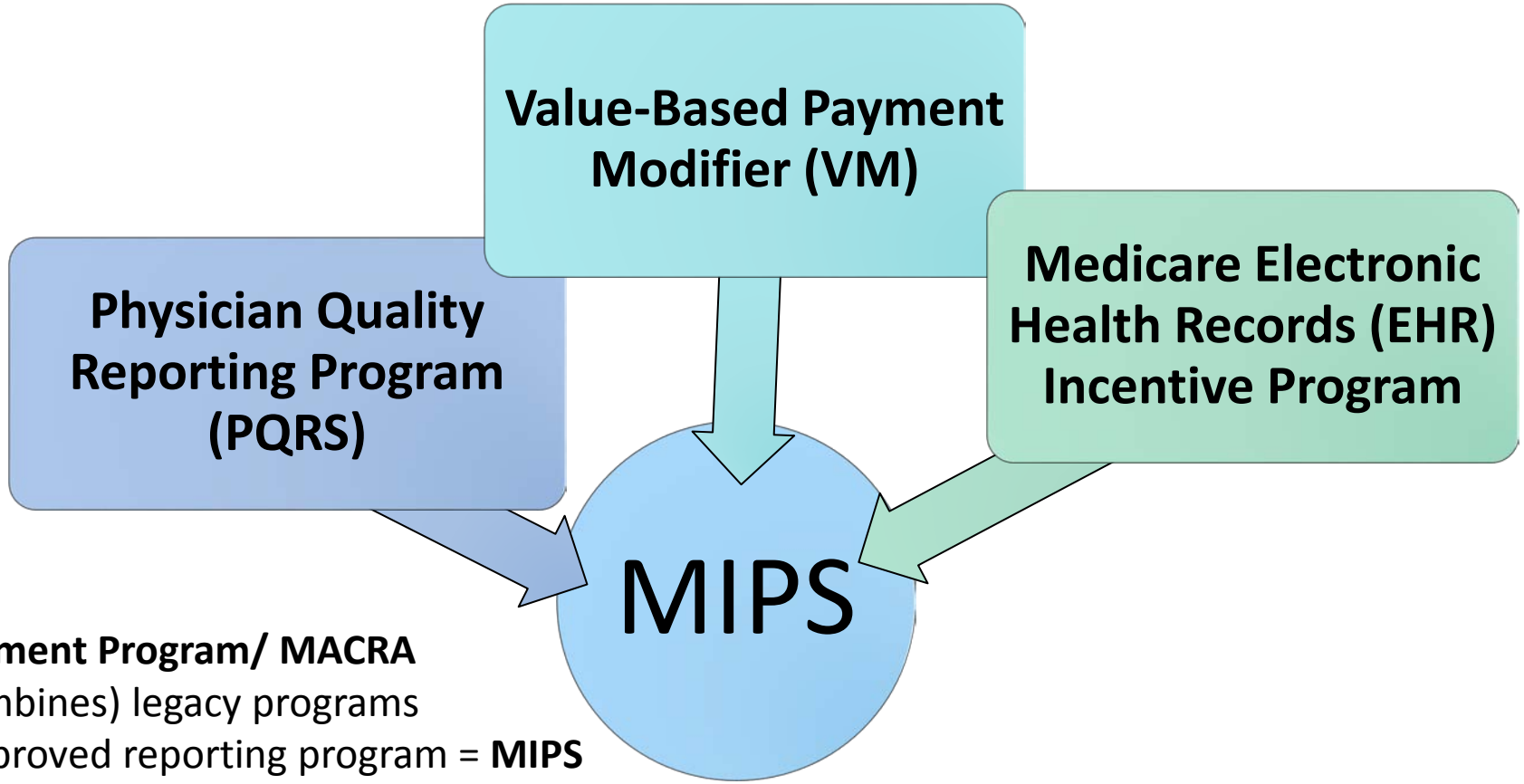
If you decide to participate in MIPS, you will earn a performance-based payment adjustment through MIPS.

Advanced Alternative Payment Models (Advanced APMs)

If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for sufficiently participating in an innovative payment model.

