

Quality Payment Program



## The CMS Quality Payment Program

National Association of Clinical Nurse Specialists  
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Quality Payment Program

## Disclaimers

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Quality Payment Program

Topics

- Quality Payment Program Overview
- Merit-based Incentive Payment System (MIPS)
  - Overview
  - Who is Included?
  - Performance Period
  - Reporting and Data Submission Options
  - Performance Categories
  - Performance Threshold and Payment Adjustment
  - Scoring
- Changes for Year 2 (2018)
- Resources
- Questions & Answers



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### 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

IF Overall physician costs > Target Medicare expenditures → Physician payments cut across the board

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)

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### QUALITY PAYMENT PROGRAM

Overview

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### Quality Payment Program

MIPS and Advanced APMs

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS by law to implement an incentive program, referred to as the Quality Payment Program, that provides for two participation tracks:

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

**OR**

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

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Quality Payment Program

### Quality Payment Program

Considerations

Improve beneficiary outcomes	Reduce burden on clinicians
Increase adoption of Advanced APMs	Maximize participation
Improve data and information sharing	Deliver IT systems capabilities that meet the needs of users
Ensure operational excellence in program implementation	

Quick Tip: For additional information on the Quality Payment Program, please visit [qpp.cms.gov](http://qpp.cms.gov)

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### MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

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### Merit-based Incentive Payment System (MIPS)

Quick Overview

Combined legacy programs into a single, improved program.

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graph LR; PQRS[Physician Quality Reporting System (PQRS)] --> MIPS[MIPS]; VM[Value-Based Payment Modifier (VM)] --> MIPS; EHR[Medicare EHR Incentive Program (EHR) for Eligible Professionals] --> MIPS;
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Quality Payment Program

## 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



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## 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.



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## MIPS Participation Basics


Must be a MIPS clinician type billing more than \$30,000 a year in Medicare Part B allowed charges **AND** providing care for more than 100 Medicare patients a year.


AND



**MIPS clinician types include:**




Physicians




Physician Assistants




Nurse Practitioners



Clinical Nurse Specialists



Certified Registered Nurse Anesthetists



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### Who is exempt 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

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### 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  $\leq 100$  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

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### Quality Payment Program

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

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### Pick Your Pace for Participation in 2017

Participate in an Advanced Alternative Payment Model

	MIPS			
	TEST	PARTIAL YEAR	FULL YEAR	
 <p>Some practices may choose to participate in an Advanced Alternative Payment Model in 2017</p>	 <p>Submit something</p> <ul style="list-style-type: none"> <li>Submit <b>some</b> data after January 1, 2017</li> <li>Neutral or small payment adjustment</li> </ul>	 <p>Submit a Partial Year</p> <ul style="list-style-type: none"> <li>Report for 90-day period after January 1, 2017</li> <li>May earn neutral or positive payment adjustment</li> </ul>	 <p>Submit a Full Year</p> <ul style="list-style-type: none"> <li>Fully participate starting January 1, 2017</li> <li>Positive payment adjustment</li> </ul>	
	<p>Not participating in the Quality Payment Program for the Transition Year will result in a negative 4% payment adjustment.</p>			
				
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### MIPS: Choosing to Test for 2017

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

Submit Something

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

 <p>1 Quality Measure</p>	OR	 <p>1 Improvement Activity</p>	OR	 <p>4 or 5 Advancing Care Information Measures</p>
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### Quality Payment Program

## Individual vs. Group Reporting

OPTIONS

 <p>Individual</p>	 <p>Group</p>
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- Individual**—under an NPI number and TIN where they reassign benefits
- As a Group**
  - 2 or more clinicians (NPIs) who have reassigned their billing rights to a single TIN\*
  - As an APM Entity

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

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Quality Payment Program Train-the-Trainer

