The Merit-based Incentive Program

November 29, 2016

The foundation of the program is delivery of high-quality patient care. Using a variety of tools, physicians report data to CMS, receive valuable feedback about their practice, and are eligible for payment adjustments

Major Topics Covered

The Quality Payment Program

The Merit-based Incentive Payment System at-a-glance

Preparing for 2017 MIPS Participation

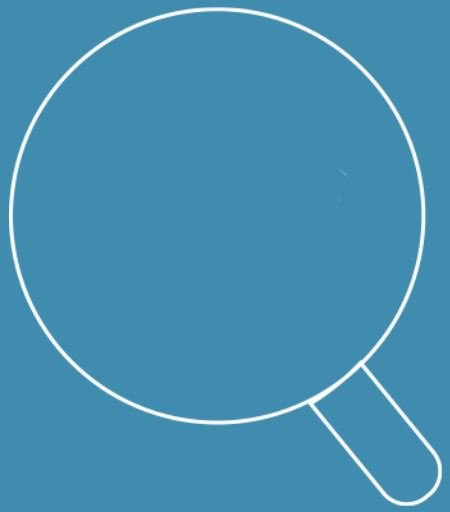
Medicare Payment Prior to MACRA

Fee-for-service (FFS) payment system, where clinicians are paid based on **volume** of services, not **value.**

The Sustainable Growth Rate (SGR)

- Established in 1997 to **control the cost of Medicare payments** to physicians

Each year, Congress passed temporary **"doc fixes"** to avert cuts (no fix in 2015 would have meant a **21% cut** in Medicare payments to clinicians)



What is the Quality Payment Program?

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.

How Does the Quality Payment Program Benefit Clinicians and Patients?

