Welcome to PMI’s Webinar Presentation

Brought to you by:
Practice Management Institute®
pmiMD.com

Meet the Presenter…

On the topic:

QPP Understanding MIPS & APMs

Pam Joslin, MM, CMC, CMIS, CMOM, CMCO
Welcome to Practice Management Institute’s Webinar and Audio Conference Training. We hope that the information contained herein will give you valuable tips that you can use to improve your skills and performance on the job. Each year, more than 40,000 physicians and office staff are trained by Practice Management Institute. For 30 years, physicians have relied on PMI to provide up-to-date coding, reimbursement, compliance and office management training. Instructor-led classes are presented in 400 of the nation’s leading hospitals, healthcare systems, colleges and medical societies.

PMI provides a number of other training resources for your practice, including national conferences for medical office professionals, self-paced certification preparatory courses, online training, educational audio downloads, and practice reference materials. For more information, visit PMI’s web site at www.pmiMD.com

Please be advised that all information in this program is provided for informational purposes only. While PMI makes all reasonable efforts to verify the credentials of instructors and the information provided, it is not intended to serve as legal advice. The opinions expressed are those of the individual presenter and do not necessarily reflect the viewpoint of Practice Management Institute. The information provided is general in nature. Depending on the particular facts at issue, it may or may not apply to your situation. Participants requiring specific guidance should contact their legal counsel.

CPT® is a registered trademark of the American Medical Association.
QPP – Understanding MIPS and APMs

Brought to you by:
Pam Joslin, MM, CMC, CMIS, CMOM, CMCO, CEMA
Practice Management Institute®

THE MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015 (MACRA)
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

• The passage of the Affordable Care Act in 2010 was the catalyst for extensive reform of the U.S. healthcare delivery system.

• The passage of MACRA supports the transition to paying providers based on quality and establishes an incentive payment system for rewarding high-value care.

CMS Quality Strategy Aims:

...and toward transforming our health care system.

3 goals for our health care system:

BETTER care
SMARTER spending
HEALTHIER people

Via a focus on 3 areas

Incentives
Care Delivery
Information Sharing

©2017 Practice Management Institute®
What’s the Quality Payment Program?

• The Quality Payment Program improves Medicare by helping you focus on care quality and the one thing that matters most — making patients healthier.

• The Quality Payment Program has two tracks you can choose:
  – Advanced Alternative Payment Models (APMs) or
  – The Merit-based Incentive Payment System (MIPS)
Quality Payment Program Aims To:

- Improve beneficiary outcomes
- Enhance clinician experience
- Increase adoption of Advanced APMs
- Maximize participation
- Improve data and information sharing
- Ensure operational excellence in program implementation

Who’s in the Quality Payment Program?

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

Quick Tip:
Physician means doctor of medicine, doctor of osteopathy (including osteopathic practitioner), doctor of dental surgery, doctor of dental medicine, doctor of podiatric medicine, or doctor of optometry, and, with respect to certain specified treatment, a doctor of chiropractic legally authorized to practice by a State in which he/she performs this function.

These clinicians include:

- Physicians
- Physician Assistants
- Nurse Practitioner
- Clinical Nurse Specialist
- Certified Registered Nurse Anesthetists
Who is Excluded from MIPS?

- 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
  - See 100 or fewer Medicare Part B patients a year

- Significantly participating in Advanced APMs
  - Receive 25% of your Medicare payments
  - See 20% of your Medicare patients through an Advanced APM

Eligibility Scenario

- To be eligible for the Quality Payment Program, a clinician must bill more than $30,000 and see more than 100 Medicare beneficiaries.

- Quick Tip: "And" is the key to eligibility

- In the example provided in this incident where a clinician billed $29,000 and saw 101 patients, this clinician would be exempt from the program because the clinician did not bill more than $30,000.
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 Qualifying APM Participant (QP) or Partial QP that elects not to report data to MIPS.
- A group is non-patient facing is greater than 75% of NPIs billing under the group’s TIN during a performance period are labeled as non-patient facing. There are more flexible reporting requirements for non-patient facing clinicians.

