Quality Payment Program
Health IT Policy and Standards Committee

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The Quality Payment Program

The Quality Payment Program policy will:
- Reform Medicare Part B payments for more than 600,000 clinicians
- Improve care across the entire health care 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 Alternate 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.

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

What is the Merit-based Incentive Payment System?

Performance Categories

Quality

Cost

Improvement Activities

Advancing Care Information

- 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

Who Participates in the Merit-based Incentive Payment System?

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

  OR
- See 100 or fewer Medicare Part B patients a year

Significantly participating in Advanced APMs

- Receive 25% of your Medicare payments

  OR
- See 20% of your Medicare patients through an Advanced APM

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 $\leq$ 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

How do Eligible Clinicians Participate in the Merit-based Incentive Payment System?

Pick Your Pace for Participation for the Transitional Year

Participate in an Advanced Alternative Payment Model

MIPS

Test Pace

Partial Year

Full Year

Submit Something

Submit a Partial Year

Submit a Full Year

- Some practices may choose to participate in an Advanced Alternative Payment Model in 2017

- Submit **some** data after January 1, 2017

- Neutral or small payment adjustment

- Report for 90-day period after January 1, 2017

- Small positive payment adjustment

- Fully participate starting January 1, 2017

- Modest positive payment adjustment

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 Something

- 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	**OR**	1 Improvement Activity	**OR**	5 **Required** Advancing Care Information Measures

MIPS: Partial Participation for 2017

Submit a Partial Year

- 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**

JAN 1

Need to send performance data by **March 31, 2018**

Oct 2

MIPS: Full Participation for 2017

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

Bonus Payments and Reporting Periods

MIPS payment adjustment is based on data submitted. Clinicians should pick what's best for their practice.

Submit a Full Year

Full year participation

- Is the best way to get the max adjustment

- Gives you the most measures to choose from

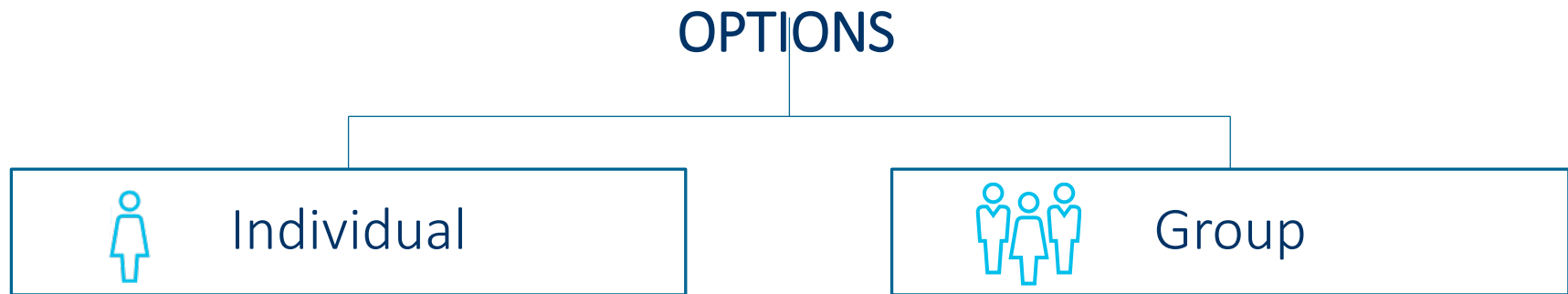- Prepares you the most for the future of the program

Submit a Partial Year

Partial participation (report for 90 days)

- You can still earn the max adjustment

Individual vs. Group Reporting

OPTIONS

Individual	Group

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 a MIPS APM entity

* If clinicians participate as a group, they are assessed as group across all 4 MIPS performance categories

The Merit-based Incentive Payment System Performance Categories
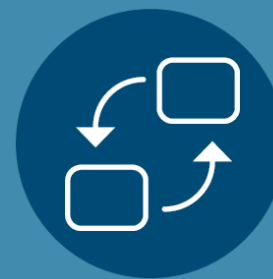
What are the Performance Category Weights?

