Quality Payment
PROGRAM

QUALITY PAYMENT PROGRAM YEAR 3 (2019) FINAL RULE OVERVIEW

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DECEMBER 12, 2018

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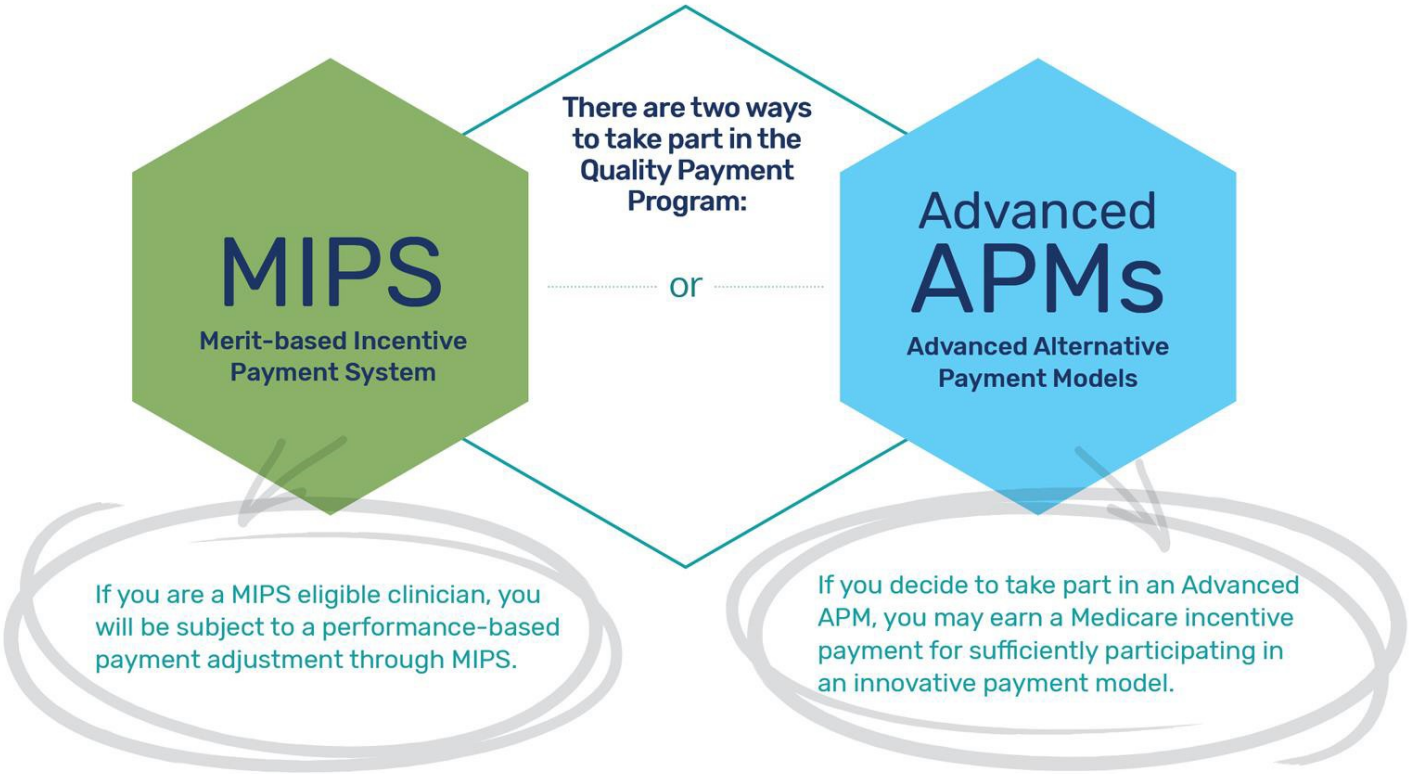
Quality Payment Program

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:



QPP Year 1 (2017) Performance Data

Payment Adjustments

The 2017 performance year for the Quality Payment Program was:

THE FIRST YEAR OF THE PROGRAM	A TRANSITION YEAR FOR MANY CLINICIANS	IMPLEMENTED GRADUALLY THROUGH "PICK YOUR PACE"	FOCUSED ON FLEXIBILITY TO REDUCE PARTICIPATION BURDEN

Snapshot of Payment Adjustments for MIPS Eligible Clinicians

71% earned a positive adjustment and an adjustment for exceptional performance

22% earned a positive payment adjustment only

2% received a neutral adjustment (no increase or decrease)

5% received a negative payment adjustment

Payment Adjustment Highlights

	Negative* 0 pts 5%	Neutral 3 pts 2%	Positive Only >3.01-69.99 pts 22%	Positive with Additional Adjustment for Exceptional Performance ≥70-100 pts 71%
Min Adjustment	0.00%	0.00%	0.00%	0.28%
Max Adjustment	-4.00%	0.00%	0.20%	1.88%
Min Final Score	0.00	3.00	3.01	70.00
Max Final Score	2.99	3.00	69.99	100

For negative payment adjustments only: The Minimum Final Score is associated with the Maximum Payment Adjustment

General Participation in 2017:

- 1,057,824 total MIPS eligible clinicians* received a MIPS payment adjustment (positive, neutral, or negative)
- 1,006,319 total MIPS eligible clinicians reported data and received a neutral payment adjustment or better
- 99,076 total Qualifying APM Participants (QPs)
- 52 total number of Partial QPs

*Clinicians are identified under the Quality Payment Program by their unique Taxpayer Identification Number/National Provider Identifier Combination (TIN/NPI)

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Overview

Merit-based Incentive Payment System (MIPS)

