Centers for Medicare & Medicaid Services (CMS)

Merit-Based Incentive Payment System (MIPS) Overview

Held on November 29, 2016

>> Ladies and Gentlemen, thank you for standing by and welcome to The Merit-Based Incentive Payment System MIPS Overview. All lines have been placed on mute to prevent any background noise. Questions will be taken via the Q&A Box on your webcast screen. The questions and answers will be read aloud for everyone to hear. The speakers will get through as many questions as time allows. If your question is not answered during the Webinar, please contact the Quality Payment Program Service Center at qpp@cms.hhs.gov. Thank you. I would now like to turn the conference over to Ashley Spence, Health Insurance Specialist. Ashley, you may begin your call.

>> Thank you and good afternoon, everyone. My name is Ashley Spence, and I'm with CMS. Welcome to the call today. We're going to focus today's Webinar on the Merit-Based Incentive Program. You probably, by now -- Many of you have participated in several of our other programs, or other Webinars under the Quality Payment Program. So today we're going to take a deep dive into the Merit-Based Incentive Program affectionately known as MIPS, and I have two colleagues here with me that will drive this presentation -- Molly MacHarris and Mary Wheatley.

Next slide, please. Just a note is that you should see a poll now visible on your screen. What we would like is for you to complete a pre- and post-Webinar poll. So what we would like to gauge is your confidence level in your knowledge of the Quality Payment Program right now, so before we get started, and then we're going to ask you the same question at the end, and please be honest. It really helps us with our education and outreach and how we tailor it for your needs. So we ask that you please complete the pre- and post-poll.

The foundation of the Quality Payment Program is to deliver high-quality patient care, and using a variety of tools, physicians can report data to CMS and receive feedback about their practice by way they are eligible for payment adjustments via two paths. Next slide, please.

So we're going to cover a few main topics still under MIPS, but a few high-level topics. We're going to give a really quick overview on the Quality Payment Program. If you were not able to participate in the Quality Payment Program Webinar, we also have that full Webinar recording available on -- You can go to our website, which is also included in the slide, and there's a link there that will take you to the Webinar, the slide, and the recording. So we won't give a ton of information about the umbrella of the Quality Payment Program because we do have that information provided for you online, but we will focus on -- again, on MIPS. We'll give you an at-a-glance view, and then we'll take a deeper dive into the performance category. We'll talk about scoring, and then we'll talk about what you need to do for 2017, in particular, which is also known as the transition year. Next slide, please.

And so before I hand it off to my colleague Molly MacHarris, we also just provide this background slide for you, because, as you know, the Quality Payment Program changes the payment system for Medicare, and so the slide that you have in front of you basically shows you what Medicare -- well, what it looked like prior to MACRA, and then Molly will basically go into what it looks now with MACRA and specifically under MIPS.

So, next slide, please, and then I will turn it over to Molly MacHarris. And we can advance one more slide. Thank you.

>> Thank you so much, Ashley, and thank you, everyone, for joining us here today. As Ashley mentioned, the focus of today's Webinar is really going to be related to the Merit-Based Incentive Payment System, the MIPS branch of the Quality Payment Program. We won't really be getting into a lot of detail into the alternate track of the Quality Payment Program, the Advanced APM, so if you are particularly interested in participation in an advanced APM, I would recommend that you come back and look for a future presentation that we will be doing at a later time related to the APM side of the Quality Payment Program.

So there's a lot of slides that we have to cover here today, there's a lot of information that was contained within the final rule, so I'll try to go through this as quickly as I can in catching the highlights. We will be taking questions along the way and then there will be a Q&A session at the end. So, as I mentioned, the Quality Payment Program impacts clinicians who have their payments rendered under Medicare Part B, and there are two tracks to the Quality Payment Program. There's MIPS and Advanced APM.