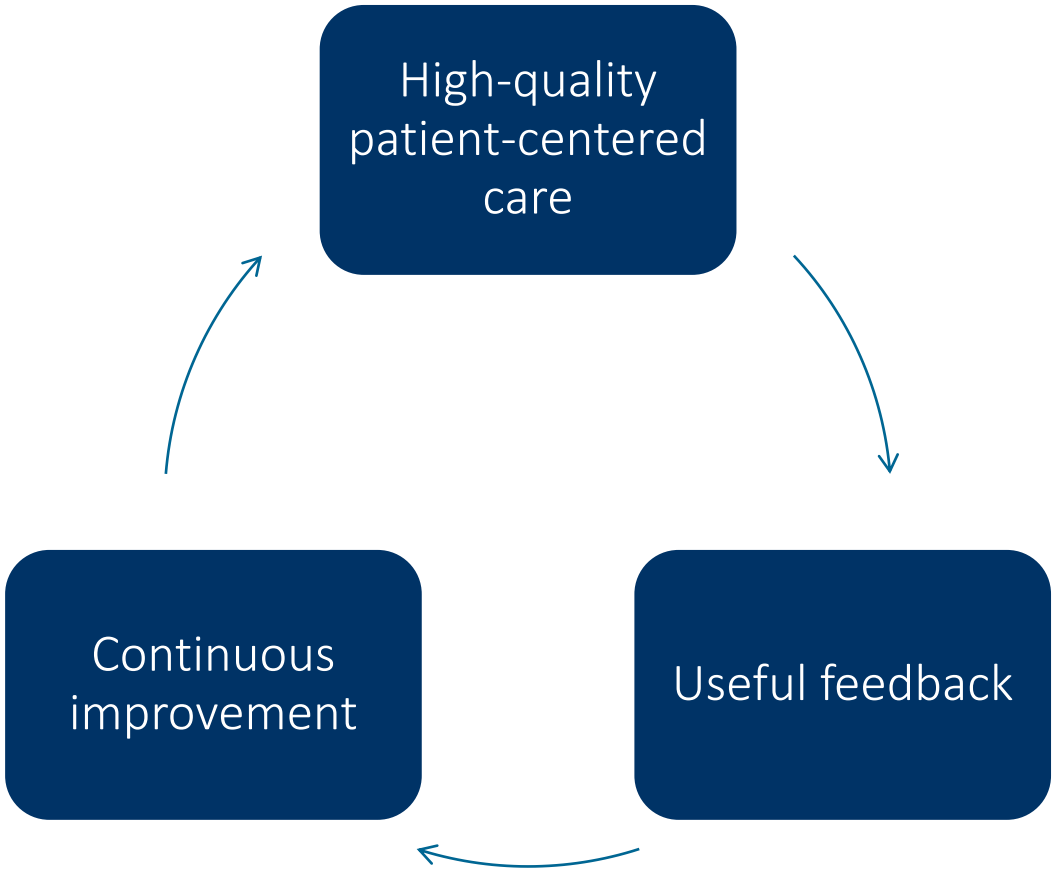
Clinicians

- Streamlines reporting
- Standardizes measures (evidence-based)
- Eliminates duplicative reporting, which allows clinicians to spend more time with patients
- Promotes industry alignment through multi-payer models
- Incentivizes care that focuses on improved quality outcomes

Patients

- Increases access to better care
- Enhances coordination through a patient-centered approach
- Improves results

Quality Payment Program Bedrock



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 Does the Quality Payment Program Do?

Creates Medicare payment methods that promote quality over volume by:

Repealing SGR formula

Creating two tracks:

MIPS

Merit-based Incentive Payment System (MIPS)

Advanced APMs

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

The Quality Payment Program Allows 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 Quality Payment Program, Small, Rural and Underserved Support (QPP-SURS) as well as through the Transforming Clinical Practice Initiative.

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

OR

- Less than or equal to 100 Medicare patients

Reduced requirements for Improvement Activities performance category

- One high-weighted activity

OR

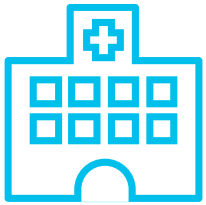
- Two medium-weighted activities

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).

Flexible Start for Clinicians: Pick Your Pace

MIPS

Participate in an Advanced Alternative Payment Model



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

Test Pace

Submit Something

- Submit **some** data after January 1, 2017
- Neutral or small payment adjustment

Partial Year

Submit a Partial Year

- Report for 90-day period after January 1, 2017
- Small positive payment adjustment

Full Year

Submit a Full Year

- 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.

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

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

Ready, Set, Go!

Preparing for 2017 participation in MIPS

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!

Eligible Clinicians:

- 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

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 special reporting requirements for non-patient facing clinicians

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

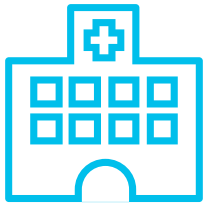
- Receive 25% of your Medicare payments

OR

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

Pick Your Pace for Participation for the Transition Year

Participate in an Advanced Alternative Payment Model



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MIPS

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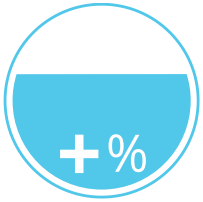
Partial Year



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Full Year

Submit a Full Year

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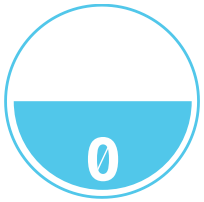
Not participating in the Quality Payment Program for the Transition Year will result in a negative 4% payment adjustment.

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

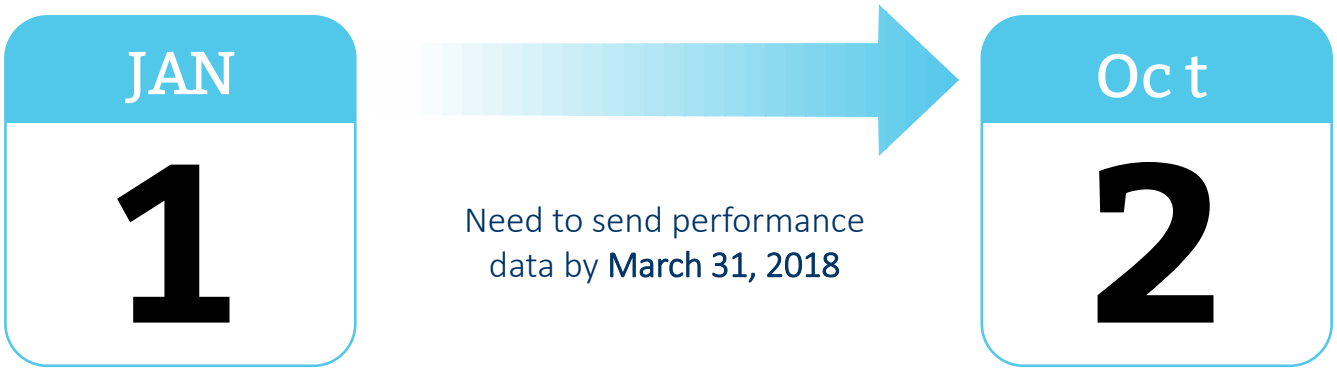
4 or 5 **Required** Advancing Care Information Measures