## What Are the MIPS Performance Categories?



Quality



Improvement Activities



Advancing Care Information



Cost



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## Get your Data to CMS

	Individual	Group
Quality	<ul style="list-style-type: none"> <li>✓ QCDR (Qualified Clinical Data Registry)</li> <li>✓ Qualified Registry</li> <li>✓ EHR</li> <li>✓ Claims</li> </ul>	<ul style="list-style-type: none"> <li>✓ QCDR (Qualified Clinical Data Registry)</li> <li>✓ Qualified Registry</li> <li>✓ EHR</li> <li>✓ Administrative Claims</li> <li>✓ CMS Web Interface (groups of 25 or more)</li> <li>✓ CAHPS for MIPS Survey</li> </ul>
Advancing Care Information	<ul style="list-style-type: none"> <li>✓ Attestation</li> <li>✓ QCDR</li> <li>✓ Qualified Registry</li> <li>✓ EHR Vendor</li> </ul>	<ul style="list-style-type: none"> <li>✓ Attestation</li> <li>✓ QCDR</li> <li>✓ Qualified Registry</li> <li>✓ EHR Vendor</li> <li>✓ CMS Web Interface (groups of 25 or more)</li> </ul>
Improvement Activities	<ul style="list-style-type: none"> <li>✓ Attestation</li> <li>✓ QCDR</li> <li>✓ Qualified Registry</li> <li>✓ EHR Vendor</li> </ul>	<ul style="list-style-type: none"> <li>✓ Attestation</li> <li>✓ QCDR</li> <li>✓ Qualified Registry</li> <li>✓ EHR Vendor</li> </ul>



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Quality Payment Program Learn About the Program | Explore Measures | Education & Tools

Learn About Program > Register for the CMS Web Interface and/or CAHPS for MIPS Survey

## Register for the CMS Web Interface

**Do I need to register?**

If your group would like to participate in MIPS via the CMS Web Interface and/or elect to administer the CAHPS for MIPS survey, you should register between April 1 - June 30, 2017.

If your group registered for the GPBD Web Interface in 2016 to report for The Physician Quality Reporting System (PQRS), CMS automatically registered your group to use the CMS Web Interface in 2017 for MIPS. If your group would like to participate through another data submission option, you should "cancel" your election in the registration system between April 1 - June 30, 2017. Please note if under PQRS you elected the CAHPS for PQRS survey, you were not automatically registered to administer the CAHPS for MIPS survey and will need to log in to the registration system to make that election.

Groups that participate in a Shared Savings Program ACO are not required to register; the Shared Savings Program ACO is required to report quality measures on behalf of participating eligible clinicians for purposes of MIPS.

[Register for the CMS Web Interface](#) ↗

**Do I need to do anything else?**

If you registered for the Web Interface in 2016 and wish to continue in 2017, you should review and update your information. [Between April 1, 2016, to April 30, 2017](#) ↗

**Additional resources**

[CMS Web Interface Registration Guide](#)  
PDF | UPDATED MARCH 31ST, 2017

[CMS Web Interface Fact Sheet](#)  
PDF | UPDATED APRIL 12TH, 2017

[CAHPS for MIPS Fact Sheet](#)  
PDF | UPDATED MARCH 31ST, 2017



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## 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 default weights; the weights can be adjusted in certain circumstances.



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## 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 271 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)



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

**Select 6 of the approximately 271 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



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## 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 exist (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

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Quality Payment Program Train-the-Trainer




## 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

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

Total Quality  
Performance  
Category  
Score

=

Points earned on  
required 6 quality  
measures


+

Any bonus  
points

}

Maximum number  
of points\*

**Quick Tip:** Maximum score cannot exceed 100%  
\*Maximum number of points = # of required measures x 10

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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



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### 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



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Train-the-Trainer

### MIPS Performance Category: Improvement Activities – Reporting



- Must perform selected activities for 90 consecutive days
- Must attest each activity performed for 90-day period by selecting “Yes” during reporting
- May report activities through:
  - Qualified Registry
  - Electronic Health Record (EHR)
  - Qualified Clinical Data Registry (QCDR)
  - CMS Web Interface (for groups of 25 clinicians or more)
  - Attestation data submission methods



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### MIPS Performance Category: Improvement Activities

- 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



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

**Total points = 40**

<p><b>Activity Weights</b></p> <ul style="list-style-type: none"> <li>Medium = 10 points</li> <li>High = 20 points</li> </ul>	<p><b>Alternate Activity Weights*</b></p> <ul style="list-style-type: none"> <li>Medium = 20 points</li> <li>High = 40 points</li> </ul> <p><small>*For clinicians in small, rural, and underserved practices or with non-patient facing clinicians or groups</small></p>	<p>Full credit for clinicians in a patient-centered medical home, Medical Home Model, or similar specialty practice</p>
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### MIPS Scoring for Improvement Activities (15% of Final Score in Transition Year)

$$\text{Improvement Activities Performance Category Score} = \left[ \frac{\text{Total number of points scored for completed activities}}{\text{Total maximum number of points (40)}} \right] \times 100$$

**Quick Tip:** Maximum score cannot exceed 100%



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### 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



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

50%

Base score (worth 50%)

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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.



