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## Quality Payment Program Year 2

Session 73, March 6, 2018

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# ENGAGED

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DISCLAIMER: The views and opinions expressed in this presentation are those of the author and do not necessarily represent official policy or position of HIMSS.

# Conflict of Interest

Molly MacHarris and Jean Moody-Williams

Have no real or apparent conflicts of interest to report.

# Learning Objectives

1. Provide a Quality Payment Program overview
2. Identify the differences between Year 1 and Year 2 of the program
3. Outline requirements for the Merit-based Incentive Payment System (MIPS)

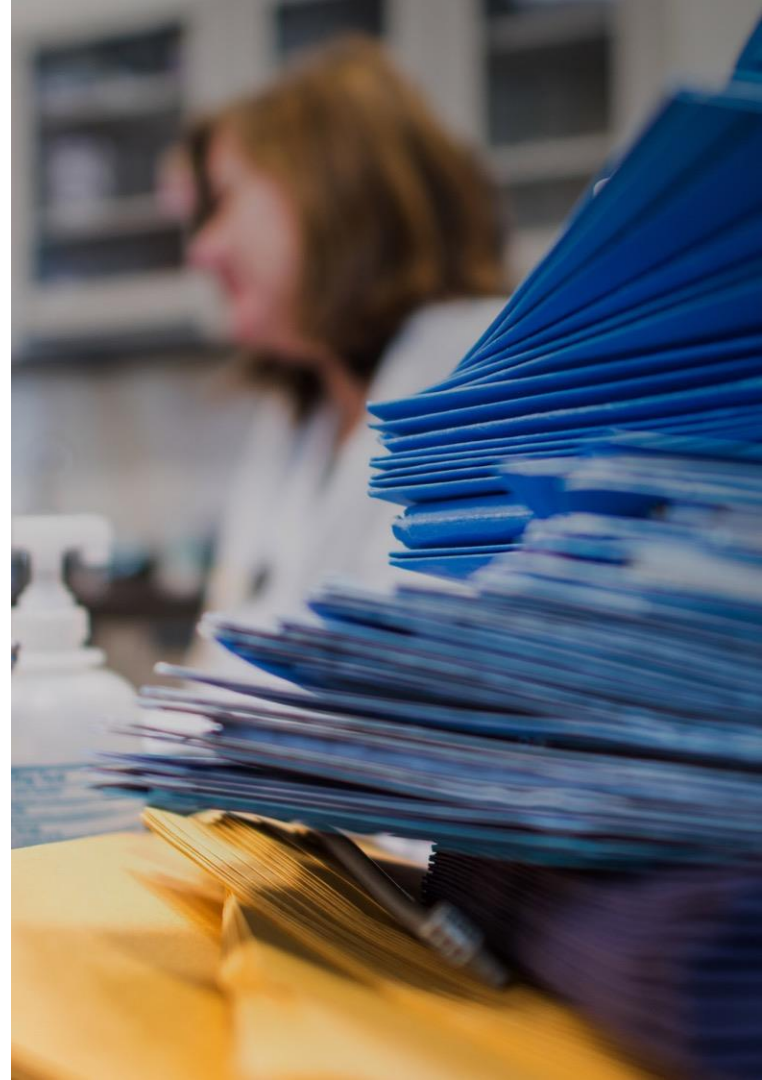
# CMS Strategic Goals

- Empower patients and doctors to make decisions about their health care
- Usher in a new era of state flexibility and local leadership
- Support innovative approaches to improve quality, accessibility, and affordability
- Improve the CMS customer experience