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



MIPS: Full Participation for 2017

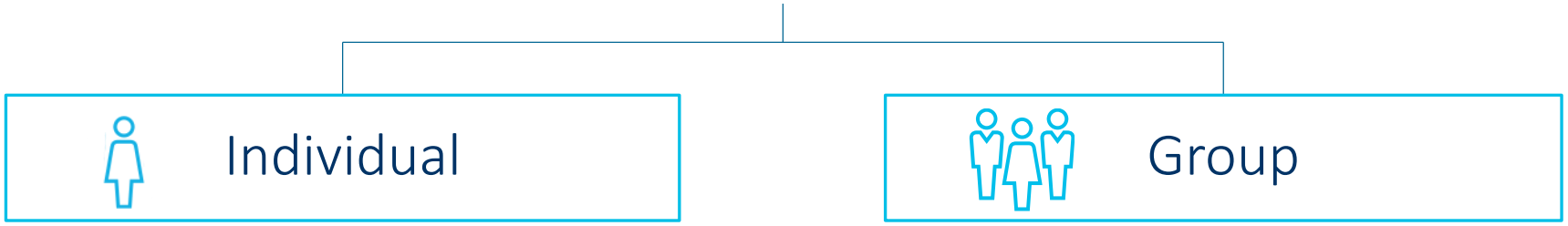
Submit a Full Year

- 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.**

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 group across all 4 MIPS performance categories

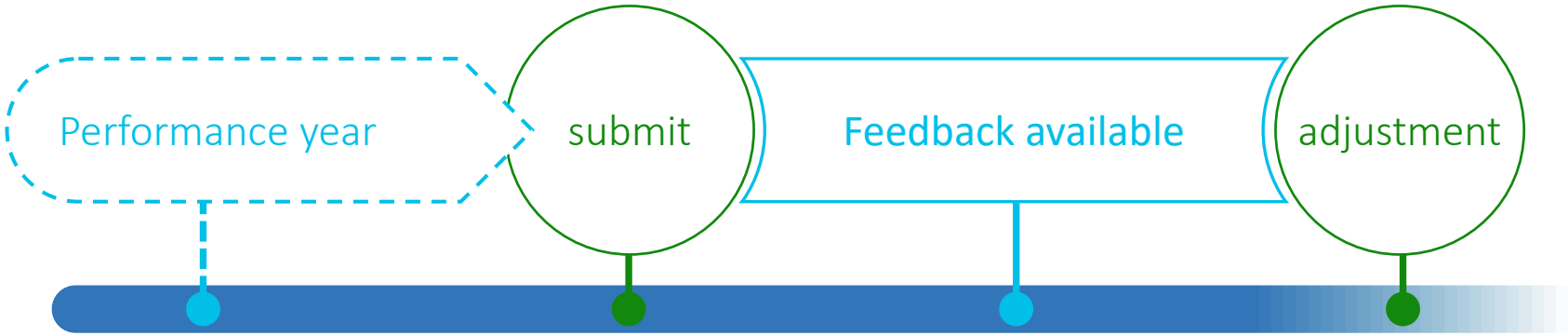
Get your Data to CMS

	Individual	Group
Quality	✓ QCDR *(Qualified Clinical Data Registry)* ✓ Qualified Registry ✓ EHR ✓ Claims	✓ QCDR *(Qualified Clinical Data Registry)* ✓ Qualified Registry ✓ EHR ✓ Administrative Claims ✓ CMS Web Interface (groups of 25 or more) ✓ CAHPS for MIPS Survey
Advancing Care Information	✓ Attestation ✓ QCDR ✓ Qualified Registry ✓ EHR Vendor	✓ Attestation ✓ QCDR ✓ Qualified Registry ✓ EHR Vendor ✓ CMS Web Interface (groups of 25 or more)
Improvement Activities	✓ Attestation ✓ QCDR ✓ Qualified Registry ✓ EHR Vendor	✓ Attestation ✓ QCDR ✓ Qualified Registry ✓ EHR Vendor

