

**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



STAKEHOLDERS:

Consumers | Businesses
Payers | Providers
State Partners



Set **internal goals** for HHS



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

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**

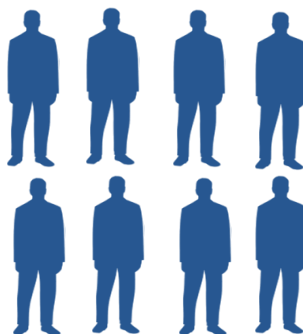
Note: Most clinicians will be subject to MIPS.

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.

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**

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.**

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**

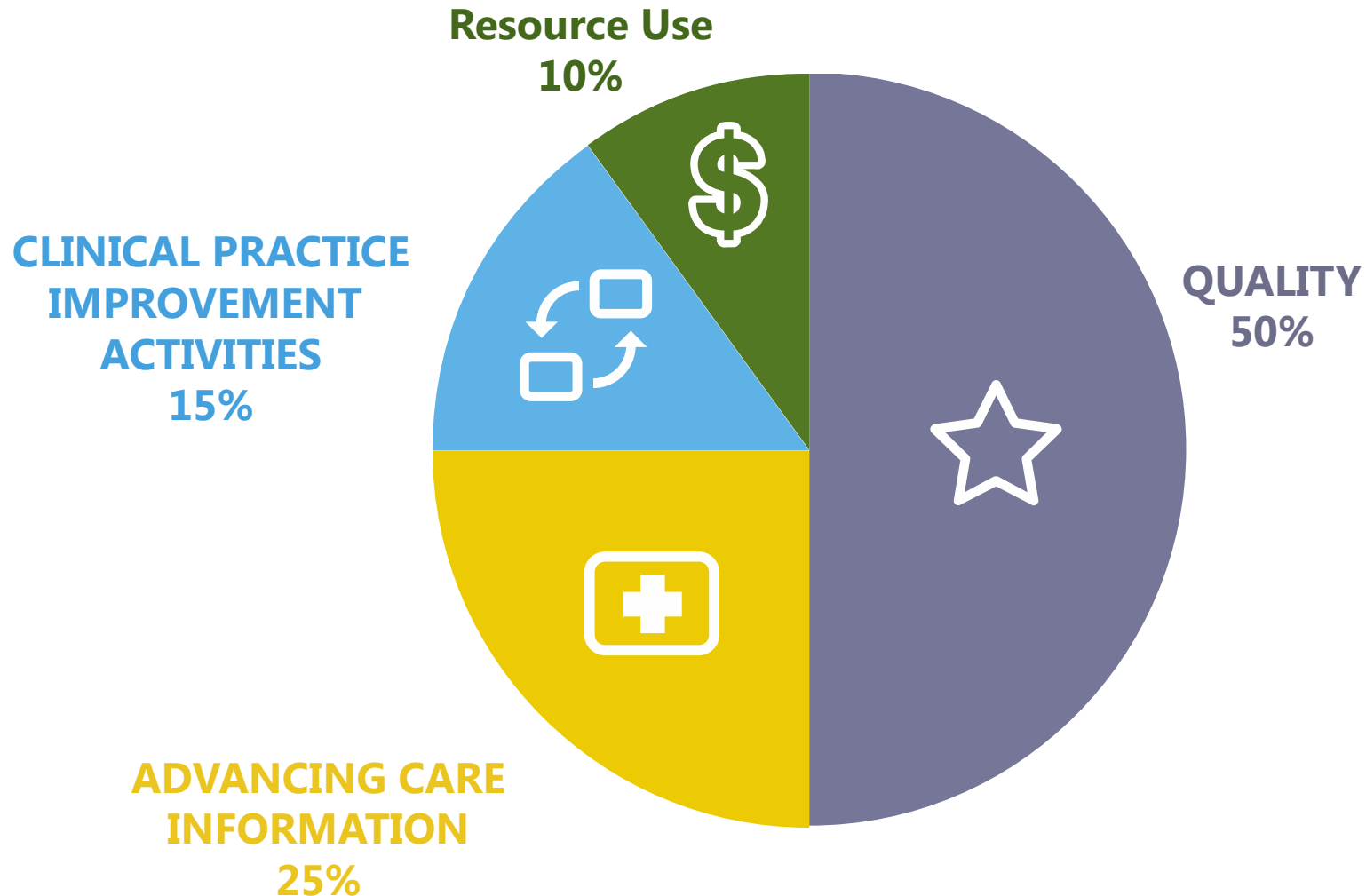


**Advancing
care
information**







**MIPS
Composite
Performance
Score (CPS)**

Year 1 Performance Category Weights for MIPS



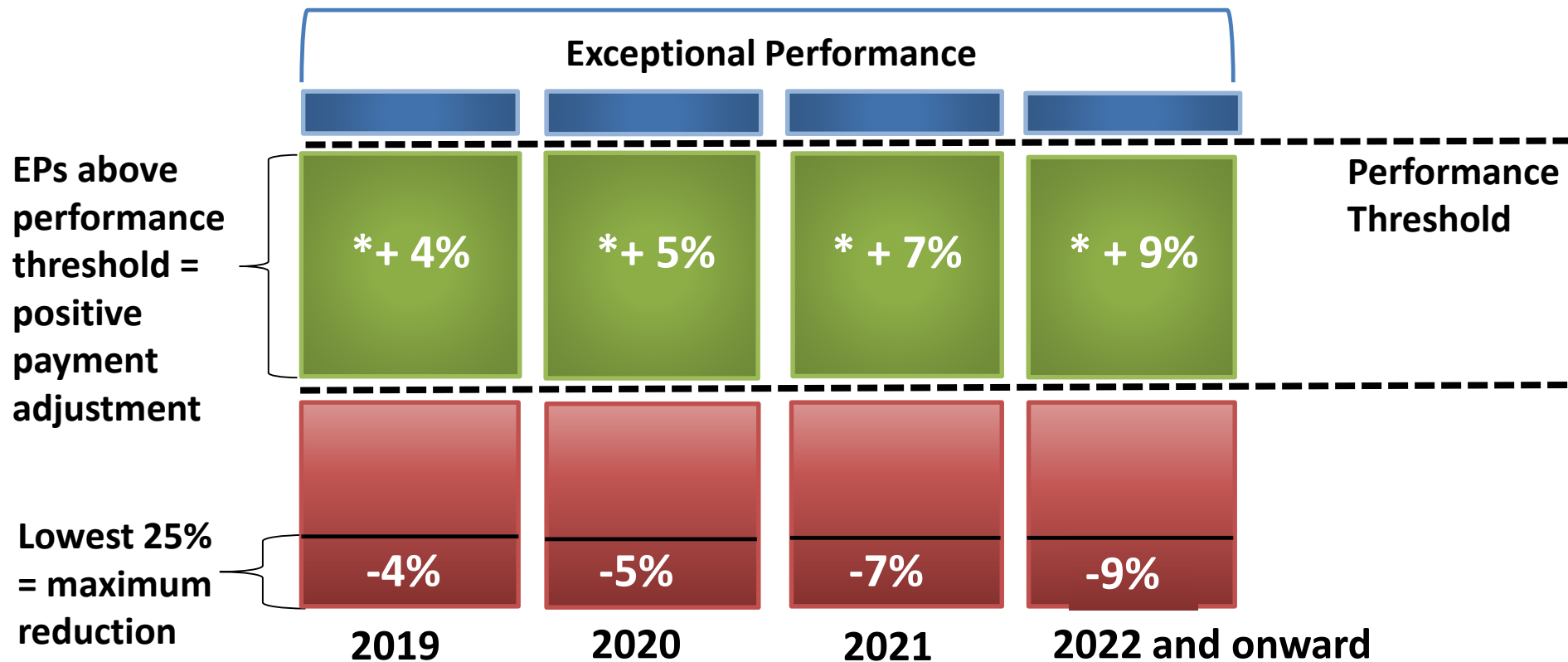
Calculating the Composite Performance Score (CPS) for MIPS