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

Advancing Care Information Measures		Advancing Care Information Transitional Measures	
Measure	Performance Score	Measure	Performance Score
Provide Patient Access	Up to 10%	Provide Patient Access	Up to 20%
Patient-Specific Education	Up to 10%	Health Information Exchange	Up to 20%
View, Download and Transmit (VDT)	Up to 10%	View, Download, or Transmit	Up to 10%
Secure Messaging	Up to 10%	Patient-Specific Education	Up to 10%
Patient-Generated Health Data	Up to 10%	Secure Messaging	Up to 10%
Send a Summary of Care	Up to 10%	Medication Reconciliation	Up to 10%
Request/Accept a Summary of Care	Up to 10%	Immunization Registry Reporting	0 or 10%
Clinical Information Reconciliation	Up to 10%		
Immunization Registry Reporting	0 or 10%		



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## 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%



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

**5% BONUS** for reporting on one or more of the following Public Health and Clinical Data Registry Reporting measures:

- Syndromic Surveillance Reporting
- Specialized Registry Reporting (14)
- Electronic Case Reporting (15)
- Public Health Registry Reporting (15)
- Clinical Data Registry Reporting(15)

**10% BONUS** for using **CEHRT** to report certain Improvement Activities



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## MIPS Performance Category: Advancing Care Information

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



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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:**

<b>50%</b> Required Base score (50%)	<b>90%</b> Performance score (up to 90%)	<b>15%</b> Bonus score (up to 15%)
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*Keep In mind:* You need to fulfill the Base score or you will get a zero in the Advancing Care Information Performance Category



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### Calculating the Final Score Under MIPS

**Final Score =**

$$\left[ \frac{\text{Clinician Quality performance category score} \times \text{actual Quality performance category weight}}{\text{actual Quality performance category weight}} \right] + \left[ \frac{\text{Clinician Cost performance category score} \times \text{actual Cost performance category weight}}{\text{actual Cost performance category weight}} \right] + \left[ \frac{\text{Clinician Improvement Activities performance category score} \times \text{actual Improvement Activities performance category weight}}{\text{actual Improvement Activities performance category weight}} \right] + \left[ \frac{\text{Clinician Advancing Care Information performance category score} \times \text{actual Advancing Care Information performance category weight}}{\text{actual Advancing Care Information performance category weight}} \right] \times 100$$


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### Transition Year 2017

Final Score	Payment Adjustment
<b>≥70 points</b>	<ul style="list-style-type: none"> <li>Positive adjustment</li> <li>Eligible for exceptional performance bonus—minimum of additional 0.5%</li> </ul>
<b>4-69 points</b>	<ul style="list-style-type: none"> <li>Positive adjustment</li> <li>Not eligible for exceptional performance bonus</li> </ul>
<b>3 points</b>	<ul style="list-style-type: none"> <li>Neutral payment adjustment</li> </ul>
<b>0 points</b>	<ul style="list-style-type: none"> <li>Negative payment adjustment of -4%</li> <li>0 points = does not participate</li> </ul>



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**Merit-based Incentive Payment System (MIPS)** 

Quick Overview

MIPS Performance Categories for Year 2 (2018)

 Quality 50	+	 Cost 10	+	 Improvement Activities 15	+	 Advancing Care Information 25	=>	100 Possible Final Score Points
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- Comprised of **four** performance categories in 2018.
- **So what?** The points from each performance category are added together to give you a **MIPS Final Score**.
- The MIPS Final Score is compared to the MIPS performance threshold to determine if you receive a **positive, negative, or neutral payment adjustment**.

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MIPS YEAR 2 (2018)  
Who is Included for Year 2?



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MIPS Year 2 (2018)  
Who is Included?

