Quality Payment
PROGRAM

QUALITY PAYMENT PROGRAM YEAR 3 PROPOSED RULE OVERVIEW

NEAL LOGUE, HEALTH INSURANCE SPECIALIST
DIVISION OF FINANCIAL MANAGEMENT & FEE FOR SERVICE OPERATIONS

AUGUST 22, 2018

Disclaimers

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

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

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

Quality Payment Program

Topics

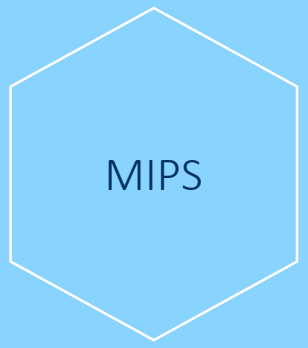
- Quality Payment Program Overview
- Merit-based Incentive Payment System (MIPS) Overview
- Proposed Rule for Year 3- MIPS
  - Eligibility
  - Data Submission
  - Reporting Options
  - Performance Categories
  - Performance Threshold and Payment Adjustments
- Help & Support

QUALITY PAYMENT PROGRAM

Overview

Quality Payment Program

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:



The Merit-based Incentive Payment System (MIPS)

If you are a MIPS eligible clinician, you will be subject to a performance-based payment adjustment through MIPS.

OR

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

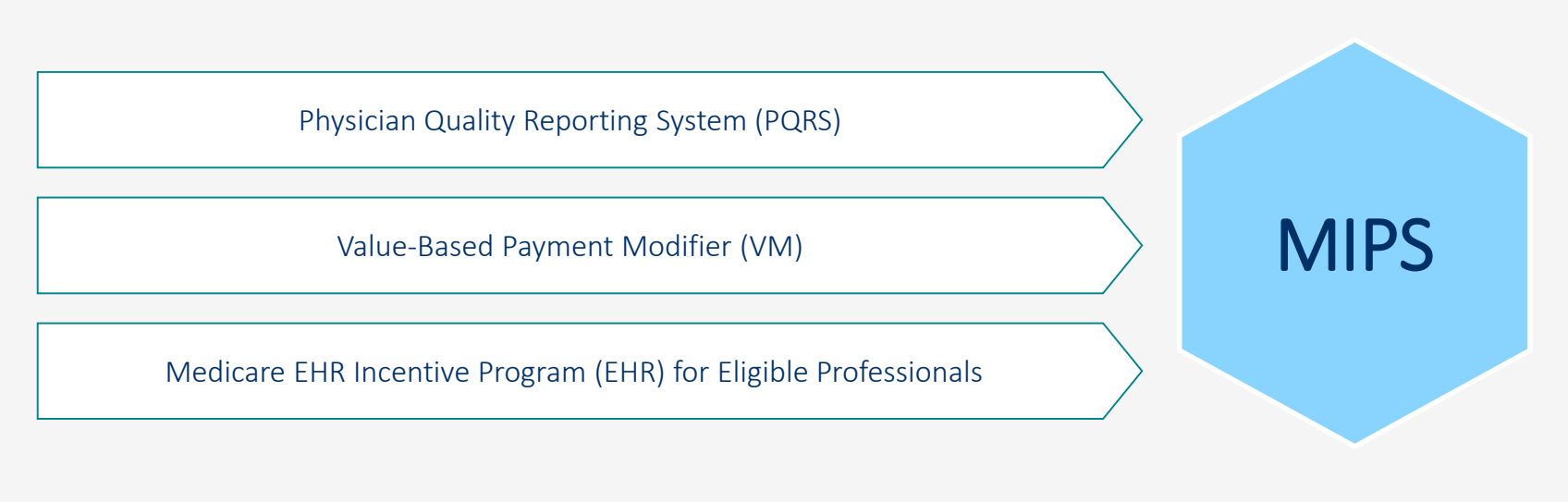
MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Overview

Merit-based Incentive Payment System (MIPS)