Working with a Third Party Intermediary

Intermediary	Approval Needed	Cost to Clinician
EHR Vendor	EHR Vendors Must be certified by ONC	x
QCDR	QCDRs must be approved by CMS	x
Qualified Registry	Qualified Registries must be approved by CMS	x
CMS Approved CAHPS Vendor	CAHPS Vendors must be approved by CMS	x

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% incentive payment for participating in an Advanced APM, just send quality data through your Advanced APM.

Feedback

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

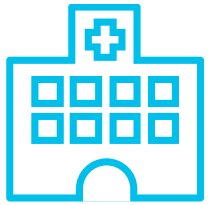
January 1, 2019
Payment Adjustment

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.

Bonus Payments and Reporting Periods for Transition Year

Submit a Full Year

Submit a Partial Year



MIPS payment adjustment is based on data submitted.

Best way to get the max adjustment is to participate for a full year- beginning in 2017.

A full year gives you the most measures to pick from. BUT if you report for 90 days, you could still earn the max adjustment.

We're encouraging clinicians to pick what's best for their practice. Choosing to participate for a full year will prepare you most for the future of the program.

Assess Your Feedback: Prepare for Year 2

The QRUR released on September 26, 2016 (referred to as the 2015 Annual QRUR) is being utilized as the first MIPS performance feedback

The September 2016 QRURs are available and can be accessed at https://portal.cms.gov/wps/portal/unauthportal/home/

We encourage physicians and physician groups to access their report and review the quality and cost information to prepare for the Quality Payment Program

Understanding the MIPS Performance Categories

Example of 2017 MIPS Partial Participation for a Cardiologist

Sample Quality Measures (6, Including 1 Outcome):

1. Closing the referral loop with referring provider
2. Documentation of current medications
3. Statins for primary prevention in high-risk patients and for treatment in patients with known CVD
4. *Chronic anticoagulation therapy for patients with non-valvular atrial fibrillation (AFib) based on CHADS2 risk score
5. *Avoidance of inappropriate cardiac stress imaging in low-risk patients
6. Controlling high blood pressure (outcome measure)

Sample Improvement Activities (2 High-Weighted):

1. Provide 24/7 access to eligible clinicians or groups who have real-time access to patient's medical record.
2. Use of QCDR for feedback reports that incorporate population health.

Advancing Care Information (Use of Technology) Measures (5 Base Score and 1 Performance Score):

1. Security Risk Analysis
2. e-Prescribing
3. Provide Patient Access
4. Send a Summary of Care
5. Request/Accept a Summary of Care
6. Secure Messaging (performance score)

Flexibility to CHOOSE WHAT and HOW you report

Payment adjustments according to composite score

**measure supported by American College of Cardiology*

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% of final score

Select 6 of about 300 quality measures (minimum of 90 days to be eligible for maximum payment adjustment); 1 must be:

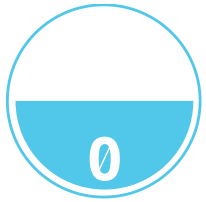
- Outcome measure OR
- High-priority measure—defined as outcome measure, appropriate use measure, patient experience, patient safety, efficiency measures, or care coordination

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

May also select specialty-specific set of measures

Readmission measure for group submissions that have ≥ 16 clinicians and a sufficient number of cases (no requirement to submit)

Quality: Requirements for the Transition Year



Submit Something

- Test Pace means…
  - Submitting a minimum amount of data for one measure set for 2017.

Submit a Partial Year

Submit a Full Year

- Partial and Full Participation means…
  - Submitting at least six quality measures, including at least one outcome measures, for a full year.

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

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

Advancing Care Information

Who can participate?

