



American Medical Association's National Advocacy Conference

Kate Goodrich, MD MHS

Director, Center for Clinical Standards & Quality,
Chief Medical Officer

Centers for Medicare & Medicaid Services



Disclaimers

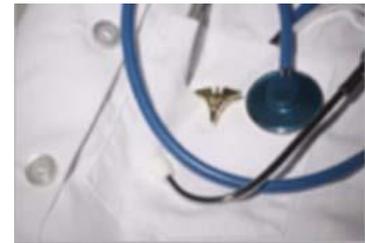
This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response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

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.

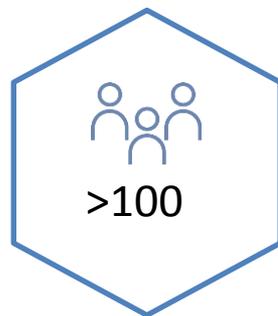
MIPS Eligibility Year 2

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



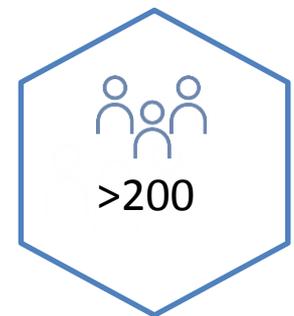
AND



Year 2 (2018) Final



AND



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

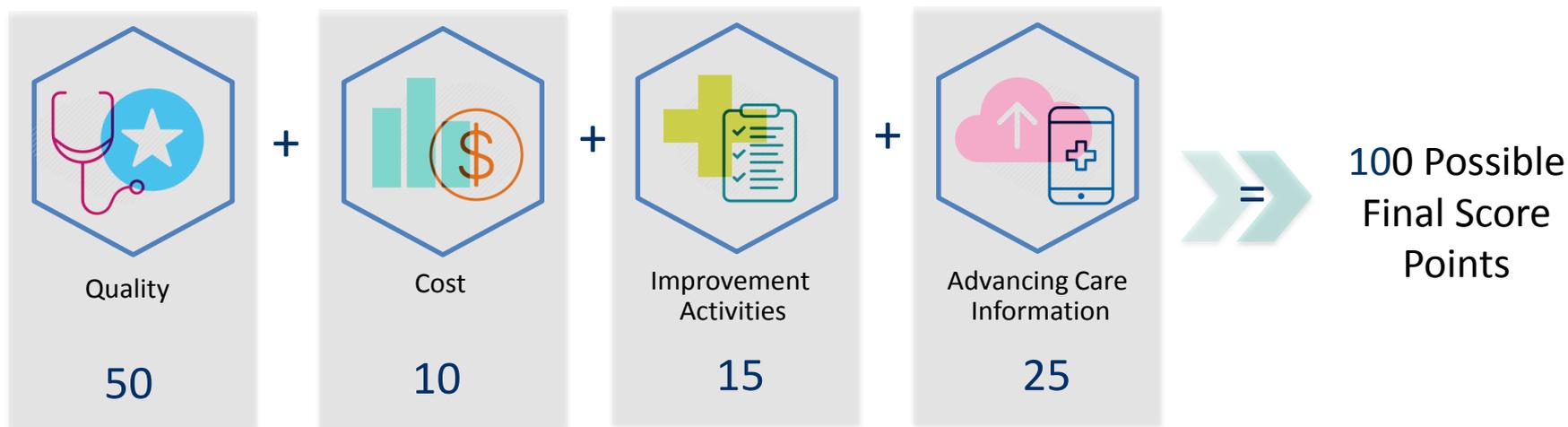
Performance Category	Minimum Performance Period
 Quality	90-days minimum; full year (12 months) was an option
 Cost	Not included. 12-months for feedback only.
 Improvement Activities	90-days
 Advancing Care Information	90-days



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

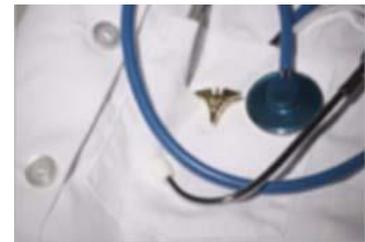
- 15 point threshold
- Exceptional performer set at 70 points
- Payment adjustment set at +/- 5%

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.

Quality Payment PROGRAM

MIPS Merit-based Incentive Payment System | APMs Alternative Payment Models | About The Quality Payment Program | Sign In Submit and Manage Data

Sign in to QPP

To sign in to QPP, you need to use your Enterprise Identity Management (EIDM) credentials, and you must have an appropriate user role associated with your organization.

