Quality Payment
PROGRAM

# **PROPOSED** RULE FOR QUALITY PAYMENT PROGRAM YEAR 2

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# QUALITY PAYMENT PROGRAM

## Overview

# Quality Payment Program

## MIPS and Advanced APMs

Quality Payment PROGRAM

The Quality Payment Program is:

- Promoting greater value in Medicare Part B payments for more than 600,000 clinicians
- Improving care across the entire healthcare delivery system

Clinicians have two tracks to choose from:


The Merit-based Incentive Payment System (MIPS)

*If you decide to participate in MIPS, you may earn 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

Quality Payment PROGRAM

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

Quick Tip:

For additional information on the Quality Payment Program, please visit QPP.CMS.GOV

# Quality Payment Program

## Considerations

Quality Payment PROGRAM

- CMS has a responsibility to make healthcare accessible and affordable for all Americans.
- Four considerations guide our overall policies for the Quality Payment Program:
  - Empowering patients and doctors to make decisions about their healthcare
  - Ushering in a new era of state flexibility and local leadership
  - Supporting innovative approaches to improving quality, accessibility, and affordability
  - Improving the CMS customer experience
- Taken together, our four considerations will help ensure that we always put people first in everything we do at CMS – and in our healthcare system.

# **PROPOSED** RULE FOR YEAR 2

Merit-based Incentive Payment System

# Proposed Rule for Year 2

## MIPS: Low-Volume Threshold

Quality Payment PROGRAM

### Transition Year 1 Final

Exclude individual MIPS eligible clinicians or groups who bill ≤$30,000 in Part B allowed charges OR provide care for ≤100 Part B enrolled beneficiaries during the performance period or a prior period.

**Note:** Individual MIPS eligible clinicians and groups who are excluded may voluntarily participate in MIPS, but would not subject to the MIPS payment adjustments.

### Year 2 Proposed

Exclude MIPS eligible clinicians or groups who bill ≤$90,000 in Part B allowed charges OR provide care for ≤ 200 Part B enrolled beneficiaries during the performance period or a prior period.

**Note:** Individual MIPS eligible clinicians and groups who are excluded may voluntarily participate in MIPS, but would not be subject to the MIPS payment adjustments.

# Proposed Rule for Year 2

## Who Participates in MIPS?

Quality Payment PROGRAM

- No change in the types of clinicians eligible to participate in 2018.
- Other types may be added for the 2019 MIPS performance period.
- The same exclusions will remain in the 2018 MIPS performance period:
  - Eligible clinicians new to Medicare.
  - Clinicians below the low-volume threshold.
  - Clinicians significantly participating in Advanced APMs.

**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.

MIPS eligible clinicians include:

Physicians

Physician Assistants

Nurse Practitioners

Clinical Nurse Specialists

Certified Registered Nurse Anesthetists

# Proposed Rule for Year 2

## MIPS: Virtual Groups

Quality Payment PROGRAM

- Definition: A combination of two or more Taxpayer Identification Numbers (TINs) composed of a solo practitioner (individual MIPS eligible clinician who bills under a TIN with no other NPIs billing under such TIN), or a group with 10 or fewer eligible clinicians under the TIN that elects to form a virtual group with at least one other such solo practitioner or group for a performance period for a year.
- All MIPS eligible clinicians within a TIN must participate in the virtual group.
- Virtual groups must elect to participate in MIPS as a virtual group prior to the beginning of the performance period and such election cannot be changed once the performance period starts. If TIN/NPIs move to an APM, we propose to use waiver authority to use the APM score over the virtual group score.

# Proposed Rule for Year 2

## MIPS: Virtual Groups

Quality Payment PROGRAM

- Generally, policies that apply to groups would apply to virtual groups with a few exceptions such as the definition of a non-patient facing MIPS eligible clinician; and small practice, rural area, and Health Professional Shortage Area (HPSA) designations.
  - Virtual groups use same submission mechanisms as groups.
- Virtual groups may determine their own composition without restrictions based on geographic area or specialty.
- Initially, there will be no restriction on overall virtual group size.
- CMS will define a “Model Agreement” and will provide a template through additional communications guidance for virtual groups that choose to use it.

# Proposed Rule for Year 2

## MIPS: Non-patient Facing

Quality Payment PROGRAM

- Non patient-facing:
  - Individuals ≤100 patient facing encounters.
  - Groups: >75% of NPIs billing under the group's TIN during a performance period are labeled as non-patient facing.
  - Virtual Groups: >75% of NPIs within a virtual group during a performance period are labeled as non-patient facing.