Transitional Performance Year

- CMS has recognized, through many insightful comments, that many eligible clinicians face challenges in understanding the requirements and being prepared to participate in the Quality Payment Program until 2017.
- The initial development of the QPP implementation would allow physicians to pick their pace of participation for the first performance period that began January 1, 2017.
In the transition year CY2017 of the program, clinicians can choose their course of participation in this year with four options:

1. Clinicians can choose to report to MIPS for a full year and maximize the MIPS eligible clinician’s chances to qualify for a positive adjustment.

2. Clinicians can choose to report to MIPS for a period of time less than the full year performance period 2017 but for a full 90-day period at a minimum and report more than one quality measure, more than one improvement activity, or more than the required measures in the advancing care information performance category in order to avoid a negative MIPS payment adjustment and to possibly receive a positive MIPS payment adjustment.

3. Clinicians can choose to report one measure in the quality performance category; one activity in the improvement activities performance category; or report the required measures of the advancing care information performance category and avoid a negative MIPS payment adjustment.

4. MIPS eligible clinicians can participate in Advanced APMs, and if they receive a sufficient portion of their Medicare payments or see a sufficient portion of their Medicare patients through the Advanced APM, they will qualify for a 5 percent bonus incentive payment in 2019.
Small Practices

- For 2017, many small practices will be excluded from new requirements due to low-volume threshold.
- MACRA also provides that solo and small practices may join “virtual groups” and combine their MIPS reporting.
- Priority will be given to practices located in rural areas, defined as clinicians in zip codes designated as rural, using the most recent Health Resources and Service Administration (HRSA) Area Health Resource File data set available, medically underserved areas (MUAs) and practices with low MIPS final scores or in transition to APRM participation.

When does the Quality Payment Program Start?

If you were ready, you could have begun January 1, 2017 and started collecting your performance data. If you were not ready on January 1, you can choose to start anytime between January 1 and October 2, 2017. Whenever you choose to start, you’ll need to send in your performance data by March 31, 2018.

The first payment adjustments based on performance go into effect on January 1, 2019.
Pick Your Pace in MIPS

If you choose the MIPS path of the Quality Payment Program, you have three options:

- Don’t Participate
- Submit Something
- Submit a Partial Year
- Submit a Full Year

MIPS: Choosing to Test for 2017

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

You Have Asked: “What is the minimum amount of data?”
MIPS: Partial Participation for 2017

- 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

Submit a Partial Year
MIPS: Full Participation for 2017

- 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.
Bonus Payments and Reporting Periods

Full Year Participation
- Is the best way to get the max adjustment
- Gives you the most measures to choose from
- Prepares you the most for the future of the program

Submit a Full Year

Partial Participation (Report for 90 Days)
- You can still earn the max adjustment

Submit a Partial Year

Participate in the Advanced APM path:
If you receive 25% of Medicare payments or see 20% of your Medicare patients through an Advanced APM in 2017, then you earn a 5% incentive payment in 2019.

+5%

©2017 Practice Management Institute®
Forward Together

• As the program grows, so does the possibility to be rewarded for providing better care.

• These kinds of smarter payments give you more time to spend with your patients and to care for them in the way you think is best.

What’s the Merit-based Incentive Payment System (MIPS)?

• CMS’ proposed rule sets out to implement MACRA’s requirements related to MIPS and APMs, through the creation of the QPP.

• The first route clinicians may take under the QPP (Quality Performance Program) is to participate in MIPS.
Performance Category Weights

• First, the quality category makes up 60% of the performance score in year 1 of MIPS, and replaces the PQRS and the quality component of the VM.

• Clinicians report a minimum of six measures – compared to nine under PQRS – and one additional outcome measure or a high priority measure, such as patient safety, patient experience, and care coordination.

• Second, the resource use category makes up 0% of the performance score in year 1, and replaces the cost component of the VM.
- Third, the clinical practice improvement activities category makes up 15% of the performance score in year 1, and allows clinicians to choose pertinent activities from over 90 options, such as care coordination, patient engagement, and patient safety.

- Lastly, the advancement of care information category makes up 25% of the performance score in year 1, and replaces the Meaningful Use program.

What are the Performance Category Weights?

