Introduction to the Quality Payment Program

Health Care Compliance Association
Annual Regional Meeting
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Chief Medical Officer, CMS, Region X

What is the Quality Payment Program?
What Does the Quality Payment Program Do?

Creates Medicare payment methods that promote quality over volume by:

- Repealing SGR formula
- Creating two tracks:
  - Merit-based Incentive Payment System (MIPS)
  - Advanced Alternative Payment Models (Advanced APMS)
- Streamlining legacy programs
  - Providing 5% incentive to Advanced APM participants
- Establishing PTAC, the Physician-focused Payment Model Technical Advisory Committee

Quality Payment Program Strategic Goals

- Improve beneficiary outcomes
- Enhance clinician experience
- Increase adoption of Advanced APMs
- Maximize participation
- Improve data and information sharing
- Ensure operational excellence in program implementation

Quick Tip:
For additional information on the Quality Payment Program, please visit QPP.CMS.GOV
Ready, Set, Go!
Preparing for 2017 participation in MIPS

Eligible Clinicians:
Medicare Part B clinicians billing more than $30,000 a year AND providing care for more than 100 Medicare patients a year.

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.

These clinicians include:

- Physicians
- Physician Assistants
- Nurse Practitioner
- Clinical Nurse Specialist
- Certified Registered Nurse Anesthetists
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% of your Medicare payments
  - See 20% of your Medicare patients through an Advanced APM

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

- Established low-volume threshold
  - Less than or equal to $30,000 in Medicare Part B allowed charges
  - Less than or equal to 100 Medicare patients

- Reduced requirements for Improvement Activities performance category
  - One high-weighted activity
  - 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).
Quality Payment Program

Non-Patient Facing Clinicians

- Non-patient facing clinicians are eligible to participate in MIPS as long as they exceed the low-volume threshold, are not newly enrolled, and are not a Qualifying APM Participant (QP) or Partial QP that elects not to report data to MIPS

- The non-patient facing MIPS-eligible clinician threshold for individual MIPS-eligible clinicians is < 100 patient facing encounters in a designated period

- A group is non-patient facing if > 75% of NPIs billing under the group’s TIN during a performance period are labeled as non-patient facing

- There are more flexible reporting requirements for non-patient facing clinicians

Pick Your Pace for Participation for the Transition Year

<table>
<thead>
<tr>
<th>Participate in an Advanced Alternative Payment Model</th>
<th>MIPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participate in an Advanced Alternative Payment Model in 2017</td>
<td>Test Pace: Submit some data after January 1, 2017&lt;br&gt;Neutral or small payment adjustment</td>
</tr>
</tbody>
</table>

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

- Submit minimum amount of 2017 data to Medicare
- Avoid a downward adjustment

You Have Asked: "What is a minimum amount of data?"

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

MIPS: Partial Participation for 2017

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

"So what?" - If you’re not ready on January 1, you can start anytime between January 1 and October 2

Need to send performance data by March 31, 2018
Quality Payment Program

MIPS: Full Participation for 2017

- 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 the performance data on the performance information submitted, not the amount of information or length of time submitted.

Introduction to the Merit-based Incentive Payment System (MIPS)
What is the Merit-based Incentive Payment System?

Combines legacy programs into single, improved reporting program

- PQRS
- VM
- EHR
- MIPS

Legacy Program Phase Out

- Last Performance Period: 2016
- PQRS Payment End: 2018

What is the Merit-based Incentive Payment System?

- Moves Medicare Part B clinicians to a performance-based payment system
- Provides clinicians with flexibility to choose the activities and measures that are most meaningful to their practice
- Reporting standards align with Advanced APMs wherever possible
Quality Payment Program

When Does the Merit-based Incentive Payment System Officially Begin?

- **Performance year**: 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% incentive payment for participating in an Advanced APM, just send quality data through your Advanced APM.

- **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 5% incentive payment in 2019.

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Quality Payment Program

How Do Clinicians Participate in MIPS?