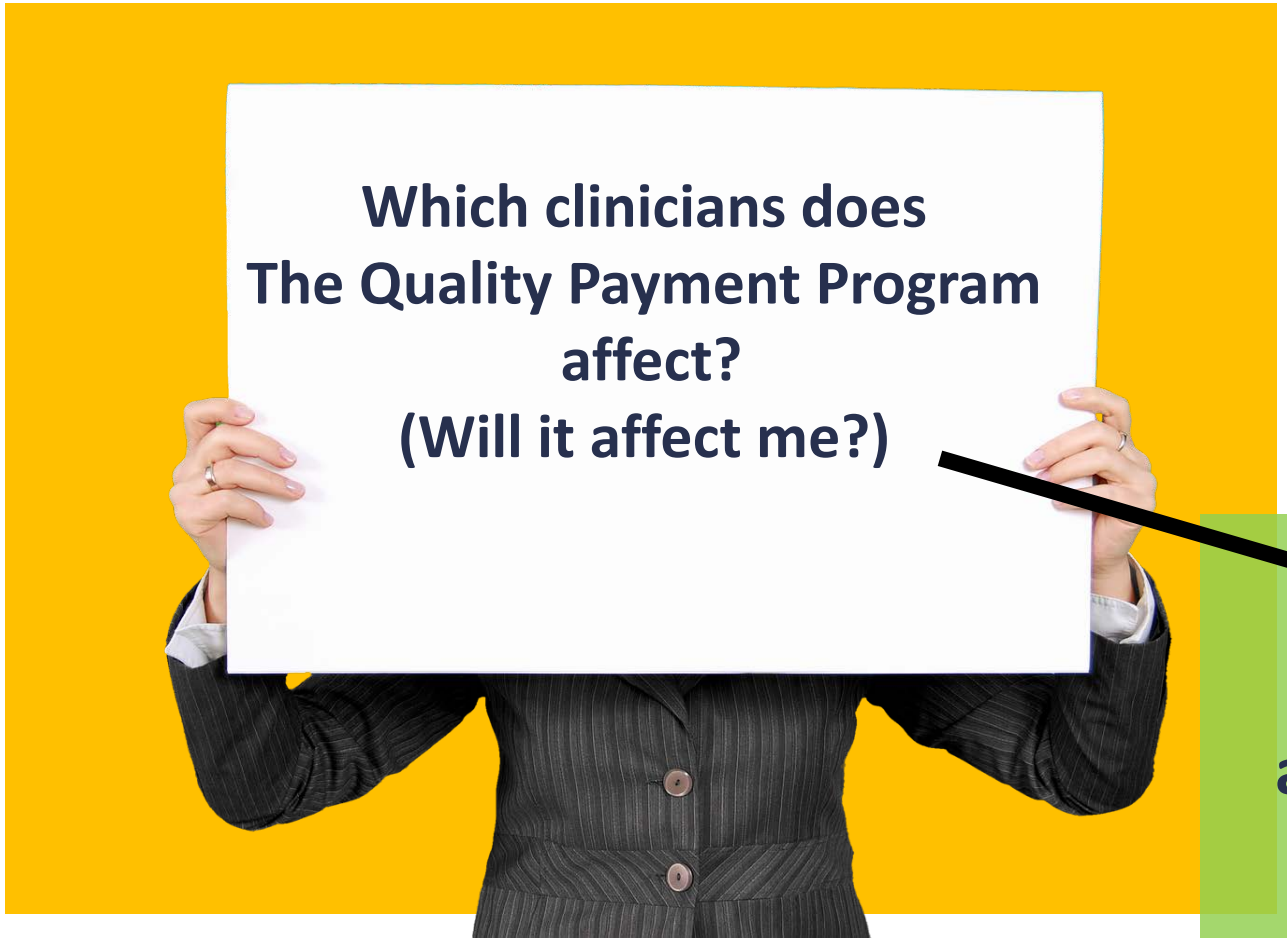
What is MIPS

Currently there are **multiple quality and value reporting programs** for Medicare clinicians.



The Quality Payment Program/ MACRA streamlines (combines) legacy programs into a single, improved reporting program = **MIPS**

Clinician Impact

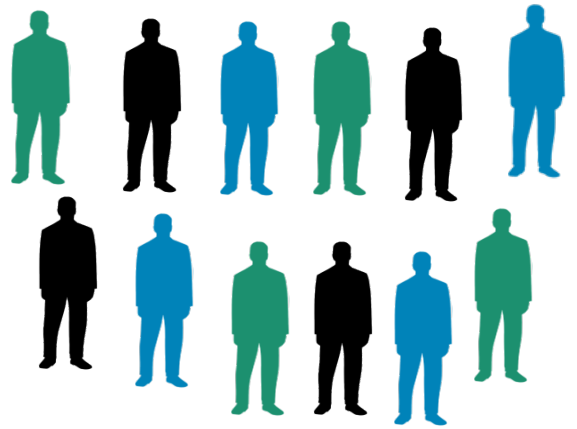


Short answer:
Quality Payment Program affects clinicians who participate in Medicare Part B.

MIPS Quality Payment Program Eligibility

For 2017 and 2018 , types of clinicians:

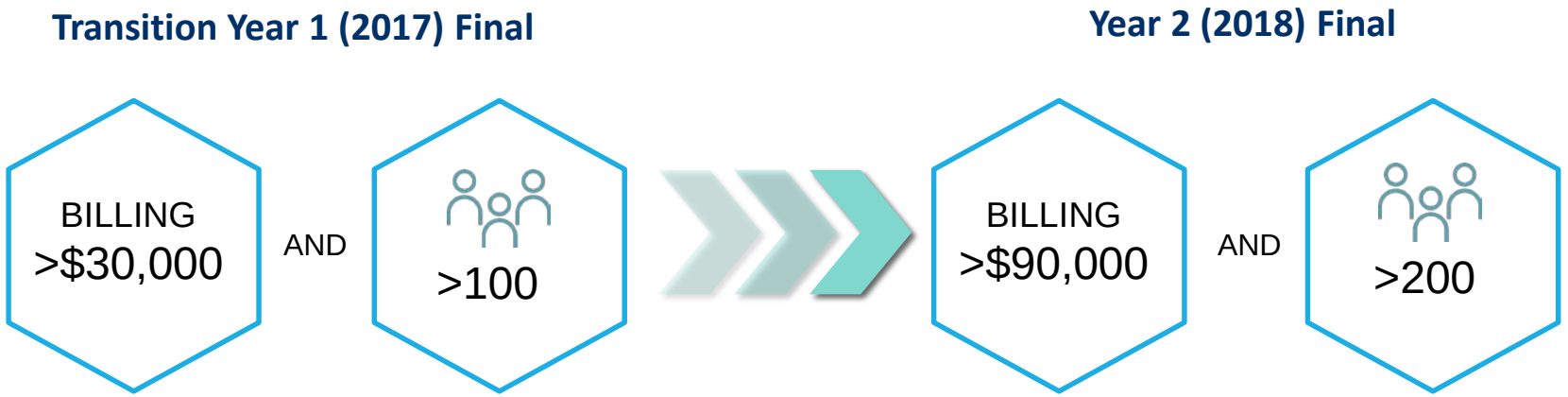
- **Physician**
  - Doctors of Medicine
  - Doctors of Osteopathy
- **Dentists**
- **Optometrists**
- **Chiropractors**
- **Podiatrists**
- **Physician assistant**
- **Nurse practitioner**
- **Clinical nurse specialist**
- **Certified registered nurse anesthetist**



***No change** in the types of clinicians eligible to participate in 2018*

Who is included in MIPS? (2017 & 2018)

***Change** to the Low-Volume Threshold for 2018.* Includes MIPS eligible clinicians billing more than $90,000 a year in Medicare Part B allowed charges **AND** providing care for more than 200 Medicare patients a year.



Voluntary reporting remains an option for those clinicians who are exempt from MIPS.

What is MIPS (2017)

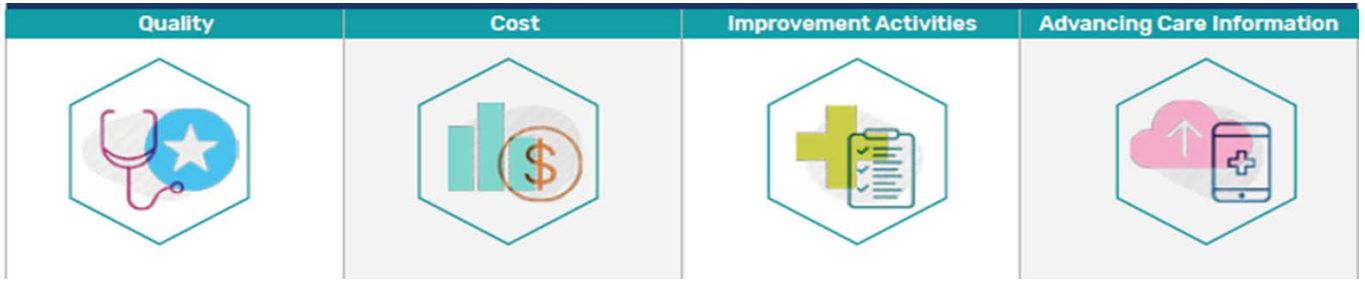
MIPS participants receive a payment adjustment based on performance in four categories

Quality	Cost	Improvement Activity	Advancing Care Information
Replaces PQRS	Replaces Value-Based Modifier	New performance category	Replaces the EHR Incentive Program
Assesses the value of care to ensure patients get the right care at the right time.		Supports: Care coordination, Beneficiary engagement, Population management, Patient safety	Supports the secure exchange of health information and the use of certified EHR technology
60% of MIPS Score	0% of MIPS Score	15% of MIPS Score	25% of MIPS Score

MIPS Performance Categories Transition Year (2017)

How will physicians and practitioners be scored under MIPS?