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

<table>
<thead>
<tr>
<th>Category</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>60%</td>
</tr>
<tr>
<td>Cost</td>
<td>0%</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>15%</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>25%</td>
</tr>
</tbody>
</table>

©2017 Practice Management Institute®
Quality Category Requirements

- Select 6 of about 300 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, appreciate use measure, patient safety, efficiency measures, or care coordination

Advancing Care Information Category

- The Advancing Care Information category (formerly Meaningful Use) would account for 25 percent of the MIPS score in the first year.
- For this category, clinicians must use certified EHR technology and would choose to report a customizable set of measures that reflects how they use EHR technology in their day-to-day practice, with a particular emphasis on interoperability and information exchange.
- The overall Advancing Care Information score would be made up of a base score and a performance score for a maximum score of 100 points.
Base Score

- The base score accounts for 50 points of the total Advancing Care Information category score.
- CMS proposes five objectives and their measures that would require reporting for the base score:
  - Security Risk Analysis
  - e-Prescribing
  - Patient Access
  - Summary of Care
  - Request/Accept Summary of Care

Performance Score

- The performance score accounts for up to 90 points towards the total Advancing Care Information category score.
- Clinicians select the measures that best fit their practice from the following objectives, which emphasize patient care and information access:
  - Patient Electronic Access
  - Coordination of Care Through Patient Engagement
  - Health Information Exchange
  - Public Health and Clinical Data Registry Reporting (yes/no)
• Public Health Registry Bonus Point: Immunization registry reporting is required. In addition, clinicians may choose to report on more than one public health registry, and will receive one additional point for reporting beyond the immunization category.

• The clinicians’ base score, performance score, and bonus point (if applicable) are added together for a total of up to 155 points.

• For clinicians for whom the objectives and measures are not applicable, CMS proposes to reweight the Advancing Care Information performance category to zero, and adjust the other MIPS performance category scores to make up the difference in the MIPS score.

Keep in mind that you need to fulfill the Base score or you will get a zero in the Advancing Care Information Performance Category.
Clinical Practice Improvement Activities Category

- The clinical practice improvement activities category accounts for 15 percent of the MIPS score in the first year.
- For this category, MIPS would reward clinical practice improvement activities such as activities focused on care coordination, beneficiary engagement, and patient safety, which clinicians would select from a list of more than 90 options.

Based on the law and the feedback received in the 2015 Request for Information, CMS proposes more than 90 activities (which will be updated annually) that clinicians may choose from in the following 9 subcategories:

|----------------------------|-------------------------|--------------------|
No clinician or group has to attest to more than 4 activities. Special consideration for:

- Practices with 15 or fewer clinicians
- Rural or geographic HPSA
- Non-patient facing
- APM
- Certified Medical Home

The maximum total points in this category would be 60 points. CMS proposes to determine a clinicians’ score by weighting the activities on which they report.

- Highly weighted activities would be worth 20 points, and other activities would be worth 10 points.
- CMS proposes that activities that would be highly weighted would be those activities that support the patient-centered medical home, as well as activities that support the transformation of clinical practice or a public health priority.
Total points = 40

Activity Weights
- Medium = 10 points
- High = 20 points

Alternate Activity Weights*
- Medium = 20 points
- High = 40 points

*For clinicians in small, rural, and underserved practices or with non-patient facing clinicians or groups

Full credit for clinicians in a patient-centered medical home, Medical Home Model, or similar specialty practice

Cost Category

- The cost category accounts for 0 percent of the MIPS score in the first year.
- Clinicians must see a sufficient number of patients in each cost measure to be scored, which is generally a minimum of a 20-patient sample.
- If a clinician does not have enough patient volume for any cost measures, then a cost score would not be calculated.
No submission requirements

Clinicians assessed through claims data

Clinicians earn a maximum of 10 points per episode cost measure

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

Reporting

• The rule proposes to allow third parties, including registries, Qualified Clinical Data Registries, health information technology developers, and certified survey vendors to act as intermediaries on behalf of clinicians and submit data for the performance categories as applicable.
GETTING READY FOR MIPS

Should I participate in MIPS as an individual or a group?

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
Should I Participate in MIPS as an Individual or a Group?