**OPTIONS**

**Individual**

1. **Individual** – under an NPI number and TIN where they reassigned benefits

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

* If clinicians participate as a group, they are assessed as group across all 4 MIPS performance categories
Get your Data to CMS

<table>
<thead>
<tr>
<th>Individual</th>
<th>Group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality</strong></td>
<td></td>
</tr>
<tr>
<td>✓ QCDB (Qualified Clinical Data Registry)</td>
<td>✓ QCDB (Qualified Clinical Data Registry)</td>
</tr>
<tr>
<td>✓ Qualified Registry</td>
<td>✓ Qualified Registry</td>
</tr>
<tr>
<td>✓ EHR</td>
<td>✓ EHR</td>
</tr>
<tr>
<td>✓ Claims</td>
<td>✓ Administrative Claims</td>
</tr>
<tr>
<td>✓ CMS Web Interface (groups of 25 or more)</td>
<td>✓ CAHPS for MIPS Survey</td>
</tr>
</tbody>
</table>

| **Improvement Activities** |       |
| ✓ Attestation | ✓ Attestation |
| ✓ QCDB | ✓ QCDB |
| ✓ Qualified Registry | ✓ Qualified Registry |
| ✓ EHR Vendor | ✓ EHR Vendor |

Working with a Third Party Intermediary

<table>
<thead>
<tr>
<th>Intermediary</th>
<th>Approval Needed</th>
<th>Cost to Clinician</th>
</tr>
</thead>
<tbody>
<tr>
<td>EHR Vendor</td>
<td>EHR Vendors Must be certified by ONC</td>
<td>x</td>
</tr>
<tr>
<td>QCDB</td>
<td>QCDBs must be approved by CMS</td>
<td>x</td>
</tr>
<tr>
<td>Qualified Registry</td>
<td>Qualified Registries must be approved by CMS</td>
<td>x</td>
</tr>
<tr>
<td>CMS Approved CAHPS Vendor</td>
<td>CAHPS Vendors must be approved by CMS</td>
<td>x</td>
</tr>
</tbody>
</table>
Quality Payment Program

Technical Assistance

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

- **Quality Payment Program Portal**
  - Learn about the Quality Payment Program, explore the measures, and find educational tools and resources.

- **Transforming Clinical Practice Initiative (TCPI):**
  - 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.

- **Quality Innovation Network (QIN)-Quality Improvement Organizations (QIOs):**
  - Includes 14 QIN-QIOs
  - Promotes data-driven initiatives that increase patient safety, make communities healthier, better coordinate post-hospital care, and improve clinical quality.

The Innovation Center’s Learning Systems provides specialized information on:
- Successful Advanced APM participation
- The benefits of APM participation under MIPS

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Understanding the MIPS Performance Categories
What are the Performance Category Weights?

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

**Transition Year Weights— 25%**

<table>
<thead>
<tr>
<th>Category</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>60%</td>
</tr>
<tr>
<td>Cost</td>
<td>0%</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>15%</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>25%</td>
</tr>
</tbody>
</table>

**Note:** These are defaults weights; the weights can be adjusted in certain circumstances

MIPS Performance Category: Quality

- Category Requirements
  - Replaces PQRS and Quality Portion of the Value Modifier
  - “So what?”—Provides for an easier transition due to familiarity

Select 6 of about 300 quality measures (minimum of 90 days to be eligible for maximum payment adjustment); 1 must be:
- Outcome measure OR
- High-priority measure—defined as outcome measure, appropriate use measure, patient experience, patient safety, efficiency measures, or care coordination

Different requirements for groups reporting CMS Web Interface or those in MIPS APMs

May also select specialty-specific set of measures
Quality Payment Program

QPP Website Home Page

Quality Payment Program
Modernizing Medicare to provide better care and smarter spending for a healthier America.

