The Quality Payment Program Overview Fact Sheet

Background

On October 14, 2016, the Department of Health and Human Services (HHS) issued its final rule with comment period implementing the Quality Payment Program that is part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The Quality Payment Program improves Medicare by helping you focus on care quality and the one thing that matters most — making patients healthier. MACRA ended the Sustainable Growth Rate formula, which threatened clinicians participating in Medicare with potential payment cliffs for 13 years. If you participate in Medicare, you are part of the dedicated team of clinicians who serve more than 55 million of the country's most vulnerable Americans. The Quality Payment Program's purpose is to provide new tools and resources to help you give your patients the best possible, highest-value care.

The Quality Payment Program policy will reform Medicare 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. You can choose how you want to participate in the Quality Payment Program based on your practice size, specialty, location, or patient population.

The Quality Payment Program has two tracks you can choose from:

Advanced Alternative Payment Models (APMs)

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

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.

The Quality Payment Program is focused on moving the payment system to reward high-value, patient-centered care. To be successful in the long run, the Quality Payment Program must account for diversity in care delivery, giving clinicians options that work for them and their patients. CMS expects the Quality Payment Program to evolve over multiple years and therefore, finalizes the rule with an additional 60-day comment period to continue to solicit input from clinicians, patients, and others.

There is a new Quality Payment Program website, which explains the new program and help clinicians easily identify the measures and activities most meaningful to their practice or specialty. This tool allows interested clinicians and practice managers to browse and explore the program options that best fit their practice.

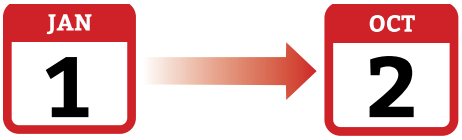
Who is in the Quality Payment Program?

You are eligible to participate in the MIPS track of the Quality Payment Program if you bill more than $30,000 to Medicare, and provide care to more than 100 Medicare patients per year, and you are a:

Physician	Physician Assistant	Nurse Practitioner	Clinical Nurse Specialist	Certified Registered Nurse Anesthetist

If 2017 is your first year participating in Medicare, then you are not required to participate in the Quality Payment Program in 2017.

When does the Quality Payment Program start?



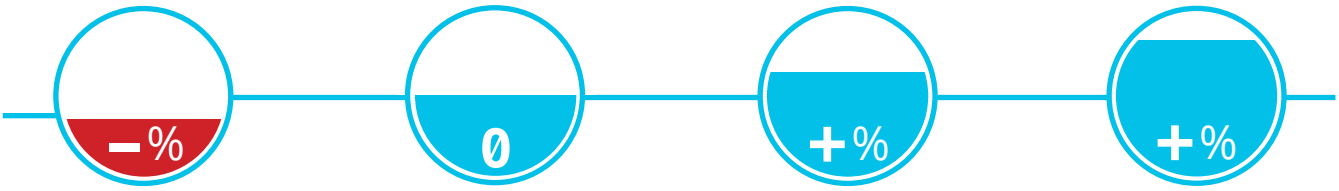
If you're ready, you can begin January 1, 2017 and start collecting your performance data. If you're not ready on January 1, you can choose to start anytime between January 1 and October 2, 2017. Whenever you choose to start, you'll need to send in your performance data by March 31, 2018.

The first payment adjustments based on performance go into effect on January 1, 2019.

How will the Quality Payment Program change my Medicare payments?

Depending on the track of the Quality Payment Program you choose and the data you submit by March 31, 2018, your 2019 Medicare payments will be adjusted up, down, or not at all. The information provided below is only relevant for the 2019 payment year. CMS will provide additional information on payment adjustments for 2020 and beyond beginning next year.

Pick your pace in MIPS: If you choose the MIPS track of the Quality Payment Program, you have three options.



Don't Participate

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

Submit Something

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.

