The Merit-based Incentive Payment System:

Quality and Cost Performance Categories

January 12, 2017

Q&A Session Information

- The speakers will answer as many questions as time allows at the end of the presentation.
- If your question is not answered during the webinar, please contact the Quality Payment Program Service Center at qpp@cms.hhs.gov or 1-866-288-8292.

Please note: questions will be taken via phone. The Q&A chat box is meant for technical issues only.

Major Topics Covered

MIPS

The Merit-based Incentive Payment System At-A-Glance

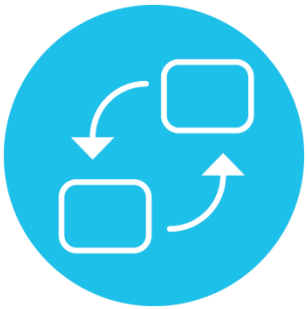
Overview of Quality and Cost Performance Categories

What is the Merit-based Incentive Payment System?

Performance Categories

Quality

Cost



Improvement Activities

Advancing Care Information

- Moves Medicare Part B clinicians to a performance-based payment system
- Provides clinicians with flexibility to choose the activities and measures that are most meaningful to their practice
- Reporting standards align with Advanced APMs wherever possible

What are the Performance Category Weights?

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

Transition Year Weights

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

Note: These are default weights; the weights can be adjusted in certain circumstances

Eligible Clinicians:

- Medicare Part B clinicians billing more than $30,000 a year **AND** providing care for more than 100 Medicare patients a year.

These clinicians include:

Physicians	Physician Assistants	Nurse Practitioners	Clinical Nurse Specialists	Certified Registered Nurse Anesthetists

Non-Patient Facing Clinicians

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

Who is excluded from MIPS?

Clinicians who are:

Newly-enrolled in Medicare

- Enrolled in Medicare for the first time during the performance period (exempt until following performance year)

Below the low-volume threshold

- Medicare Part B allowed charges less than or equal to $30,000 a year

OR

- See 100 or fewer Medicare Part B patients a year

Significantly participating in Advanced APMs

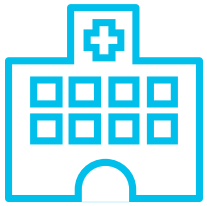
- Receive 25% of your Medicare payments

OR

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

Pick Your Pace for Participation for the Transition Year

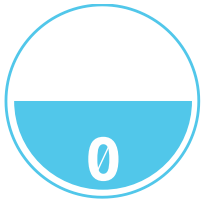
Participate in an Advanced Alternative Payment Model



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

MIPS

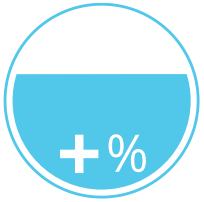
Test



Submit Something

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

Partial Year



Submit a Partial Year

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

Full Year

Submit a Full Year

- Fully participate starting January 1, 2017
- Modest positive payment adjustment

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

MIPS: Choosing to Test for 2017

Submit Something

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

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

1 Quality Measure

OR

1 Improvement Activity

OR

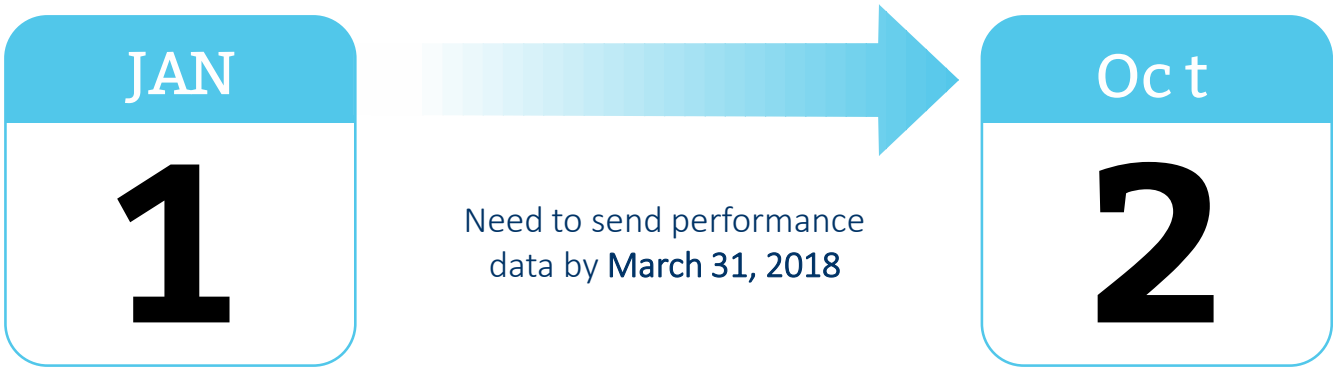
4 or 5 **Required** Advancing Care Information Measures

MIPS: Partial Participation for 2017

Submit a Partial Year

- Submit 90 days of 2017 data to Medicare
- May earn a positive payment adjustment

"So what?" - If you're not ready on January 1, you can start anytime between January 1 and October 2