Quick Overview

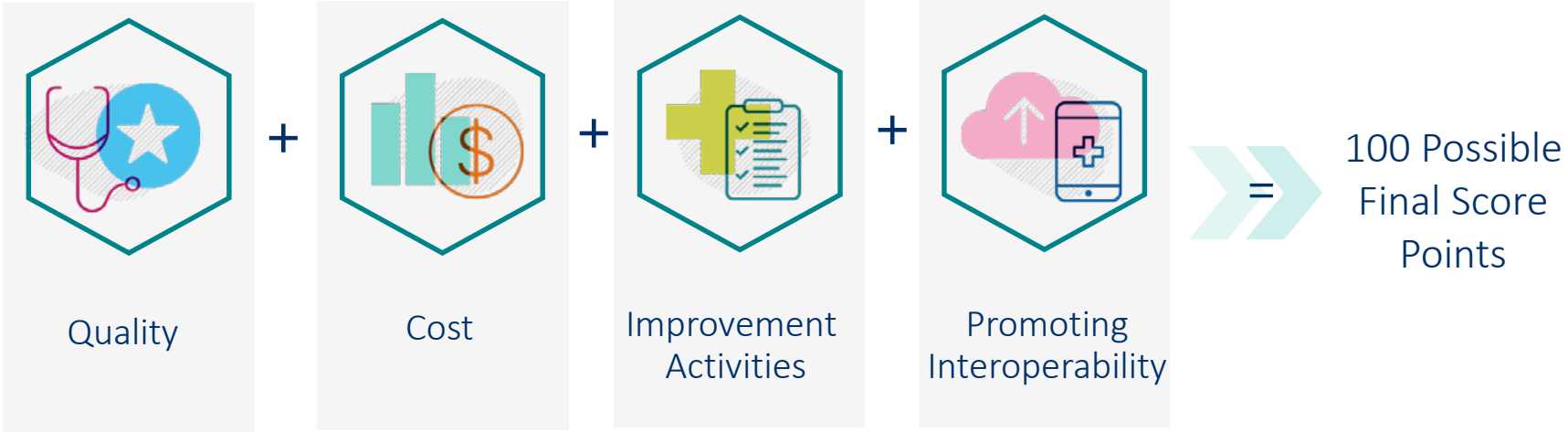
Combined legacy programs into a single, improved program.



Merit-based Incentive Payment System (MIPS)

Quick Overview

MIPS Performance Categories



- Comprised of **four** performance categories.
- 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**.

Merit-based Incentive Payment System (MIPS)

Terms and Timelines

As a refresher…

- TIN - Tax Identification Number
  - Used by the Internal Revenue Service to identify an entity, such as a group medical practice, that is subject to federal taxes
- NPI – National Provider Identifier
  - 10-digit numeric identifier for individual clinicians
- TIN/NPI
  - Identifies the individual clinician and the entity/group practice through which the clinician bills services to CMS

Performance Period	Also referred to as…	Corresponding Payment Year
2017	2017 “Transition” Year	2019
2018	“Year 2”	2020
2019	“Year 3”	2021

Merit-based Incentive Payment System (MIPS)

Timelines

2019
Performance Year

- Performance period opens January 1, 2019
- Closes December 31, 2019
- Clinicians care for patients and record data during the year

March 31, 2020
Data Submission

- Deadline for submitting data is March 31, 2020
- Clinicians are encouraged to submit data early

Feedback

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

January 1, 2021
Payment Adjustment

- MIPS payment adjustments are prospectively applied to each claim beginning January 1, 2021

Merit-based Incentive Payment System (MIPS)

Bipartisan Budget Act of 2018

Provides additional authority to continue the gradual transition in MIPS, including:

- Changing the application of MIPS payment adjustments, so adjustments will *not* apply to all items and services under Medicare Part B, but will now apply only to **covered professional services** under the Physician Fee Schedule (PFS) beginning in 2019, which is the first payment year for MIPS.
- Changing the way MIPS eligibility is determined with respect to low-volume threshold. Beginning in 2018 (current performance period), low-volume threshold determinations are based on allowed charges for **covered professional services** under the PFS, *not* all Medicare Part B allowed charges.
- Providing flexibility in the weighting of the Cost performance category for three additional years.
- Allowing flexibility in establishing the performance threshold for three additional years to ensure gradual and incremental transition to the estimated performance threshold based on the mean or median of final scores from prior year that will apply in 6th year of program.