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 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%	<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

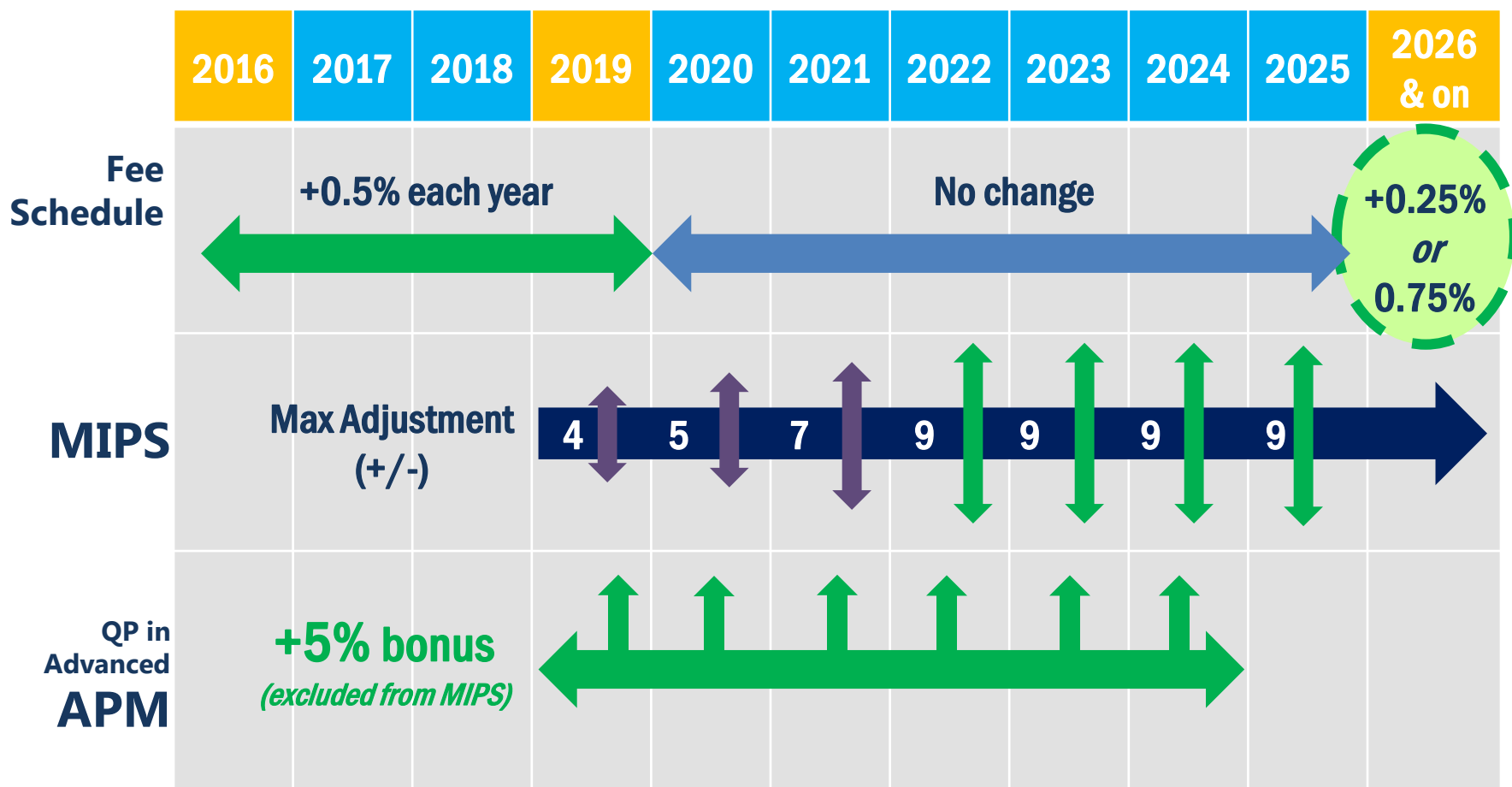
MIPS Incentive Payment Formula

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*

Putting it all together:

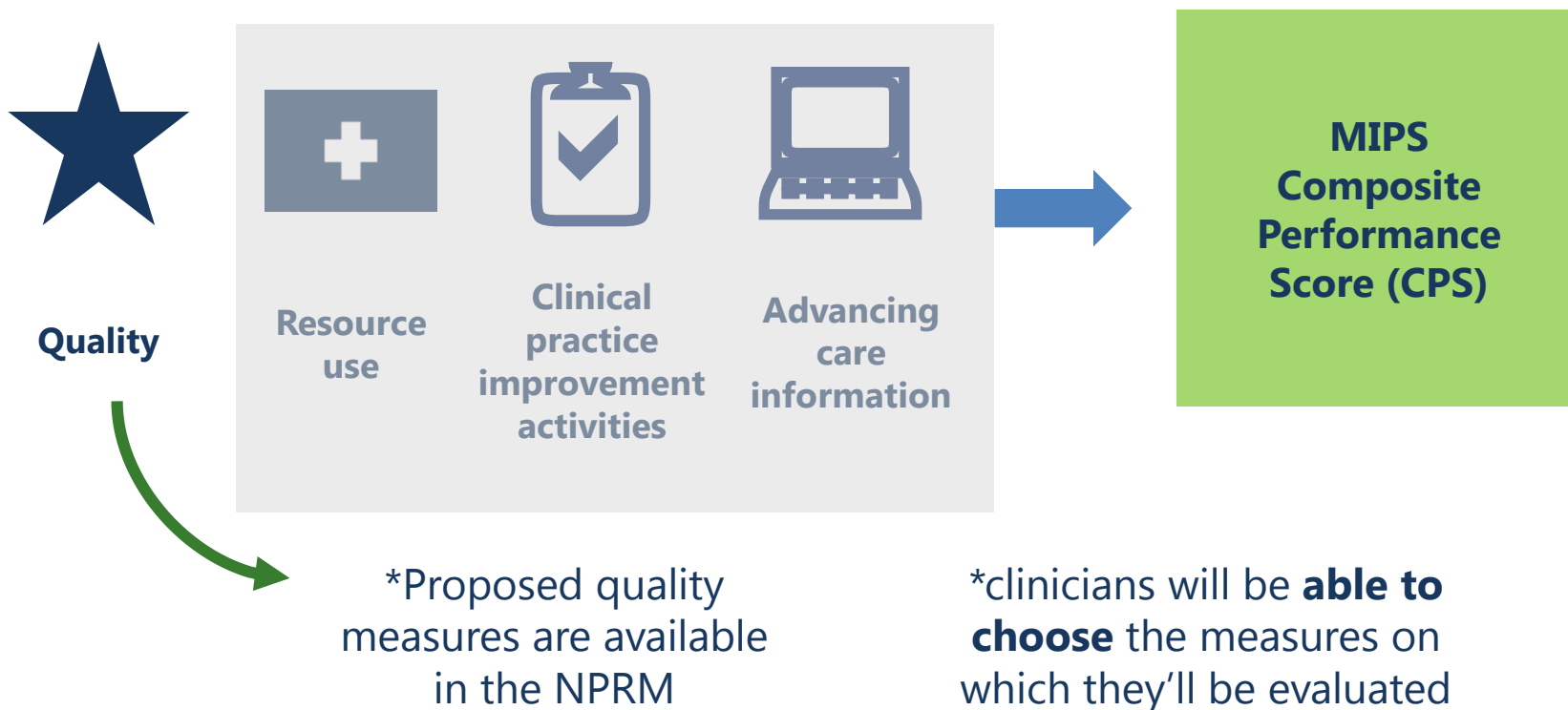




QUALITY PERFORMANCE CATEGORY

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** :



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.