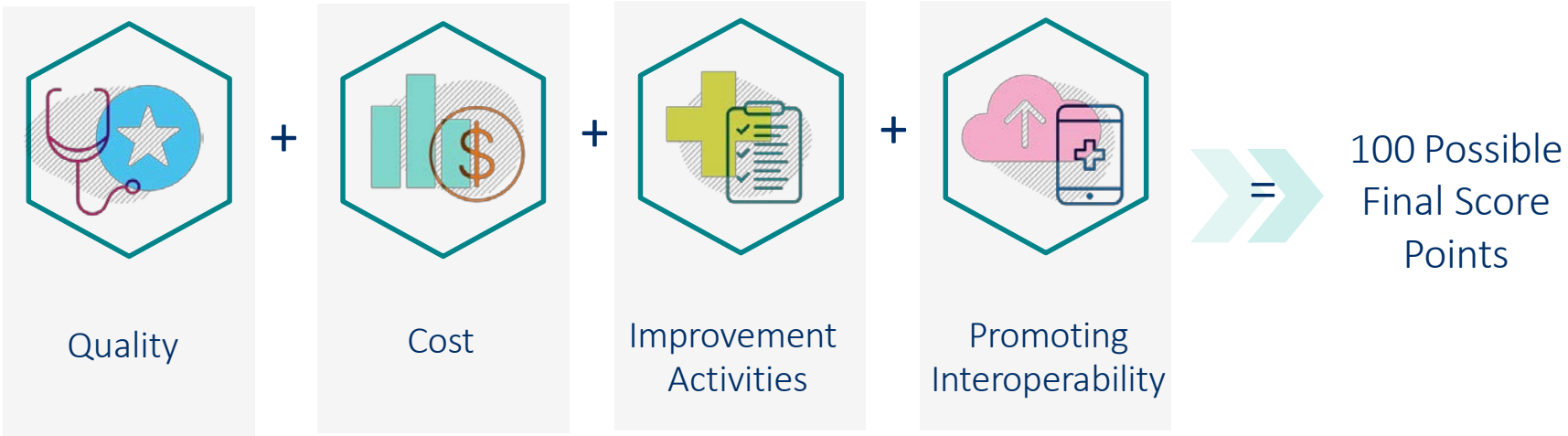
Quick Overview

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 to Know

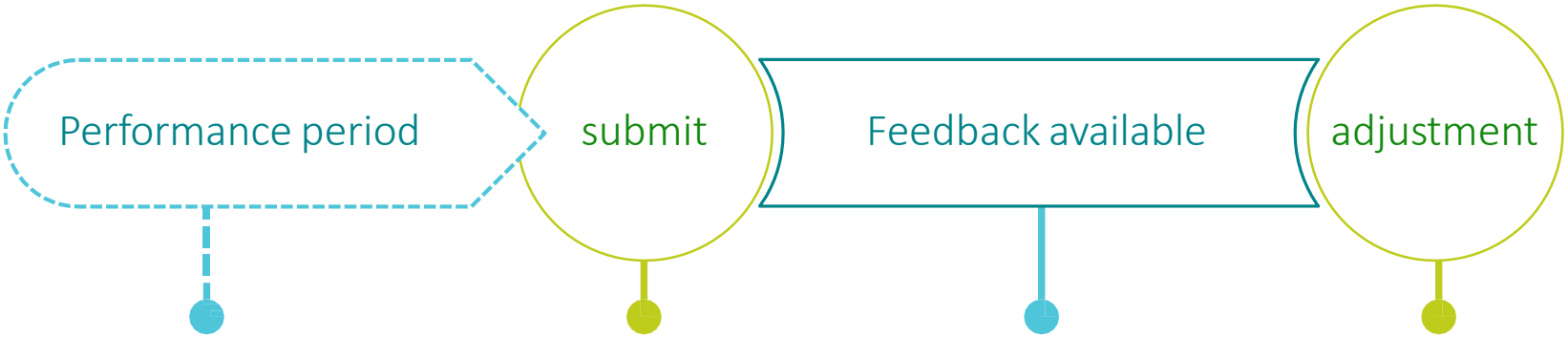
As a refresher…

- TIN - Taxpayer 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	Corresponding Adjustment
2017	2017 "Transition" Year	2019	Up to +4%
2018	"Year 2"	2020	Up to +5%
2019	"Year 3"	2021	Up to +7%

Merit-based Incentive Payment System (MIPS)

Timeline



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

FINAL RULE FOR YEAR 3 (2019) - MIPS

Eligibility

MIPS Year 3 (2019) Final

MIPS Eligible Clinician Types

Year 2 (2018) Final

MIPS eligible clinicians include:

- Physicians
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
- Groups of such clinicians

Year 3 (2019) Final

MIPS eligible clinicians include:

- Same five clinician types from Year 2 (2018)

AND:

- Clinical Psychologists
- Physical Therapists
- Occupational Therapists
- Speech-Language Pathologists*
- Audiologists*
- Registered Dieticians or Nutrition Professionals*

**We modified our proposals to add these additional clinician types for Year 3 as a result of the significant support we received during the comment period*

MIPS Year 3 (2019) Final

Low-Volume Threshold Criteria

What do I need to know?

1. Threshold amounts remain the same as in Year 2 (2018)

2. Added a third element – Number of Services – to the low-volume threshold determination criteria

    - The finalized criteria now includes:

        - Dollar amount - $90,000 in covered professional services under the Physician Fee Schedule (PFS)
        - Number of beneficiaries – 200 Medicare Part B beneficiaries
        - Number of services* *(New)* – 200 covered professional services under the PFS

*When we say "service", we are equating one professional claim line with positive allowed charges to one covered professional service

MIPS Year 3 (2019) Final

Low-Volume Threshold Determination

How does CMS determine if I am included in MIPS in Year 3 (2019)?

1. Be a MIPS eligible clinician type (*as listed on slide 18*)

2. Exceed all three elements of the low-volume threshold criteria:

   ✓ Bill more than $90,000 a year in allowed charges for covered professional services under the Medicare Physician Fee Schedule (PFS)

   AND

   ✓ Furnish covered professional services to more than 200 Medicare Part B beneficiaries

   AND

   ✓ Provide more than 200 covered professional services under the PFS *(New)*

MIPS Year 3 (2019) Final

Low-Volume Threshold Determination

What happens if I am excluded, but want to participate in MIPS?