- To reduce burden, non-patient facing MIPS eligible clinicians, groups, and virtual groups would have reduced requirements for two performance categories in the 2018 MIPS performance period.

For **improvement activities**, non-patient facing MIPS eligible clinicians, groups, and virtual groups can report fewer activities (2 medium or 1 high activity) and achieve a maximum improvement activities performance score.

For **advancing care information**, non-patient facing MIPS eligible clinicians, groups, and virtual groups qualify for the reweighting policy, which sets the performance category weight to zero and reallocates the points to other performance categories.

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# Proposed Rule for Year 2

## MIPS: Performance Period

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### Transition Year 1 Final

- Minimum 90-day performance period for quality, advancing care information, and improvement activities. Exception: measures through CMS Web Interface, CAHPS, and the readmission measures are 12 months.
- Cost (which is not included in Year 1) is based on 12 months of data for feedback purposes only.

### Year 2 Proposed

- 12-month calendar year for quality and cost performance categories.
- 90-days for advancing care information and improvement activities.
- Although the cost category will still be weighted at 0% for next year and clinicians don't need to report on this category, we will still provide feedback to clinicians on cost and we believe a 12-month period will provide more reliable measures.

Need to submit MIPS performance data by March 31, 2019

# Proposed Rule for Year 2

## MIPS: Performance Threshold

Quality Payment PROGRAM

### Transition Year 1 Final

- 3 points
- Additional performance threshold set at 70 points for exceptional performance.
- Payment adjustment for the 2019 MIPS payment year ranges from -4% to +(4% x 3 scaling factor).

### Year 2 Proposed

- 15 points
- Additional performance threshold remains at 70 points for exceptional performance.
- Payment adjustment for the 2020 MIPS payment year ranges from -5% to + (5% x 3 scaling factor).

Some examples of how to 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.

# Proposed Rule for Year 2

## MIPS: Performance Threshold

Quality Payment PROGRAM

| Final Score (Transition Year) | Transition Year Payment Adjustment | Final Score (Year 2) | Year 2 Proposed Payment Adjustment |
|---|---|---|---|
| ≥70 points | • Positive adjustment<br>• Eligible for exceptional performance bonus—minimum of additional 0.5% | ≥70 points | • Positive adjustment<br>• Eligible for exceptional performance bonus—minimum of additional 0.5% |
| 4-69 points | • Positive adjustment<br>• Not eligible for exceptional performance bonus | 16-69 points | • Positive adjustment<br>• Not eligible for exceptional performance bonus |
| 3 points | • Neutral payment adjustment | 15 points | • Neutral payment adjustment |
| 0 points | • Negative payment adjustment of -4%<br>• 0 points = does not participate | 0 points | • Negative payment adjustment of -5%<br>• 0 points = does not participate |

# Proposed Rule for Year 2

## MIPS: Submission Mechanisms

Quality Payment PROGRAM

- **Transition Year 1 Final**

Only one submission mechanism is allowed per performance category.

- **Year 2 Proposed**

- No change in the types of submission mechanisms available in each performance category.
- Virtual groups would have the same submission mechanisms available to groups.
- Multiple submission mechanisms would be allowed (except for CMS Web Interface) as necessary to meet the requirements of the quality, improvement activities, or advancing care information performance categories.

# Submission Mechanisms

## MIPS

Quality Payment PROGRAM

| Performance Category | Submission Mechanisms for Individuals | Submission Mechanisms for Groups |
|---|---|---|
|  Quality | Claims<br>QCDR<br>Qualified registry<br>EHR | QCDR<br>Qualified registry EHR<br>CMS Web Interface (groups of 25 or more)<br>CMS-approved survey vendor for CAHPS for MIPS (must be reported in conjunction with another data submission mechanism.)<br>Administrative claims (for readmission measure – no submission required) |
|  Cost | Administrative claims (no submission required) | Administrative claims (no submission required) |
|  Advancing Care Information | Attestation<br>QCDR<br>Qualified registry<br>EHR | Attestation<br>QCDR<br>Qualified registry<br>EHR<br>CMS Web Interface (groups of 25 or more) |
|  Improvement Activities | Attestation<br>QCDR<br>Qualified registry<br>EHR | Attestation<br>QCDR<br>Qualified registry<br>EHR<br>CMS Web Interface (groups of 25 or more) |