MIPS: Full Participation for 2017

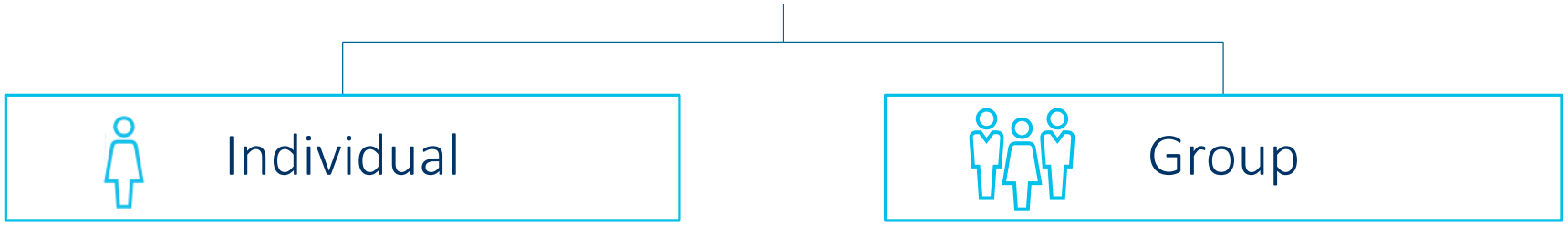
Submit a Full Year

- Submit a full year of 2017 data to Medicare
- May earn a positive payment adjustment
- Best way to earn largest payment adjustment is to submit data on all MIPS performance categories

Key Takeaway:
Positive adjustments are based on the performance data on the performance information submitted, not the **amount** of information or **length of time submitted.**

Individual vs. Group Reporting

OPTIONS



1. **Individual**—under an NPI number and TIN where they reassign benefits

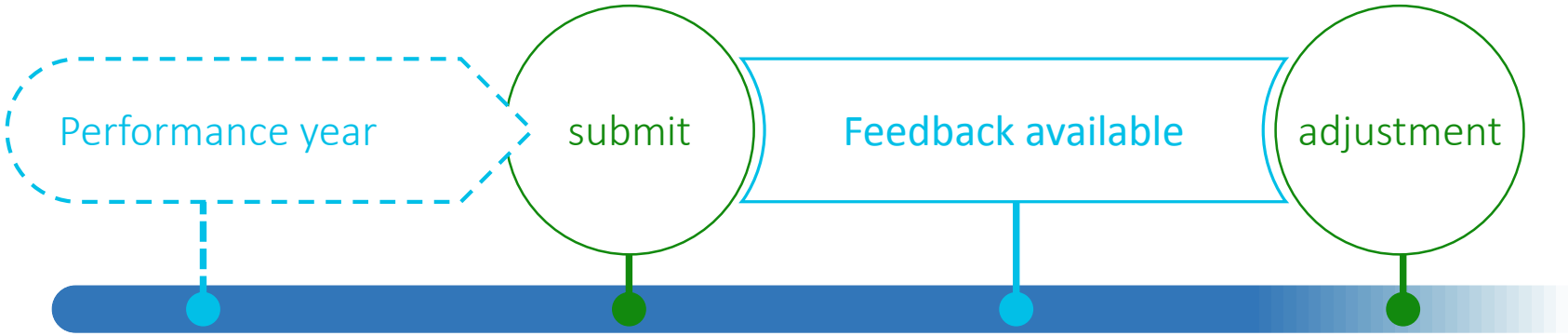
2. **As a Group**
   a) 2 or more clinicians (NPIs) who have reassigned their billing rights to a single TIN*
   b) As an APM Entity

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

Get your Data to CMS

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

When Does the Merit-based Incentive Payment System Officially Begin?



2017
Performance Year

Performance: The first performance period opened 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

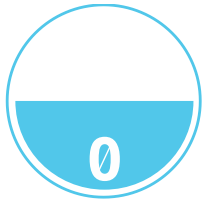
Feedback: Medicare gives you feedback about your performance after you send your data.

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.

Quality Performance Category Overview

Quality: Requirements for the Transition Year



Submit Something

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

Submit a Partial Year

Submit a Full Year

- Partial and Full means…
  - Submitting at least six quality measures, including at least one outcome measure, for 90 days or a full year.

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

MIPS Performance Category: Quality

- Category Requirements
  - Replaces PQRS and Quality portion of the Value Modifier
  - *"So what?"*—Provides for an easier transition due to familiarity

60% of final score

Select 6 of 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)

Scoring Methodology for Quality

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

Select 6 of the approximately 300 available quality measures (minimum of 90 days)

- Or a specialty set
- Or CMS Web Interface measures
- Readmission measure is included for group reporting with groups with at least 16 clinicians and sufficient cases

Clinicians receive 3 to 10 points on each quality measure based on performance against benchmarks

Failure to submit performance data for a measure = 0 points

Quick Tip:
Easier for a clinician that participates longer to meet case volume criteria needed to receive more than 3 points

Bonus points are available

MIPS Scoring for Quality (60% of Final Score)

Year 1 participants automatically receive 3 points for completing and submitting a measure

