YEAR 2 (2018)

Quality Payment Program

Richard E. Wild, MD, JD, MBA, Chief Medical Officer
CMS Atlanta Region IV
MIPS QPP Summit
January 25, 2018
Atlanta, GA
Disclaimers

This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.

This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference.

The Centers for Medicare & Medicaid Services (CMS) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide.
Quality Payment Program

Topics

- 2017 QPP Data Submission
- Quality Payment Program Overview
- Final Rule Year 2 (Performance Year 2018)
  - 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
  - Alternative Payment Models (APMs)
    - Advanced APMs
    - All-Payer Combination Option & Other Payer Advanced APMs
    - APM Scoring Standard
- Resources
- Questions & Answers
Navigate to the Quality Payment Program

- Visit qpp.cms.gov and look for the login icon at the top of the screen.
Clinicians who may be included in MIPS should check their National Provider Identifier (NPI) in the MIPS Participation Status Tool (https://qpp.cms.gov/participation-lookup), which has been updated with the most recent eligibility data, to confirm whether they are required to submit data under MIPS for 2017.
MIPS Participation Status

To check if you need to submit data to MIPS, enter your 10-digit National Provider Identifier (NPI) number.

Final MIPS eligibility status has been determined for the 2017 Performance Period. If you’re exempt from MIPS, you won’t need to do anything else for MIPS for the 2017 Performance Period. Learn more about MIPS eligibility.

NATIONAL PROVIDER IDENTIFIER (NPI)

Check Now

The MIPS Participation Status Tool does not reflect your participation in an APM. If you are a participant in an APM, which includes Track 1 of the Medicare Shared Savings Program, information regarding your participation status is available in the APM Lookup Tool.

To the extent there is a conflict between the MIPS Participation Status Tool and the APM Lookup Tool, the results of the APM Lookup tool replaces the results of the MIPS Participation Lookup Tool.
Quality Payment Program resource library

In this resource library, you'll find links to official information to help you get ready for the Quality Payment Program. To make it easier for you to search and find what you're looking for by topic, year, or title, we've moved the resource library from QPP.CMS.gov. You can find out about new QPP resources by subscribing to email updates.

Quality Payment Program final rule with comment

We've been listening to stakeholder feedback and have used it to finalize policies for Year 2 of the Quality Payment Program. In Year 2, we're keeping many of the flexibilities from the transition year and making modest changes to help you get ready for full implementation in Year 3.

Learn more about the final rule with comment and the interim final rule with comment and what it means for you:

- Year 2 Overview fact sheet 11/2/2017
- Final rule executive summary 11/2/2017
- 2017 Extreme & Uncontrollable Circumstances Policy for MIPS fact sheet (interim final rule with comment fact sheet) 12/14/2017

Find 2017 resources by provider type or topic
Find 2018 resources by provider type or topic
Find resources for all years by provider type
Find resources for all years by topic
The following counties in Texas: Aransas; Austin; Bastrop; Bee; Bexar; Brazoria; Burleson; Caldwell; Calhoun; Chambers; Colorado; Comal; Dallas; Dewitt; Fayette; Fort Bend; Galveston; Goliad; Gonzales; Grimes; Guadalupe; Hardin; Harris; Jackson; Jasper; Jefferson; Jim Wells; Karnes; Kleberg; Lavaca; Lee; Liberty; Madison; Matagorda; Milam; Montgomery; Newton; Nueces; Orange; Polk; Refugio; Sabine; San Augustine; San Jacinto; San Patricio; Tarrant; Travis; Tyler; Victoria; Walker; Waller; Washington; and Wharton.
Extreme and uncontrollable circumstances

Additional Changes for Year 2

• How do I know if I’m in a hurricane-impacted area?

  • You can find the hurricane-impacted areas on our Emergency Response and Recovery page.

  • What areas impacted by the hurricanes are included in the interim final rule with comment period?