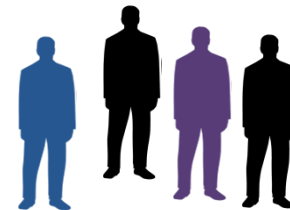
Years 1 and 2



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.

PROPOSED RULE

MIPS: Quality Performance Category

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)

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

PROPOSED RULE

MIPS Data Submission Options

Quality

Individual Reporting



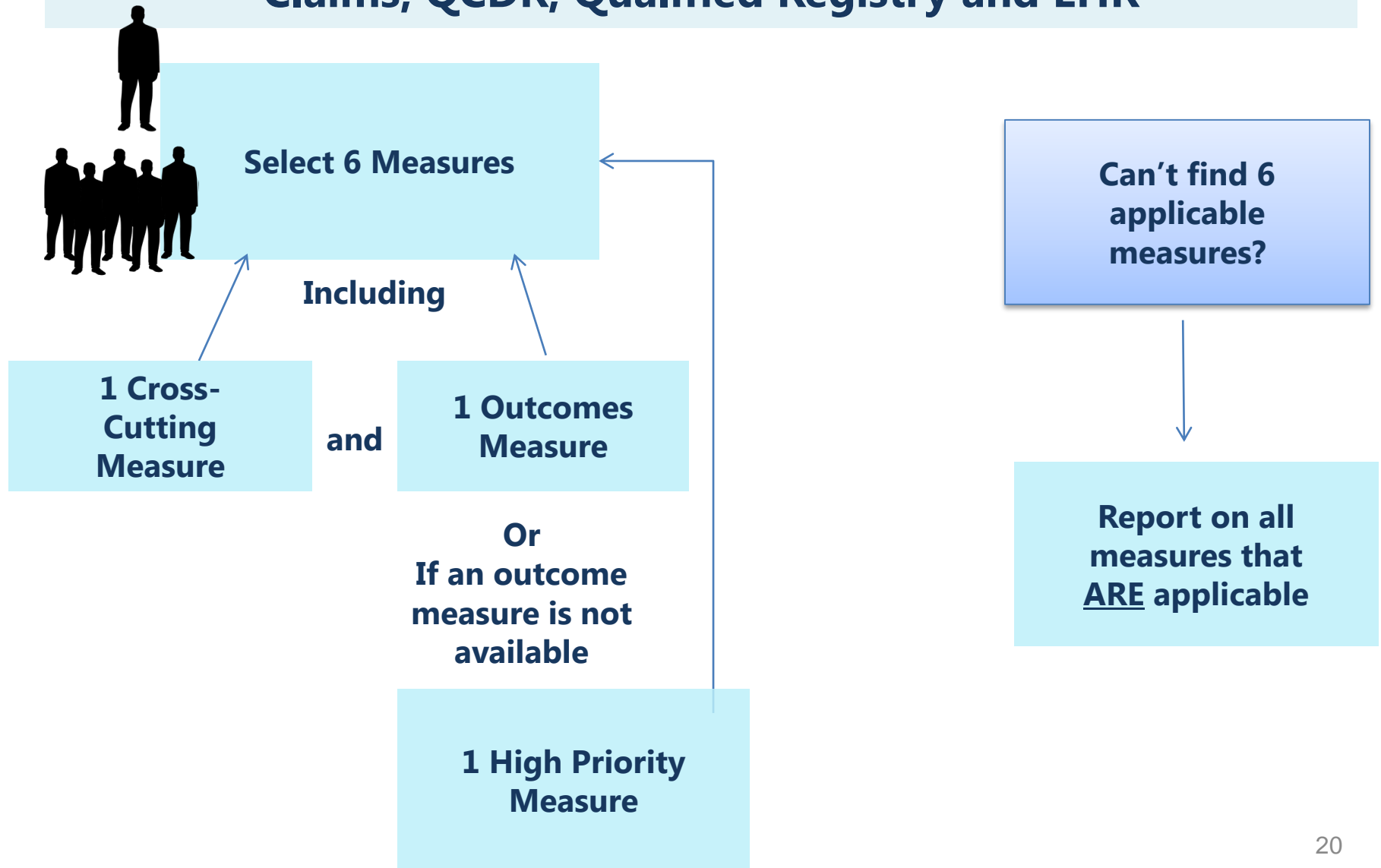
Group Reporting



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

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

Quality Reporting Model for Claims, QCDR, Qualified Registry and EHR



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.**

Group Submission: CMS Web Interface



- ✓ **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**

Group Submission: CAHPS for MIPS

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



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

**Each
measure is
converted
to points
(1-10)**

DECILE	Decile 1	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Possible Points	1.0-1.9	2.0-2.9	3.0-3.9	4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10

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

DECILE	Decile 1	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10	
Possible POINTS	1.0-1.9	2.0-2.9	3.0-3.9	4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10	
	0%	7%	16%	23%	36%	41%	62%	69%	79%	85%	100%

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.

Handling Topped Out Measures

- ✓ **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