You have two options:

1. Voluntarily participate

   - You'll submit data to CMS and receive performance feedback
   - You will not receive a MIPS payment adjustment

2. Opt-in *(Newly added for Year 3)*

   - Opt-in is available for MIPS eligible clinicians who are excluded from MIPS based on the low-volume threshold determination
   - If you are a MIPS eligible clinician and meet or exceed at least one, but not all, of the low-volume threshold criteria, you may opt-in to MIPS
   - If you opt-in, you'll be subject to the MIPS performance requirements, MIPS payment adjustment, etc.

MIPS Year 3 (2019) Final

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

FINAL RULE FOR YEAR 3 (2019) - MIPS

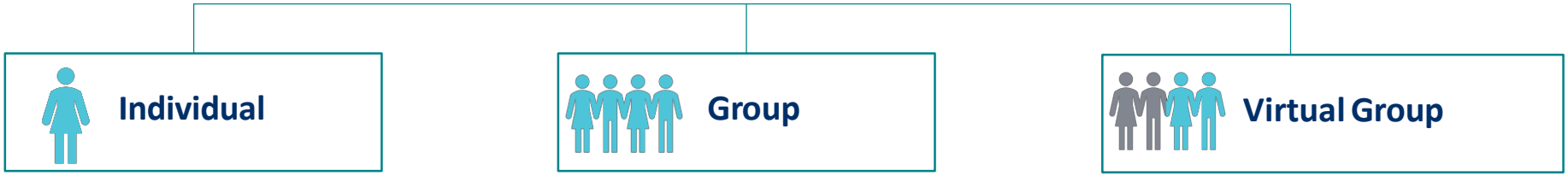
Reporting Options and Data Submission

MIPS Year 3 (2019) Final

Reporting Options

What are my reporting options if I am required to participate in MIPS?

Same reporting options as Year 2. Clinicians can report as an/part of a:



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) Final

Submitting Data - Collection, Submission, and Submitter Types

What do I need to know about submitting my performance data?

- For Year 3 (2019), we have revised existing terms and defined additional terminology to help clarify the process of submitting data:
  - Collection Types
  - Submission Types
  - Submitter Types

Why did you make this change?

- In Year 2 (2018), we used the term "submission mechanism" all-inclusively when talking about:
  - The 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)
- We found that this caused confusion for clinicians and those submitting on behalf of clinicians

MIPS Year 3 (2019) Final

Submitting Data - Collection, Submission, and Submitter Types

Definitions for Newly Finalized Terms:

- Collection type- a set of quality measures with comparable specifications and data completeness criteria including, as applicable, including, but not limited to: 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, but not limited to: direct, log in and upload, log in and attest, Medicare Part B claims, and the CMS Web Interface.
    - The Medicare Part B claims submission type is for clinicians or groups in small practices only to continue providing reporting flexibility
- Submitter type- the MIPS eligible clinician, group, virtual group, or third party intermediary acting on behalf of a MIPS eligible clinician, group, or virtual 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 clinicians that don’t use a registry may submit data on these measures.

MIPS Year 3 (2019) Final

Collection, Submission, and Submitter Types - Example

Data Submission for MIPS Eligible Clinicians Reporting as Individuals

Performance Category	Submission Type	Submitter Type	Collection Type
 Quality	• Direct • Log-in and Upload • Medicare Part B Claims (small practices only)	• Individual • Third Party Intermediary	• eCQMs • MIPS CQMs • QCDR Measures • Medicare Part B Claims Measures (small practices only)
 Cost	• No data submission required	• Individual	-
 **Improvement** Activities	• Direct • Log-in and Upload • Log-in and Attest	• Individual • Third Party Intermediary	-
 **Promoting** Interoperability	• Direct • Log-in and Upload • Log-in and Attest	• Individual • Third Party Intermediary	-