*No change in the types of clinicians eligible to participate in 2018*


MIPS eligible clinicians include:




Physicians




Physician Assistants




Nurse Practitioners



Clinical Nurse Specialists



Certified Registered Nurse Anesthetists



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MIPS Year 2 (2018)  
Who is Included?

As a reminder: the definition of **Physicians** includes:

- Doctors of Medicine
- Doctors of Osteopathy (including Osteopathic Practitioners)
- Doctors of Dental Surgery
- Doctors of Dental Medicine
- Doctors of Podiatric Medicine
- Doctors of Optometry
- Chiropractors
  - With respect to certain specified treatment, a Doctor of Chiropractic legally authorized to practice by a State in which he/she performs this function.



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### MIPS Year 2 (2018)

Who is Included?

**Change to the Low-Volume Threshold for 2018.** Include MIPS eligible clinicians billing more than **\$90,000** a year in Medicare Part B allowed charges **AND** providing care for more than **200** Medicare patients a year.

**Transition Year 1 (2017) Final**

**Year 2 (2018) Final**

Voluntary reporting remains an option for those clinicians who are exempt from MIPS.

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### MIPS Year 2 (2018)

Who is Exempt?

**No Change in Basic Exemption Criteria\***

**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 **\$90,000** a year **OR**
- See **200** or fewer Medicare Part B patients a year

**Advanced APMs**

**Significantly participating in Advanced APMs**

- Receive 25% of their Medicare payments **OR**
- See 20% of their Medicare patients through an Advanced APM

\*Only Change to Low-volume Threshold

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### MIPS Year 2 (2018)

Non-patient Facing

**No Change in Non-Patient Facing Criteria**

**Transition Year 1 (2017) Final**

- Individual – If you have  $\leq 100$  patient facing encounters.
- Groups – If your group has  $>75\%$  of NPIs billing under your group's TIN during a performance period are labeled as non-patient facing.

**Year 2 (2018) Final**

- No Change to Individual and Group policy.**
- NEW - Virtual Groups** are included in the definition.
  - Virtual Groups that have  $>75\%$  of NPIs within a virtual group during a performance period are labeled as non-patient facing

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**MIPS Year 2 (2018)**  
Other Special Statuses

Special Status	Component	Year 2 (2018) Final	Application
Small Practice	Definition	<ul style="list-style-type: none"> <li>Practices consisting of 15 or fewer <u>eligible</u> clinicians.</li> </ul>	<ul style="list-style-type: none"> <li>No change to the application of these special statuses from Year 1 to Year 2.</li> </ul>
Rural and Health Professional Shortage Areas	Rural and HPSA practice designations	<ul style="list-style-type: none"> <li>An individual MIPS eligible clinician, a group, or a virtual group with multiple practices under its TIN (or TINs within a virtual group) with <b>more than 75 percent</b> of NPIs billing under the individual MIPS eligible clinician or group's TIN or within a virtual group in a ZIP code designated as a rural area or HPSA.</li> </ul>	

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**MIPS YEAR 2 (2018)**  
Performance Period

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**MIPS Year 2 (2018)**  
Performance Period

*Change: Increase to Performance Period*

Transition Year 1 (2017) Final		Year 2 (2018) Final	
Performance Category	Minimum Performance Period	Performance Category	Minimum Performance Period
Quality	90-days minimum; full year (12 months) was an option	Quality	12-months
Cost	Not included. 12-months for feedback only.	Cost	12-months
Improvement Activities	90-days	Improvement Activities	90-days
Advancing Care Information	90-days	Advancing Care Information	90-days