Submit a Partial Year

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

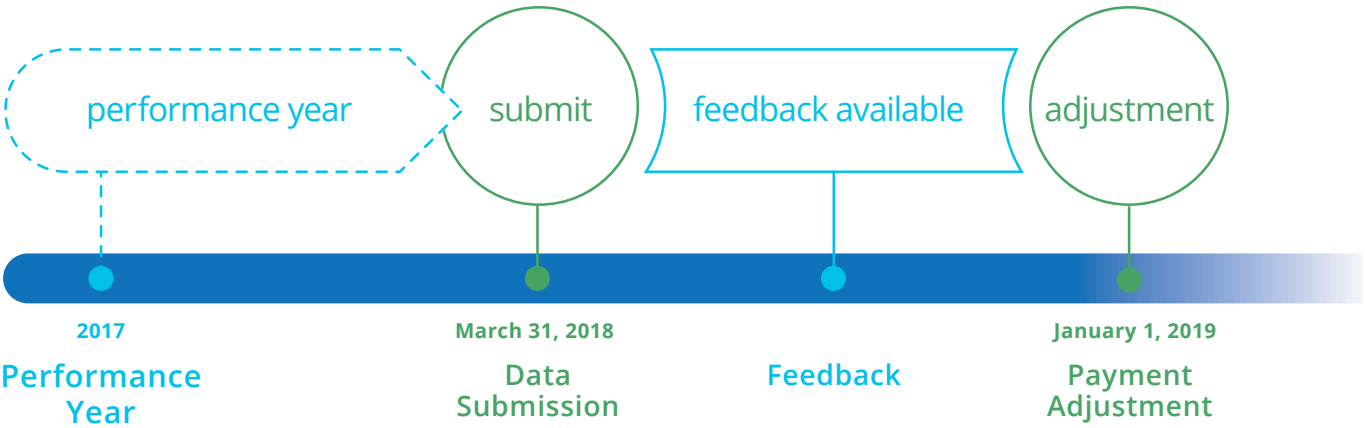
Submit a Full Year

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

The size of your payment adjustment will depend both on how much data you submit and your quality results.

Participate in the Advanced APM track: If you receive 25% of Medicare covered professional services or see 20% of your Medicare patients through an Advanced APM in 2017, then you earn a 5% Medicare incentive payment in 2019.

For providers participating in either MIPS or an Advanced APM, the cycle of the program works like this for the 2019 payment 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.

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.

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.

What are Advanced Alternative Payment Models (APMs)?

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.

Advanced APMs are a subset of APMs and let practices earn more for taking on some risk related to patients' outcomes. You may earn a 5% Medicare incentive payment during 2019 through 2024 and be exempt from MIPS reporting requirements and payment adjustments if you have sufficient participation in an Advanced APM. Earning an incentive payment in one year does not guarantee receiving the incentive payment in future years.

Advanced APMs must meet the following requirements:

- ✓ Be CMS Innovation Center models, Shared Savings Program tracks, or certain federal demonstration programs
- ✓ Require participants to use certified EHR technology
- ✓ Base payments for services on quality measures comparable to those in MIPS
- ✓ Be a Medical Home Model expanded under Innovation Center authority **or** require participants to bear more than nominal financial risk for losses. The final rule with comment period defined the risk requirement for an Advanced APM to be in terms of either total Medicare expenditures or participating organizations' Medicare revenue (which may vary significantly). This enhanced flexibility allows for the creation of more Advanced APMs tailored to physicians and other clinicians, such as advanced practice nurses, generally, and small practice participation in particular.

In order to qualify for the 5% APM incentive payment for participating in an Advanced APM during a payment year, you must receive a certain percentage of payments for covered professional services or see a certain percentage of patients through the Advanced APM during the associated performance year.

Table 1: Requirements for APM Incentive Payments for Participation in Advanced APMs (Clinicians must meet payment or patient requirements)

Performance Year	2017	2018	2019	2020	2021	2022 and later
Percentage of Medicare Payments through an Advanced APM	25%	25%	50%	50%	75%	75%
Percentage of Medicare Patients through an Advanced APM	20%	20%	35%	35%	50%	50%

Approximately 70,000-120,000 clinicians will qualify for the 5% bonus.

For performance years 2017 and 2018, the participation requirements only apply to Medicare payments and patients. Starting in performance year 2019, clinicians may also meet an alternative standard for Advanced APMs that will include non-Medicare payments and patients.

Increasing Advanced APM Opportunities

CMS stated its intent to broaden opportunities for clinicians to participate in Advanced APMs by retrofitting existing models to qualify as Advanced APMs and using the CMS Innovation Center to create new models, including those recommended by the Physician- Focused Payment Models Technical Advisory Committee.

One opportunity CMS is considering is testing a new ACO (Accountable Care Organization) Track 1+ model that would be a new Advanced APM in 2018 with lower risk levels than currently available to Medicare ACOs. The final rule also eases the risk criteria for Advanced APMs from the proposal, allowing a broader range of future models, including those tailored to small practices or specialties.

For the 2017 performance year, we estimate that approximately 70,000 to 120,000 clinicians will participate in Advanced APMs and qualify for the 5% incentive payment.