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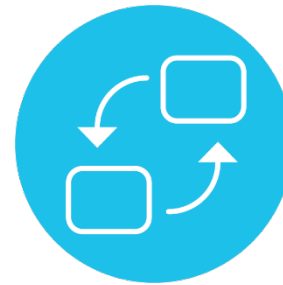
Transition Year Weights

Quality	Cost	Improvement Activities	Advancing Care Information
60%	0%	15%	25%

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

60%

60% of final score

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

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MIPS Performance Category:
Cost

- No reporting requirement; 0% of final score in 2017

- Clinicians assessed on Medicare claims data

- CMS will still provide feedback on how you performed in this category in 2017, but it will not affect your 2019 payments.

- *Keep in mind:*

Uses measures previously used in the Physician Value-Based Modifier program or reported in the Quality and Resource Use Report (QRUR)

Only the scoring is different

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:
Improvement Activities, continued

- No clinician or group has to attest to more than 4 activities

- *Special consideration for:*

Practices with 15 or fewer clinicians	Rural or geographic HPSA	Non-patient facing

APM	Certified Medical Home

- *Keep in mind:* *This is a new category*

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

MIPS Performance Category:
Advancing Care Information, continued

- Clinicians must use certified EHR technology to report

For those using EHR Certified to the 2015 Edition:		For those using 2014 Certified EHR Technology:	
Option 1	*Option 2*	*Option 1*	*Option 2*
Advancing Care Information Objectives and Measures	Combination of the two measure sets	2017 Advancing Care Information Transition Objectives and Measures	Combination of the two measure sets

Advancing Care Information Requirements for the Transition Year

Submit Something

Test pace means…

- Submitting 4 or 5 base score measures
  - Depends on use of 2014 or 2015 Edition
- Reporting *all* required measures in the base score to earn any credit in the advancing care information performance category

Submit a Partial Year   **Submit a Full Year**

Partial and full participation means…

- Submitting more than the base score in year 1

For a full list of measures, please visit qpp.cms.gov

MIPS Performance Category: Advancing Care Information

Advancing Care Information Objectives and Measures:

Base Score Required Measures

Objective	Measure
Protect Patient Health Information	Security Risk Analysis
Electronic Prescribing	e-Prescribing
Patient Electronic Access	Provide Patient Access
Health Information Exchange	Send a Summary of Care
Health Information Exchange	Request/Accept a Summary of Care

2017 Advancing Care Information Transition Objectives and Measures:

Base Score Required Measures

Objective	Measure
Protect Patient Health Information	Security Risk Analysis
Electronic Prescribing	e-Prescribing
Patient Electronic Access	Provide Patient Access
Health Information Exchange	Health Information Exchange

MIPS Performance Category: Advancing Care Information, continued

Advancing Care Information Objectives and Measures:

Performance Score Measures

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

2017 Advancing Care Information Transition Objectives and Measures

Performance Score Measures

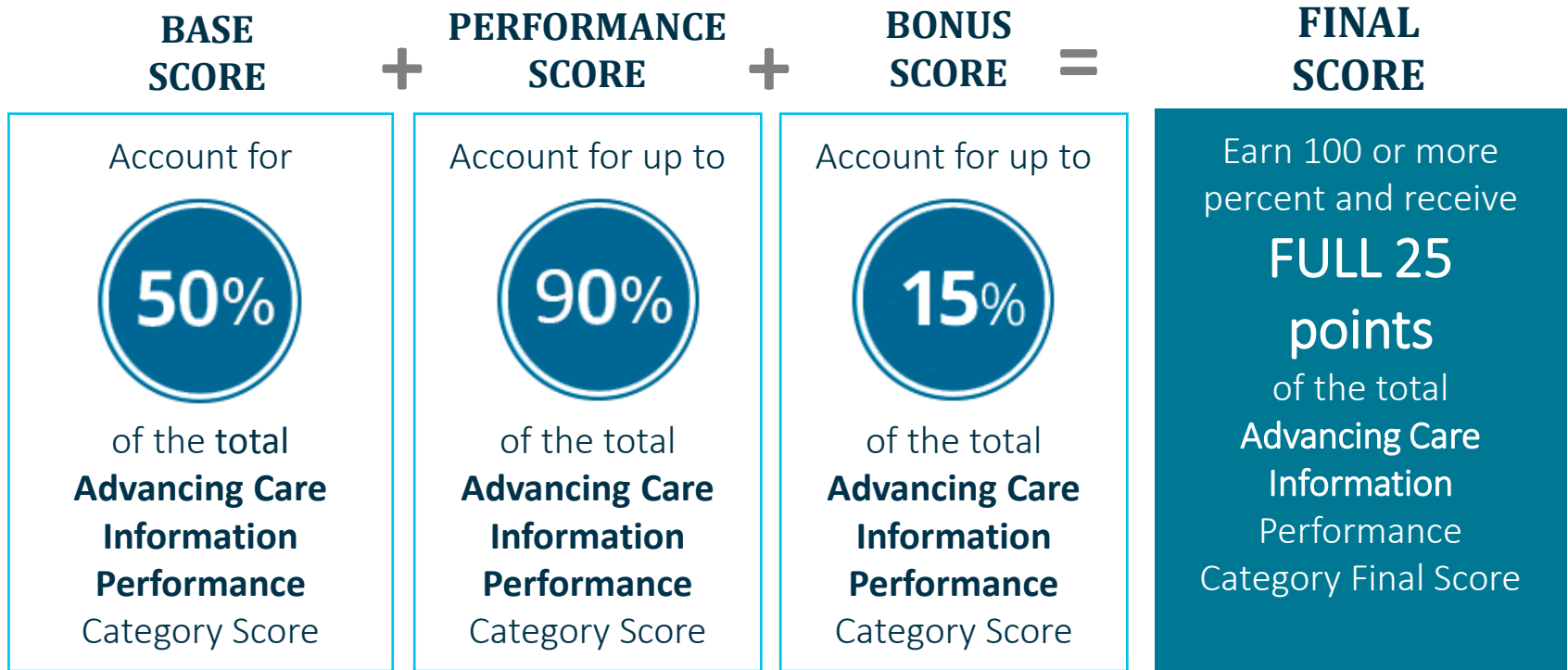| Objective	Measure
Patient Electronic Access	Provide Patient Access*
Patient Electronic Access	View, Download and Transmit (VDT)
Patient-Specific Education	Patient-Specific Education
Secure Messaging	Secure Messaging
Health Information Exchange	Health Information Exchange*
Medication Reconciliation	Medication Reconciliation
Public Health Reporting	Immunization Registry Reporting

Advancing Care Information: Flexibility

1 CMS will automatically reweight the Advancing Care Information performance category to zero for Hospital-based MIPS clinicians, clinicians with lack of Face-to-Face Patient Interaction, NP, PA, CRNAs and CNS
- Reporting is optional although if clinicians choose to report, they will be scored.

2 If clinician faces a significant hardship and is unable to report advancing care information measures, they can apply to have their performance category score weighted to zero

MIPS Performance Category: Advancing Care Information

BASE SCORE	**+**	**PERFORMANCE SCORE**	**+**	**BONUS SCORE**	**=**	**FINAL SCORE**

Account for

50%

of the **total** **Advancing Care Information Performance** Category Score

Account for up to

90%

of the total **Advancing Care Information Performance** Category Score

Account for up to

15%

of the total **Advancing Care Information Performance** Category Score

Earn 100 or more percent and receive

FULL 25 points

of the total **Advancing Care Information Performance** Category Final Score

The overall Advancing Care Information score would be made up of a base score, a performance score, and a bonus score for a maximum score of 100 percentage points

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

50% 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

0% 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

90% Performance Score
(worth up to 90%)

- Report up to **9** Advancing Care Information measures

OR

- Report up to **7** 2017 Advancing Care Information Transition Measures

Each measure is worth 10-20%.
The percentage score is based on the performance rate for each measure:

Performance Rate 1-10	1%
Performance Rate 11-20	2%
Performance Rate 21-30	3%
Performance Rate 31-40	4%
Performance Rate 41-50	5%
Performance Rate 51-60	6%
Performance Rate 61-70	7%
Performance Rate 71-80	8%
Performance Rate 81-90	9%
Performance Rate 91-100	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