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

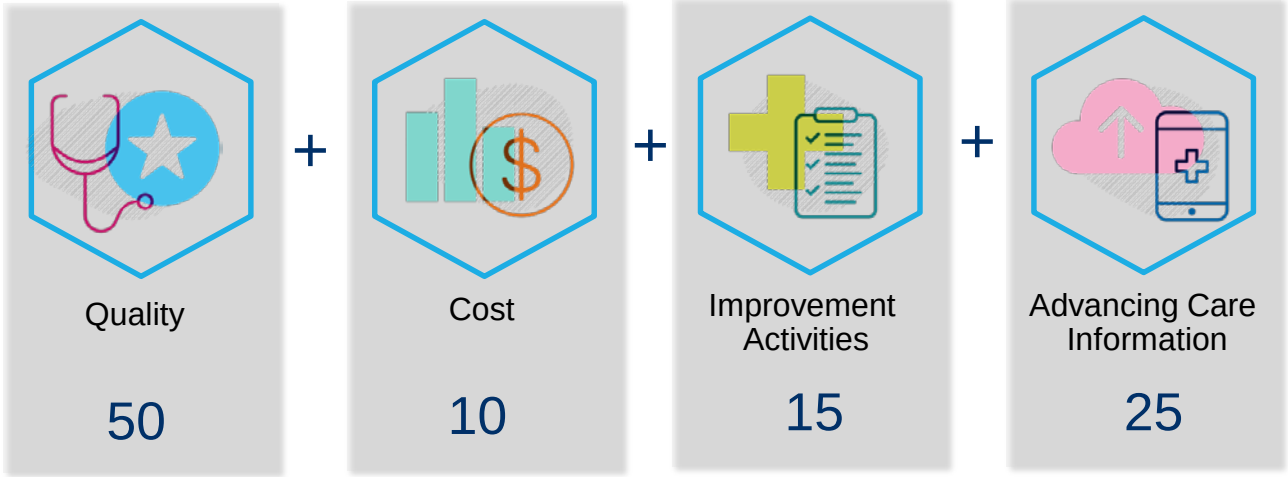


Quality | ***Cost** | **Improvement Activities** | **Advancing Care Information**

→ **FINAL SCORE**

*Cost= 0 % weighting the first year

MIPS Performance Categories for Year 2 (2018)



Comprised of **four** performance categories in 2018.

So what? *The points from each performance category are added together to give you a MIPS Final Score.* Performance threshold set at 15 points.

The MIPS Final Score is compared to the MIPS performance threshold to determine if one receive a **positive**, **negative**, or **neutral payment adjustment**.

Who is Exempt?
MIPS Year 2 (2018)

No Change in Basic Exemption Criteria*

Newly-enrolled in Medicare

- Enrolled in Medicare for the first time during the performance period (exempt until following performance year)

Below the low-volume threshold

- Medicare Part B allowed charges less than or equal to **$90,000** a year

OR

- See **200** or fewer Medicare Part B patients a year

Significantly participating in Advanced APMs

- Receive 25% of their Medicare payments

OR

- See 20% of their Medicare patients through an Advanced APM

**Only Change to Low-volume Threshold*

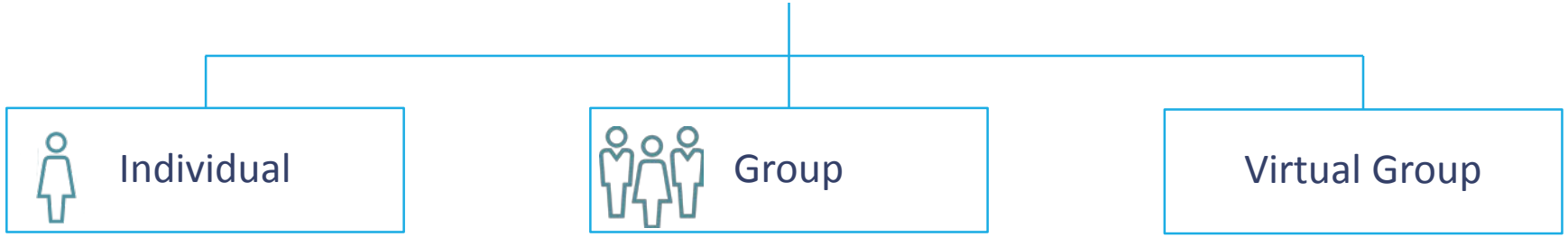
What is a Virtual Group ?

Year 2 (2018): Added **Virtual Groups** as a way to participate

- Solo practitioners and groups of 10 or fewer eligible clinicians who come together “virtually” (no matter what specialty or location) to participate in MIPS for a performance period of a year.
- Solo practitioners and small groups may only participate in a Virtual Group if they exceed the low-volume threshold.
- Are not a newly Medicare-enrolled eligible clinician, a Qualifying APM Participant (QP), or a Partial QP choosing not to participate in MIPS.
- Election period is October 11, 2017 to December 31, 2017, for the 2018 MIPS performance period.
- To learn more, see the 2018 Virtual Groups Toolkit.

Reporting Options
MIPS Year 2 (2018)

OPTIONS



1. Individual—under an National Provider Identifier (NPI) number and Taxpayer Identification Number (TIN) where they reassign benefits

2. As a Group

a) Two or more clinicians identified by their National Provider Identifier (NPIs) who have reassigned their billing rights to a single Tax Identification Number (TIN)*.

b) As an APM Entity

3. As a Virtual Group – made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together "virtually" (no matter what specialty or location) to participate in MIPS for a performance period for a year

* If clinicians participate as a group, they are assessed as a group across all 4 MIPS performance categories. The same is true for clinicians participating as a Virtual Group.