All MIPS Eligible Clinicians → Participating as an…

- Individual
- **or**
- Group

Optional for 2017 → Hospital-based MIPS clinicians, Nurse Practitioners, Physician Assistants, Clinical Nurse Specialists, CRNAs

Not Eligible → Facilities (i.e. Skilled Nursing facilities)

MIPS Performance Category:
Advancing Care Information

- Clinicians must use certified EHR technology to report

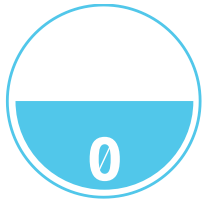
For those using EHR Technology Certified to the 2015 Edition:

Option 1	*Option 2*
Advancing Care Information Objectives and Measures	Combination of the two measure sets

For those using EHR Technology Certified to the 2014 Edition:

Option 1	*Option 2*
2017 Advancing Care Information Transition Objectives and Measures	Combination of the two measure sets

Advancing Care Information Requirements for the Transition Year



Submit Something

Submit a Partial Year

Submit a Full Year

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

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

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 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

Improvement Activity Requirements for the Transition Year

Submit Something

Test Pace means…

- Submitting 1 improvement activity
  - Activity can be high weight or medium weight

Submit a Partial Year

Submit a Full Year

Partial and full participation means…

- Choosing 1 of the following combinations:
  - 2 high-weighted activities
  - 1 high-weighted activity and 2 medium-weighted activities
  - At least 4 medium-weighted activities

Improvement Activities: Flexibilities

Groups with 15 or fewer participants, non-patient facing clinicians, 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.

Shared Savings Program Track 1 or the 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.

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

Cost: Reporting

Cost Measures from VM

1. Medicare Spending Per Beneficiary (MSPB)
2. Total Per-Capita Cost for All Attributed Beneficiaries

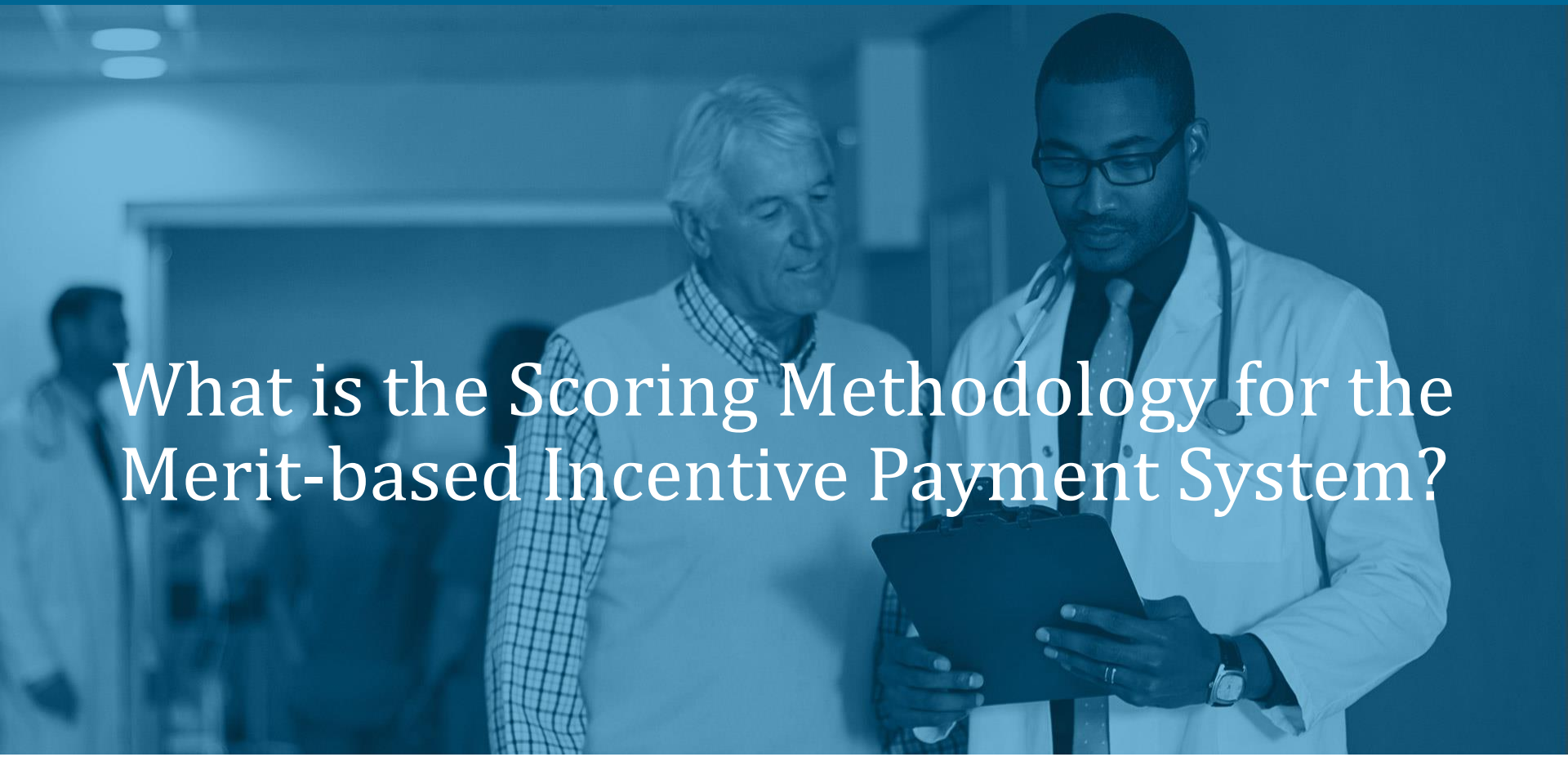
For the transition year, there are no requirements for the Cost Performance Category