Next slide. And when we talk about the Quality Payment Program and the two tracks, we really want to highlight what the benefits are by participation under the Quality Payment Program for both clinicians and for patients. I won't go into all of these that are listed on the slide here, but when we approach the proposed rule, and then we went into the final rule, we took into consideration the close to 4,000 public comments that we received from all of you, as well as the various listening sessions and engagements that we had had across the year to really get an understanding of how your group practices, how your clinician practices, how your practice actually works, and we really wanted to try to ensure that the program is, at its base, patient-focused while still ensuring that meaningful measurement is occurring.

So let's move on to Slide 8, and as you can see, this slide, the bedrocks of the Quality Payment Program are the high-quality patient-centered care. So, again, making sure that the patient is always in mind and that we are improving patient outcomes, and that as part of that, we see amass along with how you participate in the program, whether it's through an electronic health record or registry, that you receive useful feedback so you can monitor your performance both within the program and on behalf of your patient, and then also ensuring that continuous improvement is occurring. We went into the Quality Payment Program for the first year knowing this would be the first step on a journey, that there will be improvement to the program over time. So let's move on to the next slide.

So I did just want to highlight some of our strategic goals that we have for the Quality Payment Program. Again, some of these will be familiar if you have participated in prior Quality Programs here at CMS or under other payers, and I've also mentioned a few of these already here today -- so really improving beneficiary and patient outcomes, maximizing participation, improving data and information sharing, and really enhancing the experience that clinicians have within the program and ensuring that clinicians have the time to really focus on their patient. We didn't want the Quality Payment Program to be a program where you are spending all your time trying to comply with what our regulations are and that you don't have the time to focus on the patient. So let's move on to the next slide.

So what does the Quality Payment Program do? So, first, it was authorized by the Medicare Access and CHIP Reauthorization Act of 2015 that passed last year, and it did a couple things. One, it repealed a sustainable growth rate formula, and then it created the Quality Payment Program and the two tracks

that are under that -- Again, MIPS track and the Advanced APM. The Quality Payment Program also sunsetted the legacy programs. Those programs include the Physician Quality Reporting System, or PQRS Program, the Physician Value-based Payment Modifier, or VM Program, and the Medicare EHR Incentive Program for eligible professionals. Please note that the EHR Incentive Program for Hospitals and the Medicaid EHR Incentive Program for Clinicians is still continuing.

Next slide. So one of the resounding pieces of feedback that we heard through the public-comment process is that we really needed to ensure the Quality Payment Program worked for all clinicians, most particularly not only those who are part of a large practice, but we needed to provide opportunities for those clinicians that are part of a small practice or solo practitioners. So we have made some changes from the proposed to the final rule that have reduced the time and the cost for participation. We provided an on-ramp for participation through our Pick Your Pace, which I'm going to talk about in just a couple slides, and we also have introduced new opportunities for participation in Advanced APM.

Next slide. So one of the other main pieces that we've heard loud and clear was that we needed to also address the way that small practices, rural practices, and practices that are in HPSA areas work, so we have modified some of our exclusions, as well as the way that these types of clinicians would be scored. The first is that we modified our low-volume threshold exclusion. So what it is today is that a clinician that has less than or equal to $30,000 in Medicare Part B allow charges or less than or equal to 100 Medicare patients, they are excluded from the program. And what it means to be excluded is that you do not have to participate. You would not receive any negative penalties, but that also means that you couldn't receive any positive penalties. So I'll talk about the exclusions in a little bit more detail later on. There also are different requirements for the Improvement Activities Performance Category, which I'll talk about in more detail, but, in short, these types of clinicians would have to do less under the Improvement Activities Category, and, again, we increased the ability for clinicians that practice in Critical Access Hospitals, RHCs and FQHCs to be part of an APM. So let's move on to the next slide, which talks about the Pick Your Pace.

So if you all have heard anything about the Quality Payment Program, the piece you probably heard about was the Pick Your Pace. Acting Administrator Andy Slavitt initially mentioned this within his log before the final rule was released. We also clarified it within the final rule, and we've also done a number of communication efforts to make this clear, also by working with the specialty societies to get this message out.