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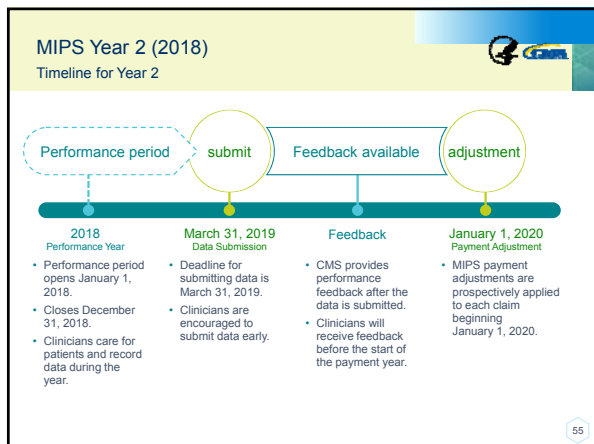
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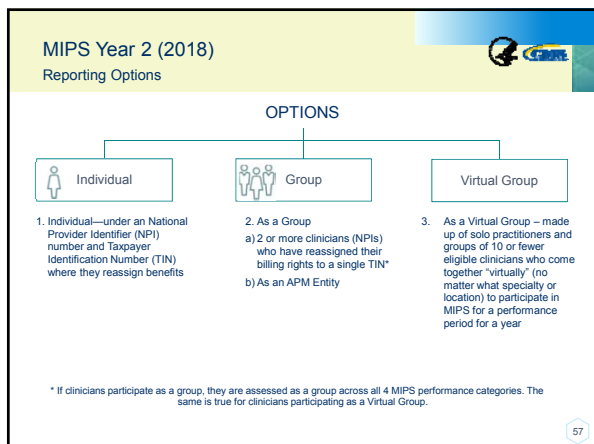
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**MIPS Year 2 (2018)**  
Virtual Groups



**New: Virtual Groups**

What else do I need to know?

- Solo practitioners and groups who want to form a virtual group must go through the **election process**.
- Virtual groups election must occur **prior** to the **beginning of the performance period** and cannot be changed once the performance period starts.
- Election period is October 11 to December 31, 2017, for the 2018 MIPS performance period.

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**MIPS Year 2 (2018)**  
Submission Mechanisms

*No change: All of the submission mechanisms remain the same from Year 1 to Year 2*

Performance Category	Submission Mechanisms for Individuals	Submission Mechanisms for Groups (Including Virtual Groups)
Quality	QCQR Qualified Registry EHR Claims	QCQR Qualified Registry EHR CMS Web Interface (groups of 25 or more)
Cost	Administrative claims (no submission required)	Administrative claims (no submission required)
Improvement Activities	Attestation QCQR Qualified Registry EHR	Attestation QCQR Qualified Registry EHR CMS Web Interface (groups of 25 or more)
Advancing Care Information	Attestation QCQR Qualified Registry EHR	Attestation QCQR Qualified Registry EHR CMS Web Interface (groups of 25 or more)

**Please note:**

- Continue with the use of **1** submission mechanism per performance category in Year 2 (2018). Same policy as Year 1.
- The use of **multiple submission mechanisms** per performance category is **deferred to Year 3 (2019)**.

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**MIPS YEAR 2 (2018)**  
Performance Categories



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**MIPS Year 2 (2018)**  
Quality



**What is the significance?**

- A measure may be considered topped out if meaningful distinctions and improvement in performance can no longer be made.
- Topped out measures could have an impact on the scores for certain MIPS eligible clinicians, and provide little room for improvement for the majority of MIPS eligible clinicians.

**Topped Out Measures:**

The six topped out measures include the following:

- Perioperative Care: Selection of Prophylactic Antibiotic-First or Second Generation Cephalosporin, (Quality Measure ID: 21)
- Melanoma: Overutilization of Imaging Studies in Melanoma, (Quality Measure ID: 224)
- Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients), (Quality Measure ID: 23)
- Image Confirmation of Successful Excision of Image-Localized Breast Lesion, (Quality Measure ID: 262)
- Optimizing Patient Exposure to Ionizing Radiation: Utilization of a Standardized Nomenclature for Computerized Tomography (CT) Imaging Description (Quality Measure ID: 359)
- Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy (Quality Measure ID: 52)

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**MIPS Year 2 (2018)**  
Cost



**Basics:**

- Change: 10% Counted toward Final Score in 2018**
- Medicare Spending per Beneficiary (MSPB) and total per capita cost measures are included in calculating Cost performance category score for the 2018 MIPS performance period.
- These measures were used in the Value Modifier and in the MIPS transition year

**Change:** Cost performance category weight is finalized at 10% for 2018.

- 10 episode-based measures adopted for the 2017 MIPS performance period will not be used.
- We are developing new episode-based measures with significant clinician input and are providing feedback on these measures this fall through field testing.
- This will allow clinicians to see their cost measure scores before the measures are potentially included in the MIPS program.
- We will propose new cost measures in future rulemaking.