You may have used these credentials in the past to login to the [CMS Enterprise Portal](#) and/or to submit data to the Physician Quality Reporting System (PQRS).

ENTER EIDM USER ID

ENTER EIDM PASSWORD

Show password

STATEMENT OF TRUTH

In order to sign in, you must agree to this: I certify to the best of my knowledge that all of the information that will be submitted will be true, accurate, and complete. If I become aware that any submitted information is not true, accurate, and complete, I will correct such information promptly. I understand that the knowing omission, misrepresentation, or falsification of any submitted information may be punished by criminal, civil, or administrative penalties, including fines, civil damages, and/or imprisonment.

Yes, I agree.

Sign in >

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

Account Dashboard > Practices >
Elig Org 25

Connected Clinicians

Report data for clinicians as individuals

You can update your data at any time the submission window is open (January 2 - March 31, 2018 for MIPS reporting or January 22 - March 16, 2018 for CMS Web Interface reporting). Once the submission window is closed, CMS will begin calculating payment adjustments.

CONNECTED CLINICIANS (5)

Isaac Brockington at Elig Org 25
NPI: #0002357453 | Doctor of Medicine

SPECIAL STATUS
Ambulatory Surgical Center (ASC)-based,
Health Professional Shortage Area (HPSA),
Non-Patient Facing, Rural

Special statuses are not currently factored into category scores.
[Read more about special statuses](#)

REPORT

- Quality Measures >
- Advancing Care Information >
- Improvement Activities >

Malcolm Ngyuen at Elig Org 25
NPI: #0002357446 | Doctor of Medicine

SPECIAL STATUS
Hospital-based, Rural

REPORT

- Quality Measures >
- Advancing Care Information >

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

The Quality score is based on the **highest score** among all submission method scores.
[Read full instructions](#)

No Quality measures have been submitted for this profile.

Please choose a submission option below to get started.

OPTION 1	OPTION 2	OPTION 3
Submit OPP Quality Data via File Upload	Submit OPP Quality Data via the CMS Web Interface	Contact your Third Party or Third Party Intermediaries to Submit Data
This method allows the upload of EHR export data in either OPP (JSON) format and QRDA-3 files. There are six required measures, including one High priority measure.	This method is only available if you have registered. There are fourteen required measures.	If using a Registry or EHR to submit data, please contact them for support.
FILE UPLOAD	GO TO CMS WEB INTERFACE	

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.

The screenshot displays a web interface for Quality scores. At the top, there's a header with the word "Quality" and a sub-header "The Quality score is based on the highest score among all submission method scores." with a "Read full instructions" link. On the right, there are buttons for "FILE UPLOAD" and "DELETE CATEGORY DATA".

The main section is titled "Your Scores by Submission Methods". It shows "Your highest score is:" followed by a circular gauge for "Registry" with a score of "4 OUT OF 40".

Below this is a "Registry Submission Summary" section with two warning icons:

- NO HIGH PRIORITY MEASURES**: There was no High Priority measure in this submission. All Quality submissions must contain at least one High Priority measure to meet the minimum reporting requirements. This submission received a zero for the missing High Priority measure.
- SUBMISSION LESS THAN 6 MEASURES**: This submission has less than six measures and has not qualified for Eligibility Measure Application. The submission was scored on the measures submitted and received a zero for required measures not reported.

A section titled "Measures that count toward Quality Performance Score (1)" states: "Your Measure Score includes both performance points and bonus points." Below this is a table with columns: Measure Name, Performance Rate, Measure Score, and Download Specifications.

Measure Name	Performance Rate	Measure Score	Download Specifications
EXPAND ALL			
Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented Measure ID: 317	100%	4.0	↓

Below the table is a "MEASURE INFO" section for "Class II Measure". It includes a description: "Measures that do not meet the minimum reporting threshold of 50% or does not have a minimum patient population of 20 are Class II measure and receive a score of three points." To the right, a "PERFORMANCE POINTS" section shows "Points from Benchmark Decline" as 3.0 and "Partial Points" as ---.

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

Kate Goodrich, M.D., MHS

*Director, Center for Clinical Standards and Quality
Chief Medical Officer*

Centers for Medicare and Medicaid Services

410-786-6841 | kate.goodrich@cms.hhs.gov