In 2017, under the Quality Payment Program, clinicians may earn a 5 percent incentive payment through participation in the following Advanced APMs:

- Comprehensive ESRD Care Model (LDO arrangement)
- Comprehensive ESRD Care Model (non-LDO arrangement)
- CPC+
- Medicare Shared Savings Program ACOs—Track 2
- Medicare Shared Savings Program ACOs—Track 3
- Next Generation ACO Model
- Oncology Care Model OCM (two-sided risk arrangement)

We will publish a final list prior to January 1, 2017.

For the 2018 performance year, we estimate that more than 125,000 clinicians will participate in Advanced APMs and qualify for the 5% incentive payment. CMS anticipates re-opening applications for new practices and payers in CPC+ and new participants in the Next Generation ACO model for the 2018 performance year.

In 2018, we anticipate that clinicians may earn the incentive payment through participation in the following additional APMs:

- ACO Track 1+
- New Voluntary Bundled Payment Model
- Comprehensive Care for Joint Replacement Payment Model (CEHRT)
- Advancing Care Coordination through Episode Payment Models Track 1 (CEHRT)
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)

These lists will continue to change and grow as more models are proposed and developed in partnership with the clinician community and the Physician-Focused Payment Model Technical Advisory Committee.

For performance years 2026 and later, you may earn a 0.75% fee schedule update for sufficiently participating in an Advanced APM, while those clinicians who do not achieve sufficient participation in Advanced APMs will earn a 0.25% fee schedule update and may also be subject to MIPS reporting requirements and payment adjustments.

Physician-Focused Payment Model Technical Advisory Committee

The 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. The final rule with comment period finalizes criteria for the committee to use in reviewing these proposals and providing recommendations to the Secretary of the Department of Health and Human Services (HHS). The criteria require that proposed Physician-Focused Payment Models are anticipated to reduce cost, improve care, or both. PTAC provides a unique opportunity for individuals and stakeholders to have a key role in the development of new APMs and to ensure that proposals recommended to the Secretary meet the established criteria and are well-developed.

We expect that the PTAC will assist HHS with improving the process for model development. By engaging with stakeholders early in the development of criteria and review processes, HHS anticipates that PTAC will encourage and facilitate submission of models that have a high likelihood of being implemented and represent the diversity of care provided by physicians across the country.

For more information on PTAC, information to support the development of proposals, and the proposal submission process, go to the PTAC website.

The Secretary is required to review the comments and recommendations submitted by the PTAC and post a detailed response to these recommendations. If CMS considers a physician-focused payment model, it will go through the CMS developmental process for APMs, including design changes as necessary, public announcement, and a request for applications. The decision to test a model recommended by the PTAC will not require stakeholders to submit a second proposal to CMS.

What is the Merit-Based Incentive Payment System (MIPS)?

If you decide to participate in traditional Medicare, rather than an Advanced APM, then you will participate in MIPS where you earn a performance-based payment adjustment to your Medicare payment. CMS estimates approximately 500,000 clinicians will be eligible to participate in MIPS in the first year of the program.

In MIPS, you earn a payment adjustment based on evidence-based and practice-specific quality data. Based on your performance in 2017, you will see a positive, neutral, or negative adjustment of up to 4% to your Medicare payments for covered professional services furnished in 2019. This adjustment percentage grows to a potential of 9% in 2022 and beyond. In addition, during the first six payment years of the program (2019-2024), MACRA allows for up to $500 million each year in additional positive adjustments for exceptional performance. In total, MACRA provides for up to $3 billion in additional positive adjustments to successful clinicians over six years.

MACRA replaced three Medicare reporting programs with MIPS (Medicare Meaningful Use, the Physician Quality Reporting System, and the Value-Based Payment Modifier). Under the combination of the previous programs, you would have faced a negative payment adjustment as high as 9% total in 2019, but the MACRA ended those programs, reduced the potential negative payment adjustments in the early years, and streamlined the overall requirements. While these three programs will end in 2018, if you have participated in these programs in the past, then you will have an advantage in MIPS because many of the requirements should be familiar.

MACRA defined four performance categories for MIPS, linked by their connection to quality and value of patient care.

What do you need to do for MIPS?