# **PATIENTS** **OVER PAPERWORK**

## **Our top priority at CMS is putting patients first**

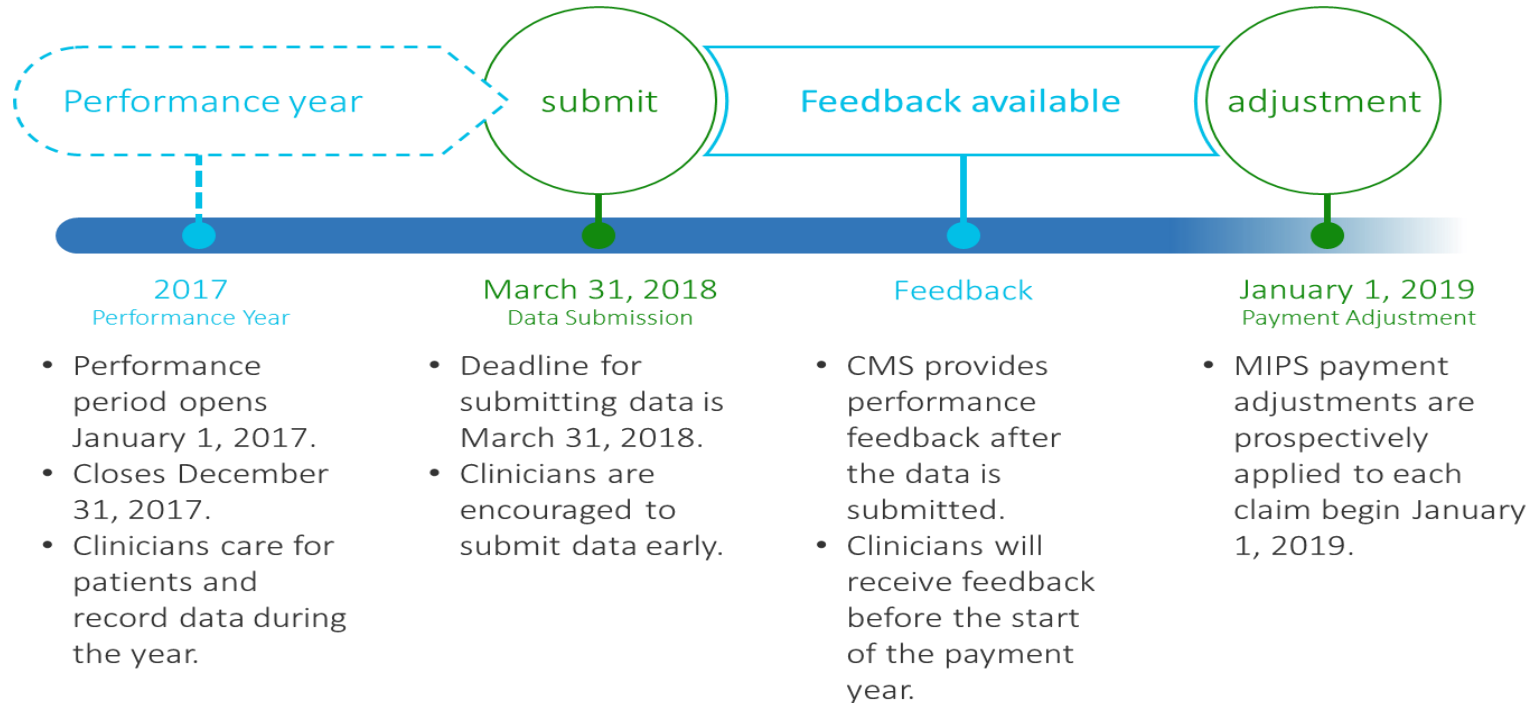
CMS is committed to reducing unnecessary burden, increasing efficiencies, and improving the beneficiary experience.



# Quality Payment Program

## Overview

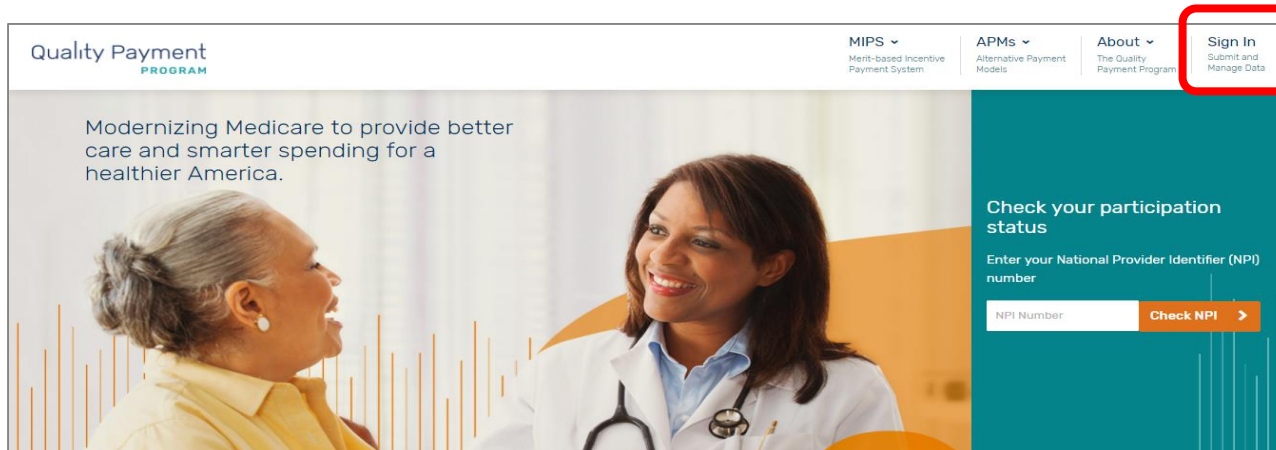
# Year 1 of the Quality Payment Program





## Year 1 Submission is Currently Underway

- Visit [qpp.cms.gov](http://qpp.cms.gov) and look for the login icon at the top of the screen.