    • Hurricanes Harvey, Irma, Maria, and Nate qualify as a “triggering event” for the automatic policy covering extreme and uncontrollable circumstances. A list of impacted areas can be found on CMS’ Emergency Response and Recovery page and include:

      • All 67 counties in Florida
      • All 159 counties in Georgia
      • All of Puerto Rico and US Virgin Islands
      • Certain counties in SC, AL, MS, LA, TX (see CMS’ Emergency Response and Recovery page )
• Under this policy, if you’re located in Federal Emergency Management Agency (FEMA) designated areas affected by Hurricanes Harvey, Irma, Maria, or Nate or the California Wildfires, we’ve tried to lessen your burden by not requiring you to submit an application to reweight the performance categories. We’ll be able to automatically identify you. If you’re an affected MIPS eligible clinician, you’ll automatically receive a neutral MIPS payment adjustment, unless you submit data for any of the MIPS performance categories by the submission deadline for 2017, in which case you will be scored on each performance category for which you submit data, according to existing MIPS scoring policies. This automatic extreme and uncontrollable circumstances policy only applies to you if you’re an individual MIPS eligible clinician in an affected area based on information in the Provider Enrollment, Chain and Ownership System (PECOS).

• APM Entities Scored under MIPS Scoring Standard

• The Extreme and Uncontrollable Circumstances policy does not apply to MIPS eligible clinicians in MIPS Alternative Payment Models (MIPS APMs) in 2017. This is because under the APM scoring standard in the first year of MIPS, an APM entity would normally receive a score that is at least equal to or higher than the performance threshold......
Extreme and uncontrollable circumstances
Additional Changes for Year 2

• What do extreme and uncontrollable circumstances mean for the MIPS Transition Year scoring?

• We’ll assign a weight of 0% in the MIPS final score for each performance category where you don’t submit data by the applicable deadline.

• If you don’t submit any data, you won’t have a negative MIPS payment adjustment for the 2019 MIPS payment year. If you have fewer than 2 performance category scores, you’ll receive a final score that’s equal to the performance threshold and a neutral MIPS payment adjustment.

• If you’re eligible for reweighting due to extreme and uncontrollable circumstances but still choose to report on two or more performance categories (either as an individual or group), you’ll be scored on those performance categories and your MIPS payment adjustment will be based on your final score.
Extreme and uncontrollable circumstances

Where Can I Learn More?

• Quality Payment Program; www.qpp.cms.gov

• 2018 Quality Payment Program final rule with comment and extreme and uncontrollable circumstance policy for the Transition Year

• FEMA designated disaster areas

• CMS’ Emergency Response and Recovery

• CMS 2017 California Wildfires guidance

You can also contact us at 1-866-288-8292 (TTY 1-877- 715-6222), Monday through Friday, 8:00 AM-8:00 PM ET or by email at: QPP@cms.hhs.gov.
Navigate to the Quality Payment Program

- Visit qpp.cms.gov and look for the login icon at the top of the screen.
To Sign-in and Submit...

• You need to use your Enterprise Identity Management (EIDM) credentials, and you must have an appropriate user role associated with your organization.

• You may have used these credentials in the past to login to the CMS Enterprise Portal and/or to submit data to the Physician Quality Reporting System (PQRS).
To Sign-in and Submit...

- If you’ve been submitting data under the some of the previous legacy programs (for example, PQRS), your user accounts will be the same in the Quality Payment Program.

- If you need to set up an EIDM account, get EIDM account information, or reset your password on an existing EIDM account contact the Quality Payment Program at 1-866-288-8292. You can also use our EIDM Guide to get started.

- To sign into qpp.cms.gov to submit data, you need to use your EIDM credentials, and you must have an appropriate user role associated with your organization.
CMS also has several self-paced training videos available to help you get started:

• Merit-based Incentive Payment System (MIPS) Data Submission

• Advancing Care Information (ACI) Data Submission for Alternative Payment Models (APMs)

• Data Submission via a Qualified Clinical Data Registry and Qualified Registry
To make it easier for clinicians to search and find information on the Quality Payment Program, CMS has moved its library of QPP resources to CMS.gov.