And what Pick Your Pace really does is - what we heard - was that not every clinician was ready to participate on January 1, 2017, for a full 365 days for all of the measures and activities and for everything that we had initially proposed. We heard that really across the board. So what we did is we created these flexible options whereby clinicians who maybe have participated in the programs previously, they can participate more fully, and then those clinicians who may never have participated, they can test out the system and still avoid a negative payment adjustment. So there are four options under the Pick Your Pace.

The first deals with participation in an Advanced Alternative Payment Model. Again, I won't be getting into too much detail in APMs today, but that will be covered in subsequent Webinars that we will be hosting. Then the three options that deal with the Pick Your Pace include a test option, a partial option, and a full-year option.

As, we've received a number of questions on exactly how this works, so I will try to spend a little bit of time here to explain this one. So the test option is the most straightforward. So this would be for a clinician who, really, they just want to get to the neutral point. They don't want to get the negative 4% MIPS penalty, and they're not really interested in receiving any positive MIPS adjustments. To just test out in the system, a clinician would just need to submit some data, and what I mean by some data is any amount of data under any of the performance categories. The performance categories that we have -- and if we actually hop to the next slide, they're present there -- if we can move to Slide 14.

So the performance categories are Quality, Cost, Improvement Activities, and Advancing Care Information. And if we actually go to the next slide, you'll see that the weight for the performance categories in the first year account for -- Quality counts for 60 points. We're not measuring Cost in the first year. Improvement Activities counts for 15 points, and Advancing Care Information counts for 25 points.

So, the Test Option would be by doing one quality measure, one improvement activity, or the base elements under the Advancing Care Information Performance Category. That would get a clinician to the neutral point.

And then if we hop back to Slide 13 -- so then the Partial Year Option and the Full Year Option. I'll talk about these in tandem, because we have received some questions on exactly what the distinctions are between these two.

So the Partial Year Option would be participation in more than one performance category for a 90-day-or-more period, and then the full option would be participation in more than one performance category for a full year.

And so some of the questions we have received have been, how can we determine which options will be best for you? What if you decide to do a full year for one of the performance categories, but you don't want to do the full year for the other performance categories?

In short, that is okay. We really just want to encourage as many clinicians to participate in the program who can, to actually participate. If a clinician is able to participate for the Quality Performance Category for only 90 days, that's okay.

If a clinician could participate in the Quality and Improvement Activities Performance Category for 90 days, or for more than 90 days, we would encourage as many clinicians to do that as they can.

And so some of the advantages for participating in more performance categories are -- and also for participating for a longer period of time are that while we have allowed for a 90-day period for the first Year, for the transition year, we did finalize in this year's rule that in year two, for Quality and for the Cost Performance Category, there will be a full-year performance period.

And then, also, depending upon the measures that are selected, clinicians will often do better for a longer period of performance. So I hope this helps clear this up. If there are questions on how Pick Your Pace works, more than happy to take those because I know this has been a confusing concept. We didn't mean for it to be confusing. The main point with Pick Your Pace is we really wanted to make it clear to everyone that there is flexibility within the program for clinicians to participate in whichever manner suits their practice the best.

So we can go ahead and hop back to Slide 15, which is the four performance categories. The other piece I just want to note on Slide 15 is that you'll note that these four categories, sum up to 100 points that is how we will determine each clinician's final score. It will be based off of a zero-to-100-point scale, and you'll notice that for -- You'll notice that Cost has a zero next to it. Again, that's because we're not measuring cost for this first year. So let's move on to the next slide.

Okay, so, now that you have the very high-level background of the Quality Payment Program, let's start talking about participation under MIPS. So if we go on to Slide 17.

So, this is just a brief checklist of items that we feel that clinicians should take into consideration before they decide how they want to participate, and I'll talk through all of these in more detail. So they include determining your eligibility status. So, are you actually eligible? Determine your readiness for participation and then how you want to participate. There are different options available based off of if you decide to participate as an individual or as part of a group, and then also if you decide that you want to work with a third-party intermediary. Third-party intermediaries come into play with actually getting your performance data over from your practice to us here at CMS.

