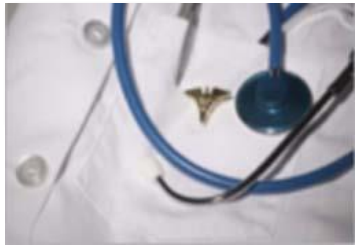
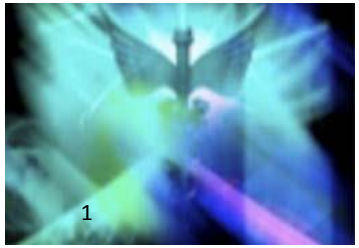
American Medical Association's National Advocacy Conference





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Centers for Medicare & Medicaid Services

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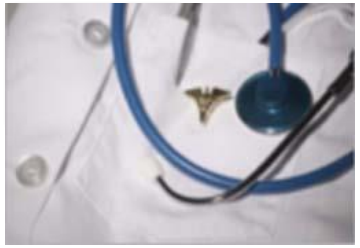
Quality Payment PROGRAM



Year 2

Quality Payment Program

Improve beneficiary outcomes

Reduce burden on clinicians

Increase adoption of Advanced APMs

Maximize participation

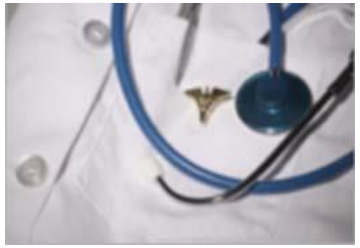
Improve data and information sharing

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.

Quality Payment PROGRAM



Merit-Based Incentive Payment System (MIPS)

MIPS Year 2 (2018)
Who is Included?

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

MIPS eligible clinicians include:

Physicians

Physician Assistants

Nurse Practitioners

Clinical Nurse Specialists

Certified Registered Nurse Anesthetists

MIPS Year 2 (2018)
Who is Included?

As a reminder: the definition of Physicians includes:

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

MIPS Eligibility Year 2

***Change** to the Low-Volume Threshold for 2018.* Include MIPS eligible clinicians billing more than $90,000 a year in Medicare Part B allowed charges **AND** providing care for more than 200 Medicare patients a year.

Transition Year 1 (2017) Final

BILLING >$30,000

AND

>100

Year 2 (2018) Final

BILLING >$90,000

AND

>200

Voluntary reporting remains an option for those clinicians who are exempt from MIPS.