• **Reporting as an individual:**
  – If you send MIPS data in as an individual, your payment adjustment will be based on your performance.
  – You’ll send your individual data for each of the MIPS categories through an electronic health record, registry, or a qualified clinical data registry.

• **Reporting as a group:**
  – If you send your MIPS data with a group, the group will get one payment adjustment based on the group’s performance.
  – Your group will send in group-level data for each of the MIPS categories through the CMS web interface or an electronic health record, registry, or a qualified clinical data registry.

How do I know if I'm ready to participate in MIPS?

• Check that your electronic health record is certified by the Office of the National Coordinator for Health Information Technology.

• If it is, it should be ready to capture information for the MIPS advancing care information category and certain measures for the quality category.
2017 MIPS Performance

MIPS Overview
Use this tool to browse the different MIPS measures and activities.

Note: This tool is only for informational and estimation purposes. You can’t use it to submit or attest to measures or activities.

<table>
<thead>
<tr>
<th>Category</th>
<th>What do you need to do</th>
<th>2017 Category Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Most participants: Report up to 6 quality measures, including an outcome measure, for a minimum of 90 days. Groups using the web interface: Report 15 quality measures for a full year. Groups in APMs qualifying for special scoring under MIPS, such as Shared Savings Program Track 1 or the Oncology Care Model: Report quality measures through your APM. You do not need to do anything additional for MIPS quality.</td>
<td>60%</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>Most participants: Attest that you completed up to 4 improvement activities for a minimum of 90 days. Groups with fewer than 15 participants or if you are in a rural of health professional shortage area: Attest that you completed up to 2 activities for a minimum of 90 days. Participants in certified patient-centered medical homes, comparable specialty practices, or an APM designated as a Medical Home Model: You will automatically earn full credit.</td>
<td>15%</td>
</tr>
</tbody>
</table>
### Fulfill the required measures for a minimum of 90 days:

- Security Risk Analysis
- e-Prescribing
- Provide Patient Access
- Send Summary of Care
- Request/Accept Summary of Care

Choose to submit up to 9 measures for a minimum of 90 days for additional credit.

**For bonus credit, you can:**

- Report Public Health and Clinical Data Registry Reporting measures.
- Use certified EHR technology to complete certain improvement activities in the improvement activities performance category.

### OR

You may not need to submit advancing care information if these measures do not apply to you.

- No data submission required. Calculated from adjudicated claims.

**Cost**

Replaces the Value-based Modifier.

**Counted starting in 2018**
Quality Measures

Instructions

1. Review and select measures that best fit your practice.
2. Add up to six measures from the list below, including an outcome measure. You can use the search and filters to help find the measures that meet your needs or specialty.
3. If an outcome measure is not available that is applicable to your specialty or practice, choose another high priority measure.
4. Download a CSV file of the measures you have selected for your records.

Groups in APMs qualify for special scoring standards under MIPS, such as Shared Savings Program Tract 1 or the Oncology Care Model: Report quality measures through your APM. You do not need to do anything additional for the MIPS quality category.

Selected Measures

Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.

<table>
<thead>
<tr>
<th>Measure Number</th>
<th>NQF Domain</th>
<th>Measure Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>eMeasure ID: CMS142v5</td>
<td>Communication and Care Coordination</td>
<td>Process</td>
</tr>
<tr>
<td>eMeasure NQF: N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NQF: 0089</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality ID: 019</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>High Priority Measure</th>
<th>Data Submission Method</th>
<th>Specialty Measure Set</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Claims</td>
<td>Ophthalmology</td>
</tr>
<tr>
<td></td>
<td>EHR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Registry</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary Measure Steward</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Consortium for Performance Improvement</td>
<td></td>
</tr>
</tbody>
</table>
Hypertension: Improvement in Blood Pressure

Percentage of patients aged 18-85 years of age with a diagnosis of hypertension whose blood pressure improved during the measurement period.

<table>
<thead>
<tr>
<th>Measure Number</th>
<th>NQS Domain</th>
<th>Measure Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>eMeasure ID: CMS65v6</td>
<td>Effective Clinical Care</td>
<td>Intermediate Outcome</td>
</tr>
<tr>
<td>eMeasure NQF: N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NQF: N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality ID: 373</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>High Priority Measure</th>
<th>Data Submission Method</th>
<th>Specialty Measure Set</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>EHR</td>
<td></td>
</tr>
</tbody>
</table>

Primary Measure Steward
Centers for Medicare & Medicaid Services

Advancing Care Information

In 2017, there are two measure set options for reporting. The option you use to submit your data is based on your electronic health record edition.