Screen Shot of Quality Measures

Select Measures

Showing 271 Measures

Acute Otitis Externa (AOE) Systems Antimicrobial Therapy - Avoidance of Inappropriate Use
AOE

Acute Otitis Externa (AOE) Topical Therapy
AOE

ADHD Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication
AOE

Adherence to Antipsychotic Medications for Individuals with Schizophrenia
AOE

Adult Kidney Disease: Blood Pressure Management
AOE

Selected Measures

0 Measures Added

Disclaimer

*NPI eligible clinicians or groups are expected to report on applicable measures. “Applicable” is defined as measures relevant to a particular type of eligible clinician’s services or care provided. NPI eligible clinicians can refer to the measures specifications to verify which measures are applicable. Not all measures in each Specialty Measure Set will be applicable to all clinicians in a given specialty. If the set includes less
**MIPS Performance Category: Improvement Activities**

- Attest to participation in activities that improve clinical practice
  - Examples: Shared decision making, patient safety, coordinating care, increasing access

- **Clinicians choose** from 90+ activities under 9 subcategories:

  1. Expanded Practice Access
  2. Population Management
  3. Care Coordination
  4. Beneficiary Engagement
  5. Patient Safety and Practice Assessment
  6. Participation in an APM
  7. Achieving Health Equity
  8. Integrating Behavioral and Mental Health
  9. Emergency Preparedness and Response

**MIPS Performance Category: Advancing Care Information**

- Promotes patient engagement and the electronic exchange of information using certified EHR technology

- Ends and replaces the Medicare EHR Incentive Program (also known as Medicare Meaningful Use)

- Greater flexibility in choosing measures

- In 2017, there are **2 measure sets for reporting based on EHR edition**:

  - Advancing Care Information Objectives and Measures
  - 2017 Advancing Care Information Transition Objectives and Measures
Quality Payment Program

MIPS Performance Category: Advancing Care Information

- Clinicians must use certified EHR technology to report

<table>
<thead>
<tr>
<th>For those using EHR Certified to the 2015 Edition:</th>
<th>For those using 2014 Certified EHR Technology:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Option 1</strong></td>
<td><strong>Option 1</strong></td>
</tr>
<tr>
<td>Advancing Care Information Objectives and Measures</td>
<td>Combination of the two measure sets</td>
</tr>
</tbody>
</table>

MIPS Performance Category: Advancing Care Information

<table>
<thead>
<tr>
<th>Advancing Care Information Objectives and Measures:</th>
<th>2017 Advancing Care Information Transition Objectives and Measures:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Base Score Required Measures</strong></td>
<td><strong>Base Score Required Measures</strong></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Objective</td>
<td>Measure</td>
</tr>
<tr>
<td>Protect Patient Health Information</td>
<td>Security Risk Analysis</td>
</tr>
<tr>
<td>Electronic Prescribing</td>
<td>e-Prescribing</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Send a Summary of Care</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Request/Accept a Summary of Care</td>
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</table>
# MIPS Performance Category: Advancing Care Information

## Advancing Care Information Objectives and Measures

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

## 2017 Advancing Care Information Transition Objectives and Measures

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<tr>
<td>Health Information Exchange</td>
<td>Health Information Exchange*</td>
</tr>
<tr>
<td>Medication Reconciliation</td>
<td>Medication Reconciliation</td>
</tr>
<tr>
<td>Public Health Reporting</td>
<td>Immunization Registry Reporting</td>
</tr>
</tbody>
</table>

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**Hospital-based MIPS eligible clinicians may choose** to report under the **Advancing Care Information** Performance Category.

**If clinicians face a significant hardship** and are unable to report Advancing Care Information measures, **they can apply to have their performance category score weighted to zero**.

**25%** If objectives and measures are not applicable to a clinician, CMS will reweight the category to zero and assign the 25% to the other performance categories to offset difference in the MIPS final score.
What is the Scoring Methodology for the Merit-based Incentive Payment System?