MIPS Year 2 (2018) *Performance Period*

Change: *Increase to Performance Period*

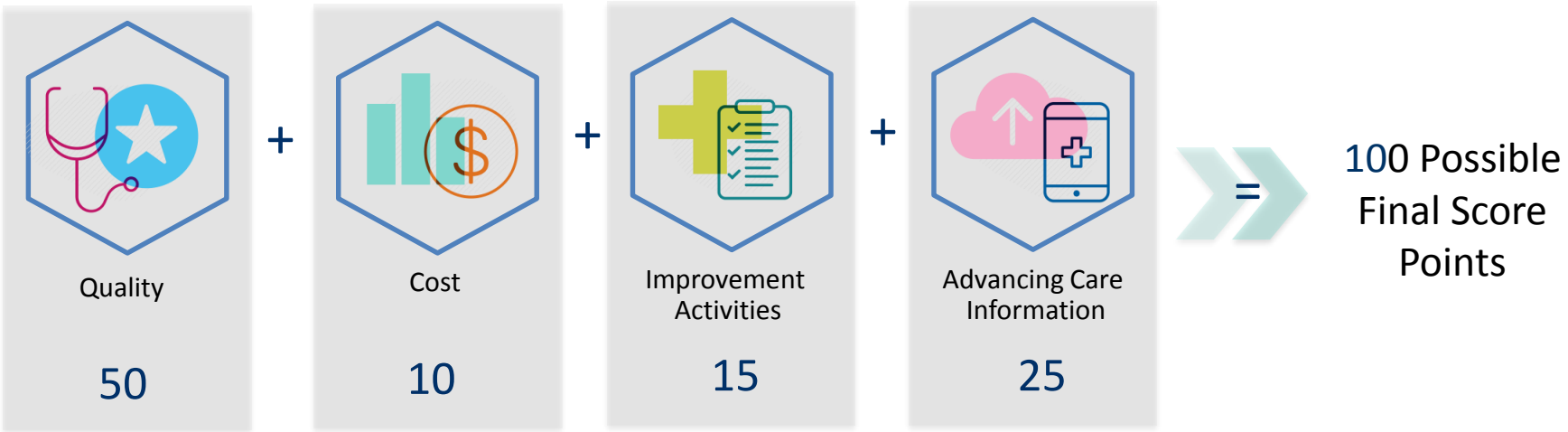
Transition Year 1 (2017) Final

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

Year 2 (2018) Final

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

MIPS Performance Categories Year 2



- Comprised of **four** performance categories in 2018.
- **So what?** *The points from each performance category are added together to give you a MIPS Final Score.*
- The MIPS Final Score is compared to the MIPS performance threshold to determine if you receive a **positive**, **negative**, or **neutral payment adjustment**.

Cost Category in Year 2

Basics:

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

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

New: Virtual Groups in Year 2

What is a virtual group?

- A virtual group can be made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together "virtually" (no matter what specialty or location) to participate in MIPS for a performance period for a year.

- To be eligible to join or form a virtual group, you would need to be a:
  - **Solo practitioners** who exceed the low-volume threshold individually, and are not a newly Medicare-enrolled eligible clinician, a Qualifying APM Participant (QP), or a Partial QP choosing not to participate in MIPS.
  - **Group** that has 10 or fewer eligible clinicians and exceeds the low-volume threshold at the group level.

Performance Threshold Year 2

Change: *Increase in Performance Threshold and Payment Adjustment*

Transition Year 1 (2017) Final

- 3 point threshold
- Exceptional performer set at 70 points
- Payment adjustment set at +/- 4%

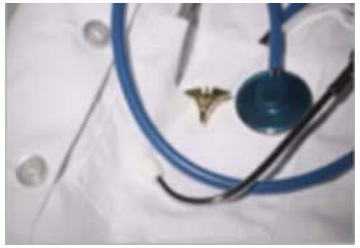
Year 2 (2018) Final

- 15 point threshold
- Exceptional performer set at 70 points
- Payment adjustment set at +/- 5%

How can I achieve 15 points?

- Report all required Improvement Activities.
- Meet the Advancing Care Information base score and submit 1 Quality measure that meets data completeness.
- Meet the Advancing Care Information base score, by reporting the 5 base measures, and submit one medium-weighted Improvement Activity.
- Submit 6 Quality measures that meet data completeness criteria.

Quality Payment PROGRAM



Alternative Payment Models

Alternative Payment Models (APMs)
Quick Overview

- As defined by MACRA, APMs include CMS Innovation Center models (authorized under section 1115A, other than a Health Care Innovation Award), MSSP (Medicare Shared Savings Program), demonstrations under the Health Care Quality Demonstration Program, and demonstrations required by federal law.
- Advanced APMs are a subset of APMs. To be an Advanced APM, a model must meet the following three statutory requirements:
  - Requires participants to use **certified EHR technology**;
  - Provides payment for covered professional services based on **quality measures** comparable to those used in the MIPS quality performance category; and
  - Either: (1) is a **Medical Home Model expanded** under CMS Innovation Center authority OR (2) requires **participants to bear a more than nominal amount of financial risk**.
- In order to achieve status as a Qualifying APM Participant (QP) and qualify for the 5% APM incentive payment for a year, eligible clinicians must receive a certain percentage of payments for covered professional services or see a certain percentage of patients through an Advanced APM during the associated performance period.

Advanced APMs
Generally Applicable Nominal Amount Standard

Transition Year 1 (2017) Final

Total potential risk under the APM must be equal to at least either:

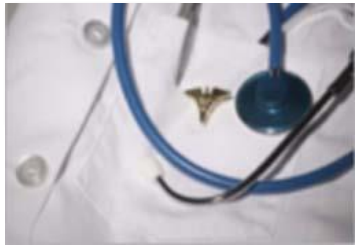
- 8% of the average estimated Parts A and B revenue of the participating APM Entities for the QP performance period in 2017 and 2018, OR
- 3% of the expected expenditures an APM Entity is responsible for under the APM for all performance years.

Year 2 (2018) Final

**The 8% revenue-based standard is extended for two additional years, through performance year 2020.

- Total potential risk under the APM must be equal to at least either:
  - 8% of the average estimated Parts A and B revenue of the participating APM Entities for QP Performance Periods 2017, 2018, 2019, and 2020, OR
  - 3% of the expected expenditures an APM Entity is responsible for under the APM for all performance years.