Cost: Flexibilities

For the transition year, the cost performance category will **not** impact payment in 2019

Clinicians' Cost performance is targeted to be included in the 2018 performance feedback to help clinicians gauge performance and prepare for year 2 of the program.

For data submission, no action is needed from the clinician.



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
- Readmission measure is included for group reporting with groups with at least 16 clinicians and sufficient cases

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 Quality (60% of Final Score)

Bonus Points

Clinicians receive bonus points for either of the following:

1. Submitting an additional high-priority measure
   - 2 bonus points for each additional outcome and patient experience measure
   - 1 bonus point for each additional high-priority measure
2. Using CEHRT to submit measures to registries or CMS
   - 1 bonus point for submitting electronically end-to-end

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

Total Quality Performance Category Score =

$$\frac{\left\{\text{Points earned on required 6 quality measures}\right\} + \left\{\text{Any bonus points}\right\}}{\text{Maximum number of points*}}$$

Quick Tip: Maximum score cannot exceed 100%

*Maximum number of points = # of required measures x 10

MIPS Scoring for Quality (60% of Final Score)

Maximum Number of Points

CMS Web Interface Reporter total score

- **120 POINTS** — for groups with complete reporting and the readmission measure
- **110 POINTS** — for groups with complete reporting and no readmission measure

Other submission mechanisms total score

- **70 POINTS** — for 6 measures + 1 readmission measure
- **60 POINTS** — if readmission measure does not apply

MIPS Scoring for Improvement Activities
(15% of Final Score in Transition Year)

Total points = 40

Activity Weights

- Medium = 10 points
- High = 20 points

Alternate Activity Weights*

- Medium = 20 points
- High = 40 points

*For clinicians in small, rural, and underserved practices or with non-patient facing clinicians or groups

Full credit for clinicians in a patient-centered medical home, Medical Home Model, or similar specialty practice

MIPS Scoring for Improvement Activities
(15% of Final Score in Transition Year)

Improvement Activities Performance Category Score = { Total number of points scored for completed activities / Total maximum number of points (40) } × 100

Quick Tip: Maximum score cannot exceed 100%

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

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

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%

Calculating the Final Score Under MIPS

Final Score =

(Clinician Quality performance category score **x** actual Quality performance category weight) + (Clinician Cost performance category score **x** actual Cost performance category weight) + (Clinician Improvement Activities performance category score **x** actual Improvement Activities performance category weight) + (Clinician Advancing Care Information performance category score **x** actual Advancing Care Information performance category weight) × 100

Public Reporting

Public Reporting

All MIPS data are available for public reporting on Physician Compare

The final score is also available for public reporting

Any questions for public reporting or Physician Compare should be directed to the Physician Compare Support Team at PhysicianCompare@Westat.com

Beyond the transition year…

Building on a User Centric Approach

We are committed to building on our lessons learned and stakeholder feedback to continuously improve the program. Here are some opportunities to get involved:

Performance feedback.

