Medicare Quality Payment Program

Rural and APMs: It Takes a Village and Everyone Gains!

OMA MACRA Playbook
Portland, Oregon
June 22, 2017

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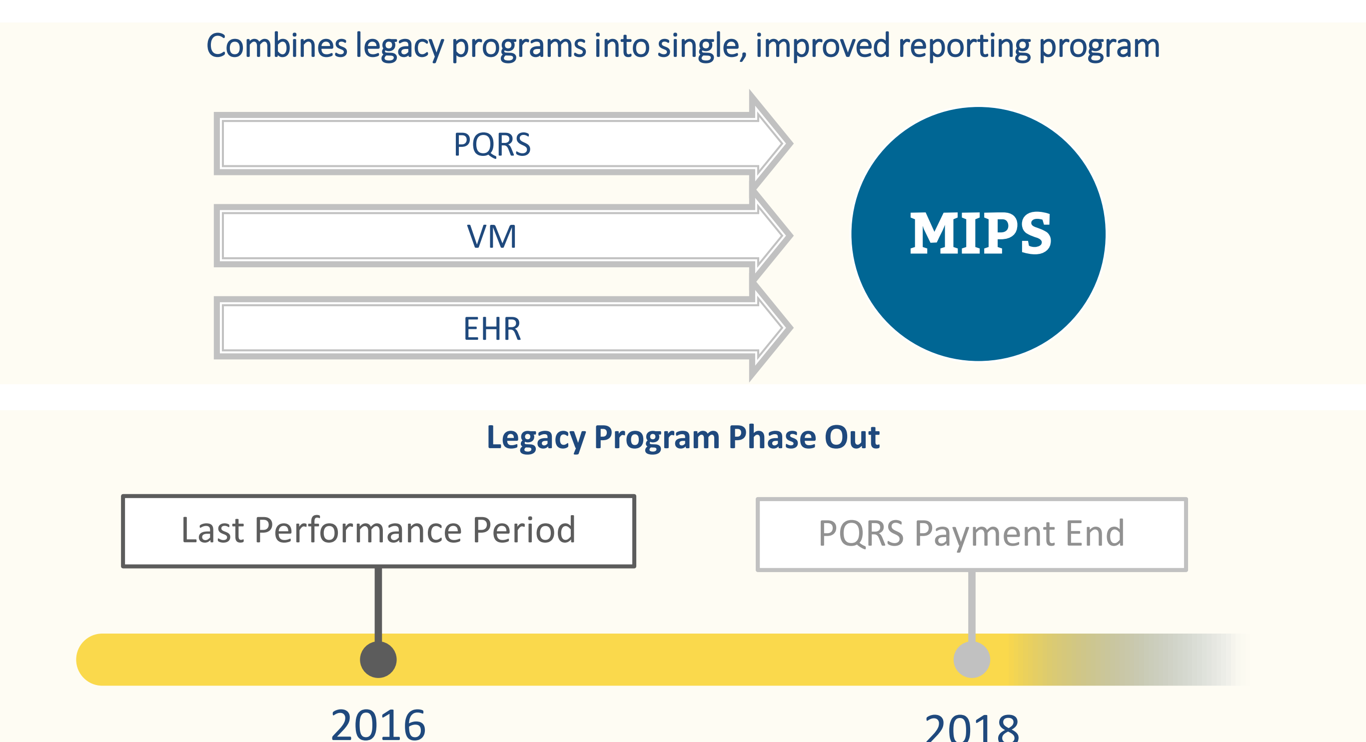
What is the Merit-based Incentive Payment System?



Special Note: Medicare EHR Incentive Program

First-time Eligible Professionals (EPs) have until October 1st of their first year to attest and avoid payment adjustments in the subsequent year.

"So what?"

- EPs who are first-first time participants in 2017 have until October 1, 2017 to attest to avoid the 2018 payment adjustment.

However…

- CMS is offering a one-time significant hardship exception to the EHR Incentive Program 2018 payment adjustment.

Special Note: Medicare EHR Incentive Program

Hardship Exception:

- A first-time EP may apply for the exception if:
  - The EP is a first-time participant in the EHR Incentive Program in 2017 **and** intends to participate in the EHR Incentive Program in 2017; and
  - The EP is transitioning to MIPS for the 2017 performance period; and
  - The EP intends to report on measures specified for the Advancing Care Information performance category under MIPS in 2017 (i.e. the Base measures, at minimum).
- Exception Form: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/PaymentAdj_Hardship.html

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)

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.

Eligible Clinicians

Clinicians billing more than $30,000 a year in Medicare Part B allowed charges **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

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 their Medicare payments

OR

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

Getting Started

- **Review the Clinician Participation Letter provided by CMS.**
-
- The letters were sent at the TIN level rather than to individual clinicians, so check-in with the representative of your practice group for details.

- You can also check online at https://qpp.cms.gov

Getting Started: Clinician Participation Letter

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Medicare Clinician:

Thank you for your participation in Medicare and the services you provide to people with Medicare. You're an integral part of the dedicated team of clinicians who serve more than 55 million people with Medicare. The clinician-patient relationship is central to our work at the Centers for Medicare & Medicaid Services and we continuously work to reduce the administrative burdens you may face when participating in Medicare programs. During this first year of transition to the Quality Payment Program, we have put together several program options, so you can choose the pace that best meets your practice needs. However, we know we can do more and are committed to diligently working with you over the next year to streamline the process as much as possible. Our goal is to further reduce burdensome requirements so that you can deliver the best possible care to patients. Our doors are open and we look forward to hearing your ideas and receiving your feedback so we can make additional improvements in year two of the Quality Payment Program.

Why am I getting this letter?

You have a practice identified by a taxpayer identification number (TIN) enrolled in Medicare. Starting in 2017, clinicians will participate in the new Quality Payment Program as a group or individually either through the Merit-based Incentive Payment System (MIPS) or participation in an Advanced Alternative Payment Model (APM). **This letter lets you know if your group and the individuals in your group (if those individuals choose to report separately to the program) are exempt from MIPS because of the following:**

- being a low-volume clinician (being below established program thresholds); or
- not being among the categories of clinicians included in the program in the first year.

In addition, you may be exempt from MIPS if you are:

- a new Medicare enrolled clinician; or
- if you are participating in certain Advanced Alternative Payment Models and your participation is sufficient to meet certain thresholds.

Attachment A provides low-volume and non-eligible provider type information in a list for each clinician and group.

MIPS replaces the Physician Quality Reporting System (PQRS), Value Modifier (VM) and the Medicare EHR Incentive Program for eligible clinicians who provide items and services under Medicare Part B. The Quality Payment Program will provide new tools and resources to help you give your patients the best possible, highest-value care. Even better, you could receive positive payment adjustments based on your participation, performance, and engaging in improvement activities. Clinicians who practice under multiple TINs will be notified at the TIN level of their eligibility, and may have different eligibilities for each TIN/practice.

This is the first year of this new program. Based on stakeholder feedback, we have made it much easier to participate in the program from the start. We reduced the number of proposed requirements and created a variety of timelines, so you can pick when you want to start and your pace of participation.

What do I need to do?

Review Attachment A. Determine whether you plan to participate as a group or if clinicians within your group will participate individually. If you participate in an Alternative Payment Model (APM), reach out to your model's support inbox to learn more information about additional support that is available.