If a measure can be reliably scored against a benchmark, then clinician can receive 3 – 10 points

- Reliable score means the following:
  - Benchmarks 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

MIPS Scoring for Quality (60% of Final Score)

More About Benchmarks

- Separate benchmarks for different reporting mechanisms
  - EHR, QCDR/registries, claims, CMS Web Interface, administrative claim measures, and CAHPS for MIPS

- All reporters (individuals and groups regardless of specialty or practice size) are combined into one benchmark

- Need at least 20 reporters that meet the following criteria:
  - Meet or exceeds the minimum case volume (has enough data to reliably measured)
  - Meets or exceeds data completeness criteria
  - Has performance greater than 0 percent

Why this matters? Not all measures will have a benchmark. If there is no benchmark, then a clinician only receives 3 points.

MIPS Scoring for Quality (60% of Final Score)

Bonus Points

Clinicians receive bonus points for either of the following:

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

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

Total Quality Performance Category Score =

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

Quick Tip: Maximum score cannot exceed 100%

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

MIPS Scoring for Quality (60% of Final Score)

Maximum Number of Points

CMS Web Interface Reporter total score

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

Other submission mechanisms total score

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

Cost Performance Category Overview

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

What is a Cost Measure?

- Generally stated, a cost measure represents the Medicare payments (for example, payments under the Physician Fee Schedule, IPPS, etc.) for the items and services furnished to a beneficiary during an episode of care.
- The episode of care is the basis for identifying items and services through claims that are furnished to address a condition within a specified timeframe.
- Our goal is that cost measures should also be aligned with quality of care assessment so that patient outcomes and smarter spending can be pursued together.

What is a Cost Measure?

Building cost measures requires ***five*** essential components:

1. Defining an episode group

2. Assigning costs to the episode group

3. Attributing the episode group to one or more responsible clinicians

4. Risk adjusting episode group resources or defining episodes to compare like beneficiaries

5. To the extent possible, aligning episode group costs with indicators of quality

Why are Cost Measures Important?

CMS' goal for developing cost measures is to provide actionable information that is *useful* to clinicians and, together with the other components of the MIPS program, drive lowered costs and improved patient outcomes.

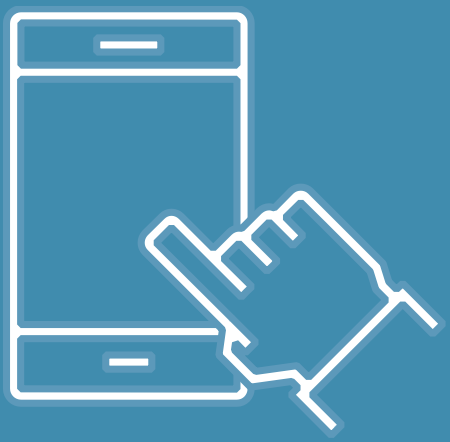
CMS seeks to provide clinicians with information to reduce healthcare spending and promote the delivery of high-value care.

Types of Episode Groups

- There are three general types of episode groups:
  - Chronic Condition Episode Groups
  - Acute Inpatient Medical Condition Episode Groups
  - Procedural Episode Groups

Stakeholder Feedback

- CMS has sought stakeholder feedback on episode groups in recent years following the annual release of the Supplemental Quality and Resource Use Reports (SQRURs) and in response to CMS Episode Groups Postings, as required by MACRA Section 101(f).
- In addition to the public comments received on the October 2015 and April 2016 postings, CMS has also received stakeholder feedback through a technical expert panel and the work of a clinical committee.
- The clinical committee was comprised of over 70 clinical experts from over 50 professional societies.
- Current Status of Cost Measures:
  - CMS posted Episode Groups and Episode Triggers in December 2016
  - CMS wants feedback on approach to Cost Measure Development
  - Public Comment open until April 24, 2017



Where can I go to learn more?

Technical Assistance

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

Quality Payment Program Portal

- Learn about the Quality Payment Program, explore the measures, and find educational tools and resources.

Transforming Clinical Practice Initiative (TCPI):

- Designed to support more than 140,000 clinician practices over the next 4 years in sharing, adapting, and further developing their comprehensive quality improvement strategies.

Quality Innovation Network (QIN)-Quality Improvement Organizations (QIOs):

- Includes 14 QIN-QIOs
- Promotes data-driven initiatives that increase patient safety, make communities healthier, better coordinate post-hospital care, and improve clinical quality.

The Innovation Center's Learning Systems provides specialized information on:

- Successful Advanced APM participation
- The benefits of APM participation under MIPS

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

PRIMARY CARE & SPECIALIST PHYSICIANS

Transforming Clinical Practice Initiative

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

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

SMALL & SOLO PRACTICES

Small, Underserved Rural Support Technical Assistance

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

LARGE PRACTICES

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

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

Locate the QIN-QIO that serves your state

Quality Innovation Network (QIN) Directory

TECHNICAL SUPPORT

All Eligible Clinicians Are Supported By:

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

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

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

Q&A Session Information

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- If prompted, use passcode: **4298955**
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