- Clinicians who participate in the Quality Payment Program have one place to submit all of their data eliminating the need for multiple visits to multiple websites.



# Reporting Data for the Quality Performance Category

< Account Dashboard

TIN# 000183746

Connected Clinicians

Group Reporting

Group Dashboard

**Quality Measures**

Advancing Care Information

Improvement Activities

→← COLLAPSE

**Measures that count toward Quality Performance Score (6)**  
Your Measure Score includes both performance points and bonus points.

Measure Name EXPAND ALL	Performance Rate	Measure Score	Download Specifications
Anti-Depressant Medication Management Measure ID: 009	93.66%	<b>11.0</b>	Download
Diabetic Retinopathy: Communication with the Physician Managing Ongoing Measure ID: 019	95.47%	<b>11.0</b>	Download
Preventive Care and Screening: Influenza Immunization Measure ID: 110	84.21%	<b>10.0</b>	Download
Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery Measure ID: 191	99.15%	<b>8.9</b>	Download
Depression Utilization of the PHQ-9 Tool Measure ID: 331	92.97%	<b>10.0</b>	Download

Clinicians will see real-time initial scoring within the Merit-based Incentive Payment System (MIPS) performance categories based on their submissions.



## Reporting Data for the Advancing Care Information Performance Category

- You must attest to the first two statements in order to continue submitting data for the Advancing Care Information performance category.

The screenshot shows a web application interface for reporting data. On the left is a dark blue sidebar with navigation links: 'Account Dashboard', 'TIN# 000183746', 'Connected Clinicians', 'Group Reporting' (expanded), 'Group Dashboard', 'Quality Measures', 'Advancing Care Information' (selected), and 'Improvement Activities'. At the bottom of the sidebar is a 'COLLAPSE' button. The main content area has a white background. At the top, there's a 'Select Measure Set:' section with three buttons: '2017 ADVANCING CARE INFORMATION TRANSITION MEASURES' (highlighted with a mouse cursor), 'ADVANCING CARE INFORMATION MEASURES', and 'COMBINATION OF BOTH MEASURE SETS'. Below this is a section titled 'ATTESTATION STATEMENTS FOR THE ADVANCING CARE INFORMATION PERFORMANCE CATEGORY'. It contains three rows, each with a statement and two circular buttons labeled 'Yes' and 'No':

- > Prevention of Information Blocking Attestation
- > ONC Direct Review Attestation
- > ONC-ACB Surveillance Attestation (Optional)

At the bottom of the main content area, a pink bar displays the text 'ADVANCING CARE INFORMATION SCORE: 0 / 100'.

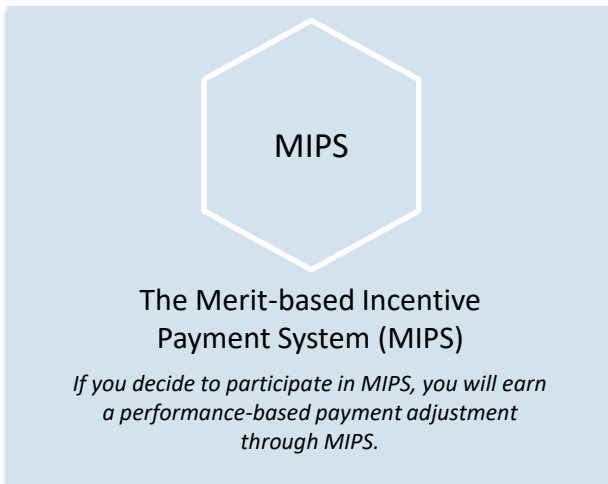
# Resource Library Update

- 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:
  - CMS.GOV Resource Library: <https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Resource-library.html>
  - Final Rule Materials Posted: <https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html>

# 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:




A light blue rectangular box containing a white hexagon with the text "MIPS" inside. Below the hexagon, the text "The Merit-based Incentive Payment System (MIPS)" is centered. At the bottom, a line of italicized text reads: "If you decide to participate in MIPS, you will earn a performance-based payment adjustment through MIPS."