- **Option 1**: Advancing Care Information Objectives and Measures
- **Option 2**: 2017 Advancing Care Information Transition Objectives and Measures

Need help identifying your electronic health record edition?

**Instructions**

1. Review the advancing care information measures available. Remember, in order to get credit for advancing care information, you must submit information for the required measures.
2. Download a CSV file of the measures for your records.
Select Measures

Security Risk Analysis
Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI data created or maintained by certified EHR technology in accordance with requirements in 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the MIPS eligible clinician’s risk management process.

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Objective Name</th>
<th>Required for Base Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACL_PPHI_1</td>
<td>Protect Patient Health Information</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Performance Score Weight
0

Request/Accept Summary of Care
For at least one transition of care or referral received or patient encounter in which the MIPS eligible clinician has never before encountered the patient, the MIPS eligible clinician receives or retrieves and incorporates into the patient’s record an electronic summary of care document.

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Objective Name</th>
<th>Required for Base Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACI_HIE_2</td>
<td>Health Information Exchange</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Performance Score Weight
Up to 10%
Next: Explore Improvement Activities

In this new performance category for 2017, clinicians are rewarded for care focused on care coordination, beneficiary engagement, and patient safety.

1. Review and select activities that best fit your practice.
   - Most participants: Attest that you completed up to 4 improvement activities for a minimum of 90 days.
   - Groups with fewer than 16 participants or if you are in a rural or health professional shortage area: Attest that you completed up to 2 activities for a minimum of 90 days.
   - Participants in certified patient-centered medical homes, comparable specialty practices, or an APM designated as a Medical Home Model: You will automatically earn full credit.
   - Participants in certain APMs under the APM scoring standard, such as Shared Savings Program Track 1 or the Oncology Care Model: You will automatically be scored based on the requirements of participating in the APM. For all current APMs under the APM scoring standard, this assigned score will be full credit. For all future APMs under the APM scoring standard, the assigned score will be at least half credit.

2. Download a CSV file of the activities you have selected for your records.

--

Improvement Activities

Diabetes screening
Diabetes screening for people with schizophrenia or bipolar disease who are using antipsychotic medication.

<table>
<thead>
<tr>
<th>Activity ID</th>
<th>Subcategory Name</th>
<th>Activity Weighting</th>
</tr>
</thead>
<tbody>
<tr>
<td>IA_BMH_1</td>
<td>Behavioral and Mental Health</td>
<td>Medium</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Activity ID</th>
<th>Subcategory Name</th>
<th>Activity Weighting</th>
</tr>
</thead>
<tbody>
<tr>
<td>IA_AHE_1</td>
<td>Achieving Health Equity</td>
<td>High</td>
</tr>
</tbody>
</table>
What are Alternative Payment Models (APMs?)

- An APM is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care.
- APMs can apply to a specific clinical condition, a care episode, or a population.
- Advanced APMs are a subset of APMs, and let practices earn more for taking on some risk related to their patients’ outcomes.
- You may earn a 5% incentive payment by going further in improving patient care and taking on risk through an Advanced APM.
Three requirements must be met for a clinician to earn incentive payments for participation in an APM under the QPP:

– (1) use of certified EHR technology
– (2) use of quality measures similar to those under MIPS in provider reimbursement, and
– (3) exist as either a Medical Home Model under the Act, or bear more than a nominal amount of risk for monetary losses.
Advanced APMs

In order to qualify for the 5% APM incentive payment for participating in an Advanced APM during a payment year, you must receive a certain percentage of payments for covered professional services or see a certain percentage of patients through the Advanced APM during the associated performance year.
Advanced APMs

In order to qualify for the 5% APM incentive payment for participating in an Advanced APM during a payment year, you must receive a certain percentage of payments for covered professional services or see a certain percentage of patients through the Advanced APM during the associated performance year.