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**MIPS Year 2 (2018)**  
Cost



**Basics:**

- Change: 10% Counted toward Final Score in 2018**
- Medicare Spending per Beneficiary (MSPB) and total per capita cost measures are included in calculating Cost performance category score for the 2018 MIPS performance period.
- These measures were used in the Value Modifier and in the MIPS transition year

**Reporting/Scoring:**

- Each individual MIPS eligible clinician's and group's cost performance will be calculated using administrative claims data if they meet the case minimum of attributed patients.
- Individual MIPS eligible clinicians and groups are not required to submit any additional information for the cost performance category.
- Performance is compared against performance of other MIPS eligible clinicians and groups during the performance period so benchmark is not based on a previous year.
- Performance category score is the average of the two measures: Medicare Spending per Beneficiary (MSPB) and total per capita cost measures.
- If only one measure can be scored, it will serve as the performance category score.

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**MIPS Year 2 (2018)**  
MIPS: Scoring Improvements

**New: MIPS Scoring Improvement for Quality and Cost**



- For Quality:
  - Improvement scoring will be based on the rate of improvement such that higher improvement results in more points for those who have not previously performed well.
  - Improvement will be measured at the performance category level.
  - Up to 10 percentage points available in the Quality performance category.



- For Cost:
  - Improvement scoring will be based on statistically significant changes at the measure level.
  - Up to 1 percentage point available in the Cost performance category.

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**MIPS Year 2 (2018)**  
Improvement Activities



**Basics:**

- 15% of Final Score in 2018
- 112 activities available in the inventory
  - Medium and High Weights remain the same from Year 1
  - Medium = 10 points
  - High = 20 points
- A simple "yes" is all that is required to attest to completing an Improvement Activity

**Number of Activities:**

- No change in the number of activities that MIPS eligible clinicians must report to achieve a total of 40 points.
- Burden Reduction Aim:** MIPS eligible clinicians in *small practices* and practices in *a rural areas* will continue to report on no more than 2 activities to achieve the highest score.

**Patient-centered Medical Home:**

- We finalized the term "recognized" is equivalent to the term "certified" as a patient centered medical home or comparable specialty practice.
- 50% of practice sites\* within a TIN or TINs that are part of a virtual group need to be recognized as patient-centered medical homes for the TIN to receive the full credit for Improvement Activities in 2018.

\*We have defined practice sites as the practice address that is available within the Provider Enrollment, Chain, and Ownership System (PECOS).

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**MIPS Year 2 (2018)**  
Improvement Activities



**Basics:**

- 15% of Final Score in 2018
- 112 activities available in the inventory
  - Medium and High Weights remain the same from Year 1
  - Medium = 10 points
  - High = 20 points
- A simple "yes" is all that is required to attest to completing an Improvement Activity

**Additional Activities:**

- We are finalizing additional activities, and changes to existing activities for the Improvement Activities Inventory including credit for using Appropriate Use Criteria (AUC) through a qualified clinical support mechanism for all advanced diagnostic imaging services ordered.

**Scoring:**

- Continue to designate activities within the performance category that also qualify for an Advancing Care Information performance category bonus.
- For group reporting, only one MIPS eligible clinician in a TIN must perform the Improvement Activity for the TIN to receive credit.
- For virtual group reporting, only one MIPS eligible clinician in a virtual group must perform the Improvement Activity for the TIN to receive credit.
- Continue to allow simple attestation of Improvement Activities.

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### MIPS Year 2 (2018)

Advancing Care Information



**Basics:**

- 25% of Final Score in 2018
- Comprised of Base, Performance, and Bonus score
- Promotes patient engagement and the electronic exchange of information using certified EHR technology
- Two measure sets available to choose from based on EHR edition.

**CEHRT Requirements:**

- **Burden Reduction Aim:** MIPS eligible clinicians may use either the 2014 or 2015 CEHRT or a combination in 2018.
- A **10% bonus** is available for using only 2015 Edition CEHRT.

**Measures and Objectives:**

- CMS finalizes exclusions for the E-Prescribing and Health Information Exchange Measures.