Quality Payment PROGRAM



QPP Submission User Interface

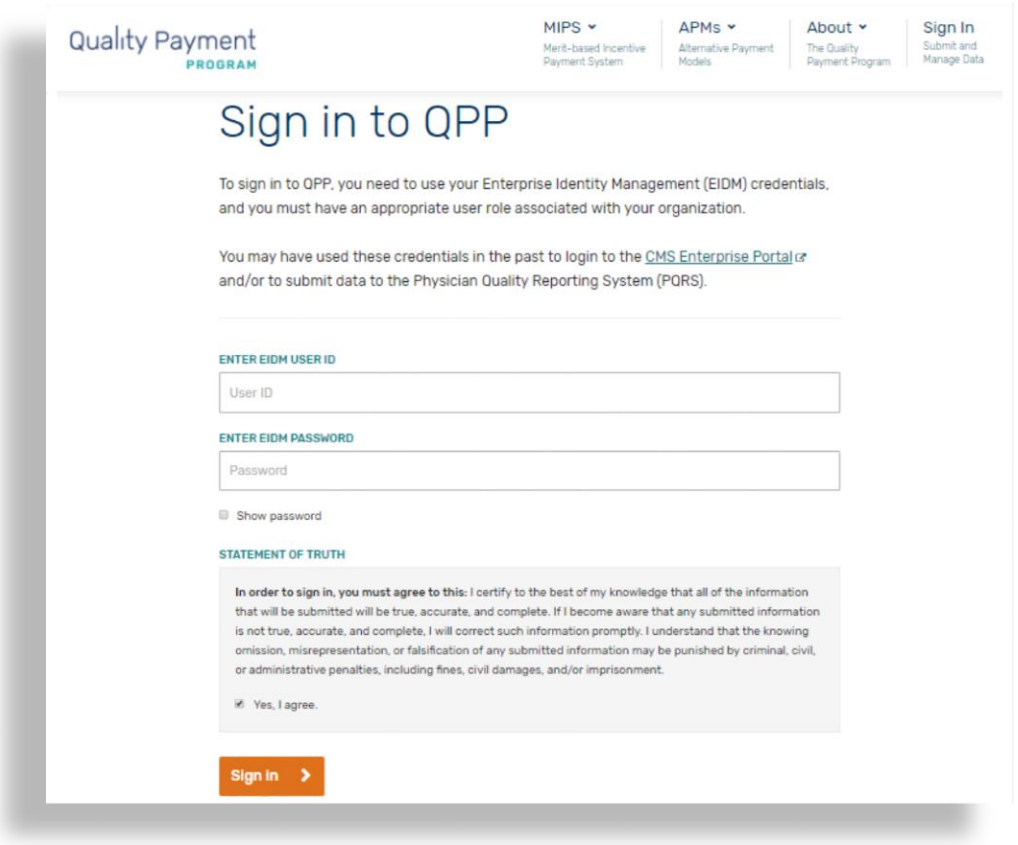
Overview

1. QPP Login
2. QPP Landing page
3. Quality
4. Advancing Care Information
5. Improvement Activities
6. File Upload

Login

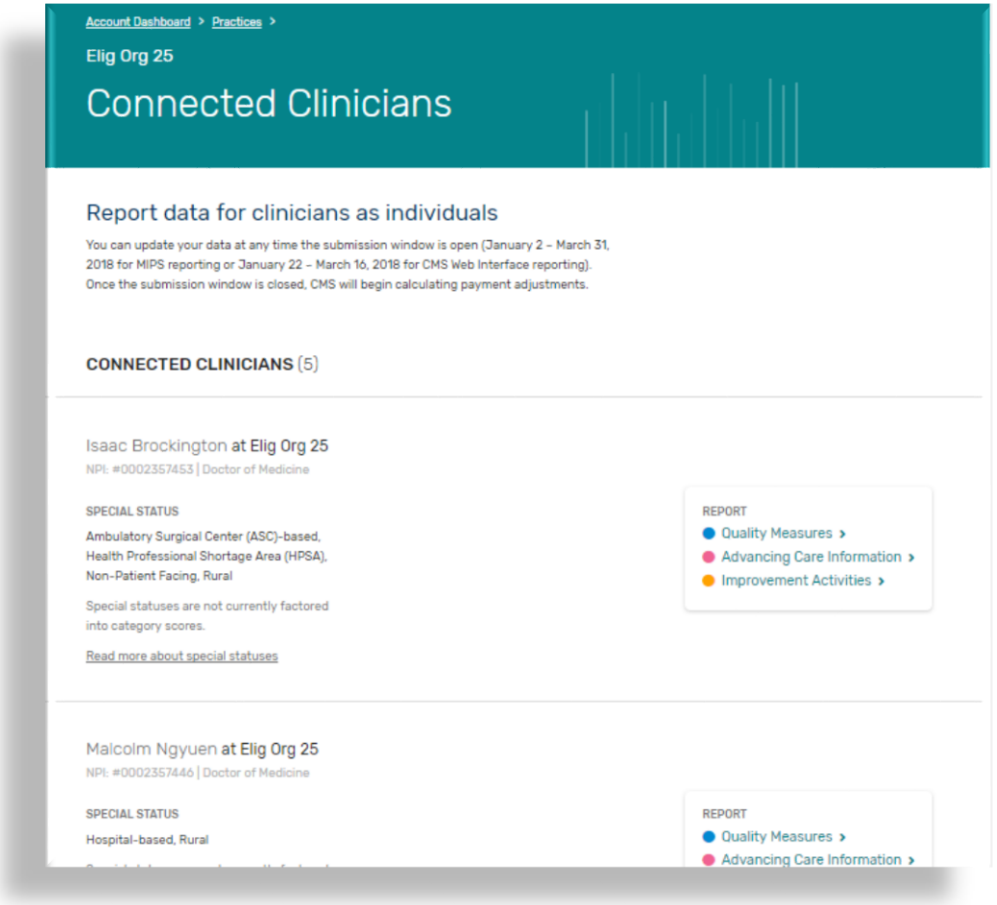
From QPP home page (https://qpp.cms.gov/):

1. User select to Sign In.