<table>
<thead>
<tr>
<th>Performance Year</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022 and later</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of Medicare Payments through an Advanced APM</td>
<td>25%</td>
<td>25%</td>
<td>50%</td>
<td>50%</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Percentage of Medicare Patients through an Advanced APM</td>
<td>20%</td>
<td>20%</td>
<td>35%</td>
<td>35%</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>
For the 2017 Performance Year

• Comprehensive ESRD Care Model (Large Dialysis Organization (LDO) arrangement)
• Comprehensive ESRD Care Model (non-LDO arrangement)
• Comprehensive Primary Care Plus (CPC+)
• Medicare Shared Savings Program ACOs - Track 2
• Medicare Shared Savings Program ACOs - Track 3
• Next Generation ACO Model
• Oncology Care Model (two-sided risk arrangement)

©2017 Practice Management Institute®

For the 2018 Performance Year

• ACO Track 1+
• New voluntary bundled payment model
• Comprehensive Care for Joint Replacement Payment Model (Certified Electronic Health Record Technology (CEHRT) track)
• Advancing Care Coordination through Episode Payment Models Track 1 (CEHRT)
MIPS SCORING AND BENCHMARKING

MIPS performance categories and how are they scored?

• There are four categories of MIPS eligible clinician performance that contribute to a composite performance score of up to 100 points.
• For the CY2017 performance year and CY2019 payment year, the category weightings are:
  – Quality (60% for 2017)
  – Advancing Care Information (ACI, renamed from Meaningful Use) (25% for 2017)
  – Improvement Activities (IA) (15% for 2017)
  – Cost (0% for 2017, but will be weighted for 2018 and beyond)
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

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

Total Quality Performance Category Score = Points earned on required 6 quality measures + Any bonus points

Maximum number of points = 100%

Quick Tip: Maximum score cannot exceed 100%

*Maximum number of points = # of required measures x 10
• Most clinicians must report up to six PQRS measures, across any combination of quality domains, where one measure is an outcome measure.

• In addition to the six PQRS measures, CMS calculates one population measure for groups with 16 or more clinicians and a minimum of 200 cases.

• Each measure is assigned a possible 10 quality points so a total of 60-70 quality points are available, respectively, depending on the number of clinicians in the group being rated for MIPS.

• MIPS also provides additional paths to achieve a Quality score of 100% by granting bonus points for certain quality reporting activities.
Bonus points may be accrued as follows:

- **Up to 10% for submitting high priority measures:** Organizations that include high priority measures in the measures they choose to submit can receive a bonus of 1-2 points per measure total up to 10% of the total denominator of the Quality score, e.g. 10% of 60 = 6 max bonus points in the example above.

- **Up to 10% for end-to-end electronic reporting:** CMS is using the QPP to drive electronic reporting forward. Organizations that use end-to-end electronic reporting can achieve a bonus of 1 point for each measure totaling up to 10% of the possible performance points in the Quality category. Note that this bonus cap is a separate bonus cap from the high priority measures.

![MIPS Scoring for Cost (0% of Final Score in Transition Year)]

No submission requirements.

Clinicians assessed through claims data

Clinicians earn a maximum of 10 points per episode cost measure

Cost Performance Category Score = \[ \frac{10 \times \text{Number of scored measures}}{\text{Points assigned for scored measures}} \]

Quick Tip: No bonus points in cost performance category.
MIPS Performance Category: Advancing Care Information (25% of Final Score in Transition Year)

- Earn up to 155% maximum score, which will be capped at 100%.

Advancing Care Information category score includes:

- 50% Required Base score (50%)
- 90% Performance score (up to 90%)
- 15% Bonus score (up to 15%)

Keep in mind that you need to fulfill the Base score or you will get a zero in the Advancing Care Information Performance Category.

Example:

\[
\text{Advancing Care Information Performance Category Score} = \text{Base Score} + \text{Performance Score} + \text{Bonus Score}
\]

\[
\text{Advancing Care Information Performance Category Score} = 50 + \text{Performance Score} + \text{Bonus Score}
\]

\[
50 \times 25\% \text{ weight} \times 100 = 12.5
\]
MIPS changes Meaningful Use (renamed to ACI) from an all-or-nothing compliance program to a continuous scoring system where MU measure rates are compared to benchmarks in much the same way as described for the MIPS Quality category immediately above.