Let the clinicians assigned to your TIN know if they're included in MIPS or exempt from MIPS if individual clinician participation is chosen as the method of participation.

- **If included in MIPS, the clinician:**
  - Must participate to potentially earn an upward adjustment and avoid a negative adjustment to their Medicare Part B payments.
  - Can participate as an individual or as part of their group.
  - Can pick the pace of their participation for the first performance period. If they're ready, they can collect performance data beginning with services that were furnished beginning on January 1, 2017. Clinicians can also choose to start anytime between January 1 and October 2, 2017.
  - Must submit any MIPS data to Medicare no later than March 31, 2018 to qualify for a positive or neutral payment adjustment, which will affect their 2019 Medicare Part B payments, and avoid up to a 4% negative payment adjustment in 2019.

SAMPLE

Getting Started: Clinician Participation Letter

- **If the clinician is not included in MIPS, the clinician:**
  - Won't be subject to a positive or negative Medicare Part B payment adjustment in 2019 under MIPS.
  - No further action is required unless your TIN decides to participate as a group and is above one of the low volume thresholds.
  - May choose to voluntarily submit data individually to Medicare to learn, to obtain feedback on quality measures, and to prepare in the event MIPS is expanded in the future. Clinicians who submit data voluntarily will not be subject to a positive or negative payment adjustment.

- **If the clinician is a participant in an Advanced APM, the clinician:**
  - Should determine and confirm participation in the Advanced APM (visit **http://go.cms.gov/APMlist** to see an up to date list of Advanced APMs).
  - Should continue to fulfill the participation requirements of the Advanced APM. The Quality Payment Program does NOT change how any particular Advanced APM rewards value or operates, and Advanced APMs have their own quality reporting and participation requirements.
  - Should know that there are special benefits for those who meet threshold levels of participation in an Advanced APM for a year. These benefits include exemption from the MIPS reporting and payment adjustments, and a 5% lump sum APM incentive payment, if CMS determines the clinician is a Qualifying APM Participant (QP) in any one of three determinations conducted throughout a performance year. A clinician can become a QP by participating in an Advanced APM and reaching the thresholds for sufficient Medicare Part B payments or Medicare patients through the Advanced APM.
  - Should know that eligible clinicians participating in Advanced APMs who do not meet the threshold to be QPs may qualify as a Partial Qualifying APM Participant (Partial QP) if they meet certain minimum thresholds of Medicare Part B payments or Medicare patients through the Advanced APM. Partial QPs can elect to report to MIPS and be subject to MIPS payment adjustments, or not to report to MIPS, and be excluded from MIPS payment adjustments.
  - Should know that MIPS eligible clinicians participating in Advanced APMs who do not meet the threshold to be QPs or Partial QPs will be subject to MIPS. However, they may receive special MIPS scoring considerations.
  - Should consider the impact under the Quality Payment Program if the clinician wants to exit the Advanced APM during the year, as exiting early could nullify these benefits.

If your TIN would like to report MIPS data as a group, the group will get one MIPS final score based on the group's performance. You should plan your participation and let the eligible clinicians assigned to your TIN know what they need to do for your group to successfully participate in MIPS. If you participate as a group, you'll be assessed as a group across all MIPS performance categories.

Get help & more information

Attachment B has further guidance, including helpful questions and answers about the Quality Payment Program. If you need more help, you can also:

- **Visit** qpp.cms.gov for helpful resources or
- **Contact the** Quality Payment Program at QPP@cms.hhs.gov or **1-866-288-8292** (Monday-Friday 8AM-8PM ET) to find local help in your community. **TTY** users can call **1-877-715-6222**.

SAMPLE

SAMPLE

Getting Started: Clinician Participation Letter

Attachment A: What is this?

- Explains who is included in MIPS and should actively participate.
  - Identifies included vs. exempt status.
- Lists the NPIs associated with the TIN.
- Provides contact information to the Quality Payment Program for direct support.

Attachment A: Who's included and should actively participate in MIPS to avoid a penalty and possibly earn a positive adjustment

<TIN> Reference # QPP201701

<PROVIDER NAME> <DATE>

<PROVIDER ADDRESS>

Below is a list of the clinician(s) associated with your TIN, their National Provider Identifier(s) (NPI), and whether they are subject to the Merit-Based Incentive Payment System (MIPS).

Inclusion in MIPS is based on a number of factors, including whether the group or the individual clinician exceeds the low volume threshold criteria. Under this criteria, you will be exempt from MIPS if you bill Medicare less than $30,000 a year or provide care for less than 100 Medicare patients a year.

Note, however, that if your group chooses to report as a group, MIPS assessment will be based on all individuals in the group, and the payment adjustment will include those clinicians who do not exceed the low-volume threshold as individuals.

If you are currently subject to MIPS, please prepare to participate in the program; we will notify you of any changes in your participation status.

This information should be shared with the clinicians associated with your TIN. If you have questions, please call the Quality Payment Program at 1-866-288-8292 (Monday-Friday 8AM-8PM ET). TTY users can call 1-877-715-6222.

TIN	NPI	MIPS Participation
*********		Included in MIPS; OR
		Your group fell below threshold for Medicare Part B payments or patients
	##########	Included in MIPS
	##########	Exempt from MIPS. Below threshold for Medicare Part B payments or patients, unless participating as a Group.
	##########	Exempt from MIPS. Not an eligible provider type.

Please note, clinicians who practice under multiple TINs will be notified at the TIN level of their eligibility and therefore may have different eligibilities for each of their TIN/practice combinations.

SAMPLE

Eligibility for Clinicians in Specific Facilities

- Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC)
  - Eligible clinicians billing under the RHC or FQHC payment methodologies **are not** subject to the MIPS payment adjustment.

  However…

  - Eligible clinicians in a RHC or FQHC billing under the Physician Fee Schedule (PFS) **are** required to participate in MIPS and are subject to a payment adjustment.

Eligibility for Clinicians in Specific Facilities

- Critical Access Hospitals (CAH)

1 For eligible clinicians practicing in Method I:

- MIPS payment adjustment would apply to payments made for items and services that are Medicare Part B charges billed by the MIPS eligible clinicians.
- Payment adjustment would not apply to the facility payment to the CAH itself.

2 For eligible clinicians practicing in Method II (who assigned their billing rights to the CAH):

- MIPS payment adjustment would apply to the Method II CAH payments

For eligible clinicians practicing in Method II (who have not assigned their billing rights to the CAH):

- MIPS payment adjustment would apply similar to Method I CAHs.

Eligibility for Non-Patient Facing Clinicians

- Non-patient facing clinicians are eligible to participate in MIPS as long as they exceed the low-volume threshold, are not newly enrolled, and are not a Qualifying APM Participant (QP) or Partial QP that elects not to report data to MIPS
- The non-patient facing MIPS-eligible clinician threshold for individual MIPS-eligible clinicians is ≤ 100 patient facing encounters in a designated period
- A group is non-patient facing if > 75% of NPIs billing under the group's TIN during a performance period are labeled as non-patient facing
- There are more flexible reporting requirements for non-patient facing clinicians

Decide on your track

Clinicians have two tracks from which to choose:

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 Alternative Payment Models (APMs)

If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.