MIPS Scoring for Quality
(60% of Final Score in Transition Year)

Select 6 of the approximately 300 available quality measures (minimum of 90 days)
- Or a specialty set
- Or CMS Web Interface measures

Clinicians receive 3 to 10 points on each quality measure based on performance against benchmarks

Failure to submit performance data for a measure = 0 points

Quick Tip:
Easier for a clinician that participates longer to meet case volume criteria needed to receive more than 3 points

Bonus points are available
MIPS Scoring for Quality (60% of Final Score)

Year 1 participants automatically receive 3 points for completing and submitting a measure

If a measure can be reliably scored against a benchmark, then clinician can receive 3 – 10 points
- Reliable score means the following:
  - Benchmarks exists (see next slide for rules)
  - Sufficient case volume (≥20 cases for most measures; ≥200 cases for readmissions)
  - Data completeness met (at least 50 percent of possible data is submitted)

If a measure cannot be reliably scored against a benchmark, then clinician receives 3 points
- Easier for a clinician that participates longer to meet case volume criteria needed to receive more than 3 points

MIPS Scoring for Quality (60% of Final Score)

More About Benchmarks

- Separate benchmarks for different reporting mechanisms
  - EHR, QCDR/registries, claims, CMS Web Interface, administrative claim measures, and CAHPS for MIPS

- All reporters (individuals and groups regardless of specialty or practice size) are combined into one benchmark

- Need at least 20 reporters that meet the following criteria:
  - Meet or exceeds the minimum case volume (has enough data to reliably measured)
  - Meets or exceeds data completeness criteria
  - Has performance greater than 0 percent

Why this matters? Not all measures will have a benchmark. If there is no benchmark, then a clinician only receives 3 points.
## MIPS Scoring for Improvement Activities
(15% of Final Score in Transition Year)

### Total points = 40

<table>
<thead>
<tr>
<th>Activity Weights</th>
<th>Alternate Activity Weights*</th>
<th>Full credit for clinicians in a patient-centered medical home, Medical Home Model, or similar specialty practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Medium = 10 points</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- High = 20 points</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Medium = 20 points</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- High = 40 points</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*For clinicians in small, rural, and underserved practices or with non-patient facing clinicians or groups</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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## MIPS Performance Category: Advancing Care Information (25% of Final Score in Transition Year)

- **Earn up to 155% maximum score**, which will be capped at 100%

**Advancing Care Information category score includes:**

<table>
<thead>
<tr>
<th>50%</th>
<th>90%</th>
<th>15%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required Base score (50%)</td>
<td>Performance score (up to 90%)</td>
<td>Bonus score (up to 15%)</td>
</tr>
</tbody>
</table>

*Keep in mind:* You need to fulfill the Base score or you will get a zero in the Advancing Care Information Performance Category
MIPS Scoring for Advancing Care Information (25% of Final Score): Base Score

Base score (worth 50%)

Clinicians must submit a numerator/denominator or Yes/No response for each of the following required measures:

- Advancing Care Information Measures
  - Security Risk Analysis
  - e-Prescribing
  - Provide Patient Access
  - Send a Summary of Care
  - Request/Accept a Summary of Care

- 2017 Advancing Care Information Transition Measures
  - Security Risk Analysis
  - e-Prescribing
  - Provide Patient Access
  - Health Information Exchange

Failure to meet reporting requirements will result in base score of zero, and an advancing care information performance score of zero.

MIPS Scoring for Advancing Care Information (25% of Final Score)

Performance Score

6 optional measures:
1. Patient Specific Education
2. View, Download or Transmit
3. Secure Messaging
4. Patient Generated Health Data
5. Clinical Information Reconciliation
6. Public Health and Clinical Data Registry Reporting (5 options)

Each measure is worth 10 percentage points. Clinicians are given a “performance rate” for each measure, and rates correspond to category percentages as follows:

- 1-10 = 1%
- 11-20 = 2%
- 21-30 = 3%
- 31-40 = 4%
- 41-50 = 5%
- 51-60 = 6%
- 61-70 = 7%
- 71-80 = 8%
- 81-90 = 9%
- 90-100 = 10%
MIPS Scoring for Advancing Care Information (25% of Final Score): Bonus Score

5% BONUS for reporting on any of these Public Health and Clinical Data Registry Reporting measures:

- Syndromic Surveillance Reporting
- Electronic Case Reporting
- Public Health Registry Reporting
- Clinical Data Registry Reporting