MIPS Year 3 (2019) Final

Collection, Submission, and Submitter Types - Example

Data Submission for MIPS Eligible Clinicians Reporting as Groups

Performance Category	Submission Type	Submitter Type	Collection Type
 Quality	• Direct • Log-in and Upload • CMS Web Interface (groups of 25 or more eligible clinicians) • Medicare Part B Claims (small practices only)	• Group • Third Party Intermediary	• eCQMs • MIPS CQMs • QCDR Measures • CMS Web Interface Measures • CMS Approved Survey Vendor Measure • Administrative Claims Measures • Medicare Part B Claims (small practices only)
 Cost	• No data submission required	• Group	-
 Improvement Activities	• Direct • Log-in and Upload • Log-in and Attest	• Group • Third Party Intermediary	-
 Promoting Interoperability	• Direct • Log-in and Upload • Log-in and Attest	• Group • Third Party Intermediary	-

FINAL RULE FOR YEAR 3 (2019) - MIPS

Performance Categories

MIPS Year 3 (2019) Final

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) Final - *No Change*

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

MIPS Year 3 (2019) Final

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) Final

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

MIPS Year 3 (2019) Final

Quality Performance Category

Basics:

- 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

Meaningful Measures

- Goal: The Meaningful Measures Initiative is aimed at identifying the highest priority areas for quality measurement and quality improvement to assess the core quality of care issues that are most vital to advancing our work to improve patient outcomes
- For 2019, we are:
  - Removing 26 quality measures, including those that are process, duplicative, and/or topped-out
  - Adding 8 measures (4 Patient-Reported Outcome Measures), 6 of which are high-priority
- Total of 257 quality measures for 2019

MIPS Year 3 (2019) Final

Quality Performance Category

Basics:

- 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) Final
• 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 changes: • Add small practice bonus of 6 points for MIPS eligible clinicians in small practices who submit data on at least 1 quality measure • Updated the definition of high-priority to include the opioid-related measures

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

MIPS Year 3 (2019) Final

Cost Performance Category

Basics:

- 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) Final
• 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) Final

Improvement Activities Performance Category

Basics:

- 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

- Added 6 new Improvement Activities
- Modified 5 existing Improvement Activities
- Removing 1 existing Improvement Activity
- Total of 118 Improvement Activities for 2019

CEHRT Bonus

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

MIPS Year 3 (2019) Final

Promoting Interoperability Performance Category

Basics:

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

Reweighting

Year 2 (2018) Final	Year 3 (2019) Final

• 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:
	• Extended the automatic reweighting for:
	  • Physical Therapists
	  • Occupational Therapists
	  • Clinical Psychologists
	  • Speech-Language Pathologists
	  • Audiologists
	  • Registered Dieticians or Nutrition Professionals

FINAL RULE FOR YEAR 3 (2019) - MIPS

Additional Bonuses, Performance Threshold, and Payment Adjustments

MIPS Year 3 (2019) Final

Complex Patient Bonus

Same requirements as Year 2:

- Up to 5 bonus points available for treating complex patients based on medical complexity
  - As measured by Hierarchical Condition Category (HCC) risk score and a score based on the percentage of dual eligible beneficiaries
- MIPS eligible clinicians or groups must submit data on at least 1 performance category in an applicable performance period to earn the bonus

MIPS Year 3 (2019) Final

Performance Threshold and Payment Adjustments

Year 2 (2018) Final

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

Year 3 (2019) Final

- 30 point performance threshold
- Additional performance threshold for exceptional performance bonus set at 75 points
- Payment adjustment could be up to +7% or as low as -7%*
- Payment adjustment (and additional payment adjustment for exceptional performance) 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) Final

Performance Threshold and Payment Adjustments

Year 2 (2018) Final

Final Score 2018	Payment Adjustment 2020
≥70 points	• Positive adjustment greater than 0% • Eligible for additional payment for exceptional performance —minimum of additional 0.5%
15.01-69.99 points	• Positive adjustment greater than 0% • Not eligible for additional payment for exceptional performance
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) Final

Final Score 2019	Payment Adjustment 2021
≥75 points	• Positive adjustment greater than 0% • Eligible for additional payment for exceptional performance —minimum of additional 0.5%
30.01-74.99 points	• Positive adjustment greater than 0% • Not eligible for additional payment for exceptional performance
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%

QUALITY PAYMENT PROGRAM

Help & Support

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

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