2. User is then prompted to provide User Id and Password.
3. User is able to login after authentication.



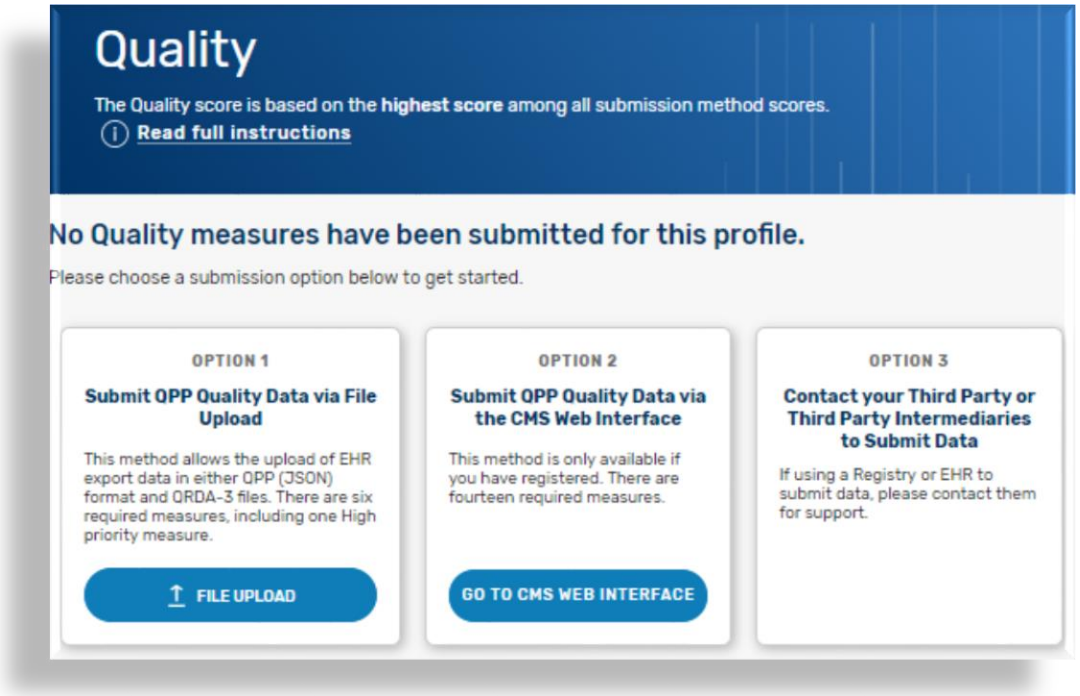
Landing Page

1. User arrives at account dashboard
2. User will view associated practices (Group or Individual), for which they can report.
3. User selects to report Performance Category Data