Merit-based Incentive Payment System

Performance Categories

Quality

Cost

Improvement Activities

Advancing Care Information

- Comprised of four performance categories
- Provides clinicians with flexibility to choose the activities and measures that are most meaningful to their practice

Consideration: may report as an individual or group

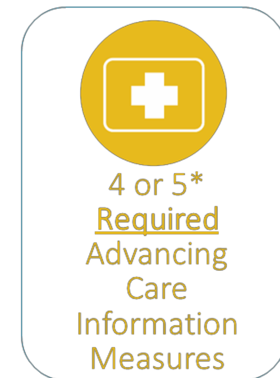
MIPS: Choosing to Test for 2017

- Submit **minimum** amount of 2017 data to Medicare
- **Avoid** a downward adjustment
- Gain familiarity with the program

Minimum Amount of Data

OR

OR

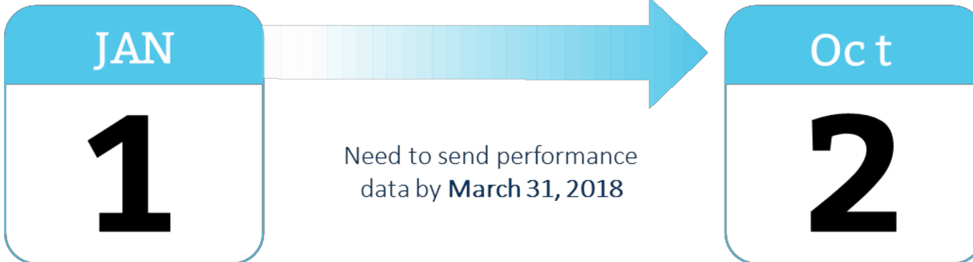


MIPS: Partial Participation for 2017

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



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

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.**

Submission Methods

	Individual	Group
Quality	• Qualified Clinical Data Registry (QCDR) • Qualified Registry • EHR • Claims	• QCDR • Qualified Registry • EHR • Administrative Claims • CMS Web Interface • CAHPS for MIPS Survey
Improvement Activities	• QCDR • Qualified Registry • EHR • Attestation	• QCDR • Qualified Registry • EHR • CMS Web Interface • Attestation
Advancing Care Information	• QCDR • Qualified Registry • EHR • Attestation	• QCDR • Qualified Registry • EHR • Attestation • CMS Web Interface

*Must be reported via a CMS approved survey vendor together with another submission method for all other Quality measures.

MIPS Performance Category: Quality

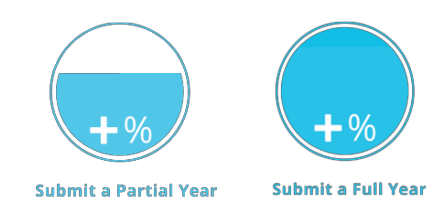
- 60% of Final Score in 2017
- 270+ measures available
  - You **select 6** individual measures
    - 1 must be an **Outcome** measure
      OR
    - **High-priority** measure
      - Defined as outcome measures, appropriate use measure, patient experience, patient safety, efficiency measures, or care coordination.
  - You may also select specialty-specific set of measures
- *Keep in mind:*

Replaces PQRS and Quality portion of the Value Modifier

Provides for an easier transition for those who have reporting experience due to familiarity

Quality: Requirements for the Transition Year

- Test means:
  - Submitting 1 Quality measure



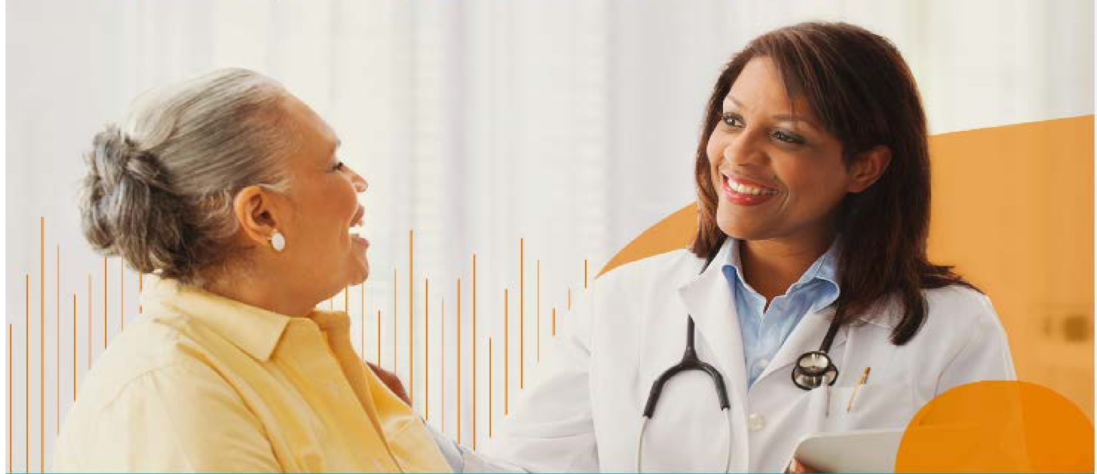
- Partial and Full means:
  - Submitting at least 6 quality measures, including 1 Outcome or 1 High-Priority measure
    - 90 days for Partial Year
    - 1 year for Full Year

For a full list of measures, please visit QPP.CMS.GOV

Quality Payment
PROGRAM

Help

Menu

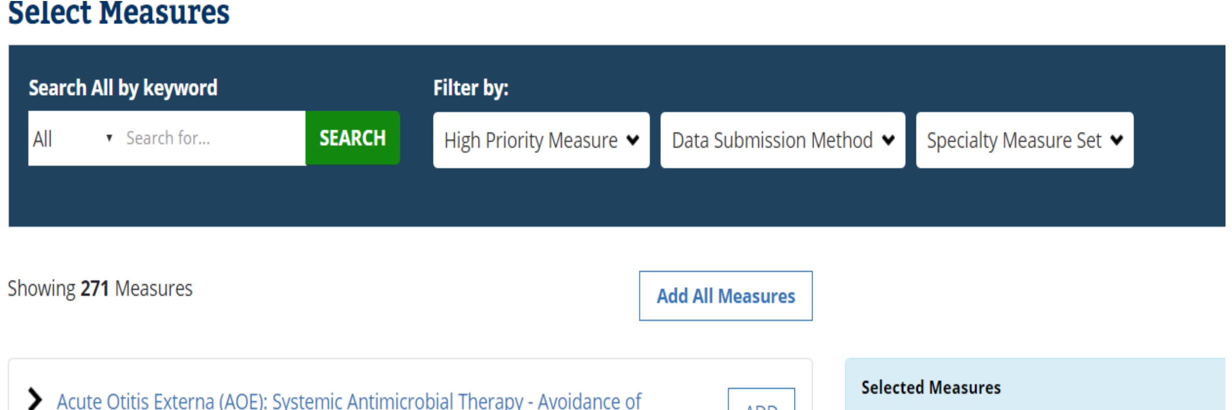


Check your participation status

Enter your National Provider Identifier (NPI) number

NPI Number

Check NPI



Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy - Avoidance of Inappropriate Use ADD

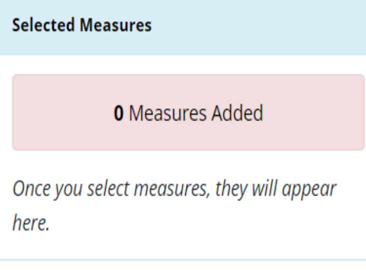
Acute Otitis Externa (AOE): Topical Therapy ADD