MIPS Year 2 (2018) Performance Period

Change: *Increase to Performance Period*

Transition Year 1 (2017) Final

Performance Category	Minimum Performance Period
Quality	90-days minimum; full year (12 months) was an option
Cost	Not included. 12-months for feedback only.
Improvement Activities	90-days
Advancing Care Information	90-days

Year 2 (2018) Final

Performance Category	Minimum Performance Period
Quality	12-months
Cost	12-months
Improvement Activities	90-days
Advancing Care Information	90-days

Submission Methods

No change: *All of the submission mechanisms remain the same from Year 1 to Year 2*

Performance Category	Submission Mechanisms for Individuals	Submission Mechanisms for Groups (Including Virtual Groups)
 Quality	QCDR Qualified Registry EHR Claims	QCDR Qualified Registry EHR CMS Web Interface (groups of 25 or more)
 Cost	Administrative claims (no submission required)	Administrative claims (no submission required)
 Improvement Activities	Attestation QCDR Qualified Registry EHR	Attestation QCDR Qualified Registry EHR CMS Web Interface (groups of 25 or more)
 Advancing Care Information	Attestation QCDR Qualified Registry EHR	Attestation QCDR Qualified Registry EHR CMS Web Interface (groups of 25 or more)

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

MACRA **does not change how any particular APM rewards value**.
APM participants who are not "QPs" will receive **favorable scoring under MIPS**.
Only **some** of these APMs will be **Advanced** APMs.

Rewards for APM Participants

QPP provides additional rewards for participating in APMs.

Potential financial **rewards**

Not in APM	In APM	In Advanced APM
MIPS adjustments	MIPS adjustments	
	+	
	APM-specific rewards	APM-specific rewards
		+
		5% lump sum bonus

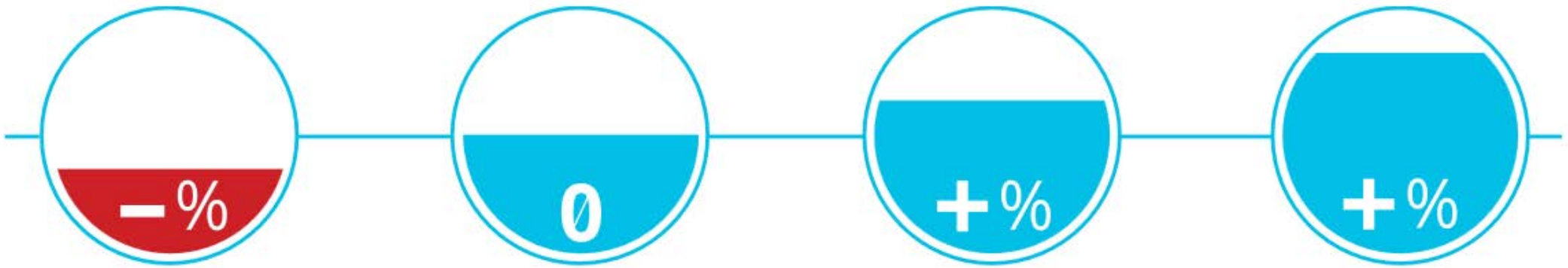
If you are a **qualifying APM participant (QP)**

Putting It All Together 2017 and Beyond

Quality Payment Program: Pick Your Pace (CY 2017)

- Ready- Begin January 1, 2017
- Not Quite Ready
  - Start anytime between January 1, 2017 - October 2, 2017.
- Send in Performance Data by March 31, 2018

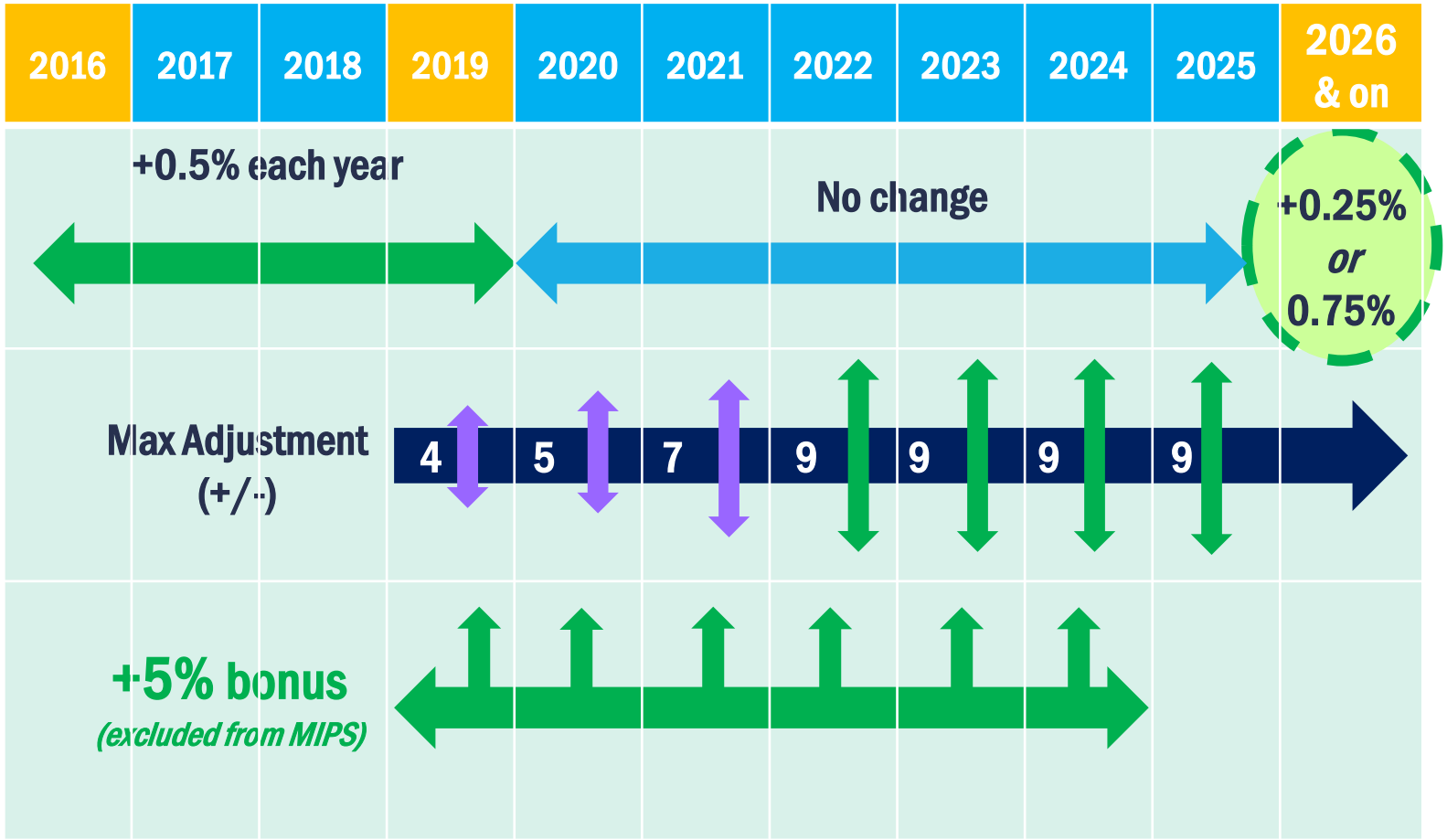
MIPS: Pick Your Pace (CY 2017)



Don't Participate | Submit Something | Submit a Partial Year | Submit a Full Year

Positive adjustments are based on performance data from the performance information submitted- **Not the amount of information or the length of times submitted**.