**Scoring:**

- No change to the **base score** requirements for the 2018 performance period/2020 payment year.
- For the **performance score**, MIPS eligible clinicians and groups will earn 10% for reporting to any one of the Public Health and Clinical Data Registry Reporting measures as part of the performance score.
- For the **bonus score** a 5% bonus score is available for reporting to an additional registry not reported under the performance score.
- Additional Improvement Activities are eligible for a 10% Advancing Care Information bonus for completion of at least 1 of the specified Improvement Activities using CEHRT.
- Total bonus score available is 25%

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### MIPS Year 2 (2018)

Advancing Care Information



**Basics:**

- 25% of Final Score in 2018
- Comprised of Base, Performance, and Bonus score
- Promotes patient engagement and the electronic exchange of information using certified EHR technology
- Two measure sets available to choose from based on EHR edition.

**Exceptions:**

- Based on authority granted by the 21<sup>st</sup> Century Cures Act and MACRA, CMS will reweight the Advancing Care Information performance category to 0 and reallocate the performance category weight of 25% to the Quality performance category for the following reasons:

**Automatic reweighting:**

- o Hospital-based MIPS eligible clinicians:
  - o Ambulatory Surgical Center (ASC)—based MIPS eligible clinicians, finalized retroactive to the transition year;
  - o Nurse practitioners, physician assistants, clinical nurse specialist, certified registered nurse anesthetists
- o Non-patient-facing clinicians and groups

**Reweight through an approved application:**

- o **New hardship exception for clinicians in small practices** (15 or fewer clinicians);
- o **New decertification exception** for eligible clinicians whose EHR was decertified, retroactively effective to performance periods in 2017.
- o **Significant hardship exceptions**—CMS will not apply a 5-year limit to these exceptions.

- **New deadline of December 31** of the performance year for the submission of hardship exception applications for 2017 and future years.
- Revised definition of hospital-based MIPS eligible clinician to include covered professional services furnished by MIPS eligible clinicians in an off-campus-outpatient hospital (POS 19).

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### MIPS YEAR 2 (2018)

Performance Threshold and Payment Adjustment



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## MIPS Year 2 (2018)

MIPS: Performance Threshold & Payment Adjustment

*Change: Increase in Performance Threshold and Payment Adjustment*

**Transition Year 1 (2017) Final**

- 3 point threshold
- Exceptional performer set at 70 points
- Payment adjustment set at +/- 4%

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**Year 2 (2018) Final**

- 15 point threshold
- Exceptional performer set at 70 points
- Payment adjustment set at +/- 5%

*How can I achieve 15 points?*

- Report all required Improvement Activities.
- Meet the Advancing Care Information base score and submit 1 Quality measure that meets data completeness.
- Meet the Advancing Care Information base score, by reporting the 5 base measures, and submit one medium-weighted Improvement Activity.
- Submit 6 Quality measures that meet data completeness criteria.

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## MIPS Year 2 (2018)

MIPS: Performance Threshold & Payment Adjustment

*Change: Increase in Performance Threshold and Payment Adjustment*

**Transition Year 1 (2017) Final**

Final Score 2017	Payment Adjustment 2019
≥70 points	<ul style="list-style-type: none"> <li>• Positive adjustment</li> <li>• Eligible for exceptional performance bonus—minimum of additional 0.5%</li> </ul>
4-69 points	<ul style="list-style-type: none"> <li>• Positive adjustment</li> <li>• Not eligible for exceptional performance bonus</li> </ul>
3 points	• Neutral payment adjustment
0 points	<ul style="list-style-type: none"> <li>• Negative payment adjustment of -4%</li> <li>• 0 points = does not participate</li> </ul>

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**Year 2 (2018) Final**

Final Score 2018	Change Y/N	Payment Adjustment 2020
≥70 points	N	<ul style="list-style-type: none"> <li>• Positive adjustment greater than 0%</li> <li>• Eligible for exceptional performance bonus—minimum of additional 0.5%</li> </ul>
15.01-69.99 points	Y	<ul style="list-style-type: none"> <li>• Positive adjustment greater than 0%</li> <li>• Not eligible for exceptional performance bonus</li> </ul>
15 points	Y	• Neutral payment adjustment
3.76-14.99 points	Y	• Negative payment adjustment greater than -5% and less than 0%
0-3.75 points	Y	• Negative payment adjustment of -5%

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## MIPS YEAR 2 (2018)

Scoring

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### MIPS Year 2 (2018)

Calculating the Final Score

Remember: All of the performance category points are added together to give you a MIPS Final Score.