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

Adherence to Antipsychotic Medications For Individuals with Schizophrenia ADD

Adult Kidney Disease: Blood Pressure Management ADD

Adult Kidney Disease: Catheter Use at Initiation of Hemodialysis ADD

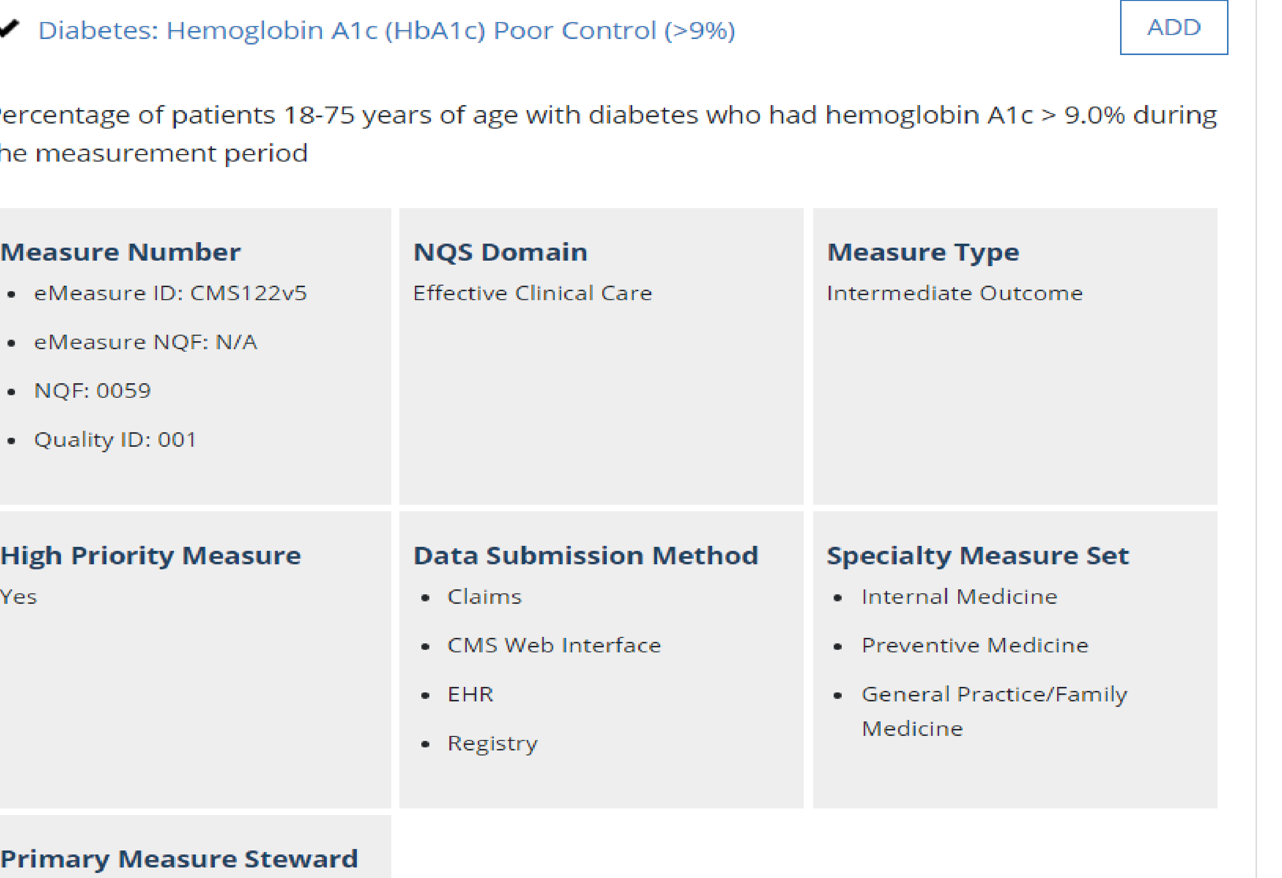


Disclaimer

*MIPS eligible clinicians or groups are expected to report on applicable measures. "Applicable" is defined as measures relevant to a particular MIPS eligible clinician's services or care rendered. MIPS eligible clinicians can refer to the measures specifications to verify which measures are applicable. Not all measures in each Specialty Measure Set will be applicable to all clinicians in a given specialty. If the set includes less than six applicable measures, the eligible clinician should only report the measures that are applicable.

Specialty Measure Set

- Allergy/Immunology
- Anesthesiology
- Cardiology
- Dermatology
- Diagnostic Radiology
- Electrophysiology Cardiac Specialist
- Emergency Medicine
- Gastroenterology
- General Oncology
- General Practice/Family Medicine
- General Surgery
- Hospitalists
- Internal Medicine
- Interventional Radiology
- Mental/Behavioral Health
- Neurology
- Obstetrics/Gynecology
- Ophthalmology
- Orthopedic Surgery
- Otolaryngology
- Pathology
- Pediatrics
- Physical Medicine
- Plastic Surgery
- Preventive Medicine
- Radiation Oncology
- Rheumatology
- Thoracic Surgery
- Urology
- Vascular Surgery



Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)

ADD

Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period

Measure Number

- eMeasure ID: CMS122v5
- eMeasure NQF: N/A
- NQF: 0059
- Quality ID: 001

NQS Domain

Effective Clinical Care

Measure Type

Intermediate Outcome

High Priority Measure

Yes

Data Submission Method

- Claims
- CMS Web Interface
- EHR
- Registry

Specialty Measure Set

- Internal Medicine
- Preventive Medicine
- General Practice/Family Medicine

Primary Measure Steward

National Committee for Quality Assurance

MIPS Performance Category: Improvement Activities

- 15% of Final Score in 2017
- 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

Engagement of new Medicaid patients and follow-up

ADD

Seeing new and follow-up Medicaid patients in a timely manner, including individuals dually eligible for Medicaid and Medicare.

Activity ID	Subcategory Name	Activity Weighting
IA_AHE_1	Achieving Health Equity	High

Improvement Activity: Requirements for the Transition Year

Submit Something

Test means:

- Attesting to 1 Improvement Activity
  - Activity can be high or medium weight
  - In most cases, to attest you need to indicate that you have done the activity for **90 days**.

Submit a Partial Year

Submit a Full Year

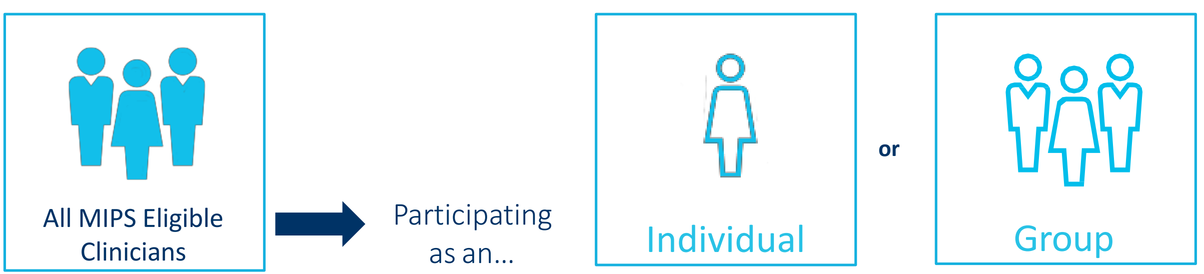
Partial and Full means:

- Attesting to 1 of the following combinations:
  - 2 high-weighted activities
  - 1 high-weighted activity and 2 medium-weighted activities
  - At least 4 medium-weighted activities
- Clinicians with **special considerations**:
  - 1 high-weighted activity
  - 2 medium-weighted activities

For a full list of activities, please visit QPP.CMS.GOV

Advancing Care Information

Who can participate?