10% BONUS for using CEHRT to report certain Improvement Activities

Calculating the Final Score Under MIPS

Final Score =

Clinician Quality performance category score \times actual Quality performance category weight

Clinician Cost performance category score \times actual Cost performance category weight

Clinician Improvement Activities performance category score \times actual Improvement Activities performance category weight

Clinician Advancing Care Information performance category score \times actual Advancing Care Information performance category weight

\times 100


### Transition Year 2017

<table>
<thead>
<tr>
<th>Final Score</th>
<th>Payment Adjustment</th>
</tr>
</thead>
</table>
| ≥70 points  | • Positive adjustment  
|             | • Eligible for exceptional performance bonus—minimum of additional 0.5% |
| 4-69 points | • Positive adjustment  
|             | • Not eligible for exceptional performance bonus |
| 3 points    | • Neutral payment adjustment |
| 0 points    | • Negative payment adjustment of -4%  
|             | • 0 points = does not participate |

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### Getting Started...

- Determine you eligibility status
- Gauge your readiness and choose “how” you want to start
- Choose if you will be reporting as an individual or group
- Decide if you will work with a third party intermediary
- Review the program timeline for dates
- Choose a data submission option
- Reach agreement with Bonus Payments and Reporting Periods
- Assess your Feedback
- Ready, set, go!
Introduction to Advanced Alternative Payment Models (APMs)

What is an Alternative Payment Model (APM)?

Alternative Payment Models (APMs) are new approaches to paying for medical care through Medicare that incentivize quality and value. The CMS Innovation Center develops new payment and service delivery models. Additionally, Congress has defined—both through the Affordable Care Act and other legislation—a number of demonstrations that CMS conducts.

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
What are the Benefits of Participating in an Advanced APM as a Qualifying APM Participant (QP)?

QPs:
- Are excluded from MIPS
- Receive a 5% lump sum bonus
- Receive a higher Physician Fee Schedule update starting in 2026

Advanced APMs in 2017

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

- Comprehensive End Stage Renal Disease Care Model (Two-Sided Risk Arrangements)
- Comprehensive Primary Care Plus (CPC+)
- Shared Savings Program Track 2
- Shared Savings Program Track 3
- Next Generation ACO Model
- Oncology Care Model (Two-Sided Risk Arrangement)

The list of Advanced APMs is posted at QPP.CMS.GOV and will be updated with new announcements as needed.
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What are the Requirements to be Considered a MIPS APM?

The APM scoring standard applies to APMs that meet these criteria:

- APM Entities participate in the APM under an agreement with CMS;
- APM Entities include one or more MIPS eligible clinicians on a Participation List; and
- APM bases payment incentives on performance (either at the APM Entity or eligible clinician level) on cost/utilization and quality.

Quality Payment Program

To which APMs does the APM Scoring Standard apply in 2017?

For the 2017 performance year, the following models are considered MIPS APMs:

- Comprehensive ESRD Care (CEC) Model (All Arrangements)
- Comprehensive Primary Care Plus (CPC+) Model
- Shared Savings Program Tracks 1, 2, and 3
- Next Generation ACO Model
- Oncology Care Model (OCM) (All Arrangements)

The list of MIPS APMs is posted at QPPCMS.GOV and will be updated on an ad hoc basis.
**What is the APM Scoring Standard?**

**Shared Savings Program (All Tracks) under the APM Scoring Standard**

<table>
<thead>
<tr>
<th>Quality Payment Program</th>
<th>Reporting Requirement</th>
<th>Performance Score</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality</strong></td>
<td>No additional reporting necessary. ACOs submit quality measures to the CMS Web Interface on behalf of their participating MIPS eligible clinicians.</td>
<td>The MIPS quality performance category requirements and benchmarks will be used to score quality at the ACO level.</td>
<td></td>
</tr>
<tr>
<td><strong>Cost</strong></td>
<td>MIPS eligible clinicians will not be assessed on cost.</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>Improvement Activities</strong></td>
<td>No additional reporting necessary.</td>
<td>CMS will assign a 100% score to each APM Entity group based on the activities required of participants in the Shared Savings Program.</td>
<td></td>
</tr>
<tr>
<td><strong>Advancing Care</strong></td>
<td>Each ACO participant TIN in the ACO submits under this category according to MIPS reporting requirements.</td>
<td>All of the ACO participant TIN scores will be aggregated as a weighted average based on the number of MIPS eligible clinicians in each TIN to yield one APM Entity group score.</td>
<td></td>
</tr>
</tbody>
</table>