PROPOSED RULE FOR YEAR 3 - MIPS

Eligibility

MIPS Year 3 (2019) Proposed

MIPS Eligible Clinician Types

Year 2 (2018) Final

MIPS eligible clinicians include:

- Physicians
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Register Nurse Anesthetists

Year 3 (2019) Proposed

MIPS eligible clinicians include:

- Same five clinician types from Year 2 (2018)

AND:

- Clinical Psychologists
- Physical Therapists
- Occupational Therapists
- Clinical Social Workers

MIPS Year 3 (2019) Proposed

Low-volume Threshold Criteria

Year 2 (2018) Final

Low-volume threshold determination criteria:

- Dollar amount
- Number of beneficiaries

Year 3 (2019) Proposed

Low-volume threshold determination criteria:

- Dollar amount
- Number of beneficiaries
- Number of services (*Newly proposed)*

MIPS Year 3 (2019) Proposed

Low-Volume Threshold Determination

Proposed low-volume threshold includes MIPS eligible clinicians billing more than $90,000 a year in allowed charges for covered professional services under the Medicare Physician Fee Schedule **AND** furnishing covered professional services to more than 200 Medicare beneficiaries a year **AND** providing more than 200 covered professional services under the PFS. To be included, a clinician must exceed all three criterion.

Year 2 (2018) Final

Year 3 (2019) Proposed

Note: For MIPS APMs participants, the low-volume threshold determination will continue to be calculated at the APM Entity level.

MIPS Year 3 (2019) Proposed

Opt-in Policy

Proposing an opt-in policy for MIPS eligible clinicians who are excluded from MIPS based on the low-volume threshold determination.

- MIPS eligible clinicians who meet or exceed at least one of the low-volume threshold criteria may choose to participate in MIPS.

MIPS Opt-in Scenarios

Dollars	Beneficiaries	Professional Services (New-proposed)	Eligible for Opt-in?
≤ 90K	≤ 200	≤ 200	No – excluded
≤ 90K	≤ 200	> 200	Yes (may also voluntarily report or not participate)
> 90K	≤ 200	≤ 200	Yes (may also voluntarily report or not participate)
≤ 90K	> 200	> 200	Yes (may also voluntarily report or not participate)
> 90K	> 200	> 200	No – required to participate

MIPS Year 3 (2019) Proposed

Opt-in Policy – Example

Physical Therapist (Individual)

✓ Billed $100,000	x Saw 100 patients	✓ Provided 201 covered professional services

- Did not exceed **all** three elements of the low-volume threshold determination criteria, therefore exempt from MIPS in Year 3.

However…

- This clinician could **opt-in** to MIPS and participate in Year 3 (2019) since the clinician met or exceeded at least **one** (in this case, two) of the low-volume threshold criteria and is also a MIPS eligible clinician type.

MIPS Year 3 (2019) Proposed

Opt-in Policy

What else do I need to know?

Proposing that to make an election to opt-in (or voluntarily report), individual eligible clinicians and groups would:

- Sign-in to qpp.cms.gov
- Select the option to opt-in (or voluntarily report).
  - Once an election has been made, the decision to opt-in to MIPS would be **irrevocable** and **could not be changed**.
  - Clinicians or groups who opt-in are subject to all of the MIPS rules, special status, and MIPS payment adjustment.
  - Please note that APM Entities interested in opting-in to participate in MIPS under the APM Scoring Standard would do so at the APM Entity level.

*We encourage you to review the wireframe drawings on the three different approaches to MIPS participation on qpp.cms.gov/design-examples.