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

- 25% of Final Score in 2017
- 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 to choose from based on EHR* edition:

Advancing Care Information Objectives and Measures

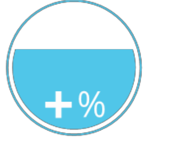
2017 Advancing Care Information Transition Objectives and Measures

Advancing Care Information: Requirements for the Transition Year

Submit Something

Test 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 means:

- Submitting more than the base score in the Transition Year

For a full list of measures, please visit QPP.CMS.GOV

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

Failure to meet reporting requirements will result in base score of zero, and an Advancing Care Information performance score of zero.

MIPS Performance Category: Advancing Care Information-how to fulfill the base score

Advancing Care Information Objectives and Measures:

Base Score Required Measures

Measure	Result
Security Risk Analysis	yes
e-Prescribing	1 patient
Provide Patient Access	1 patient
Send a Summary of Care	1 patient
Request/Accept a Summary of Care	1 patient

2017 Advancing Care Information Transition Objectives and Measures:

Base Score Required Measures

Measure	Result
Security Risk Analysis	yes
e-Prescribing	1 patient
Provide Patient Access	1 patient
Health Information Exchange	1 patient

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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

***Performance Score:** Additional achievement on measures above the base score requirements

Advancing Care

Clinical Information Reconciliation

ADD

For at least one transition of care or referral received or patient encounter in which the MIPS eligible clinician has never before encountered the patient, the MIPS eligible clinician performs clinical information reconciliation. The MIPS eligible clinician must implement clinical information reconciliation for the following three clinical information sets: (1) Medication. Review of the patient's medication, including the name, dosage, frequency, and route of each medication. (2) Medication allergy. Review of the patient's known medication allergies. (3) Current Problem list. Review of the patient's current and active diagnoses.

Measure ID
ACI_HIE_3

Objective Name
Health Information Exchange

Required for Base Score
No

Performance Score Weight
Up to 10%

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

for using CEHRT to report certain Improvement Activities

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Improvement Activities Eligible for ACI Bonus Score

Improvement Activity Performance Category Subcategory	Activity Name	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

Advancing Care Information: Flexibility

1

CMS will automatically **reweight** the Advancing Care Information performance category to zero for Hospital-based MIPS clinicians, clinicians who 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

A clinician can **apply** to have their performance category score **weighted to zero** and the **25%** will be **assigned to the Quality category** for the following reasons:

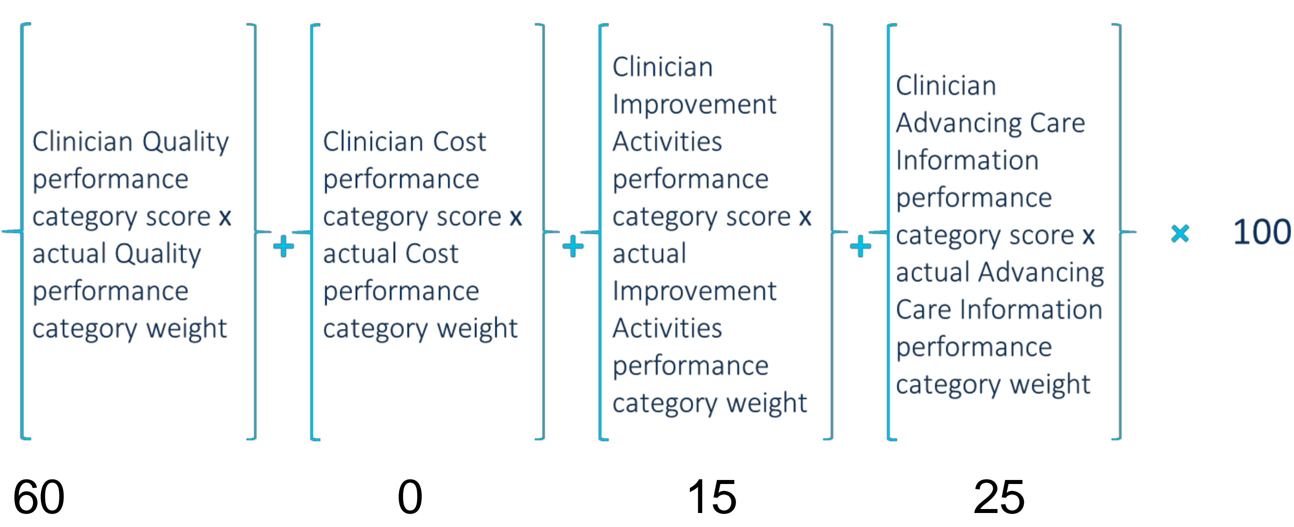
1. Insufficient internet connectivity
2. Extreme and uncontrollable circumstances
3. Lack of control over the availability of CEHRT

Advancing Care Information: Flexibility

- Hospital-based MIPS clinicians qualify for an automatic reweighting of the Advancing Care Information Performance category.
  - 75% or more of Medicare services performed in the inpatient, on campus outpatient department or emergency department
- CMS will reweight the category to zero and assign the 25% to the quality performance category.
- If data is submitted, CMS will score their performance and weight their Advancing Care Information performance accordingly.

CMS

Calculating the Final Score Under MIPS



Transition Year 2017

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

Small and Rural Providers Participating in MIPS: A Checklist

- ❑ Determine your eligibility and understand the requirements.
- ❑ Choose whether you want to submit data as an individual or as a part of a group.
- ❑ Choose your submission method and verify its capabilities.
- ❑ Verify your EHR vendor or registry's capabilities before your chosen reporting period.
- ❑ Prepare to participate by reviewing practice readiness, ability to report, and the Pick Your Pace options.
- ❑ Choose your measures. Visit **qpp.cms.gov** for valuable resources on measure selection and remember to review your current billing codes and Quality Resource Use Report to help identify measures that best suit your practice.
- ❑ Verify the information you need to report successfully.
- ❑ Care for your patients and record the data.
- ❑ Submit your data by March 2018.