# Proposed Rule for Year 2

## MIPS: Facility Based Measurement

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- **Year 2 Proposed**

- Facility-based measurement assesses clinicians in the context of the facilities at which they work to better measure their quality.
- Facility-based scoring will be implemented in a limited fashion in the first year for the quality and cost performance categories.
- This voluntary facility-based scoring mechanism will be aligned with the Hospital Value Based Purchasing Program (Hospital VBP) to help reduce burden for clinicians.
- Eligible as individual: You must have 75% of services in the inpatient hospital or emergency room.
- Eligible as group: 75% of eligible clinicians must meet eligibility criteria as individuals.
- We propose for the 2020 MIPS payment year to include all the measures adopted for the FY 2019 Hospital VBP Program on the MIPS list of quality and cost measures.
- Scores are derived using the data at the facility where the clinician treats the highest number of Medicare beneficiaries.
- The facility-based measurement option converts a hospital Total Performance Score into a MIPS quality performance category and cost performance category score.

# Proposed Rule for Year 2

Quality Payment PROGRAM

- MIPS: Facility Based Measurement

- **Year 2 Proposed**

- We seek comments on our proposed election process:

**Opt-in**

(proposed method)

Individual MIPS eligible clinicians or groups actively elect to have their facility's performance attributed to their quality and cost performance category scores. Note: if a clinician does not opt-in, he or she could lose out on possible higher scores.

**Opt-out**

(seeking comments on this alternative approach)

We would use facility-based scores if they are higher than the scores for any other option submitted. Clinicians would need to take no action for this option, but they may also not be aware their facility scores are being used for MIPS

# Proposed Rule for Year 2

## MIPS: Quality

Quality Payment PROGRAM

**Weight to final score:**

- Retain 60% in 2020 payment year
- Maintain 30% in 2021 payment year and beyond

### Data completeness:

- No change, but we intend to increase the data completeness threshold to 60% for the 2019 MIPS performance period.
- Measures that fail data completeness will receive 1point instead of 3 points, **except that small practices will continue to receive 3 points**

### Scoring:

- Maintain 3-point floor for measures scored against a benchmark.
- Maintain 3 points for measures that do not have a benchmark or do not meet case minimum.
- No change to bonuses.
- Proposed changes to CAHPS survey collection and scoring.

# Proposed Rule for Year 2

## MIPS: Quality Topped Out Measures

Quality Payment PROGRAM

- Starting with the 2018 MIPS performance period, in the second consecutive year, or beyond, we will apply a cap of 6 points for a select set of 6 topped out measures.
- We propose after three years to consider removal of consider removing the topped out measures through notice and comment rulemaking for the fourth year.
- This policy would not apply to CMS Web Interface measures.

# Proposed Rule for Year 2

## MIPS: Cost

Quality Payment PROGRAM

**Weight to final score:**

- Propose 0% in 2020 MIPS payment year but seek comment on a 10% weight.
- Maintain 30% in 2021 MIPS payment year and beyond.

### Measures:

- Even though we are proposing that the cost performance category be weighted at 0, we are proposing to calculate measures for feedback purposes.
- Include only the Medicare Spending Per Beneficiary (MSPB) and total per capita cost measures in calculating cost performance category score.
- Did not include previous episode-based measures as we continue to develop new episode-based measures in collaboration with expert clinicians..
- We'll continue to offer feedback on episode-based measures prior to potential inclusion of these measures in MIPS to increase clinician familiarity with these measures .

### Scoring:

- Cost improvement scoring is proposed, but will not contribute to the 2018 final score.

# Proposed Rule for Year 2

## MIPS Scoring: Scoring Improvements

Quality Payment PROGRAM

Rewards improvement in performance for a MIPS eligible clinician or group for a current performance period compared to the prior performance period

- **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 is measured at the performance category level.
  - Up to 10 percentage points available in the performance category.
- **For cost**:
  - Improvement scoring will be based on statistically significant changes at the measure level.
  - Although, we propose an improvement scoring methodology for cost, it would not affect the MIPS final score for the 2020 MIPS payment year.
  - No improvement percentage points available for the cost category for the 2020 payment year. (The weight for the cost category is proposed to be 0 in 2020.)

In 2020, Improvement percentage points will be added to the quality performance category, but the performance category scores cannot exceed 100%.

# Proposed Rule for Year 2

## MIPS: Improvement Activities

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### Number of activities:

- No change in the number of activities that MIPS eligible clinicians must report to achieve a total of 40 points.
- 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.
- We are proposing additional activities, and changes to existing activities for the Improvement Activities Inventory including credit for using Appropriate Use Criteria (AUC).