DECILE	Decile 1	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
POINTS	1.0-1.9	2.0-2.9	3.0-3.9	4.0-4.9	5.0-5.9	8.5 points				
	0%	75%	80%	85%	95%	100%	100%	100%	100%	100%

Top 5 deciles have 100 percent performance. Midpoint is middle of decile 8 or 8.5 points

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

**Bonus for reporting
additional
outcomes, patient
experience,
appropriate use,
patient safety**

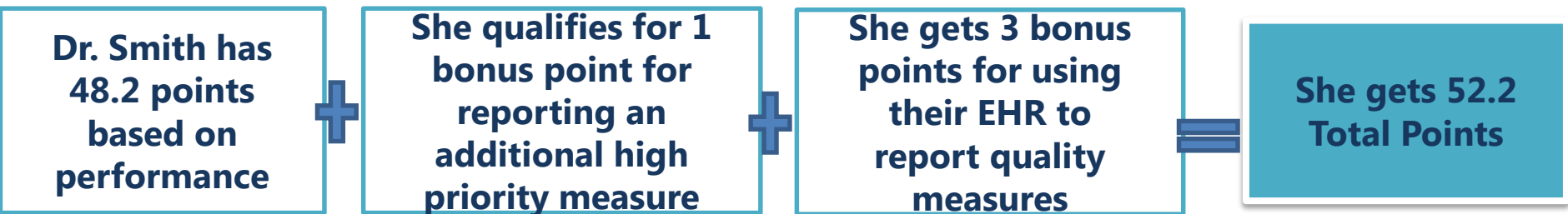
**Bonus for EHR
reporting**

- 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:

Measure	Measure Type	Number of Cases	Points Based on Performance	Total Possible Points (10 x Weight)	Quality Bonus Points For High Priority	Quality Bonus Points for EHR
Measure 1	Outcome Measure using CEHRT	20	4.1	10	0 (required)	1
Measure 2	Process using CEHRT	21	9.3	10	N/A	1
Measure 3	Process using CEHRT	22	10	10	N/A	1
Measure 4	Process	50	10	10	N/A	N/A
Measure 5	High Priority- Patient Safety	43	8.5	10	1	N/A
Measure 6 (Missing)	Cross-Cutting	N/A	0	10	N/A	N/A
Acute Composite	Admin. Claims	10	Not scored: below minimum sample size	N/A	N/A	N/A
Chronic Composite	Admin. Claims	20	6.3	10	N/A	N/A
All-Cause Hospital Readmission	Admin. Claims	N/A	N/A	N/A	N/A	N/A
Total Points	All Measures	N/A	48.2	70	1	3

Scoring: Quality Performance Category Dr Joy Smith



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> to learn of Open Door Forums, webinars, and more.

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](http://www.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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