QPP.CMS.GOV redirects to the CMS.GOV Resource Library:

- Final Rule Materials Posted: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html
Find resources by provider type

- MIPS Measures for Anesthesiologists & Certified Registered Nurse Anesthetists 9/7/2017
- MIPS Measures for Cardiologists 6/15/2017
- MIPS Measures for Emergency Medicine Clinicians 9/7/2017
- MIPS Measures for Ophthalmologists 9/7/2017
- MIPS Measures for Orthopedists 9/7/2017
- MIPS Measures for Optometrists 11/17/2017
- MIPS Measures for Podiatrists 11/2017
- MIPS Measures for Primary Care Clinicians 6/15/2017
- MIPS Measures for Radiologists 11/2017

Find resources by topic

2017

General information

- Quality Payment Program Key Objectives 10/2017
- Enterprise Idenity Data Management (EIDM) User Guide 12/20/2017
- Enterprise Idenity Data Management (EIDM) ACO User Guide 12/22/2017
- Quality Payment Program frequently asked questions 11/16/2017

Data Submission

- Data submission fact sheet 1/2/2018

Data submission instructional videos:
- Merit-based Incentive Payment System (MIPS) data submission 1/2/2018
- Advancing Care Information (ACI) data submission for APMs 1/2/2018
- QCDRs and Qualified Registries data submission 1/2/2018

MIPS

- Overall
  - MIPS 101 Guide 11/2017
  - MIPS Data Validation Criteria 11/21/2017
  - MIPS Participation fact sheet 5/4/2017
  - MIPS Scoring Tool 11/11/2017
Data Submission Deadline

• You have until **March 31, 2018** to submit data for the 2017 transition year, except for CMS Web Interface users whose submission window is **January 22, 2018 to March 16, 2018**.

• We encourage you to **log-in early and often to familiarize yourself** with the system and to help you prepare your data for submission.

• You can **also submit your data as often as you like, which is another benefit to log-in early**. The system is designed to help you **identify underperforming measures or highlight issues with your data**. This will help to ensure that your data is complete and accurate in order **to receive the best final score** and payment adjustment.
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.*
Quality Payment Program
Considerations

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

Quick Tip: For additional information on the Quality Payment Program, please visit qpp.cms.gov.
MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)
Combined legacy programs into a single, improved program.

- Physician Quality Reporting System (PQRS)
- Value-Based Payment Modifier (VM)
- Medicare EHR Incentive Program (EHR) for Eligible Professionals

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

Quick Overview

MIPS Performance Categories for Year 2 (2018)

- 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.
MIPS YEAR 2 (2018)

Who is Included for Year 2?
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
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
  o With respect to certain specified treatment, a Doctor of Chiropractic legally authorized
to practice by a State in which he/she performs this function.
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**

BILLING >$30,000 AND >100

**Year 2 (2018) Final**

BILLING >$90,000 AND >200

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

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
MIPS Year 2 (2018)
Non-patient Facing

No Change in Non-Patient Facing Criteria

Transition Year 1 (2017) Final

• Individual – If you have <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.
  o Virtual Groups that have >75% of NPIs within a virtual group during a performance period are labeled as non-patient facing
### MIPS Year 2 (2018)

#### Other Special Statuses

<table>
<thead>
<tr>
<th>Special Status</th>
<th>Component</th>
<th>Year 2 (2018) Final</th>
<th>Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small Practice</td>
<td>Definition</td>
<td>• Practices consisting of 15 or fewer eligible clinicians.</td>
<td>• <strong>No change</strong> to the application of these special statuses from Year 1 to Year 2.</td>
</tr>
<tr>
<td>Rural and Health Professional Shortage Areas</td>
<td>Rural and HPSA practice designations</td>
<td>• An individual MIPS eligible clinician, a group, or a virtual group with multiple practices under its TIN (or TINs within a virtual group) with <strong>more than 75 percent</strong> 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.</td>
<td></td>
</tr>
</tbody>
</table>
MIPS YEAR 2 (2018)

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

Performance Period

**Change: Increase to Performance Period**

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Minimum Performance Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>90-days minimum; full year (12 months) was an option</td>
</tr>
<tr>
<td>Cost</td>
<td>Not included. 12-months for feedback only.</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>90-days</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>90-days</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Minimum Performance Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>12-months</td>
</tr>
<tr>
<td>Cost</td>
<td>12-months</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>90-days</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>90-days</td>
</tr>
</tbody>
</table>
MIPS Year 2 (2018)

Timeline for Year 2

- Performance period opens January 1, 2018.
- Closes December 31, 2018.
- Clinicians care for patients and record data during the year.