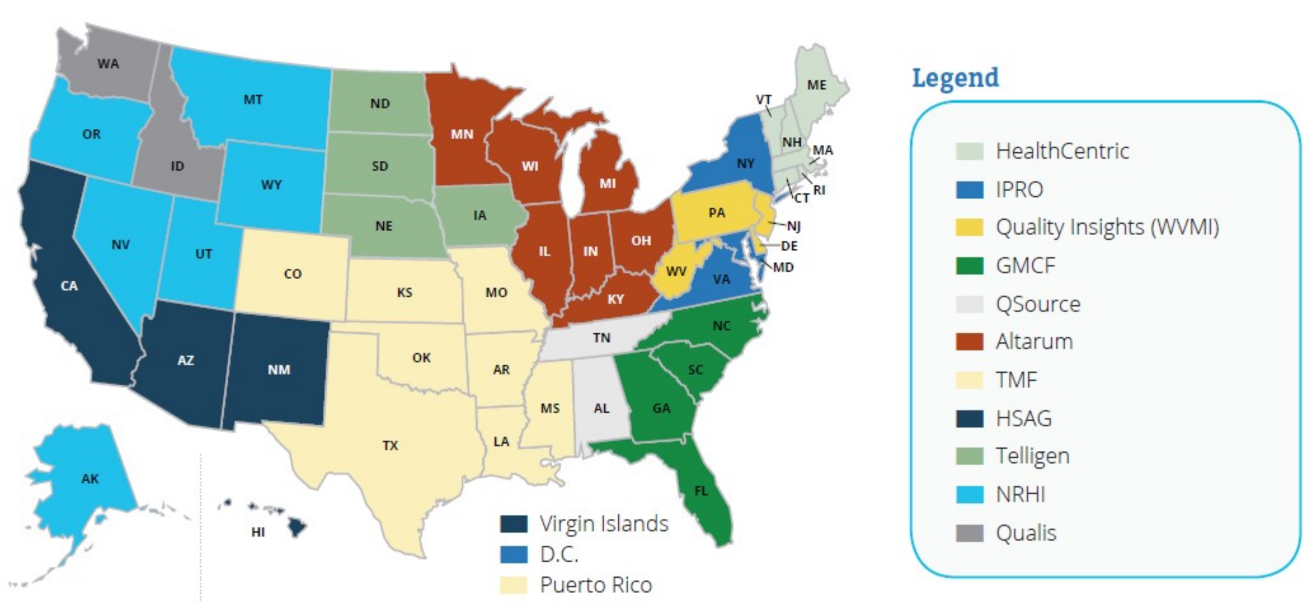
Virtual Groups

Requirements:

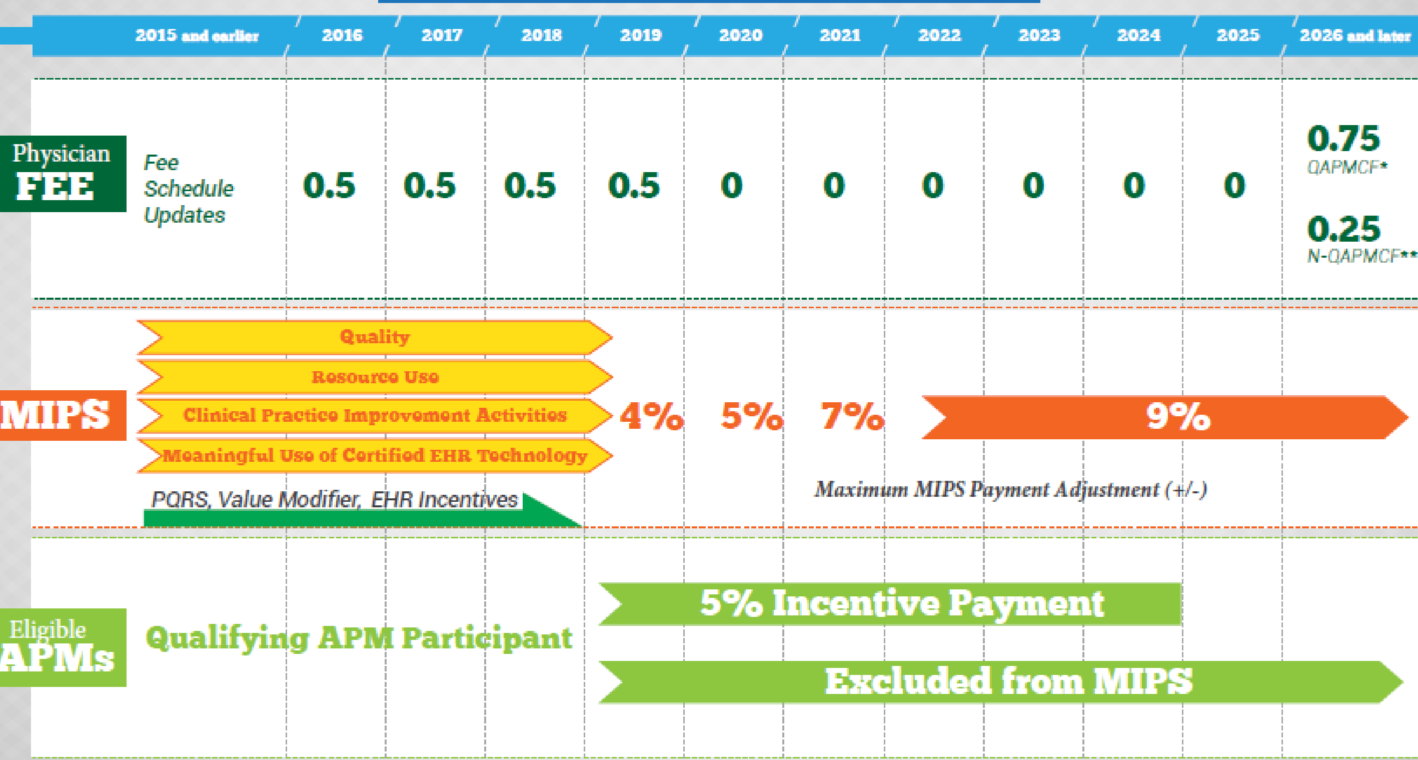
- Eligible clinicians and groups must elect to participate prior to the performance year and may be not be changed during the performance period.
- If a group practice elects to join a Virtual Group, all group practice members must be included in the Virtual Group. A group can only be in ONE virtual group.
- A Virtual Group must be comprised of a combination of TINs.
- CMS must provide for formal written agreements between clinicians entering into a Virtual Group.
- Other requirements as the Secretary determines appropriate.

National Coverage of Technical Assistance for Small, Underserved and Rural Clinicians

11 uniquely experienced organizations to provide national coverage to eligible clinicians in small practices.



Timeline

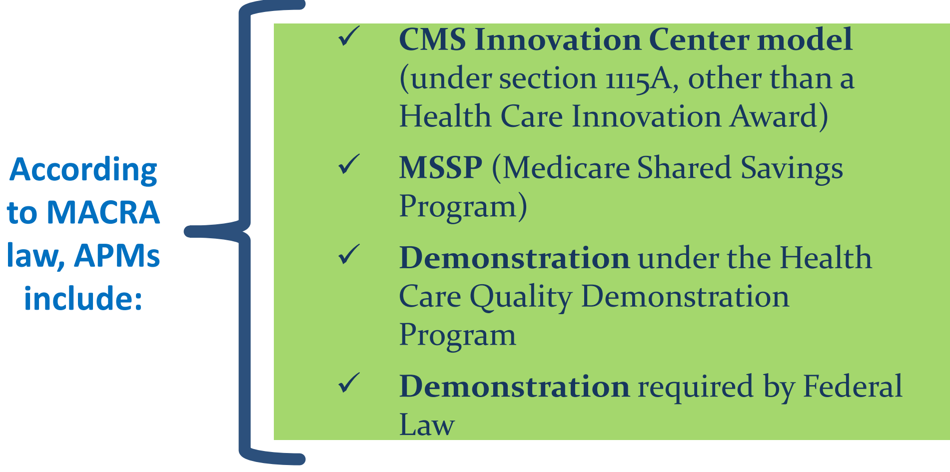


*Qualifying APM conversion factor

**Non-qualifying APM conversion factor

Alternative Payment Models (APMs)

APMs are **new approaches to paying** for medical care through Medicare that **incentivize quality and value.**



- MACRA **does not change how any particular APM rewards value**.
- APM participants who are not "QPs" will receive **favorable scoring under MIPS**.
- Only **some** of these APMs will be **eligible or advanced** APMs.