Putting it all together



Additional Information:
Quality Payment Program Year 2 (2018)

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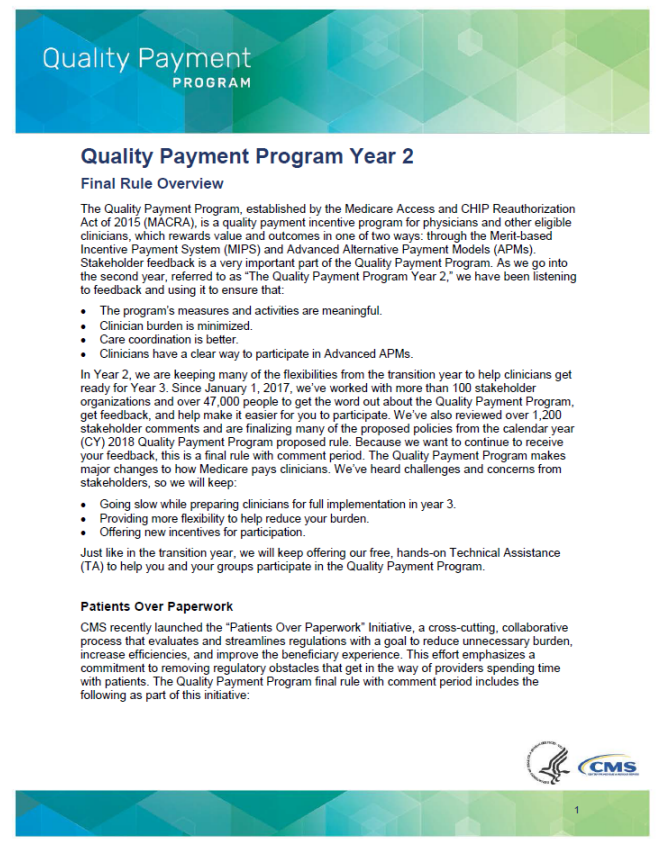
Final Rule for QPP Year 2 (2018)



Quality Payment PROGRAM

Quality Payment Program Year 2

Final Rule Overview

The Quality Payment Program, established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), is a quality payment incentive program for physicians and other eligible clinicians, which rewards value and outcomes in one of two ways: through the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). Stakeholder feedback is a very important part of the Quality Payment Program. As we go into the second year, referred to as "The Quality Payment Program Year 2," we have been listening to feedback and using it to ensure that:

- The program's measures and activities are meaningful.
- Clinician burden is minimized.
- Care coordination is better.
- Clinicians have a clear way to participate in Advanced APMs.

In Year 2, we are keeping many of the flexibilities from the transition year to help clinicians get ready for Year 3. Since January 1, 2017, we've worked with more than 100 stakeholder organizations and over 47,000 people to get the word out about the Quality Payment Program, get feedback, and help make it easier for you to participate. We've also reviewed over 1,200 stakeholder comments and are finalizing many of the proposed policies from the calendar year (CY) 2018 Quality Payment Program proposed rule. Because we want to continue to receive your feedback, this is a final rule with comment period. The Quality Payment Program makes major changes to how Medicare pays clinicians. We've heard challenges and concerns from stakeholders, so we will keep:

- Going slow while preparing clinicians for full implementation in year 3.
- Providing more flexibility to help reduce your burden.
- Offering new incentives for participation.

Just like in the transition year, we will keep offering our free, hands-on Technical Assistance (TA) to help you and your groups participate in the Quality Payment Program.

Patients Over Paperwork

CMS recently launched the "Patients Over Paperwork" Initiative, a cross-cutting, collaborative process that evaluates and streamlines regulations with a goal to reduce unnecessary burden, increase efficiencies, and improve the beneficiary experience. This effort emphasizes a commitment to removing regulatory obstacles that get in the way of providers spending time with patients. The Quality Payment Program final rule with comment period includes the following as part of this initiative:

CMS

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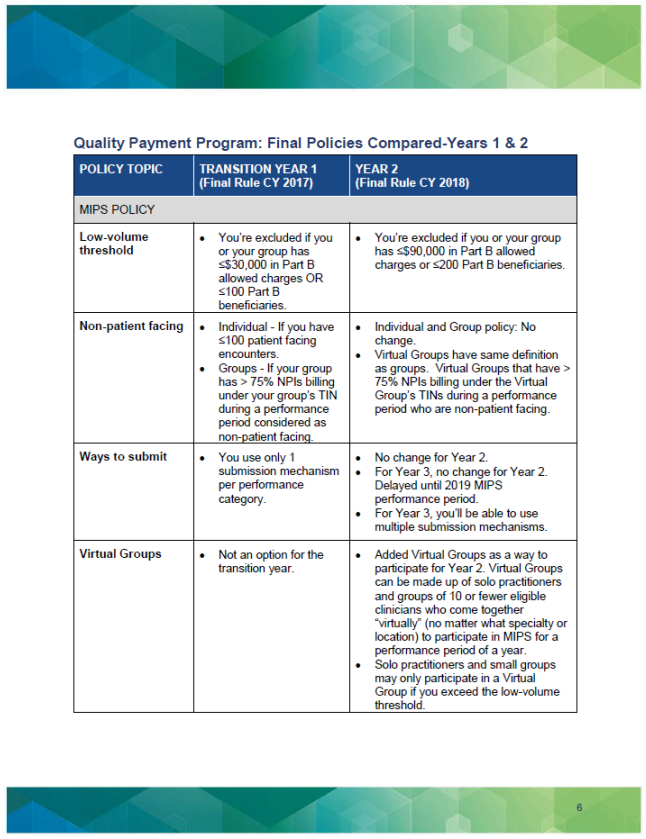