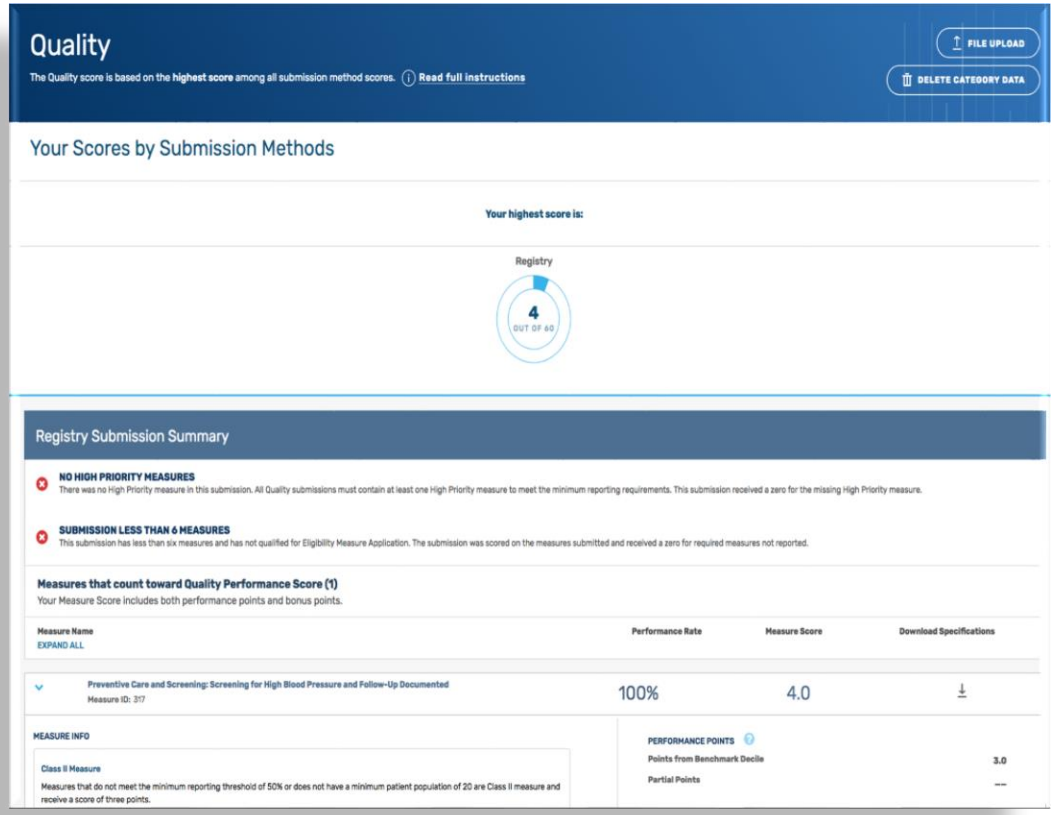
Quality Submission

1. Users with no Quality data submitted will be notified and provided the opportunity to submit data.
2. CMS Web Interface option is only provided for registered Users.



Quality

1. User will view Category score and measure details.
2. User can select to upload data file.
3. Notifications and warnings are provided to guide users on submission requirements.



Key Takeaways on Data Submission Feature

- Single site to submit all data
- Designed using Human-centered design techniques
  - Frequent proto-typing and testing with practicing clinicians and practice managers
- On-screen notifications and warnings
- Drag and drop File Upload
- No “Submit” button
- Submit data as often as you like
- Real-time performance category scoring
  - New “claims to quality” feature
  - Scoring changes if you upload new data – you can re-submit data any time
- **Data submission ends March 31st, 2018**

What's Next?

- 2018 Eligibility look-up for MIPS
- Predictive Qualified Participant status (Advanced APMs)
- Multi-payer Advanced APMs
- Feedback reports
  - New look and feel
  - Easier to access
  - Will include MIPS payment adjustment in addition to quality/cost performance information
- Year 3 rule-making
  - Reviewing flexibilities provided in the CR bill
  - Simplification of some of the complex policies and scoring
  - Facility-based scoring details
  - Exploring ways to further reduce burden on clinicians

Contact Information

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