Improvement Activities Eligible for Advancing Care Information Bonus

Improvement Activity Performance Category Subcategory	Activity Name	Improvement Activity Performance Category Weight
Expanded Practice Access	Provide 24/7 access to eligible clinicians or groups who have real-time access to patient's medical record	High
Population Management	Anticoagulant management improvements	High
Population Management	Glycemic management services	High
Population Management	Chronic care and preventative care management for empanelled patients	Medium
Population Management	Implementation of methodologies for improvements in longitudinal care management for high risk patients	Medium
Population Management	Implementation of episodic care management practice improvements	Medium
Population Management	Implementation of medication management practice improvements	Medium
Care Coordination	Implementation of use of specialist reports back to referring clinician or group to close referral loop	Medium
Care Coordination	Implementation of documentation improvements for practice/process improvements	Medium
Care Coordination	Implementation of practices/processes for developing regular individual care plans	Medium
Care Coordination	Practice improvements for bilateral exchange of patient information	Medium
Beneficiary Engagement	Use of certified EHR to capture patient reported outcomes	Medium
Beneficiary Engagement	Engagement of patients through implementation of improvements in patient portal	Medium
Beneficiary Engagement	Engagement of patients, family and caregivers in developing a plan of care	Medium
Patient Safety and Practice Assessment	Use of decision support and standardized treatment protocols	Medium
Achieving Health Equity	Leveraging a QCDR to standardize processes for screening	Medium
Integrated Behavioral and Mental Health	Implementation of integrated PCBH model	High
Integrated Behavioral and Mental Health	Electronic Health Record Enhancements for BH data capture	Medium

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

Advancing Care Information Performance Category Score =

Base Score ➕ Performance Score ➕ Bonus Score

Quick Tip:
Maximum score will be capped at 100%

Surveillance and Information Blocking Attestations

Support for Health Information Exchange & Interoperability in Health IT Infrastructure

- Section 106(b)(2) of the MACRA requires eligible providers to demonstrate that they have not knowingly and willfully limited or restricted the interoperability of certified EHR technology.

- CMS finalized a new required attestation for health care providers using CEHRT in the EHR Incentive Programs and Merit Based Incentive Program (MIPS) to support the prevention of information blocking.

| **Prevention of Information Blocking** | **and** | **Cooperation with Health IT Surveillance** |

The Prevention of Information Blocking

A health care provider would be required to attest that it:

- Did not knowingly and willfully take action to limit or restrict the interoperability of certified EHR technology.

- Responded to requests to retrieve or exchange information—including requests from patients and other health care providers regardless of the requestor's affiliation or technology.

  - Implemented appropriate standards and processes to ensure that its certified EHR technology was connected in accordance with applicable law and standards, allowed patients timely access to their electronic health information; and supported exchange of electronic health information with other health care providers

Supporting Providers with the Performance of Certified EHR Technology

Engaging in Activities Related to

ONC Direct Review and ONC-ACB Surveillance of Certified Health IT

- ONC has required surveillance of certified health IT since 2011 and has recently expanded these programs through the EOA final rule to include a stronger focus on ensuring that health IT products and capabilities continue to perform as expected when they are implemented and used "in the field." ONC direct review and ONC-ACB surveillance of health IT provides confidence that technology meets federal standards and possesses the capabilities that health care providers need to improve patient care and

  meet program requirements.

  - CMS finalized a two part attestation for health care providers using CEHRT in the EHR Incentive Programs and Merit Based Incentive Program (MIPS). As it relates to ONC direct review, the attestation is required. As it relates to ONC-ACB surveillance, the attestation is optional.

Introduction to
Advanced Alternative Payment Models (APMs)

Alternative Payment Models (APMs)

- A payment approach that provides added incentives to clinicians to provide high-quality and cost-efficient care.

- Can apply to a specific condition, care episode or population.

- May offer significant opportunities for eligible clinicians who are not ready to participate in Advanced APMs.