- We expand the definition of certified patient centered medical home, to include the CPC+ model, and clarify that the term “recognized” is equivalent to the term “certified” as a patient centered medical home or comparable specialty practice.
- For the number of practice sites within a TIN that need to be recognized as patient-centered medical homes for the TIN to receive the full credit for improvement activities, we propose a threshold of 50% for 2018.

# Proposed Rule for Year 2

## MIPS: Improvement Activities

Quality Payment PROGRAM

Scoring:

- Continue to designate activities within the performance category that also qualify for an advancing care information bonus.
- For group reporting, only one MIPS eligible clinician in a TIN must perform the improvement activity for the TIN to receive credit. We recommend no change to this policy for 2018, but seek comment on a threshold for the future.
- Continue to allow simple attestation of improvement activities.

# Proposed Rule for Year 2

## MIPS: Advancing Care Information

Quality Payment PROGRAM

- Allow clinicians to use either the 2014 or 2015 CEHRT Edition in 2018 and provide a bonus for use of 2015 CEHRT edition.
- Add more improvement activities to the list eligible for an advancing care information bonus.
- Expand options beyond the one immunization registry reporting measure for 10% toward the performance score and allow reporting on a combination of other public health registry measures that may be more readily available for 5% each toward the performance score (up to 10%).
- For the 5% bonus, must report to a different public health agency or registry than those used to earn the performance score.

- Add a decertification hardship for eligible clinicians whose EHR was decertified.
- Change the deadline for the significant hardship application for 2017 and going forward to be December 31 of the performance period.
- Add new category of exception, for MIPS eligible clinicians in small practices and those practicing in HPSAs to reweight advancing care information category to zero and reallocating the 25% to the quality performance category.

# Proposed Rule for Year 2

## MIPS Scoring: Complex Patient Bonus

Quality Payment PROGRAM

- Apply an adjustment of 1 to 3 bonus points to the final score by adding the average Hierarchical Conditions Category (HCC) risk score to the final score.
- Generally, this will award between 1 to 3 points to clinicians based on the medical complexity for the patients treated.

It is important to reward and incentivize clinicians who treat complex patients, so we are adding a bonus to the final score.

# Proposed Rule for Year 2

## MIPS Scoring: Small Practice Bonus

Quality Payment PROGRAM

- Adjust the final score of any MIPS eligible clinician or group who is in a small practice (15 or fewer clinicians) by adding 5 points, so long as the MIPS eligible clinician or group submits data on at least 1 performance category in an applicable performance period.
- Seek comment on whether the small practice bonus should be extended to those who practice in rural areas as well.
- Add **5 additional points** for small practices to the final score.

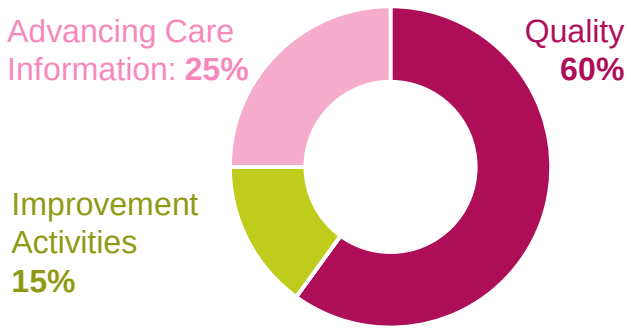
We recognize the challenges of small practices and will provide a 5 point bonus to help them successfully meet MIPS requirements to incentivize their participation.

# Proposed Rule for Year 2

## MIPS Scoring: 2018 MIPS Performance Year Final Score

Quality Payment PROGRAM

- Quality 60%, Cost 0%, Improvement Activities 15%, and Advancing Care Information 25%.




- Continue to allow reweighting of the advancing care information performance category to the quality performance category (for hardships, and other specified situations).
- Proposed Propose new extenuating circumstances for quality, cost, and improvement activities performance categories.
- Add 5 bonus points for small practices.
- Add 1 to 3 points to the final score for caring for complex patients.
- Add a 10-point bonus for those clinicians who use 2015 CEHRT.
- Seek comment on adding bonus points for practices in rural areas.

# QUALITY PAYMENT PROGRAM

Resources

# Technical Assistance

Available Resources

Quality Payment PROGRAM

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.

To learn more, view the Technical Assistance Resource Guide:
https://qpp.cms.gov/resources/education

# Proposed Rule: Comments Were Due 8/21/2017

# Questions???

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