What are MIPS APMs?

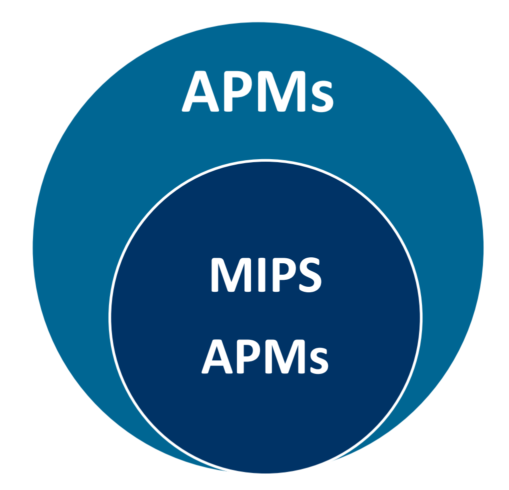
Goals

- Reduce eligible clinician reporting burden.
- Maintain focus on the goals and objectives of APMs.

How does it work?

- Streamlined MIPS reporting and scoring for eligible clinicians in certain APMs.
- Aggregates eligible clinician MIPS scores to the APM Entity level.
- All eligible clinicians in an APM Entity receive the same MIPS final score.
- Uses APM-related performance to the extent practicable.

MIPS APMs are a Subset of APMs



What are the Requirements to be Considered a MIPS APM?

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

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

What are key dates for the APM scoring standard?

- To be considered part of the APM Entity for the APM scoring standard, an eligible clinician must be on an APM Participation List on at least one of the following three snapshot dates (March 31, June 30 or August 31) of the performance period.
- Otherwise an eligible clinician must report to MIPS under the standard MIPS methods.

MAR 31

JUN 30

AUG 31

Participation in MIPS APMs

You Have Asked: *"How does the low-volume threshold apply to MIPS clinicians in MIPS APMs?"*

- Similar to the low-volume threshold at the group level.
- Applies to MIPS eligible clinician types practicing as a part of an APM Entity group in a MIPS APM.
- Will be calculated by CMS for the APM Entity group as a collective whole.

Scenarios:

✓ The APM Entity group is required to participate in MIPS if it **exceeds** the low-volume threshold.

× The APM Entity group is exempt from MIPS if it **does not exceed** the low-volume threshold.

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

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

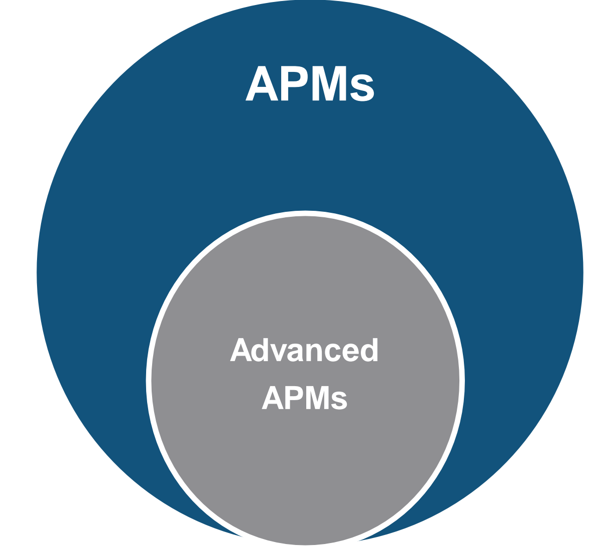
- Comprehensive ESRD Care (CEC) Model (All Arrangements)
- Comprehensive Primary Care Plus (CPC+) Model
- Shared Savings Program Tracks 1, 2, and 3
- Next Generation ACO Model
- Oncology Care Model (OCM) (All Arrangements)

The list of MIPS APMs is posted at QPP.CMS.GOV and will be updated on an ad hoc basis.

Alternative Payment Models

- An Alternative Payment Model (APM) is a payment approach, developed in partnership with the clinician community, that provides added incentives to clinicians to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.
- APMs may offer significant opportunities to eligible clinicians who are not immediately able or prepared to take on the additional risk and requirements of Advanced APMs.

Advanced APMs are a Subset of APMs



Advanced APMs Must Meet Certain Criteria

To be an Advanced APM, the following three requirements must be met.

The APM:

1 Requires participants to use **certified EHR technology**;

2 Provides payment for covered professional services based on **quality measures** comparable to those used in the MIPS quality performance category; and

3 **Either**: (1) is a **Medical Home Model expanded** under CMS Innovation Center authority OR (2) requires **participants to bear a more than nominal amount of financial risk.**

Medicaid Medical Home Model

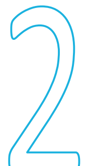
- Planned coordination of chronic and preventive care.
- Patient access and continuity of care.
- Risk-stratified care management.
- Coordination of care across the medical neighborhood.
- Patient and caregiver engagement.
- Shared decision-making.
- Payment arrangements in addition to, or substituting for, fee-for-service payments.

How do Clinicians become Qualifying APM Participants?—Step 1

1

- ✓ Qualifying APM Participant determinations are made at the Advanced APM Entity level, with certain exceptions:
  - ✓ Individuals participating in multiple Advanced APM Entities, none of which meet the QP threshold as a group, and
  - ✓ Clinicians on an Affiliated Practitioner List when that list is used for the QP determination because there are no clinicians on a Participation List for the Advanced APM Entity. For example, gain sharers in the Comprehensive Care for Joint Replacement Model (Track 1-CEHRT) will be assessed individually.

How do Clinicians become Qualifying APM Participants?—Step 2



✓ The two methods for calculation are Payment Amount Method and Patient Count Method.

Payment Amount Method

$$\frac{\text{\$\$\$ for Part B professional services to attributed beneficiaries}}{\text{\$\$\$ for Part B professional services to attribution-eligible beneficiaries}} = \text{Threshold Score \%}$$

Patient Count Method

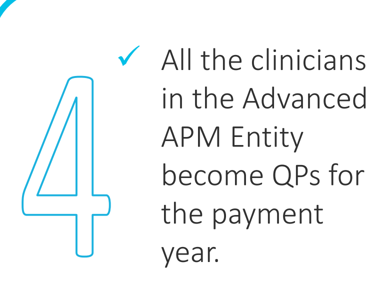
$$\frac{\text{\# of attributed beneficiaries given Part B professional services}}{\text{\# of attribution-eligible beneficiaries given Part B professional services}} =$$

How do Eligible Clinicians become Qualifying APM Participants?