Advanced APMs are a Subset of APMs
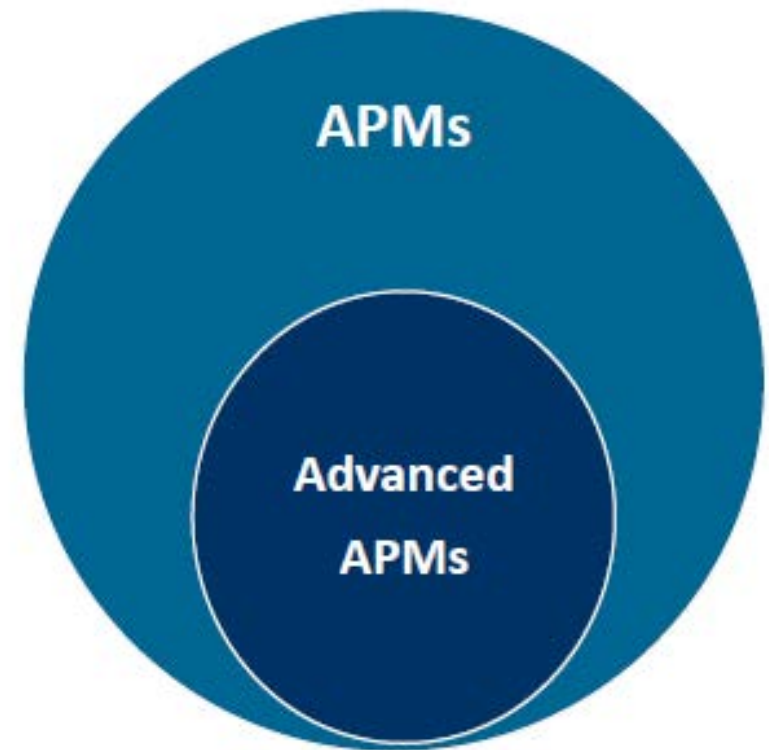
Advanced APMs in 2017

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 on an ad hoc basis.

Future Advanced APM Opportunities

- 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.

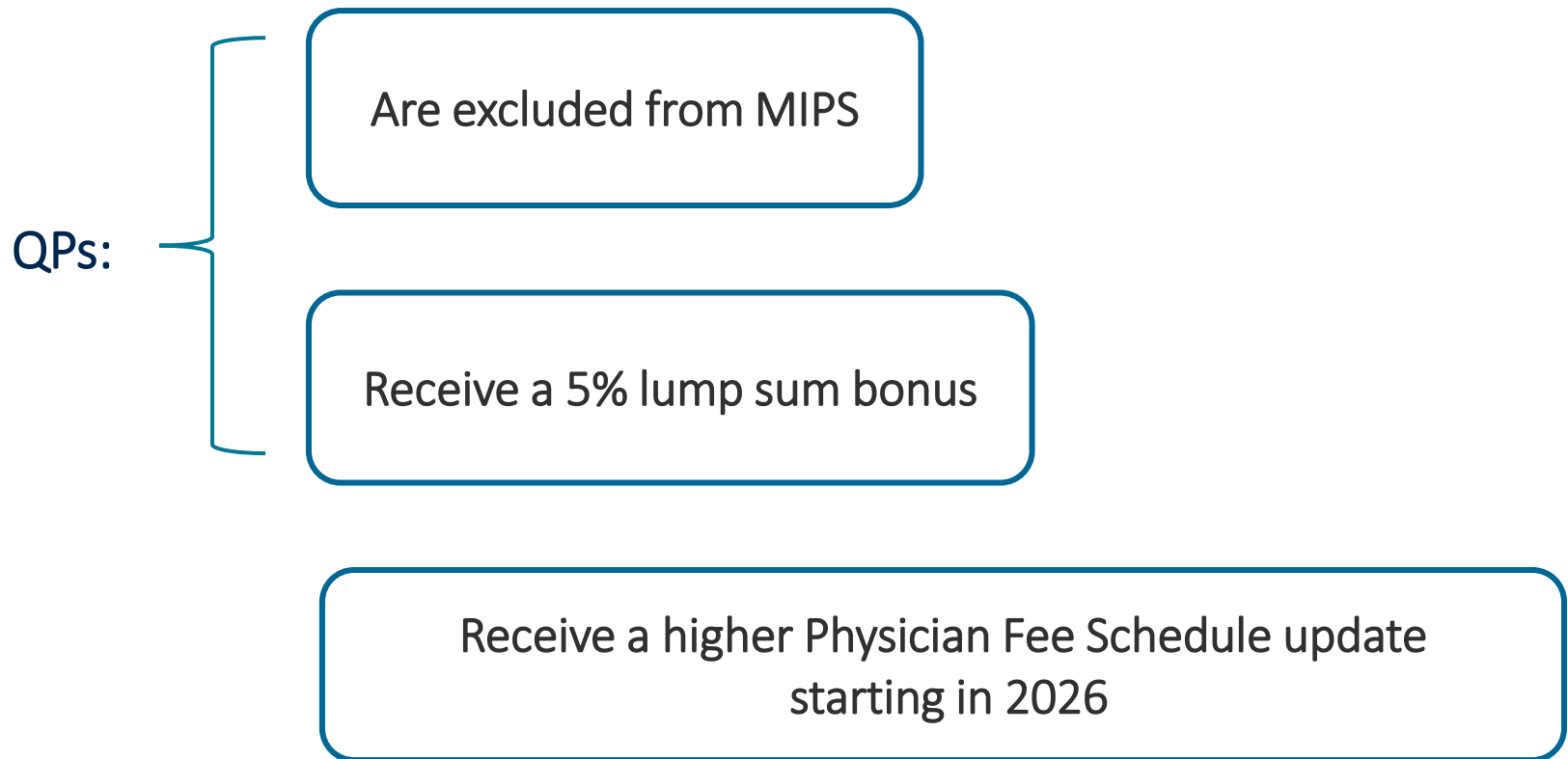- For the **2018 performance year**, we anticipate that the following models will be Advanced APMs:

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)

This list may change. Be sure clinicians review the final list that is scheduled to be published on or before January 1, 2018.

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
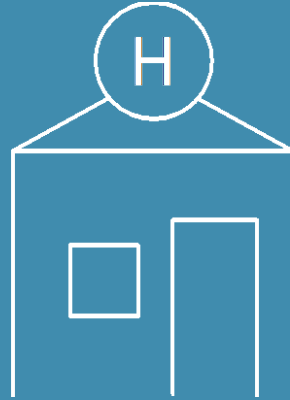
What is Being Done for Small/Rural Practices and Health Professional Shortage Areas (HPSAs)?

Easier Access for Small Practices

Small practices will be able to successfully participate in the Quality Payment Program

Why?

- Reducing the time and cost to participate

- Providing an on-ramp to participating through Pick Your Pace

- Increasing the opportunities to participate in Advanced APMs

- Including a practice-based option for participation in Advanced APMs as an alternative to total cost-based

- Conducting technical support and outreach to small practices through the forthcoming QPP Small, Rural and Underserved Support (QPP-SURS) as well as through the Transforming Clinical Practice Initiative.

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

- Established low-volume threshold

  - Less than or equal to $30,000 in Medicare Part B allowed charges <u>or</u> less than or equal to 100 Medicare patients

- Reduced requirements for Improvement Activities performance category

  - One high-weighted activity or

  - 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).

Technical Assistance and Support

Technical Assistance

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

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

When and where do I submit comments?

- Submit comments referring to file code **CMS-5517-FC** by **December 19, 2016**

- Comments must be submitted in one of the following ways:

  Electronically through Regulations.gov

  By regular mail

  By express or overnight mail

  By hand or courier

- *Note:* *Final Rule with comment includes changes not reviewed in this presentation. Presentation feedback not considered formal comments on the rule.*

For additional information, please go to: QPP.CMS.GOV

Where can I go to learn more?

The Quality Payment Program Service Center is also available to help:

qpp.cms.gov

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

TCPI

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.

QIN-QIOs

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.

APM Learning Systems

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.

Contact Information

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