Quality Payment Program: Final Policies Compared-Years 1 & 2

POLICY TOPIC	TRANSITION YEAR 1 (Final Rule CY 2017)	YEAR 2 (Final Rule CY 2018)
MIPS POLICY		
Low-volume threshold	• You're excluded if you or your group has ≤$30,000 in Part B allowed charges OR ≤100 Part B beneficiaries.	• You're excluded if you or your group has ≤$90,000 in Part B allowed charges or ≤200 Part B beneficiaries.
Non-patient facing	• Individual - If you have ≤100 patient facing encounters. • Groups - If your group has > 75% NPIs billing under your group's TIN during a performance period considered as non-patient facing.	• Individual and Group policy: No change. • Virtual Groups have same definition as groups. Virtual Groups that have > 75% NPIs billing under the Virtual Group's TINs during a performance period who are non-patient facing.
Ways to submit	• You use only 1 submission mechanism per performance category.	• No change for Year 2. • For Year 3, no change for Year 2. Delayed until 2019 MIPS performance period. • For Year 3, you'll be able to use multiple submission mechanisms.
Virtual Groups	• Not an option for the transition year.	• Added Virtual Groups as a way to participate for Year 2. Virtual Groups can be made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together "virtually" (no matter what specialty or location) to participate in MIPS for a performance period of a year. • Solo practitioners and small groups may only participate in a Virtual Group if you exceed the low-volume threshold.

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CMS Final Rule for QPP Year 2 (2018) Fact Sheet

- 26 pages
- Provides comparison summary
- Example of changes provided such as adding virtual groups for 2018.

Source : https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/QPP-Year-2-Final-Rule-Fact-Sheet.pdf

Comparison- Quality

Topic	Transition Year 1 (2017) Final	Year 2 (2018) Final
Weight to final score	• 60% in 2019 payment year. • 50% in 2020 payment year. • 30% in 2021 payment year and beyond.	• 50% in 2020 payment year. • 30% in 2021 payment year and beyond→ SAME
Data completeness:	Measures that do not meet the data completeness criteria receive 3 points.	Measures that do not meet data completeness criteria will earn 1 point instead of 3 points, except measures submitted by small practices will continue to earn 3 points.

Comparison- ACI

Topic	Transition Year 1 (2017) Final	Year 2 (2018) Final
CEHRT	• 2014 or 2015 CEHRT Edition for the 2017 transition year and require use of 2015 CEHRT edition for 2018.	• Use either the 2014 or 2015 Edition CEHRT in 2018.
Weight to final score	• 25%, made up of a base score, performance score, and bonus points for data submission on certain measures and activities.	• No change for the 2020 payment year.
Bonus	• Bonus (5%) for reporting to 1 or more additional public health and clinical data registries. • Bonus (10%) for completion of at least 1 of the specified Improvement Activities using CEHRT.	• A 5% bonus score is available for submitting to an additional public health agency or clinical data registry not reported under the performance score. • Additional Improvement Activities are eligible for a 10% Advancing Care Information bonus if CEHRT used to complete at least 1 of the specified Improvement Activities. • A 10% bonus score for using 2015 Edition exclusively.

Comparison- ACI (continued)

Topic	Transition Year 1 (2017) Final	Year 2 (2018) Final
Reweighting/ Hardship exceptions	• Allowed reweighting of the Advancing Care Information category to 0, if there are insufficient measures applicable and available to MIPS eligible clinicians.	Based on authority from the 21st Century Cures Act, CMS will reweight the Advancing Care Information performance category to 0% of the final score and reallocate the performance category weight of 25% to the Quality performance category for: • A significant hardship exception • A new significant hardship exception for MIPS eligible clinicians in small practices (15 or fewer clinicians); • An exception for hospital-based MIPS eligible clinicians; • A new exception for MIPS eligible clinicians whose EHR was decertified. New deadline of December 31 of the performance period for the submission of reweighting applications, beginning with the 2017 performance period.

Comparison- Improvement Activity

Topic	Transition Year 1 (2017) Final	Year 2 (2018) Final
Weight to final score	• 15% and measured based on a selection of different medium and high-weighted activities.	No change for the 2020 payment year.

Comparison- Cost

Topic	Transition Year 1 (2017) Final	Year 2 (2018) Final
Weight to final score	• 0% in 2019 payment year. • 10% in 2020 payment year. • 30% in 2021 payment year and beyond.	• 10% in 2020 MIPS payment year, but are soliciting feedback on keeping the weight at 10%. • 30% in 2021 MIPS payment year and beyond.
Measures	• Will include the Medicare Spending per Beneficiary (MSPB) and total per capita cost measures. • 10 episode-based cost measures. • Measures do not contribute to the score, feedback is provided for these measures.	• Include Medicare Spending per Beneficiary (MSPB) and total per capita cost measures in calculating Cost performance category score for the 2018 MIPS performance period. • For the 2018 MIPS performance period, CMS won't use the 10 episode-based measures adopted for the 2017 MIPS performance period. • CMS developing new episode-based measures with stakeholder input and soliciting feedback on some of these measures - Fall 2018. • Expect proposed new cost measures in the future.

MIPS Year 2(2018) MIPS: Performance Threshold & Payment Adjustment

Change: *Increase in Performance Threshold and Payment Adjustment*

Transition Year 1 (2017) Final

- 3 point threshold
- Exceptional performer set at 70 points
- Payment adjustment set at +/- 4%

Year 2 (2018) Final

- 15 point threshold
- Exceptional performer set at 70 points
- Payment adjustment set at +/- 5%

How can I achieve 15 points?

- Report all required Improvement Activities.
- Meet the Advancing Care Information base score and submit 1 Quality measure that meets data completeness.
- Meet the Advancing Care Information base score, by reporting the 5 base measures, and submit one medium-weighted Improvement Activity.
- Submit 6 Quality measures that meet data completeness criteria.

MIPS Year 2 (2018)
Extreme and Uncontrollable Circumstances

- CMS knows that areas affected by the recent hurricanes, specifically Hurricanes Harvey, Irma, and Maria, have experienced devastating disruptions in infrastructure and clinicians face challenges in submitting data under the Quality Payment Program.
- CMS have issued an **Interim Final Rule** with an automatic extreme and uncontrollable circumstances policy where clinicians are exempt from the Quality, Improvement Activities, and Advancing Care Information performance categories *without* submitting a hardship exception application.

What does the Interim Final Rule mean for me in the Transition Year (2017)?

- CMS will automatically reweight the Quality, Improvement Activities, and Advancing Care Information performance categories.
- This will result in the clinician receiving a MIPS Final Score equal to the performance threshold, unless the MIPS eligible clinician submits data.
- Clinicians who do submit data (as an individual or group) will be scored on their submitted data.
- This policy does not apply to APMs.