We want everyone to be really clear on what the program timelines are, how you actually want to submit your data to us, and then have an understanding of the performance period, how the payments will work, and then we will be issuing feedback. So let's move on to the next slide.

So, who is eligible? Those clinicians that are eligible are those that bill under Medicare Part B and who don't otherwise need an exclusion. I'll talk about the exclusion in more detail in a later slide, but the initial set of clinicians that are eligible are Physicians, Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, and Certified Registered Nurse Anesthetists.

So other types of clinician types such as Occupational Therapists, Physical Therapists, Audiologists -- they are not eligible for the first year of the MIPS Program.

On the next slide -- Non-Patient Facing Clinician. Non-patient facing clinicians are eligible to participate in the MIPS Program, but there are different participation requirements if you are considered to be non-patient facing. A non-patient facing clinician would typically be a pathologist and certain types of radiologists. We will be performing assessments based off of lists of patient-facing encounters to determine for each clinician whether or not they are considered non-patient facing or if they are patient-facing.

The next slide. So who is excluded from the MIPS Program? So, the middle exclusion I've already talked about, which is the low-volume threshold, which, again, is $30,000 in billing or if the clinician only sees less than 100 patients. The one on the left-hand side of the slide deals with clinicians who initially enroll in Medicare for the first time. So, if someone is newly entering the medical field, it’s the first time they enroll in Medicare, if that happens during 2017, they are excluded for the 2017 year. And then over on the right-hand side of the slide, there is exclusions that deal with significant levels of participation and advanced APMs.

I won't go into too much detail into that today, but there are -- or there is the ability for clinicians to be excluded if they participate in an advanced APM to either a qualified participant level or a partially qualified participant level.

So let's move on to the next slide. So just to briefly recap again on the Pick Your Pace for the transition year. There are four options available.

The first is dealing with participation in Advanced APM, and then there are three options available for participation under MIPS. The one thing I will note, which you'll note in the bubble on the slide there, is that clinicians that do not participate in the Quality Payment Program at all, and they are eligible, they will automatically receive the negative 4% payment adjustment. So we really don't want to have folks in that scenario, so we really encourage everyone to participate as fully as they can.

So moving on to the next slide, the Test Option. So, as I mentioned earlier, the Test Option deals with participation for just a small amount of data. It can be as minimal as one quality measure, one improvement activity, or the base elements of the Advancing Care Information Performance Category. The reason why under the Advancing Care Information, it said 4 or 5, that depends on the edition of Certified EHR Technology you have available to you.

The next slide. So the Partial Participation Option -- Again, just a quick recap of this. So this deals with clinicians who would be participating for a 90-day period or more, or for one or more performance categories. One important piece to note is that if you are only looking to participate for a 90-day performance period, the last date that you can start that, would be October 2, 2017.

And then on the next slide, just another recap of the full participation option. So this will be participating fully in the program for the full calendar year of 2017 for one or more performance categories. So one of the key takeaways I really want to emphasize here is that the positive adjustment, they will be based off of the clinician's overall final score, and, again, remember, the final score is based off of the level of participation under the three performance categories -- Quality, Improvement Activity, and Advancing Care Information. Depending upon what that final-score number is, that will determine what the amount of positive payment adjustments is that a clinician could receive. So I know this gets a little confusing, so we will dive into that in more detail later on in the presentation.

So, next slide. Okay, so how can you participate? There are two main options for participation. The first is participating as an individual, and that is defined as using your unique National Provider Identifier and your unique TIN, your Tax Identification Number. The second option is by participation as a group, and that is where two or more clinicians or two or more NPIs have reassigned their billing rights over to the TIN. You also can participate as a group if you are part of an APM. Please note that when you choose to participate as a group for the MIPS Program, that means you would do so across the board, across all of the three performance categories.