The MIPS Final Score is compared to the MIPS performance threshold to determine if you receive a positive, negative, or neutral payment adjustment.

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### MIPS Year 2 (2018)

Complex Patient Bonus

**New: Complex Patient Bonus**

- Up to **5 bonus points** available for treating complex patients based on medical complexity.
  - As measured by Hierarchical Condition Category (HCC) risk score and a score based on the percentage of dual eligible beneficiaries.
- MIPS eligible clinicians or groups must submit data on at least 1 performance category in an applicable performance period to earn the bonus.

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### MIPS Year 2 (2018)

Small Practice Bonus

**New: Small Practice Bonus**

- 5 bonus points** added to final score of any MIPS eligible clinician or group who is in a small practice (15 or fewer clinicians), so long as the MIPS eligible clinician or group submits data on at least 1 performance category in an applicable performance period.
- Burden Reduction Aim:**
  - We recognize the challenges of small practices and will provide a 5 point bonus to help them successfully meet MIPS requirements.

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## MIPS Year 2 (2018)

### Facility-based Measurement





**New: Facility-based Measurement**

Please note:

- Facility-based measurement policies are finalized, but with a **1-year delay to Year 3 (2019)**.

What you need to know:

- Facility-based measurement assesses clinicians in the context of the facilities at which they work to better measure their quality.
- Voluntary facility-based scoring mechanism will be aligned with the Hospital Value Based Purchasing Program (Hospital VBP) to help reduce burden for clinicians.
- Eligible as individual: You must have 75% of services in the inpatient hospital or emergency room.
- Eligible as group: 75% of eligible clinicians must meet eligibility criteria as individuals.
- Measures will be based on Hospital VBP for quality and cost measures.
- Scores will be derived using the data at the facility where the clinician treats the highest number of Medicare beneficiaries.
- The facility-based measurement option converts a hospital Total Performance Score into a MIPS quality performance category and cost performance category score.

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## Technical Assistance

### Available Resources

CMS has **free** resources and organizations on the ground to provide help to eligible clinicians included in the Quality Payment Program:

#### PRIMARY CARE & SPECIALIST PHYSICIANS

*Transforming Clinical Practice Initiative*

- Supports more than 140,000 clinician practices through advice, 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 clinic, site, and resources to improve quality of care and reduce costs.
- The goal is to help practices transform over time and receive shared Advanced Alternative Payment Models.
- Contact [TCPI.SCM@hhs.gov](mailto:TCPI.SCM@hhs.gov) for extra assistance.


Learn the PTNs and SANs in your state

#### SMALL & SOLO PRACTICES

*Small, Underserved, and Rural Support (SURES)*

- Provides outreach, guidance, and direct technical assistance for clinicians in **small practices (10 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 clinician.
- There are 11 SURES organizations providing guidance to small practices in all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands.

For more information or for assistance getting connected contact [QPP@cms.gov](mailto:QPP@cms.gov)



#### LARGE PRACTICES

*Quality Improvement Networks- Quality Improvement Organizations (QIN-QIO)*

- Supports clinicians in **large practices (more than 10 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 the Virgin Islands.

Identify Incentive Payment System (IPS) Inventory

#### TECHNICAL SUPPORT

*All Eligible Clinicians Are Supported By:*

- Quality Payment Program Walktor: [qpp.ahrq.gov](http://qpp.ahrq.gov)
- Quality Payment Program Service Center: [www.cms.gov/QualityPaymentProgram](http://www.cms.gov/QualityPaymentProgram)
- Center for Medicare & Medicaid Innovation (CMMI) Learning System: [www.cms.gov/innovation](http://www.cms.gov/innovation)

To learn more, view the [Technical Assistance Resource Guide: <https://www.cms.gov/Medicare/Quality-Improvement/QualityPaymentProgram/Resource-Library/Technical-Assistance-Resource-Guide.pdf>](https://www.cms.gov/Medicare/Quality-Improvement/QualityPaymentProgram/Resource-Library/Technical-Assistance-Resource-Guide.pdf)

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