MIPS Year 2 (2018)
Extreme and Uncontrollable Circumstances

Extreme and Uncontrollable Circumstances in Year 2 (2018):

- The Final Rule with Comment Period for Year 2 **extends** the Transition Year hardship exception reweighting policy for the Advancing Care Information performance category to now include Quality, Cost, and Improvement Activities.
- This policy applies to all of the 2018 MIPS performance categories.
- **A hardship exception application is required**.
- The hardship exception application **deadline** is **December 31, 2018**.

Steps to Prepare for the Quality Payment Program

Getting Ready to Participate in MIPS 2017

- Determine participants eligibility status
- Choose if participants are reporting as an individual or group
- Choose participants' submission mechanism and verify its capabilities
  - Decide if working with a third party intermediary
- Pick Your Pace (2017)
  - Choose measure(s) and activities
  - Use CMS resources (website) to explore options on measures to use
- Verify the information needed to report successfully
- Record data based on participants care for patients
- Submit data

Getting Ready to Participate in MIPS 2018

- Determine participants eligibility status
  - New eligibility Criteria
- Choose if participants are reporting as an individual or group (Virtual Group)
- Choose participants' submission mechanism and verify its capabilities
- Follow reporting requirements (2018)
  - Follow reporting durations for performance categories (e.g. 12 months for Quality and Cost Performance Period)

QPP / MACRA Next Steps for IHS

Operationalize the Quality Payment Program

- IHS's Quality Payment Program- MACRA National Working Group
- Encourage using resources - IHS Website and LISTSERV
- Provide Community Outreach - training and education
  - Webinar
  - Utilize CMS resources for technical assistance
  - Address care coordination

Future Plans for RPMS

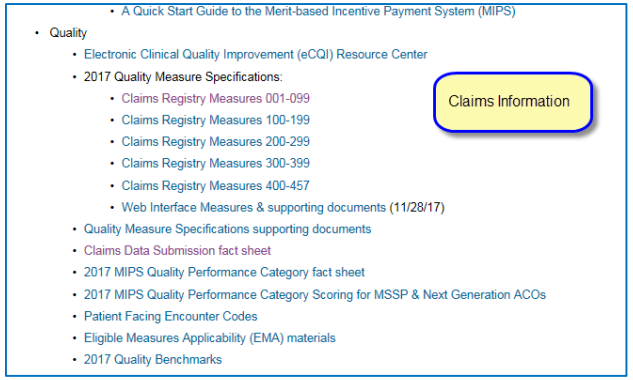
- Perform Market Research
  - Explore what products can interface with EHR to submit CQMs
- Update Clinical Quality Measures (CQM) Logic
  - Workgroup completed initial review (high level analysis)

Additional Resource Information

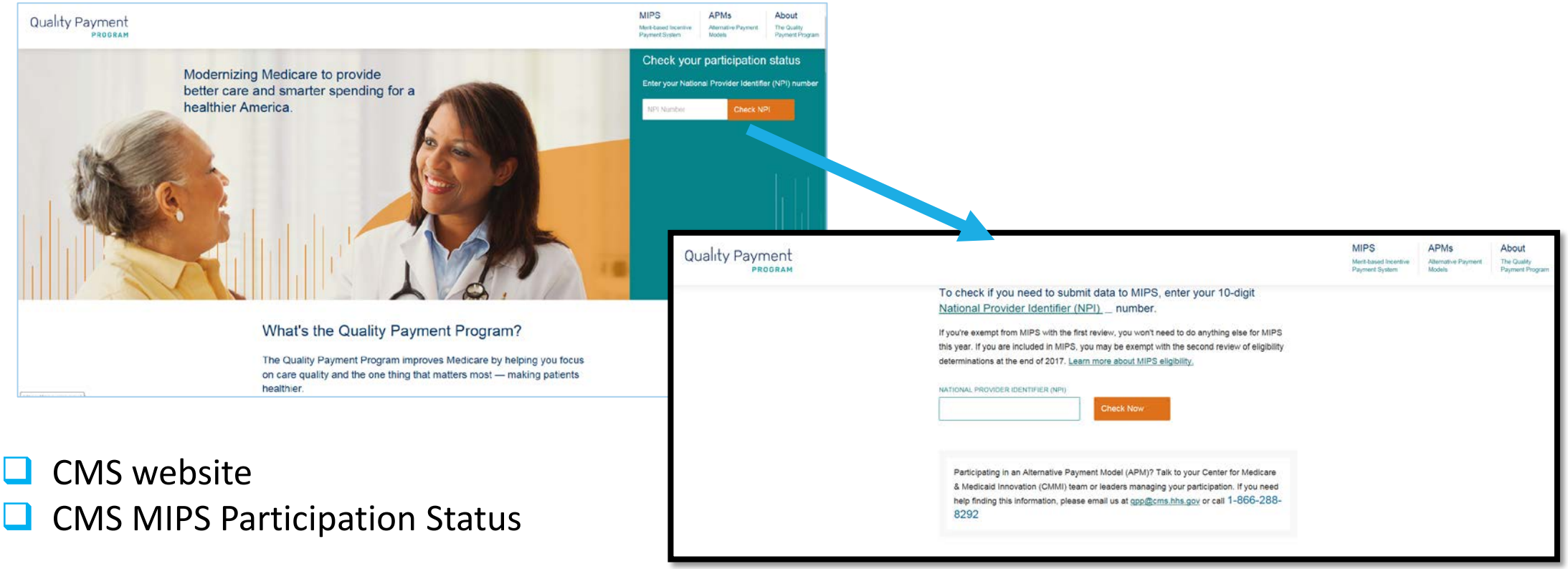
Steps to Prepare for the Quality Payment Program

Utilize Quality Payment Program Resources:

- Centers for Medicare & Medicaid Services (CMS): https://qpp.cms.gov
  - Help and Support: https://qpp.cms.gov/about/help-and-support
  - QPP Resource Library: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Resource-library.html
- IHS Resources: https://www.ihs.gov/qpp/