PROPOSED RULE FOR YEAR 3 - MIPS

Data Submission

MIPS Year 3 (2019) Proposed

Collection, Submission, and Submitter Types

Year 2 (2018) Final

"Submission mechanisms" used all-inclusively when referencing:

- Method by which data is submitted (e.g., registry, EHR, attestation, etc.)
- Certain types of measures and activities on which data are submitted
- Entities submitting such data (i.e. third party intermediaries submitting on behalf of a group)

Year 3 (2019) Proposed

To enhance clarity and reflect the user experience, we are proposing to revise existing and define additional terminology:

- Collection Types
- Submission Types
- Submitter Types

MIPS Year 3 (2019) Proposed

Collection, Submission, and Submitter Types

Definitions for Newly Proposed Terms:

- **Collection type-** a set of quality measures with comparable specifications and data completeness criteria including, as applicable: electronic clinical quality measures (eCQMs); MIPS Clinical Quality Measures* (MIPS CQMs); Qualified Clinical Data Registry (QCDR) measures; Medicare Part B claims measures; CMS Web Interface measures; the CAHPS for MIPS survey; and administrative claims measures.

- **Submission type-** the mechanism by which a submitter type submits data to CMS, including, as applicable: direct, log in and upload, log in and attest, Medicare Part B claims, and the CMS Web Interface.

- **Submitter type**- the MIPS eligible clinician, group (including APM Entities and virtual groups), or third party intermediary acting on behalf of a MIPS eligible clinician or group, as applicable, that submits data on measures and activities.

*The term MIPS CQMs would replace what was formerly referred to as “registry measures” since entities other than registries may submit data on these measures.

**We encourage you to review the proposed terms and wireframes for the submission types on qpp.cms.gov/design-examples.

PROPOSED RULE FOR YEAR 3 - MIPS

Reporting Options

MIPS Year 3 (2019) Proposed

Reporting Options – General

Same reporting options as Year 2. Clinicians can report:

1. As an Individual—under an National Provider Identifier (NPI) number and Taxpayer Identification Number (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

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

MIPS Year 3 (2019) Proposed

Virtual Group Elections

Year 2 (2018) Final

Virtual group elections:

- Must be made by December 31 of calendar year preceding applicable performance period, and cannot be changed during performance period.
- Election process broken into two stages: Stage 1 (optional) pertains to virtual group eligibility determinations, and Stage 2 pertains to virtual group formation.
- Technical assistance available to help with the election process.

Year 3 (2019) Proposed

Virtual group elections:

Same requirements as Year 2, with the following changes:

- TINs would be able to inquire about their TIN size prior to making an election during a 5-month timeframe, which would begin on August 1 and end on December 31 of a calendar year prior to the applicable performance period.
- TIN size inquiries would be made through the Quality Payment Program Service Center.

PROPOSED RULE FOR YEAR 3 - MIPS

Performance Categories

MIPS Year 3 (2019) Proposed

Performance Periods

Year 2 (2018) Final

Performance Category	Performance Period
Quality	12-months
Cost	12-months
Improvement Activities	90-days
Promoting Interoperability	90-days

Year 3 (2019)– *No Change*

Performance Category	Performance Period
Quality	12-months
Cost	12-months
Improvement Activities	90-days
Promoting Interoperability	90-days

MIPS Year 3 (2019) Proposed

Performance Category Weights

Year 2 (2018) Final

Performance Category	Performance Category Weight
Quality	50%
Cost	10%
Improvement Activities	15%
Promoting Interoperability	25%

Year 3 (2019) Proposed

Performance Category	Performance Category Weight
Quality	45%
Cost	15%
Improvement Activities	15%
Promoting Interoperability	25%

MIPS Year 3 (2019) Proposed

Quality Performance Category

Basics:

- ***Proposed Change***: **45%** of Final Score in 2019
- You select 6 individual measures
  - 1 must be an outcome measure
    OR
  - High-priority measure
- If less than 6 measures apply, then report on each applicable measure
- You may also select a specialty-specific set of measures

Bonus Points

Year 2 (2018) Final	Year 3 (2019) Proposed
• 2 points for outcome or patient experience • 1 point for other high-priority measures • 1 point for each measure submitted using electronic end-to-end reporting • Cap bonus points at 10% of category denominator	**Same requirements** as Year 2, with the following change: • Add **small practice bonus** of 3 points for MIPS eligible clinicians in small practices who submit data on at least 1 quality measure

Quick Tip: A small practice is defined as 15 or fewer eligible clinicians.