**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**



A dark gray rectangular box containing a white hexagon with the text "Advanced APMs" inside. Below the hexagon, the text "Advanced Alternative Payment Models (Advanced APMs)" is centered. At the bottom, a line of italicized text reads: "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."

**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

Reduce burden on clinicians

Increase adoption of  
Advanced APMs

Maximize participation

Improve data and  
information sharing

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](http://qpp.cms.gov).



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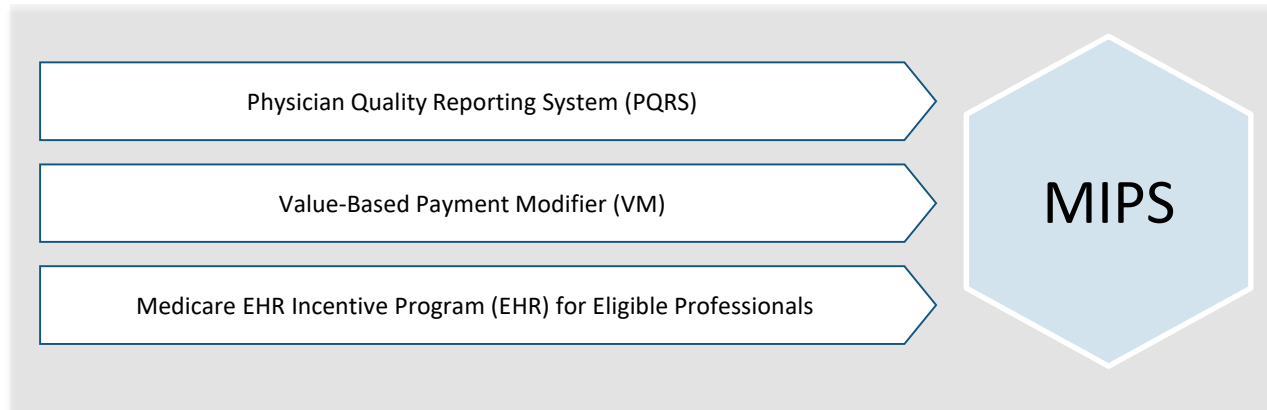
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# Merit-based Incentive Payment System (MIPS)

# Merit-based Incentive Payment System (MIPS)

## Quick Overview

Combined legacy programs into a single, improved program.

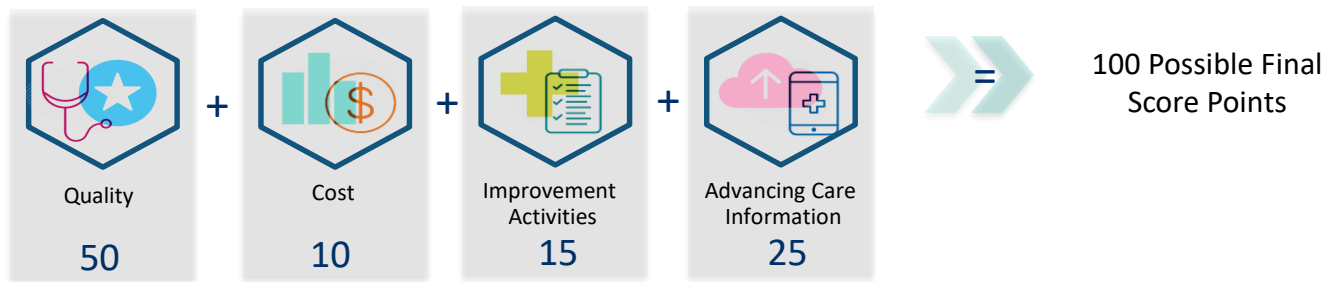




# Merit-based Incentive Payment System (MIPS)

## Who is Included?

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?

# MIPS Year 2 (2018)

## Who is Included?

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

MIPS eligible clinicians include:



Physicians



Physician Assistants



Nurse Practitioners



Clinical Nurse Specialists



Certified Registered Nurse Anesthetists

# MIPS Year 2 (2018)

## Who is Included?

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

# 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.



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



#### Year 2 (2018) Final

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



# MIPS Year 2 (2018)

## Other Special Statuses

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

# MIPS Year 2 (2018)





Performance Period

# MIPS Year 2 (2018)

## Performance Period

*Change: Increase to Performance Period*

### Transition Year 1 (2017) Final

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

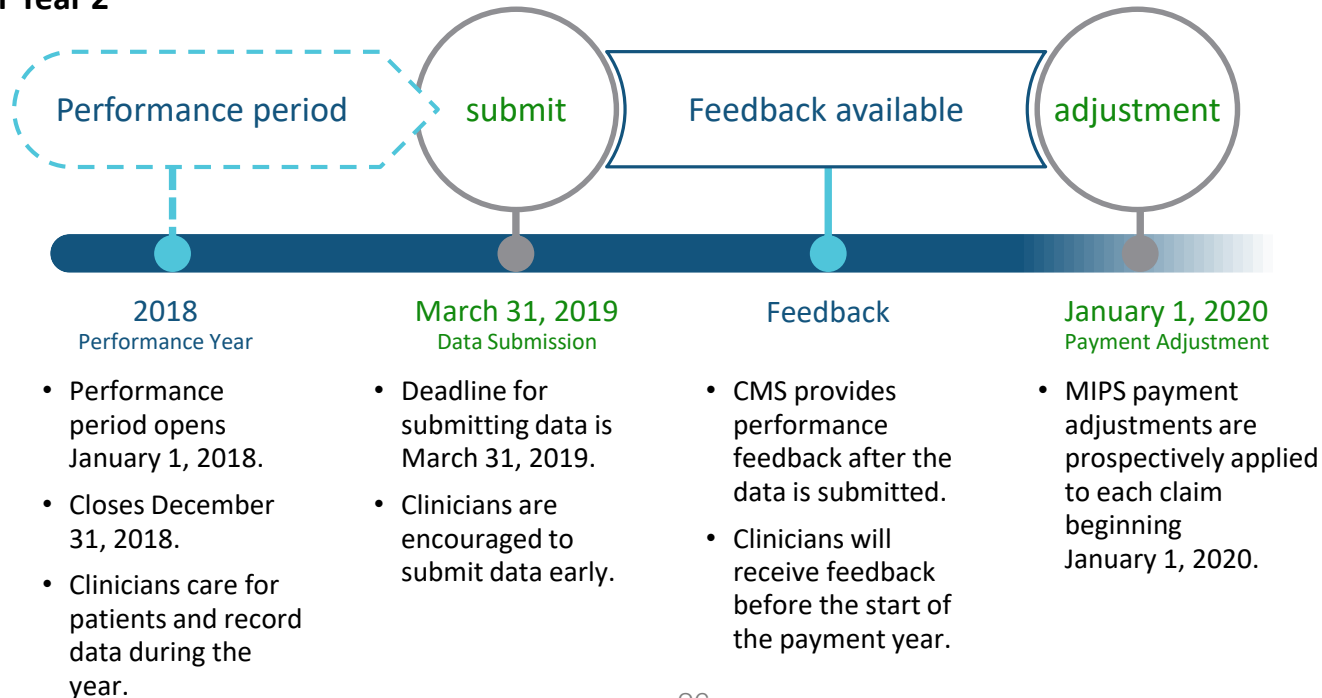


### Year 2 (2018) Final

Performance Category	Minimum Performance Period
 Quality	12-months
 Cost	12-months
 Improvement Activities	90-days
 Advancing Care Information	90-days