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**Quality Payment Program**

2/10/2017
### Next Generation ACO Model under the APM Scoring Standard

<table>
<thead>
<tr>
<th>REPORTING REQUIREMENT</th>
<th>PERFORMANCE SCORE</th>
<th>WEIGHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACOS submit quality measures to the CMS Web Interface on behalf of their participating MIPS eligible clinicians.</td>
<td>The MIPS quality performance category requirements and benchmarks will be used to score quality at the ACO level.</td>
<td>50%</td>
</tr>
<tr>
<td>MIPS-eligible clinicians will not be assessed on cost.</td>
<td>N/A</td>
<td>0%</td>
</tr>
<tr>
<td>No additional reporting necessary.</td>
<td>CMS will assign the same improvement activities score to each APM Entity group based on the activities required of participants in the Next Generation ACO Model.</td>
<td>20%</td>
</tr>
<tr>
<td>Each MIPS eligible clinician in the APM Entity group reports advancing care information to MIPS through either group reporting at the TIN level or individual reporting.</td>
<td>CMS will attribute one score to each MIPS eligible clinician in the APM Entity group. This score will be the highest score attributable to the TIN/NPI combination of each MIPS eligible clinician, which may be derived from either group or individual reporting. The scores attributed to each MIPS eligible clinician will be averaged to yield a single APM Entity group score.</td>
<td>30%</td>
</tr>
</tbody>
</table>

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### All Other APMs under the APM Scoring Standard

<table>
<thead>
<tr>
<th>REPORTING REQUIREMENT</th>
<th>PERFORMANCE SCORE</th>
<th>WEIGHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>The APM Entity group will not be assessed on quality under MIPS in the first performance period.</td>
<td>N/A</td>
<td>0%</td>
</tr>
<tr>
<td>MIPS-eligible clinicians will not be assessed on cost.</td>
<td>N/A</td>
<td>0%</td>
</tr>
<tr>
<td>No additional reporting necessary.</td>
<td>CMS will assign the same improvement activities score to each APM Entity group based on the activities required of participants in the MIPS APM.</td>
<td>25%</td>
</tr>
<tr>
<td>Each MIPS eligible clinician in the APM Entity group reports advancing care information to MIPS through either group reporting at the TIN level or individual reporting.</td>
<td>CMS will attribute one score to each MIPS eligible clinician in the APM Entity group. This score will be the highest score attributable to the TIN/NPI combination of each MIPS eligible clinician, which may be derived from either group or individual reporting. The scores attributed to each MIPS eligible clinician will be averaged to yield a single APM Entity group score.</td>
<td>75%</td>
</tr>
</tbody>
</table>
Where can I go to learn more?

Independent PFPM Technical Advisory Committee

PFPM = Physician-Focused Payment Model
Goal: Encourage new APM options for Medicare

11 appointed care delivery experts that review proposals, submit recommendations to HHS Secretary

For more information on the PTAC, go to: https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee
Quality Payment Program

Health Care Payment Learning and Action Network

*Medicare alone cannot drive sustained progress* towards alternative payment models (APM)

Success depends upon a **critical mass of partners** adopting new models


- The network purpose:
  - **Convene** payers, purchasers, consumers, states and federal partners to establish a common pathway for success
  - **Identify areas of agreement** around movement to APMs
  - **Collaborate to generate evidence, shared approaches, and remove barriers**
  - **Develop common approaches** to core issues such as beneficiary attribution
  - **Create implementation guides** for payers and purchasers

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Quality Payment Program

Thank You

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