Next slide. So when you make the decision of how to participate, whether it's as an individual or as a group, you should also take into consideration how you would want to submit your data to us here at CMS.

So as you can tell on the slide here, there are various submission mechanisms available for the performance categories. It looks like on this slide here, there's a slight error under the Improvement Activities Performance Category. We only have Attestation listed. The correction is that actually participation using a QCDR, a Qualified Registry, and an EHR that's available across all the performance categories. That is the one method that is available across all performance categories regardless if you choose to participate as an individual or as a group.

But you'll notice on the slide here that there are differing methods available if you want to participate as an individual or as a group, meaning the CMS Web Interface is only available for Group. That's not available for Individual.

So Slide 27. So options for participating and working with a third-party intermediary. This is just a quick cheat sheet of approvals that are needed or that CMS and our partners over at the office of the national coordinator, we actually provide to these third-party intermediaries. So the EHR vendor, the QCDR, the Qualified Registry, and the CMS-approved CAHPS vendor, all of those must either be approved by either CMS or ONC, and there is typically some cost involved with that participation option. So that is something you would want to take into consideration. We do plan on posting the cost related to these options available on our website at a later point in time. I also know that depending upon your specialty, some of the costs are reduced, but it does differ specialty by specialty. So I would encourage anyone who is thinking about participating through one of these options to really work with either their vendor or their registry to get the true cost.

So, next slide. So when does the MIPS Program officially begin? So, calendar year 2017 is the first performance period. We are looking for participation for 90 days, and then clinicians would submit their data up through March 31, 2018. We would issue feedback, and then the actual payment adjustment will begin being applied in 2019.

Next slide. So just, again, recapping the way that the Pick Your Pace options work. So the MIPS Payment Adjustment is based off of the data that we receive here. So, again, think of the Pick Your Pace as these are just flexible options that are available to you. The best way to get the fullest MIPS adjustment possible is by participating for a full calendar year. The full year gives you the most measures and activities to choose from, but if you only participate for a 90-day period, depending upon your scope of practice and depending upon your specialty, you could still potentially get the maximum MIPS adjustment. It's just more likely that you would get a higher or that you would get the maximum adjustment if you do a full year.

And then on the next slide, so, I just wanted to flag that the 2016 QRURs, they have been released. They were issued back on September 26th. If you haven't already taken a look at those, I would encourage you to go ahead and do that. That does provide historical quality and cost information available.

So let's move on to the next slide where I'm going to -- And I think at this point, we are going to take a couple questions.

So I will take a talking breather [Laughs] and let our team go ahead and open up for just a couple questions.

>> Sure. Thanks, Molly. This is Ashley again, and just to prompt the audiences that we've gotten questions from you via service center, via other Webinars, and so are going to try to address some of the questions that we're hearing from you repeatedly because then we know that we need to clarify. So we're going to do our best to answer those, and, of course, we are going to take as many as we can via the Chatbox, so continue to send your questions in.

In the event that we don't get to your specific question, and you would like to get an answer kind of quicker, sooner than later, we do have in the slide that the mailbox for our Service Center, where you

can e-mail your question and still get a response from CMS. So we do apologize in advance if we do not get to your question directly, but we are working really hard over here to try to sort through the questions and answer them as best as we can.

So I'll turn it back to the moderator for Q&A.

>> Yes. The first question is, "Do eligible clinicians need to register on Form CMS of their chosen Pick Your Pace option?"

>> Great question, and, no, clinicians do not need to notify us, CMS of that. So, again, think about the Pick Your Pace as just flexible options that are available to you as you determine what is the best way to participate in the Quality Payment Program. You don't have to sign up for a particular Pick Your Pace option. If you initially were just going to participate under the Test Option, but as you get going, you decide you want to participate more fully, you can do that. We will, again, base our calculations and our assessments based off of all of the data that we have available to us.

>> And the next question is, "Can you review the threshold for participation? Is the minimum threshold for participation $30,000 of Medicare payments and 100 Medicare patients, or is it $30,000 in Medicare billing or 100 patients?"