# MIPS Year 2 (2018)

## Timeline for Year 2

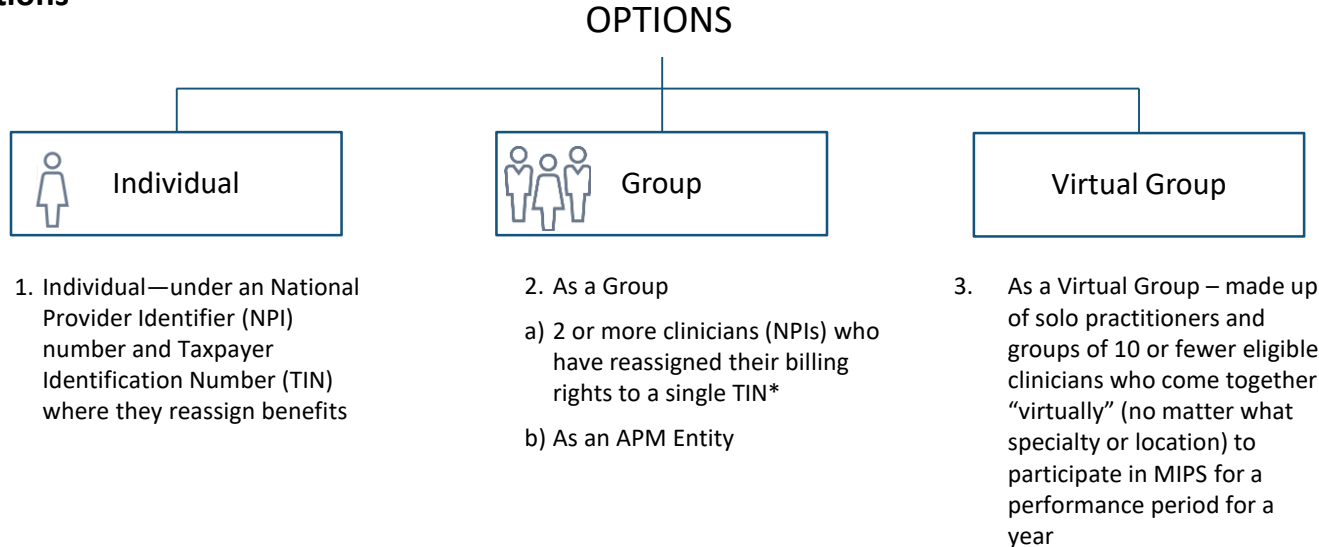


# MIPS Year 2 (2018)

Reporting and Data Submission Options

# MIPS Year 2 (2018)

## Reporting Options



\* 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.

# MIPS Year 2 (2018)

## Virtual Groups

- What is a Virtual Group?
  - A virtual group can be 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 performance period for a year.
- In order to meet the eligibility criteria for 2018, you needed to be a:
  - **Solo practitioner** who exceeded the low-volume threshold individually, and were not a newly Medicare-enrolled eligible clinician, a Qualifying APM Participant (QP), or a Partial QP choosing not to participate in MIPS.
  - **Group** that has 10 or fewer eligible clinicians and exceeds the low-volume threshold at the group level.



# MIPS Year 2 (2018)

## Virtual Groups

- What else do I need to know?
  - Election began prior to the beginning of the 2018 performance period and can no longer be changed.
  - Generally, policies that apply to groups would apply to virtual groups.
  - Virtual groups use same submission mechanisms as groups.
  - All clinicians within a TIN are part of the virtual group.
  - Virtual groups are required to aggregate their across the virtual group for each performance category and will be assessed and scored as a virtual group.
  - If TIN/NPIs is participating in both a virtual group and an APM, such TIN/NPI will receive a final score based on the virtual group performance and a final score based on performance in an APM. However, such TIN/NPI will receive a payment adjustment based on the APM score.

# MIPS Year 2 (2018)





## Virtual Groups

- Participation in 2018:
  - A virtual group must have been made before the start of the 2018 performance period and include at least the information about each TIN and NPI associated with the virtual group and the virtual group representative's contact information.
  - A virtual group's official representative is needed to acknowledge that a formal written agreement has been established between each solo practitioner and group that composes a virtual group.
  - Once the election is made, the virtual group representative must contact the Quality Payment Program Service Center before the applicable submission period starts with any updates to the election information for the applicable performance period.

# MIPS Year 2 (2018)

## Who is Included?

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

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

### Please note:

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

# MIPS Year 2 (2018)

Performance Categories

# 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



Component	Transition Year 1 (2017) Final	Year 2 (2018) Final
Weight to Final Score	<ul style="list-style-type: none"> <li>• 60%</li> </ul>	<ul style="list-style-type: none"> <li>• 50%</li> </ul>
Data Completeness	<ul style="list-style-type: none"> <li>• 50% for submission mechanisms except for Web Interface and CAHPS.</li> <li>• Measures that do not meet the data completeness criteria earn 3 points.</li> </ul>	<ul style="list-style-type: none"> <li>• 60% for submission mechanisms except for Web Interface and CAHPS.</li> <li>• Measures that do not meet data completeness criteria earn 1 point.</li> <li>• <b>Burden Reduction Aim:</b> Small practices will continue to receive 3 points.</li> </ul>

# 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



Component	Transition Year 1 (2017) Final	Year 2 (2018) Final
Scoring	<ul style="list-style-type: none"> <li>• 3-point floor for measures scored against a benchmark.</li> <li>• 3 points for measures that do not have a benchmark or do not meet case minimum.</li> <li>• Bonus for additional high priority measures up to 10% of denominator for performance category.</li> <li>• Bonus for end-to-end electronic reporting up to 10% of denominator for performance category.</li> </ul>	<ul style="list-style-type: none"> <li>• No changes</li> </ul>

# MIPS Year 2 (2018)

## Quality



### What is the significance?

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



### Topped Out Measures:

- Topped-out measures will be removed and scored on 4 year phasing out timeline.
- Topped out measures with measure benchmarks that have been topped out for *at least 2 consecutive years* will receive up to 7 points.
- The 7-point scoring policy for the 6 topped out measures identified for the 2018 performance period is finalized. These measures are identified on the next slide.
- Topped out measures will only be removed after a review of performance and additional considerations.
- Topped out policies **do not apply** to CMS Web Interface measures, but this will be monitored for differences with other submission options.