The ACI category defines 131 ACI performance points that can be earned:

- **Base Score:** 50 points for reporting either a non-zero numerator or a “yes,” as applies, for selected measures from the MU Modified Stage 2 or MU Stage 3 measure sets
- **Performance Score:** Up to 90 points for performance on eight measures per the decile scoring scale described above
- **Bonus Points:** Up to 15 bonus points for reporting to an additional public health registry and aligning with iA

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

Total points = 40.

<table>
<thead>
<tr>
<th>Activity Weights</th>
<th>Alternate Activity Weights*</th>
<th>Full credit for clinicians in a patient-centered medical home, Medical Home Model, or similar specialty practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Medium = 10 points</td>
<td>- Medium = 20 points</td>
<td>- For clinicians in small, rural, and underserved practices or with non-patient facing clinicians or groups</td>
</tr>
<tr>
<td>- High = 20 points</td>
<td>- High = 40 points</td>
<td></td>
</tr>
</tbody>
</table>

*For clinicians in small, rural, and underserved practices or with non-patient facing clinicians or groups
Under MIPS, clinicians need to either earn 20 points or 40 points, depending on their size and location.
- MIPS eligible clinicians or groups that are small practices (15 or less clinicians), practices located in rural areas or geographic HPSAs, or non-patient facing need to earn 20 points to get full credit in the IA category.
- All other MIPS-eligible clinicians need to earn 40 points to get full credit in the IA category.

To earn points, clinicians can:
- Report any combination of medium-weight (worth 10 points each) and/or high-weight (worth 20 points each) activities, or
- If a clinician participates in certain APMs, such as the Shared Savings Program Track 1 or the Oncology Care Model, the clinician earns 40 points (all future APMs under the APM scoring model will be assigned at least half credit), or
- If a clinician is in other APMs, the clinician automatically earns half credit and may report additional activities to increase the score.
Resource Use

• In 2017, the Resource Use weighting has been set to zero, but in 2018, that increases to 10%. MIPS rates clinicians for Resource Use (Medicare costs of attributed patients) based on 40+ cost measures to account for differences among specialties.

• There are no separate reporting requirements for clinicians, as the measures are calculated based on claims collected by CMS.

Calculating the Final Score under MIPS

\[
\text{Final Score} = \left( \text{Clinician Quality performance category score} \times \text{actual Quality performance category weight} \right) + \left( \text{Clinician Cost performance category score} \times \text{actual Cost performance category weight} \right) + \left( \text{Clinician Improvement Activities performance category score} \times \text{actual Improvement Activities performance category weight} \right) + \left( \text{Clinician Advancing Care Information performance category score} \times \text{actual Advancing Care Information performance category weight} \right) \times 100
\]
Assuming that the numerical examples used for the four categories as described above all apply to the same clinician, we can calculate a total MIPS score from the components:

- **Quality** = (42 of 60 points) x 60% weight x 100 = 42 points
- **ACI** = (50 of 100 points) x 25% weight x 100 = 12.5 points
- **IA** = (30 of 40 points) x 15% weight x 100 = 11.3 points (rounded up from 11.25)
- **Cost** = (14 of 20 points) x 0% weight x 100 = 0 points

**Total MIPS points = 42 + 12.5 + 11.3 + 0 = 65.8**
Transition Year 2017

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

Additional Adjustment Factors for MIPS: Exceptional Performer

“So what?”
Additional positive payment adjustments of $500,000,000 annually

Final scores of 70 or more qualify for additional payment

You Have Asked:  
‟Is the amount for top performers split amongst MIPS and APM participants?‟

No. You only are eligible for the exceptional performance bonus if you participate in MIPS.
MIPS UPDATES

New Resources for Determining Eligibility:

- MIPS Participation Status Letters
- MIPS Participation Fact Sheet
- MIPS Eligible Clinician Definitions and Exemptions
- Lookup Tool for First Year MIPS Eligibility
MIPS Participation Status Letters

- CMS has been sending out MIPS Participation Status Letters since late April, through the end of May 2017.
- They have released a “lookup tool” in order to determine prior to receiving your letter, if you will be eligible for the MIPS payment adjustment.
- If you are not eligible for the MIPS payment adjustment this year, but will be in the future, you may still report MIPS.
- You will not be eligible to receive an incentive or a penalty, but you will have access to a feedback report so you can determine changes that may need to be made in order to maximize your incentive in future years.