2018 Performance Year

- Deadline for submitting data is March 31, 2019.
- Clinicians are encouraged to submit data early.

March 31, 2019 Data Submission

- CMS provides performance feedback after the data is submitted.
- Clinicians will receive feedback before the start of the payment year.

Feedback

January 1, 2020 Payment Adjustment

- MIPS payment adjustments are prospectively applied to each claim beginning January 1, 2020.

Adjustment
MIPS YEAR 2 (2018)

Reporting and Data Submission Options
MIPS Year 2 (2018)

Reporting Options

**OPTIONS**

1. **Individual**
   - under an National Provider Identifier (NPI) number and Taxpayer Identification Number (TIN) where they reassigned benefits

2. **As a Group**
   - a) 2 or more clinicians (NPIs) who have reassigned their billing rights to a single TIN*
   - b) As an APM Entity

3. **Virtual Group**
   - made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together “virtually” (no matter what specialty or location) to participate in MIPS for a performance period for a year

---

* If clinicians participate as a group, they are assessed as a group across all 4 MIPS performance categories. The same is true for clinicians participating as a Virtual Group.
How do I make an election?

- Each virtual group has to:
  1. Have a **written formal agreement** between each of the virtual group members before election.
  2. Name an **official representative** who e-mails the group’s election to MIPS_VirtualGroups@cms.hhs.gov.
  3. Each virtual group’s official representative must e-mail the group’s election by **December 31, 2017**.
  4. Virtual group elections have to include at least the information about each TIN and NPI associated with the virtual group and the virtual group representative’s contact information. The virtual group representative would need to acknowledge that a written formal agreement has been established between each member of the virtual group prior to election.

- To learn more, see the [2018 Virtual Groups Toolkit](#).
**MIPS Year 2 (2018)**

**Submission Mechanisms**

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

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Submission Mechanisms for Individuals</th>
<th>Submission Mechanisms for Groups (Including Virtual Groups)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>QCDR Qualified Registry EHR Claims</td>
<td>QCDR Qualified Registry EHR CMS Web Interface (groups of 25 or more)</td>
</tr>
<tr>
<td>Cost</td>
<td>Administrative claims (no submission required)</td>
<td>Administrative claims (no submission required)</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>Attestation QCDR Qualified Registry EHR</td>
<td>Attestation QCDR Qualified Registry EHR CMS Web Interface (groups of 25 or more)</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>Attestation QCDR Qualified Registry EHR</td>
<td>Attestation QCDR Qualified Registry EHR CMS Web Interface (groups of 25 or more)</td>
</tr>
</tbody>
</table>

**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).
MIPS YEAR 2 (2018)
Performance Categories
### Basics:

- **Change: 50%** of Final Score in 2018
- 270+ measures available
- You select 6 individual measures
  - 1 must be an Outcome measure
  - High-priority measure
- You may also select a specialty-specific set of measures

<table>
<thead>
<tr>
<th>Component</th>
<th>Transition Year 1 (2017) Final</th>
<th>Year 2 (2018) Final</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight to Final Score</td>
<td>• 60%</td>
<td>• 50%</td>
</tr>
</tbody>
</table>
| Data Completeness             | • 50% for submission mechanisms except for Web Interface and CAHPS.  
                                 | • Measures that do not meet the data completeness criteria earn 3 points. | • 60% for submission mechanisms except for Web Interface and CAHPS.  
                                 | • Measures that do not meet data completeness criteria earn 1 point. | • Burden Reduction Aim: Small practices will continue to receive 3 points. |
MIPS Year 2 (2018)

Quality

Basics:
- **Change**: 50% of Final Score in 2018
- 270+ measures available
- You select 6 individual measures
  - 1 must be an Outcome measure OR
  - High-priority measure
- You may also select a specialty-specific set of measures

<table>
<thead>
<tr>
<th>Component</th>
<th>Transition Year 1 (2017) Final</th>
<th>Year 2 (2018) Final</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scoring</td>
<td>• 3-point floor for measures scored against a benchmark.</td>
<td>• No changes</td>
</tr>
<tr>
<td></td>
<td>• 3 points for measures that do not have a benchmark or do not meet case minimum.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Bonus for additional high priority measures up to 10% of denominator for performance category.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Bonus for end-to-end electronic reporting up to 10% of denominator for performance category.</td>
<td></td>
</tr>
</tbody>
</table>
Basics:

- **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.