MIPS Year 3 (2019) Proposed

Cost Performance Category

Basics:

- *Proposed Change*: **15%** of Final Score in 2019
- Measures:
  - Medicare Spending Per Beneficiary (MSPB)
  - Total Per Capita Cost
  - **Adding** 8 episode-based measures
- No reporting requirement; data pulled from administrative claims
- No improvement scoring in Year 3

Measure Case Minimums

Year 2 (2018) Final	Year 3 (2019) Proposed
• Case minimum of 20 for Total per Capita Cost measure and 35 for MSPB	**Same requirements** as Year 2, with the following additions: • Case minimum of 10 for procedural episodes • Case minimum of 20 for acute inpatient medical condition episodes

MIPS Year 3 (2019) Proposed

Improvement Activities Performance Category

Basics:

- ***Proposed:*** **15%** of Final Score in 2019
- Select Improvement Activities and attest "yes" to completing
- Activity weights remain the same:
  - Medium = 10 points
  - High = 20 points
- **Small practices, non-patient facing clinicians, and/or clinicians located in rural or HPSAs** continue to receive double-weight and report on no more than 2 activities to receive the highest score

Activity Inventory

- Adding 6 new Improvement Activities
- Modifying 5 existing Improvement Activities
- Removing 1 existing Improvement Activity

CEHRT Bonus

- Proposing to remove the bonus to align with the new Promoting Interoperability scoring requirements, which no longer consists of a bonus score component.*

**Contingent upon the new Promoting Interoperability scoring methodology being finalized*

MIPS Year 3 (2019) Proposed

Promoting Interoperability Performance Category

Basics:

- ***Proposed***: **25%** of Final Score in 2019
- Must use **2015 Edition Certified EHR Technology** (CEHRT) in 2019
- ***Proposed***: New performance-based scoring
- ***Proposed***: 100 total category points

Reporting Requirements

Year 2 (2018) Final	Year 3 (2019) Proposed
• Comprised of a base, performance, and bonus score • Must fulfill the base score requirements to earn a Promoting Interoperability score	• Eliminate the base, performance, and bonus scores • Propose a **new performance-based scoring** at the individual measure level • Must report the required measures under each Objective, or claim the exclusions

MIPS Year 3 (2019) Proposed

Promoting Interoperability Performance Category

Basics:

- ***Proposed***: **25%** of Final Score in 2019
- Must use **2015 Edition Certified EHR Technology** (CEHRT) in 2019
- ***Proposed***: New performance-based scoring
- ***Proposed***: 100 total category points

Objectives and Measures

Year 2 (2018) Final	Year 3 (2019) Proposed
• Two measure set options for reporting based on the MIPS eligible clinician's edition of CEHRT (either 2014 or 2015)	• One set of Objectives and Measures based on 2015 Edition CEHRT • Four Objectives: e-Prescribing, Health Information Exchange, Provider to Patient Exchange, and Public Health and Clinical Data Exchange • Add two new measures to the e-Prescribing Objective: Query of Prescription Drug Monitoring Program (PDMP) and Verify Opioid Treatment Agreement

MIPS Year 3 (2019) Proposed

Promoting Interoperability Performance Category

Objectives	Measures	Maximum Points
e-Prescribing	• e-Prescribing	• 10 points
	• Query of Prescription Drug Monitoring Program (PDMP) (new)	• 5 bonus points
	• Verify Opioid Treatment Agreement (new)	• 5 bonus points
Health Information Exchange	• Support Electronic Referral Loops by Sending Health Information (formerly Send a Summary of Care)	• 20 points
	• Support Electronic Referral Loops by Receiving and Incorporating Health Information (new)	• 20 points
Provider to Patient Exchange	• Provide Patients Electronic Access to their Health Information (formerly Provide Patient Access)	• 40 points
Public Health and Clinical Data Exchange	Choose two: • Immunization Registry Reporting • Electronic Case Reporting • Public Health Registry Reporting • Clinical Data Registry Reporting • Syndromic Surveillance Reporting	• 10 points