MIPS Participation Fact Sheet

- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) streamlines a patchwork collection of programs with a single system where you can be rewarded for better care.
- You’ll be able to practice as you always have, but you may receive higher Medicare payments based on your performance. There are two paths in this program:
  - Merit-based Incentive Payment System (MIPS)
  - Advanced Alternative Payment Models (APMs)
Focusing on MIPS Participation
Who Can Participate Now?

- Physicians, which 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, and chiropractors;
- Physician assistants (PAs);
- Nurse practitioners (NPs);
- Clinical nurse specialists;
- Certified registered nurse anesthetists; and
- Any clinician group that includes one of the professionals listed above.

Voluntary Participation

- Clinicians who are not included in MIPS now, may choose to voluntarily submit data individually to Medicare to learn, to obtain feedback on quality measures, and to prepare in the event MIPS is expanded in the future.

MIPS Participation for Clinicians Practicing in Rural Health Clinics (RHCs) or Federally Qualified Health Centers (FQHCs)

- Clinicians practicing in RHCs or FQHCs who provide services that are billed exclusively under the RHC or FQHC payment methodologies are not required to participate in MIPS and are not subject to a payment adjustment.
Support and Available Options for Small Practices

• Clinicians in small practices, including those in rural locations, health professional shortage areas, and medically underserved areas are a vital part of our healthcare system.

• To help get you started, CMS has launched the Small, Underserved, and Rural Support initiative to provide free, customized technical assistance to clinicians in small practices. This five-year program was funded by MACRA.
MIPS Lookup Tool

- This tool will help you determine whether you will need to participate in MIPS this year.
- Your status can be determined by accessing The Quality Payment Program page on CMS’ website. https://qpp.cms.gov/

Check your participation status

Enter your National Provider Identifier (NPI) number

NPI Number

Check NPI

©2017 Practice Management Institute®

Check this Tool if you are a:

- Physician
- Physician assistant
- Nurse practitioner
- Clinical nurse specialist
- Certified nurse practitioner

- You will not participate in MIPS if you are new to Medicare this year.

©2017 Practice Management Institute®
2017 Eligible Professionals Transitioning to MIPS Hardship Form

• Those EPs who are first time participants in 2017 have until October 1, 2017 to avoid the 2018 payment adjustment.
• For first time Medicare EHR Incentive Program participants in 2017, CMS is offering a one-time significant hardship exception for the Medicare EHR Incentive Program 2018 payment adjustment to provide EPs ample time to collaborate with their EHR vendors and adjust to the new reporting requirements in the advancing care information performance category of the MIPS.

A First Time Participant EP may Apply if:

• The EP is a first time participant in the EHR Incentive Program in CY 2017 and intends to participate in the Medicare EHR Incentive Program in CY 2017, and
• The EP is transitioning to MIPS for the 2017 performance period, and
• The EP intends to report on measures specified for the advancing care information performance category under the MIPS in 2017
Medicare Electronic Health Records (EHR) Incentive Program Hardship Exception Information

- An Eligible Professional (EP) may submit the EP Hardship Application transitioning to MIPS if the EP has never before successfully attested to meaningful use under the EHR Incentive Program and is transitioning to MIPS in Program Year 2017.
- The EP must submit this application no later than October 1, 2017.
- If an EP has successfully attested to meaningful use under the EHR Incentive Program in the past, but was unable to attest for a reason beyond their control in Program Year 2016, the EP can submit the standard 2018 EP Hardship Exception Application.

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** 1-866-288-8292
  - 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
Where do I Submit Comments?

- Comments must be submitted in one of the following ways:
  - Electronically through Regulations.gov
  - By regular mail
  - By express or overnight mail
  - By hand or courier

For additional information, please go to: OPPCMS.GOV

Questions?

- Thank you for your attendance!

- Get your questions answered on PMI's Discussion Forum:
  http://www.pmimd.com/pmiForums/rules.asp