We are planning to work with stakeholders to determine a new look and feel for the 2018 performance feedback. If you are interested in providing suggested ideas, then please send your thoughts to Partnership@cms.hhs.gov

Implementation of virtual groups.

Details coming soon

CMS is Currently Seeking Formal Comment on..

- Virtual Groups: Overall Implementation

- Non-Patient-Facing: Alternative terminology that could be used to reference such clinicians.

- Low-Volume Threshold: Approaches for Clinicians that do not meet the threshold to opt-in.

- Groups: Approaches for groups with eligible clinicians and non-eligible clinicians such as therapists and new Medicare-enrolled clinicians to participate

- Quality Performance Category: cross-cutting measure requirement for future years

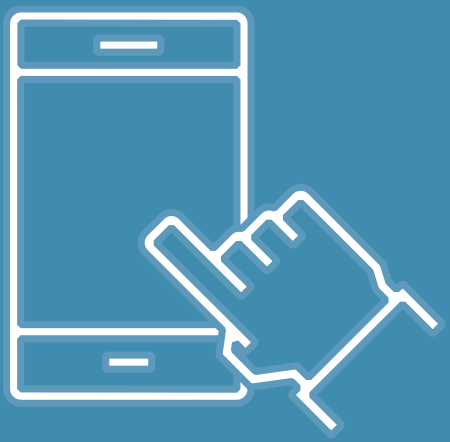
- Advancing Care Information Performance Category: Improvement activities bonus in ACI; future measures

- MIPS Scoring:
  - Approaches for Non-scoreable measures (measures that are below the case min, lack a benchmark or don't meet data complete quality measure benchmark based on specialty and/or practice size
  - Scoring approach for less criteria) in future years.
  - Stratifying the Year 2

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?

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

Do you need technical assistance to help you participate in the Quality Payment Program? The Centers for Medicare & Medicaid Services has specialized programs and resources for eligible clinicians across the country.

PRIMARY CARE & SPECIALIST PHYSICIANS

Transforming Clinical Practice Initiative

- Supports more than 140,000 clinician practices through active, collaborative and peer-based learning networks over 4 years.
- **Practice Transformation Networks (PTNs) and Support Alignment Networks (SANs)** are located in all 50 states to provide comprehensive technical assistance, as well as tools, data, and resources to improve quality of care and reduce costs.
- The goal is to help practices transform over time and move toward Advanced Alternative Payment Models.

Locate the PTN(s) and SAN(s) in your state

SMALL & SOLO PRACTICES

Small, Underserved Rural Support Technical Assistance

- Provides outreach, guidance, and direct technical assistance to clinicians in solo or small practices (15 or fewer), particularly those in rural and underserved areas, to promote successful health IT adoption, optimization, and delivery system reform activities.
  - Assistance will be tailored to the needs of the clinicians.
  - Organizations selected to provide this technical assistance will be available in late 2016.

LARGE PRACTICES

Quality Innovation Network-Quality Improvement Organizations (QIN-QIO) Education and Support

- Supports clinicians in **large practices (more than 15 clinicians)** in meeting Merit- Based Incentive Payment System requirements through customized technical assistance.
- Includes one-on-one assistance when needed.
- There are 14 QIN-QIOs that serve all 50 states, the District of Columbia, Guam, Puerto Rico, and Virgin Islands.

Locate the QIN-QIO that serves your state

Quality Innovation Network (QIN) Directory

TECHNICAL SUPPORT

All Eligible Clinicians Are Supported By:

Quality Payment Program Website: qpp.cms.gov
Serves as a starting point for information on the Quality Payment Program.

Quality Payment Program Service Center
Assists with all Quality Payment Program questions.
1-866-288-8292 TTY: 1-877-715-6222 QPP@cms.hhs.gov

Advanced Alternative Payment Model (APM) Learning Networks
Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Q&A Session Information

- All questions will be taken through the Q&A box.
- The questions and answers will be read aloud for everyone to hear.
- The speakers will get through as many questions as time allows.
- If your question is not answered during the webinar, please contact the Quality Payment Program Service Center: QPP@cms.hhs.gov.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