MIPS Year 3 (2019) Proposed

Promoting Interoperability Performance Category

Basics:

- ***Proposed***: **25%** of Final Score in 2019
- Must use **2015 Edition Certified EHR Technology** (CEHRT) in 2019
- ***Proposed***: New performance-based scoring
- ***Proposed***: 100 total category points

Reweighting

Year 2 (2018) Final	Year 3 (2019) Proposed
• Automatic reweighting for the following MIPS eligible clinicians: Non-Patient Facing, Hospital-based, Ambulatory Surgical Center-based, PAs, NPs, Clinical Nurse Specialists, and CRNAs • Application based reweighting also available for certain circumstances • Example: clinicians who are in small practices	**Same requirements** as Year 2, with the following additions: • Extend the automatic reweighting to Physical Therapists, Occupational Therapists, Clinical Social Workers, and Clinical Psychologists

PROPOSED RULE FOR YEAR 3 - MIPS

Performance Threshold and Payment Adjustments

MIPS Year 3 (2019) Proposed

Performance Threshold and Payment Adjustments

Year 2 (2018) Final

- 15 point performance threshold
- Exceptional performance bonus set at 70 points
- Payment adjustment could be up to +5% or as low as -5%*
- Payment adjustment (and exceptional performer bonus) is based on comparing final score to performance threshold and additional performance threshold for exceptional performance

Year 3 (2019) Proposed

- 30 point performance threshold
- Exceptional performance bonus set at 80 points
- Payment adjustment **could be up to +7%** or as low as -7%*
- Payment adjustment (and exceptional performer bonus) is based on comparing final score to performance threshold and additional performance threshold for exceptional performance

*To ensure budget neutrality, positive MIPS payment adjustment factors are likely to be increased or decreased by an amount called a "scaling factor." The amount of the scaling factor depends on the distribution of final scores across all MIPS eligible clinicians.

MIPS Year 3 (2019) Proposed

Performance Threshold and Payment Adjustments

Year 2 (2018) Final

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

Year 3 (2019) Proposed

Final Score 2018	Payment Adjustment 2020
≥80 points	• Positive adjustment greater than 0% • Eligible for exceptional performance bonus—minimum of additional 0.5%
30.01-79.99 points	• Positive adjustment greater than 0% • Not eligible for exceptional performance bonus
30 points	• Neutral payment adjustment
7.51-29.99	• Negative payment adjustment greater than -7% and less than 0%
0-7.5 points	• Negative payment adjustment of -7%

Comments due September 10

When and Where to Submit Comments

- See proposed rule for information on submitting comments by close of 60-day comment period on **September 10** (When commenting **refer to file code CMS CMS 1693-P)**
- Instructions for submitting comments can be found in proposed rule; FAX transmissions will not be accepted
- You must officially submit your comments in one of following ways:
  - electronically through Regulations.gov
  - by regular mail
  - by express or overnight mail
  - by hand or courier

Technical Assistance

Available Resources

CMS has free resources and organizations on the ground to provide help to clinicians who are participating 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 TCPI.ISC@TruvenHealth.com for extra assistance.

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

SMALL & SOLO PRACTICES

Small, Underserved, and Rural Support (SURS)

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

LARGE PRACTICES

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

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

Locate the QIN-QIO that serves your state

Quality Innovation Network (QIN) Directory

TECHNICAL SUPPORT

All Eligible Clinicians Are Supported By:

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

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

Center for Medicare & Medicaid Innovation (CMMI) Learning Systems
Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs. More information about the Learning Systems is available through your model's support inbox.

Learn more about technical assistance: https://qpp.cms.gov/about/help-and-support#technical-assistance

Contact information

CMS Region IX,
Division of Financial Management
and Fee for Service Operations
Email: ROSFOFM@cms.hhs.gov
Phone: (415) 744-3658
FAX: (443) 380-7177