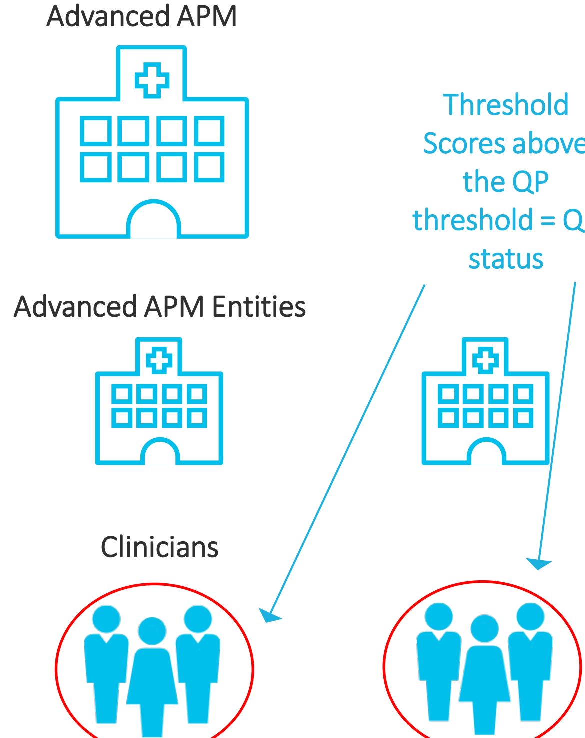
✓ The Threshold Score for each method is compared to the corresponding QP threshold table and CMS takes the better result.

Requirements for Incentive Payments for Significant Participation in Advanced APMs (Clinicians must meet payment or patient requirements)						
Performance Year	2017	2018	2019	2020	2021	2022 and later
Percentage of Payments through an Advanced APM	25%	25%	50%	50%	75%	75%
Percentage of Patients through an Advanced APM	20%	20%	35%	35%	50%	50%

How do Clinicians become Qualifying APM Participants?—Step 4



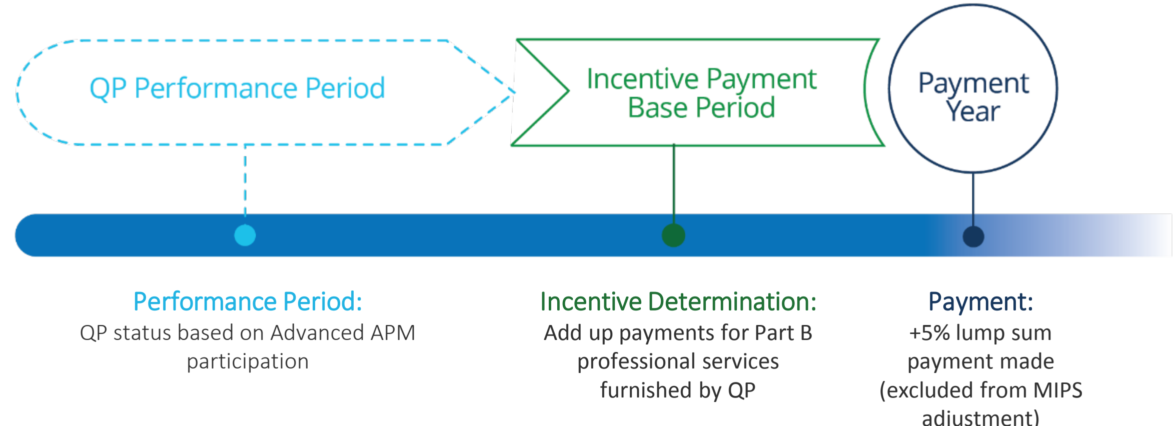
✓ All the clinicians in the Advanced APM Entity become QPs for the payment year.



Threshold Scores below the QP threshold = no QPs

What is the Performance Period for QPs?

- The QP Performance Period is the period during which CMS will assess eligible clinicians' participation in Advanced APMs to determine if they will be QPs for the payment year.
- The QP Performance Period for each payment year will be from **January 1—August 31st** of the calendar year that is **two years prior** to the **payment year**.



What are the three "Snapshots" for QPs during the Performance Period?

- During the QP Performance Period (January—August), CMS will take three "snapshots" (March 31, June 30, August 31) to determine which eligible clinicians are participating in an Advanced APM and whether they meet the thresholds to become Qualifying APM Participants.

MAR 31

JUN 30

AUG 31

What if Clinicians do not meet the QP Payment or Patient Thresholds?

- Clinicians who participate in Advanced APMs, but do not meet the QP threshold, may become "Partial" Qualifying APM Participants (Partial QPs).
- Partial QPs choose whether to participate in MIPS.

Medicare-Only Partial QP Thresholds in Advanced APMs						
Payment Year	2019	2020	2021	2022	2023	2024 and later
Percentage of Payments	20%	20%	40%	40%	50%	50%
Percentage of Patients	10%	10%	25%	25%	35%	35%

Advanced Alternative Payment Models

Clinicians and practices can:

- Receive **greater rewards** for taking on some risk related to patient outcomes.

"So what?" - It is important to understand that the Quality Payment Program does not change the design of any particular APM. Instead, it creates **extra incentives** for a sufficient degree of participation in Advanced APMs.

Advanced APMs for 2017

- Comprehensive Care for Joint Replacement (CJR) Model – Track 1
- 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)
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)

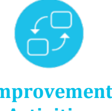
* More information at https://qpp.cms.gov

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

	REPORTING REQUIREMENT	PERFORMANCE SCORE	WEIGHT
Quality	✓ No additional reporting necessary. ACOs submit quality measures to the CMS Web Interface on behalf of their participating MIPS eligible clinicians.	✓ The MIPS quality performance category requirements and benchmarks will be used to score quality at the ACO level.	50%
Cost	✓ MIPS eligible clinicians will not be assessed on cost.	✓ N/A	0%
Improvement Activities	✓ No additional reporting necessary.	✓ CMS will assign a 100% score to each APM Entity group based on the activities required of participants in the Shared Savings Program.	20%
Advancing Care	✓ Each ACO participant TIN in the ACO submits under this category according to MIPS reporting requirements.	✓ All of the ACO participant TIN scores will be aggregated as a weighted average based on the number of MIPS eligible clinicians in each TIN to yield one APM Entity group score.	30%

CMS

Next Generation ACO Model under the APM Scoring Standard

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

All Other APMs under the APM Scoring Standard

	REPORTING REQUIREMENT	PERFORMANCE SCORE	WEIGHT
Quality	✓ The APM Entity group will not be assessed on quality under MIPS in the first performance period.	✓ N/A	0%
Cost	✓ MIPS eligible clinicians will not be assessed on cost.	✓ N/A	0%
Improvement Activities	✓ No additional reporting necessary.	✓ CMS will assign the same improvement activities score to each APM Entity group based on the activities required of participants in the MIPS APM.	25%
Advancing Care	✓ Each MIPS eligible clinician in the APM Entity group reports advancing care information to MIPS through either group reporting at the TIN level or individual reporting.	✓ CMS will attribute one score to each MIPS eligible clinician in the APM Entity group. This score will be the highest score attributable to the TIN/NPI combination of each MIPS eligible clinician, which may be derived from either group or individual reporting. The scores attributed to each MIPS eligible clinician will be averaged to yield a single APM Entity group score.	75%

The Quality Payment Program provides **additional** rewards for participating in APMs.

Potential financial rewards

Not in APM	In APM	In Advanced APM
MIPS adjustments	MIPS adjustments	
	+ APM-specific rewards	APM-specific rewards
	If you are a Qualifying APM Participant (QP) =	+ 5% lump sum bonus

Technical Assistance for Clinicians

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.
- Contact TCPI.ISC@TruvenHealth.com for extra assistance.

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

SMALL & SOLO PRACTICES

Small, Underserved, and Rural Support (SURS)

- 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 early 2017.

LARGE PRACTICES

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

- 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

Center for Medicare & Medicaid Innovation (CMMI) Learning Systems
Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs.

Questions

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