**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.
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.
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.
**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).*
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.
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%
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 21st 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:
- Hospital-based MIPS eligible clinicians;
- Ambulatory Surgical Center (ASC)—based MIPS eligible clinicians, finalized retroactive to the transition year;
- Nurse practitioners, physician assistants, clinical nurse specialist, certified registered nurse anesthetists
- Non-patient-facing clinicians and groups

Reweighting through an approved application:
- New hardship exception for clinicians in small practices (15 or fewer clinicians);
- New decertification exception for eligible clinicians whose EHR was decertified, retroactively effective to performance periods in 2017.
- 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).
MIPS YEAR 2 (2018)
Performance Threshold and Payment Adjustment
**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%

**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.
### MIPS Year 2 (2018)

**MIPS: Performance Threshold & Payment Adjustment**

**Change:** *Increase in Performance Threshold and Payment Adjustment*

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Final Score 2017</strong></td>
<td><strong>Payment Adjustment 2019</strong></td>
</tr>
</tbody>
</table>
| **>70 points** | • Positive adjustment  
• Eligible for exceptional performance bonus—minimum of additional 0.5% | **N** | • Positive adjustment greater than 0%  
• Eligible for exceptional performance bonus—minimum of additional 0.5% |
| **4-69 points** | • Positive adjustment  
• Not eligible for exceptional performance bonus | **Y** | • Positive adjustment greater than 0%  
• Not eligible for exceptional performance bonus |
| **3 points** | • Neutral payment adjustment | **Y** | • Neutral payment adjustment |
| **0 points** | • Negative payment adjustment of -4%  
• 0 points = does not participate | **Y** | • Negative payment adjustment greater than -5% and less than 0% |

| **Final Score 2018** | **Payment Adjustment 2020** |
| **>70 points** | • Positive adjustment greater than 0%  
• Eligible for exceptional performance bonus—minimum of additional 0.5% |
| **15.01-69.99 points** | • Positive adjustment greater than 0%  
• Not eligible for exceptional performance bonus |
| **15 points** | • Neutral payment adjustment |
| **3.76-14.99** | • Negative payment adjustment greater than -5% and less than 0% |
| **0-3.75 points** | • Negative payment adjustment of -5% |
MIPS YEAR 2 (2018)

Scoring
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.
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.
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.
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.
CMS knows that areas affected by the recent hurricanes, specifically Hurricanes Harvey, Irma, and Maria, have experienced devastating disruptions in infrastructure and clinicians face challenges in submitting data under the Quality Payment Program.

We have issued an **Interim Final Rule** with an automatic extreme and uncontrollable circumstances policy where clinicians are exempt from the Quality, Improvement Activities, and Advancing Care Information performance categories *without* submitting a hardship exception application.

**What does the Interim Final Rule mean for me in the Transition Year (2017)?**

- We will automatically reweight the Quality, Improvement Activities, and Advancing Care Information performance categories.

- This will result in the clinician receiving a MIPS Final Score equal to the performance threshold, unless the MIPS eligible clinician submits data.

- Clinicians who do submit data (as an individual or group) will be scored on their submitted data.

- This policy does not apply to APMs.
MIPS Year 2 (2018)

Extreme and Uncontrollable Circumstances

Extreme and Uncontrollable Circumstances in Year 2 (2018):

• The Final Rule with Comment Period for Year 2 extends the Transition Year hardship exception reweighting policy for the Advancing Care Information performance category to now include Quality, Cost, and Improvement Activities.

• This policy applies to all of the 2018 MIPS performance categories.

• A hardship exception application is required.

• The hardship exception application deadline is December 31, 2018.
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 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 TCPL@HCAMail@us.ibm.com for extra assistance.

**SMALL & SOLO PRACTICES**

**Small, Underserved, and Rural Support (SURS)**
- Provides outreach, guidance, and direct technical assistance to clinicians in 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.
  - There are 11 SURS organizations providing assistance 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 OPPSURS@IMPAQINT.COM.

**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.

**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.
  1-866-268-6292  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. More information about the Learning Systems is available through your model's support inbox.