Category	What do you need to do?	2017 category weight
 **Quality** *Replaces the Physician Quality Reporting System (PQRS).*	**Most participants:** Report up to 6 quality measures, including an outcome measure, for a minimum of 90 days. **Groups using the web interface:** Report 15 quality measures for a full year. **Groups in APMs qualifying for special scoring under MIPS, such as Shared Savings Track 1 or the Oncology Care Model:** Report quality measures through your APM. You do not need to do anything additional for MIPS quality.	 60%
 **Improvement Activities** *New category.*	**Most participants:** Attest that you completed up to 4 improvement activities for a minimum of 90 days. **Groups with fewer than 15 participants or if you are in a rural or health professional shortage area:** Attest that you completed up to 2 activities for a minimum of 90 days. **Participants in certified patient-centered medical homes, comparable specialty practices, or an APM designated as a Medical Home Model:** You will automatically earn full credit. **Groups in APMs qualifying for special scoring under MIPS, such as Shared Savings Program Track 1 or Oncology Care Model:** You will automatically receive points based on the requirements of participating in the APM. For all current APMs under the APM scoring standard, this assigned score will be full credit. For all future APMs under the APM scoring standard, the assigned score will be at least half credit. **Participants in any other APM:** You will automatically earn half credit and may report additional activities to increase your score.	 15%

Category	What do you need to do?	2017 category weight
Advancing Care Information *Replaces the Medicare EHR Incentive Program also known as Meaningful Use.*	Fulfill the required measures for a minimum of 90 days: ✓ Security Risk Analysis ✓ e-Prescribing ✓ Provide Patient Access ✓ Send Summary of Care ✓ Request/Accept Summary of Care Choose to submit up to 9 measures for a minimum of 90 days for additional credit. OR You may not need to submit Advancing Care Information if these measures do not apply to you.	25%
Cost *Replaces Value-Based Modifier.*	No data submission required. Calculated from adjudicated claims.	Counted starting in 2018.

Should I participate in MIPS as an individual or a group?

Reporting as an Individual

If you send MIPS data in as an individual, your payment adjustment will be based on your performance. An individual is defined as a single National Provider Identifier (NPI) tied to a single Tax Identification Number.

You'll send your individual data for each of the MIPS categories through a certified electronic health record, registry, or a qualified clinical data registry. You may also send in quality data through your routine Medicare claims process.

Reporting as a Group

If you send your MIPS data with a group, the group will get one payment adjustment based on the group's performance. A group is defined as a set of clinicians (identified by their NPIs) sharing a common Tax Identification Number, no matter the specialty or practice site.

Your group will send in group-level data for each of the MIPS categories through the CMS web interface or a third-party data-submission service such as a certified electronic health record, registry, or a qualified clinical data registry. To submit data through our CMS web interface, you must register as a group by June 30, 2017.

For groups to use the CMS Web Interface, you must register by June 30, 2017.

Beginning in future years, you will also be able to participate in MIPS using "virtual groups." Individual clinicians, as well as groups of 10 or fewer clinicians, will be able to form virtual groups. You will be required to indicate that you will be reporting through a virtual group prior to the start of the applicable performance period. CMS will convene user groups to solicit input on establishing final requirements for virtual groups and will propose further policies for virtual groups in future rulemaking.

Support for Small Practices

Practices with 15 or fewer clinicians and practices in rural and health professional shortage areas are a crucial part of the health care system. The Quality Payment Program provides options designed to make it easier for you to report on your performance and qualify for incentives. Physicians in small practices who report their performance can do just as well as mid-sized or larger practices. We expect the number and percentage of small practices participating in the Quality Payment Program to increase and exceed participation in legacy programs (for example, PQRS) because of the reduced reporting burden, increasing usability of technology, and stepped-up technical assistance. There are a number of other flexibilities in the final rule with comment period to help small practices, including exemptions for low volume practices, allowances for patient-centered medical homes, and increased technical assistance.

Physicians in small practices who report their performance can do just as well as mid-sized practices.

MACRA also provides $20 million each year for 5 years to fund training and education for Medicare clinicians in individual or small group practices of 15 clinicians or fewer and those working in underserved areas. Beginning December 2016, local, experienced organizations will use this funding to help small practices select appropriate quality measures and health IT to support their unique needs, train clinicians about the new improvement activities and assist practices in evaluating their options for joining an Advanced APM. Providing these tools to help physicians and other clinicians in small practices and practices in underserved areas navigate new programs is key to making sure they are able to focus on what is most important: the needs of their patients.

Where do I go for help with the Quality Payment Program?

There is a new Quality Payment Program website, which will explain the new program and help clinicians easily identify the measures and activities most meaningful to their practice or specialty. This tool allows interested clinicians and practice managers to browse and explore the program options that best fit their practice.

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.

We want to hear from you

Today's final rule with comment period incorporates input received to date, but it is only the next step in an iterative process for implementing the new law. We welcome additional feedback from patients, caregivers, clinicians, health care professionals, Congress and others on how to better achieve these goals. HHS looks forward to feedback on the final rule and will accept comments until 60 days after the date of filing for public inspection.

Comments may be submitted electronically through our e-Regulation website.