# MIPS Year 2 (2018)

## Quality



### *What is the significance?*

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



### Topped Out Measures:

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



# MIPS Year 2 (2018)

## Cost



### Basics:

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



- **Change:** Cost performance category weight is **finalized at 10% for 2018.**
- 10 episode-based measures adopted for the 2017 MIPS performance period will not be used.
- We are developing new episode-based measures with significant clinician input and are providing feedback on these measures this fall through field testing.
- This will allow clinicians to see their cost measure scores before the measures are potentially included in the MIPS program.
- We will propose new cost measures in future rulemaking.

# 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.

# MIPS Year 2 (2018)

## MIPS: Scoring Improvements



- 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).*

# MIPS Year 2 (2018)

## Improvement Activities



### Basics:

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



### Additional Activities:

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

### Scoring:

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

# MIPS Year 2 (2018)

## Advancing Care Information



### Basics:

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



### CEHRT Requirements:

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

### Measures and Objectives:

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

### Scoring:

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

# MIPS Year 2 (2018)

## Advancing Care Information



### Basics:

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



### Exceptions:

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

#### **Automatic reweighting:**

- Hospital-based MIPS eligible clinicians;
- Non-Patient Facing 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

#### **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).



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# 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*

Transition Year 1 (2017) Final

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



Year 2 (2018) Final

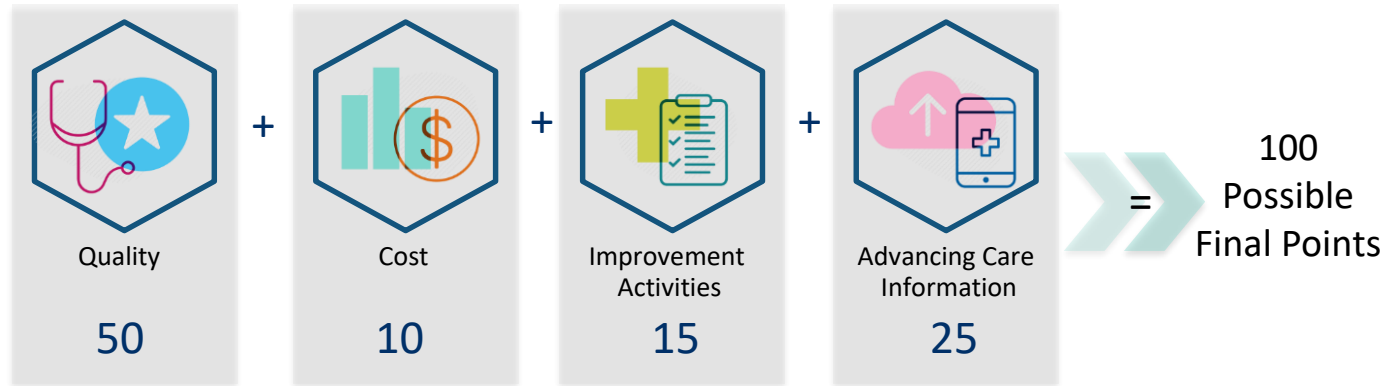
Final Score 2018	Change Y/N	Payment Adjustment 2020
≥70 points	N	<ul style="list-style-type: none"> <li>Positive adjustment greater than 0%</li> <li>Eligible for exceptional performance bonus—minimum of additional 0.5%</li> </ul>
15.01-69.99 points	Y	<ul style="list-style-type: none"> <li>Positive adjustment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

# 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

- 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

- **5 bonus points** added to the 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.

# MIPS Year 2 (2018)

## Facility-based Measurement

- What you 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 mechanisms 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 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 in a MIPS quality performance category and cost performance category score.



# MIPS Year 1 (2017)

## Extreme and Uncontrollable Circumstances

- CMS knows that areas affected by the California wildfires and recent hurricanes, specifically Hurricanes Harvey, Irma, Maria, and Nate – all of which happened in 2017, have experienced devastating disruptions in infrastructure and clinicians face challenges in submitting data under the Quality Payment Program.
- As part of the Quality Payment Program Year 2 final rule, which was released on November 2, 2017, CMS issued an interim final rule with comment period, which includes the Extreme and Uncontrollable Circumstances for the transition year of MIPS.
- This policy specifically addresses extreme and uncontrollable circumstances for the MIPS Advancing Care Information, Quality, and Improvement Activities performance categories in 2017. (It does not apply to the Cost performance category since it has a 0 percent weight in 2017.)

