Quality Payment Program Overview

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Disclosure

I have nothing to report, nor are there any real or perceived conflicts of interest, implied or expressed, in the following presentation.

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Acronyms in the Presentation

**APM**: Alternative Payment Model

**CMS**: Centers for Medicare & Medicaid Services

**EC**: Eligible Clinician

**MACRA**: Medicare Access and CHIP Reauthorization Act of 2015

**MIPS**: Merit-Based Incentive Payment System

**PTN**: Practice Transformation Network

**QIN-QIO**: Quality Innovation Network-Quality Improvement Organization

**QPP**: Quality Payment Program

**SAN**: Support and Alignment Networks

**SURS**: Small, Underserved, and Rural Support
Learning Objectives

• By the end of the session, participants will be able to:
  – Define options for QPP participation in 2017
  – Describe the QPP technical assistance available
  – Identify QPP local assistance and request support
The QIN-QIO Program

1965
President Lyndon B. Johnson signs the Medicare and Medicaid programs into law

1972
Medicare Professional Standards Review Organizations (PSROs) begin to oversee quality of care at local level

1982
PSROs become statewide Peer Review Organizations (PROs) with new authority to protect beneficiaries from underuse of necessary health services

1984
PROs begin reviewing medical records to protect beneficiaries from premature discharges from the hospital

1996
PROs launch first national quality project, the Cooperative Cardiovascular Project, to improve hospital care for heart attack patients

2002
PROs become Quality Improvement Organizations (QIOs), which better describe their proactive role in improving health care

2002-2008
QIOs expand their work into nursing homes, home health agencies, and physician offices

Today
QIOs improve quality across the continuum of care, focusing on topics and providers with the greatest opportunity to improve

Source: The Centers for Medicare & Medicaid Services
14 QIN-QIOs

Source: The National Coordinating Center
QIN-QIO Mission

- Works on initiatives to improve patient safety, reduce harm, and improve clinical care
- Engages healthcare providers, stakeholders, and beneficiaries to improve health quality, efficiency, and value
- Drives quality by offering technical assistance, and collecting, analyzing, and providing data for improvement to providers
- Facilitates learning and action networks (LANs)
- Teaches, advises, and communicates
MACRA and QPP Participation: How to Be Successful
MACRA streamlines these legacy programs into the QPP.

- Physician Quality reporting System (PQRS)
- Value-based Modifier (VBM)
- Medicare EHR Incentive Program

Quality Payment Program

MIPS or APMs

Source: The Centers for Medicare & Medicaid Services
Quality Payment Program Strategic Goals

1. Improve beneficiary outcomes
2. Increase adoption of Advanced APMs
3. Improve data and information sharing
4. Enhance clinician experience
5. Maximize participation
6. Ensure operational excellence in program implementation

Quick Tip:
For additional information on the QPP, please visit QPP.CMS.GOV.

Source: The Centers for Medicare & Medicaid Services
The QPP

• The QPP policy will:
  – Reform Medicare Part B payments for more than 600,000 clinicians
  – Improve care across the entire healthcare delivery system

Clinicians have two tracks to choose from:

MIPS
The Merit-based Incentive Payment System (MIPS)
*If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS.*

OR

Advanced APMs
Advanced Alternative Payment Models (APMs)
*If you decide to participate in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.*

Source: The Centers for Medicare & Medicaid Services
How are MIPS Performance Categories Weighted?

- Weights assigned to each category is based on a 1 to 100 point scale

**Transition Year Weights**

- **Quality**: 60%
- **Cost**: 0%
- **Improvement activities**: 15%
- **Advancing care Information**: 25%

Note: These are defaults weights; the weights can be adjusted in certain circumstances.
When Does the Merit-Based Incentive Payment System Officially Begin?

**2017 Performance Year**

**Performance:** The first performance period opens January 1, 2017 and closes December 31, 2017. During 2017, you will record quality data and how you used technology to support your practice. If an Advanced APM fits your practice, then you can provide care during the year through that model.

**March 31, 2018 Data Submission**

**Send in performance data:** To potentially earn a positive payment adjustment under MIPS, send in data about the care you provided and how your practice used technology in 2017 to MIPS by the deadline, March 31, 2018. In order to earn the 5 percent incentive payment for participating in an Advanced APM, just send your quality data through your Advanced APM.

**Feedback January 1, 2019 Payment Adjustment**

**Feedback:** Medicare gives you feedback about your performance after you send your data.

**Payment:** You may earn a positive MIPS payment adjustment beginning January 1, 2019 if you submit 2017 data by March 31, 2018. If you participate in an Advanced APM in 2017, then you could earn a 5 percent incentive payment in 2019.

Source: The Centers for Medicare & Medicaid Services
Who Is Eligible?

- 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 Practitioner
- Clinical Nurse Specialist
- Certified Registered Nurse Anesthetists

Quick Tip:
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.

Source: The Centers for Medicare & Medicaid Services
Who Is Excluded From MIPS?

Clinicians who are:

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 $30,000 a year
- See 100 or fewer Medicare Part B patients a year

Significantly participating in Advanced APMs
- Receive 25 percent of your Medicare payments
- See 20 percent of your Medicare patients through an Advanced APM

Source: The Centers for Medicare & Medicaid Services
Eligibility Scenario

To be eligible for the QPP, a clinician must bill more than $30,000 AND see more than 100 Medicare beneficiaries.

Quick Tip: “AND” is the key to eligibility.