Eligibility:
Check Your Participation Status



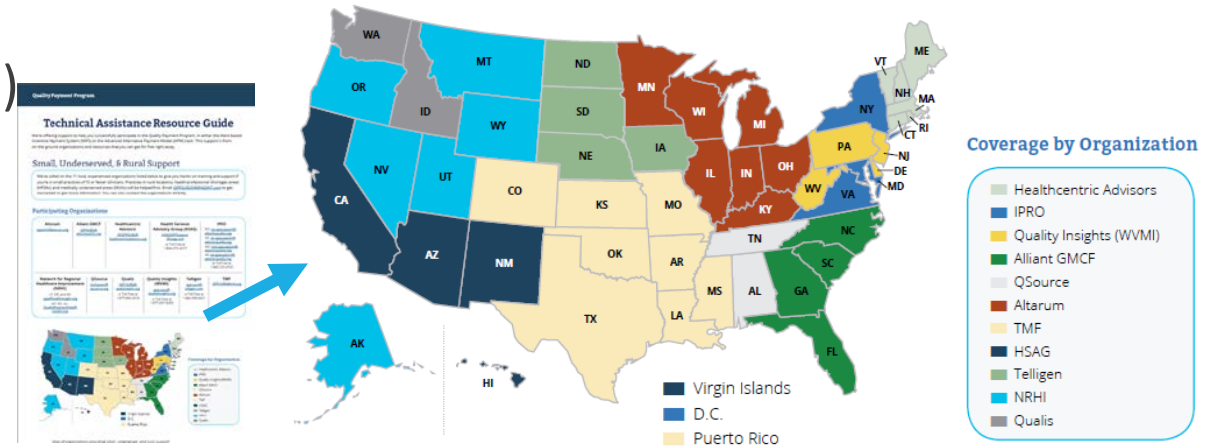
- CMS website
- CMS MIPS Participation Status

Source: https://qpp.cms.gov/
https://qpp.cms.gov/participation-lookup

Technical Assistance Support

Technical Assistance Resource Guide

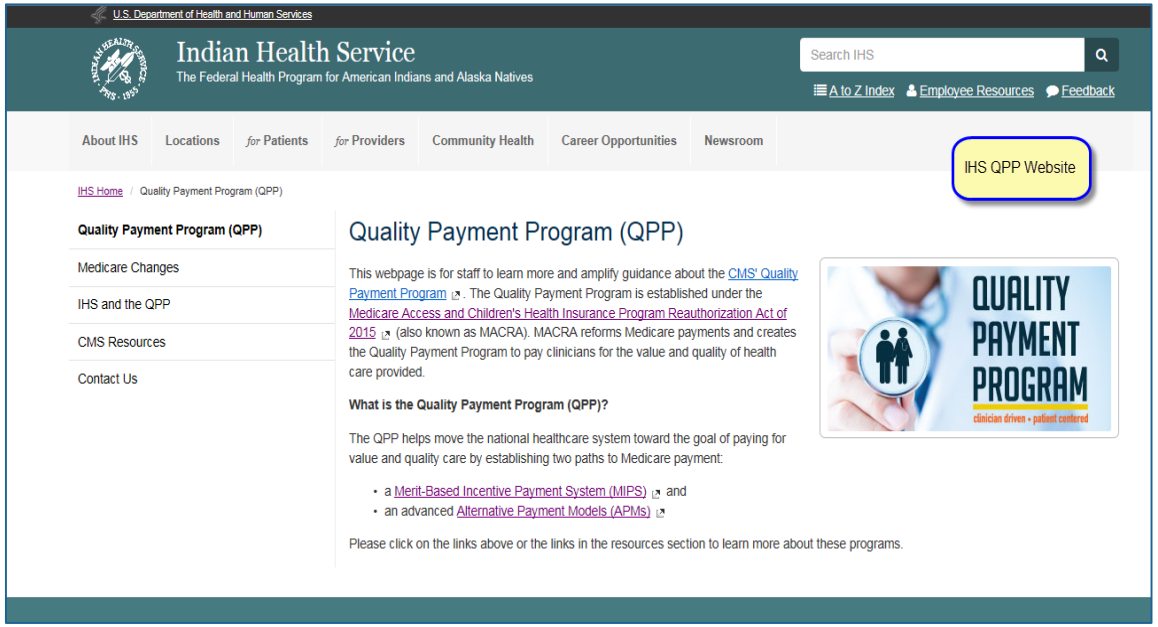
- Small, Underserved, & Rural Support (SURS)
  - Small practices of 15 or fewer clinicians
  - Practices in rural locations, health professional shortages areas (HPSAs), and medically underserved areas (MUAs)
- Quality Innovation Networks – Quality Improvement Organizations (QIN-QIOs)
  - Large practice of more than 15 clinicians
- Transforming Clinical Practice Initiative (TCPI)

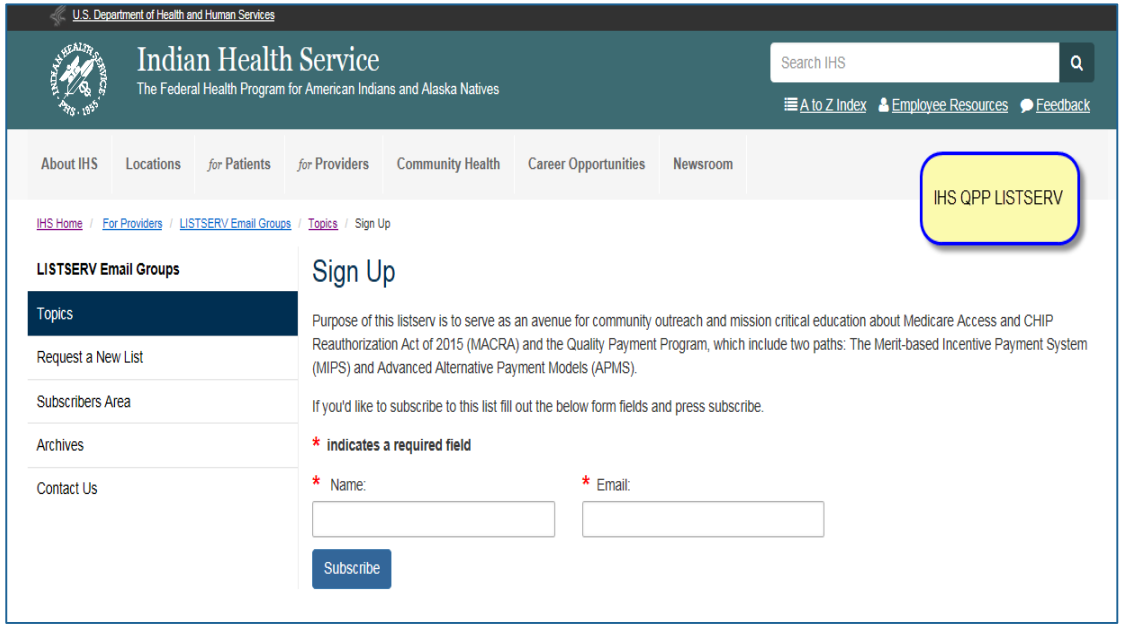


Map of organizations providing small, underserved, and rural support

Source: https://qpp.cms.gov/docs/QPP_Technical_Assistance_Resource_Guide.pdf

IHS QPP - MACRA Resources





IHS Website: https://www.ihs.gov/qpp/

LISTSERV Email: MACRA@listserv.ihs.gov

Subscribe URL: https://www.ihs.gov/listserv/topics/signup/?list_id=357

Resources

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Questions

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