# MIPS Year 1 (2017)

## Extreme and Uncontrollable Circumstances

- Under this policy, if you are a MIPS eligible clinician who has been affected by Hurricanes Harvey, Nate, Irma, or Maria, or the California wildfires:
  - **You do not need to submit an application** to reweight the performance categories. CMS will be able to identify you based on the information in the Provider Enrollment, Chain and Ownership System (PECOS).
  - **You will automatically receive a neutral MIPS payment adjustment**, unless you choose to submit data for any of the MIPS performance categories, in which case you will be scored based on the data you submitted.
- Note: this automatic extreme and uncontrollable circumstances policy only applies to you if you're a MIPS eligible clinician in an affected area. It does not apply to MIPS eligible clinicians in MIPS Alternative Payment Models (APMs) in 2017 (such as the Medicare Shared Savings Program).
- To learn more, see the 2017 Extreme & Uncontrollable Circumstances Policy Fact Sheet, posted here: <https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Resource-library.html>

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# Quality Payment Program

Help & Support



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# Technical Assistance


## Available Resources

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

### PRIMARY CARE & SPECIALIST PHYSICIANS

Transforming Clinical Practice Initiative


- Supports more than 140,000 clinician practices through 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 [TCPIJSCMail@us.ibm.com](mailto:TCPIJSCMail@us.ibm.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.
- 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 [QPPSURS@IMPAQINT.COM](mailto:QPPSURS@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.

 *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: [gpp.cms.gov](http://gpp.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](mailto: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.

To learn more, view the Technical Assistance Resource Guide: <https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Technical-Assistance-Resource-Guide.pdf>

# Questions

- Jean Moody-Williams, RN, MPP, Deputy Director of the Center for Clinical Standards and Quality, CMS
- Molly MacHarris, MIPS Program Lead, CMS



# Additional CMS Education Sessions

Session	Date	Time	Location
Quality Payment Program: Advancing Care Information	Wednesday, March 7	10-11 a.m.	Lando 4204
Advanced Alternative Payment Models (APMs)	Wednesday, March 7	1-2 p.m.	Lando 4204
Innovation in the Medicaid Enterprise: A State and Federal Priority Partnership	Thursday, March 8	11:30 a.m.-12:30 p.m.	Lando 4204
Quality Payment Program Developer Tools & EHRs Town Hall	Thursday, March 8	1-2 p.m.	Lando 4204
New Medicare Card (SSNRI)	Thursday, March 8	2:30-3:30 p.m.	Lando 4204

## CMS Office Hours Schedule - Tuesday

Booth #10110	
Electronic Clinical Quality Measures	2:30-4:30 p.m.
EHR Incentive Program – Medicaid	3-5 p.m.
QPP	4-5 p.m.

## CMS Office Hours Schedule - Wednesday

<b>Booth #10110</b>	
New Medicare Card (SSNRI)	9:30-11 a.m.
Blue Button 2.0 API Technical Experts	10:30-11:30 a.m.
Data Element Library	11 a.m.-12 p.m.
Advancing Care Information	11:30 a.m.-12:30 p.m.
New Medicare Card (SSNRI)	1-3 p.m.
Advanced Alternative Payment Models	2:30-3:30 p.m.
Blue Button 2.0 API	2:30-3:30 p.m.
EHR Incentive Program – Hospitals	3-4 p.m.
CMS Quality Systems Improvements to Data Access	3-4 p.m.
Blue Button 2.0 API	4-4:30 p.m.
QPP	4:30-5:30 p.m.



## CMS Office Hours Schedule - Thursday

Booth #10110	
New Medicare Card (SSNRI)	9:30-11 a.m.
QPP	10-11:30 a.m.
Blue Button 2.0 API	11 a.m.-12 p.m.
Data Element Library	11 a.m.-12 p.m.
Advanced Alternative Payment Models	11:30 a.m.-1 p.m.
New Medicare Card	1-3 p.m.
Electronic Clinical Quality Measures	1:30-3:30 p.m.
CMS Quality Systems Improvements to Data Access	2-3 p.m.
Advancing Care Information	2:30-3:30 p.m.
Blue Button 2.0 API	2:30-4 p.m.