In the example provided in this incident where a clinician billed $29,000 and saw 101 patients, this clinician would be **EXEMPT** from the program because the clinician did not bill more than $30,000.

Source: The Centers for Medicare & Medicaid Services
Based on a composite performance score, clinicians will receive +/- or neutral adjustments up to the percentages below.

- **+4%** to **+5%**
- **+7%** to **+9%**

- **-4%** to **-5%**
- **-7%** to **-9%**

**MIPS**

The potential maximum adjustment % will increase each year from 2019 to 2022.

Source: The Centers for Medicare & Medicaid Services
Clinicians will **pick their pace** for the first year – both in how they participate and when. We expect that everyone who is eligible for the Quality Payment Program will participate.

- Test Participation
- Partial Participation
- Full Participation
- Advanced APMs
For 2017, There Are Four Options For Participating in MIPS

Not participating in the Quality Payment Program: If you don’t send in any 2017 data, then you receive a negative 4 percent payment adjustment automatically.

Test: 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 payment adjustment.

Partial: If you submit 90 days of 2017 data to Medicare, you may earn a neutral or small positive payment adjustment.

Full: If you submit a full year of 2017 data to Medicare, you may earn a moderate positive payment adjustment.

Source: The Centers for Medicare & Medicaid Services
Submit a minimum of 2017 data to Medicare
Avoid a downward adjustment – neutral

You Have Asked: “What is the minimum amount of data?”

1 Quality Measure
1 Improvement Activity
4 or 5 Required Advancing Care Information Measures

Source: The Centers for Medicare & Medicaid Services
MIPS First Year Participation: Option 2

Submit a Partial Year

“So what?” — If you are not ready on January 1, you can start anytime between January 1 and October 2

- Submit 90 days of 2017 data to Medicare
- May earn a positive payment adjustment

Jan 1 ➔ Oct 2
Need to send performance data by **March 31, 2018**

Source: The Centers for Medicare & Medicaid Services
First Year Participation: Option 3

Submit a Full Year

- Submit a full year of 2017 data to Medicare
- May earn a positive payment adjustment
- Best way to earn largest payment adjustment is to submit data on all MIPS performance categories

Key takeaway:
Positive adjustments are based on performance data on the performance information submitted, not the amount of information or length of time submitted.
You also can choose to join to stay in an Advanced APM in 2017 and potentially qualify for a 5 percent bonus.

Remember: The Quality Payment Program does not change how any particular APM functions or rewards value. Instead, it creates extra incentives for APM participation.

In 2017, we anticipate that these will be Advanced APMs:

- Comprehensive ESRD Care (CEC)
- Comprehensive Primary Care Plus (CPC+)
- Next Generation ACO Model
- Oncology Care Model (OCM)
- Shared Savings Program - Track 2
- Shared Savings Program - Track 3

Source: The Centers for Medicare & Medicaid Services
Advanced APMs

• A way for eligible clinicians and practices to earn greater rewards for taking on some financial risk related to patient outcomes.

• Advanced APM-specific reward and 5-percent lump-sum incentive—exempt from MIPS

• The QPP does not change the design of any particular APM, but creates extra incentives for a sufficient degree of participation

• What is a “sufficient degree”?
Individual vs. Group Reporting

Options

1. Individual — under an NPI number and TIN where they reassign benefits

2. As a Group
   a) 2 or more clinicians (NPIs) who have reassigned their billing rights to a single TIN*
   b) As an APM Entity

* If clinicians participate as a group, they are assessed as a group across all four MIPS performance categories.
Technical Assistance and Education for Small and Large Practices
CMS has free resources and organizations on the ground to provide help to clinicians who are eligible for the QPP.
QPP Small, Underserved, and Rural Support (QPP SURS)

• Designed for practices with **15 or fewer eligible clinicians**.
  – Includes small practices in: rural locations, health professional shortage areas (HPSAs), and medically underserved areas (MUAs).

• Goal is to provide on-the-ground support to eligible clinicians by:
  – Assisting in the selection and reporting of appropriate Merit-based Incentive Payment System (MIPS) Quality measures and Improvement Activities;
  – Optimizing their Health Information Technology (HIT);
  – Supporting change management and strategic planning; and
  – Evaluate their options for joining an Advanced Alternative Payment Model (APM).

• Support is available **immediately** and is **at no-cost** to clinicians in small practices.
QPP Technical Assistance for Large Practices

- QIN QIOs, PTNs, and SANs provide assistance to large practices
- Designed for practices with **16 or more eligible clinicians**
  - Hospital systems outpatient clinics or large multispecialty practices

- Goal is to provide on-the-ground support to eligible clinicians by:
  - Assisting in the selection and reporting of appropriate Merit-based Incentive Payment System (MIPS) Quality measures and Improvement Activities;
  - Optimizing their Health Information Technology (HIT);
  - Supporting change management and strategic planning; and
  - Evaluate their options for joining an Advanced Alternative Payment Model (APM).

- Support is available **immediately** and is **at no cost** to clinicians.
Resources

• CMS Quality Payment Program Website
  https://qpp.cms.gov

• MACRA: Medicare Access and CHIP Reauthorization Act of 2015

• QIO Program
  http://qioprogram.org

• SURS Support Center
  Email: QPPSURS@IMPAQINT.com

• Transforming Clinical Practice Initiative
  https://innovation.cms.gov/initiatives/Transforming-Clinical-Practices/
Questions?

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HSAGQPPSupport@hsag.com
HSAG engages providers at all levels of performance for collaborative learning and action that accelerate health care quality improvement.

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