>> Sure. Great question. And you will notice in the slides we talked about it in both ways, and so this one gets a little complicated, but so when you talk about if you are eligible, when you talk about it from the positive context, you are eligible if both are true, meaning if you, as a clinician, bill $30,000 and see 100 patients. When you talk about it from the negative end, meaning are you excluded, it becomes an 'or.' So then it would be you are excluded if you bill less than or equal to $30,000 or 100 patients. It gets into a double negative, so I apologize for bringing math into this equation, but it's a great question, so I hope that clears that up.

>> And there is a quick follow-up to that. Could you confirm if that is per clinician, not the group?

>> Okay. That's another great question. Thank you for asking that. So when you look at the exclusions that we have under MIPS, the low-volume threshold exclusion is applied at the level that the clinician participates at. So what does that mean? That means that if the clinician participates as an individual, we would make the assessment at the individual level. If a clinician participates as a group, we would make the assessment at the group level. So, what that means is that if you, as an individual, if you fall below the threshold, then -- and if you participate or if you were planning on participating as an individual, you would be excluded for the year. However, let's say that you are actually part of a small practice with maybe seven clinicians and, collectively, those seven clinicians would fall above that exclusion threshold. As a small practice, you bill more than $30,000 to Medicare and you see more than 100 patients. In that instance, if you decide to participate as a group, the group would not be excluded. The group would be considered eligible.

So the follow-up question we've gotten to this is why did we implement it in this way? Because I can understand why it's a little confusing.

So we implemented it in this way based off of the initial set of feedback we had received, that this would actually reduce burden on individual providers, as well as groups, but this is an area that we are looking for more information on. The final rule that we issued actually is a final rule with comment, and this is

specifically one of the areas that we are looking to get more information on of does this approach of applying the exclusion in this manner make sense or would this be something we would want to change for a future year?

But for the first year of the program, that is how we would be doing that assessment, but if anyone either likes that approach or if they dislike that approach, please let us know so we can determine what will be the best way to move forward with that exclusion for future years.

>> So now let's dive a little bit deeper into the performance category. So if we jump to Slide 32. So Slide 32 has just a brief example of how participation could occur for a particular specialty. In this example, we chose a cardiologist, and we actually provided on here a sample of the measures and activities that a clinician could choose to participate. We are not saying that every cardiologist has to choose these measures and activities. Again, this is just an example of measures and activities that would make sense for a cardiologist.

So as you can tell on the Quality Measures side, there's a number listed there. There's a number of activities that are listed under the Improvement Activities, and then there are elements listed under the Advancing Care Information Performance Category.

Again, one of the main takeaways we really want everyone to be clear on is that the Quality Payment Program is really to ensure that meaningful measurement is occurring to really improve your patients' health, your patients' health outcome. So we don't want to dictate to you how you should participate.

That's why we have provided a number of flexible options. So let's move on to the next slide.

I'm going to talk through the Quality Performance Category first. So the Quality Performance Category comprises 60% of a clinician's final score. For those of you who have participated previously under the PQRS Program or the Physician Value Modifier, the Quality Performance Category is very similar to those. The requirements are that a clinician would need to do six measures. One of those must be an outcome measure. If an outcome measure is not available, a clinician would need to select a high-priority measure.

There are different ways that a clinician could go about choosing these six measures. They could either choose these from a comprehensive set of around 300 measures we have available, or clinicians could choose specialty-specific measure sets, and then there also are a few additional nuances that deal with whether you are participating as part of a group.

In that instance, if your group is larger than 16 clinicians, then we would also calculate a readmission measure for you automatically, and then, also, there are different measure requirements if you choose to participate through the CMS Web Interface. I would encourage folks to go to the qpp.cms.gov site, and there is an "Explore Measures" functionality. There's a Shopping Cart where you can take a look at the various measures that we have available, and it can help you determine which measures are best for you.

Next slide. And so, as I mentioned previously, the test pace means for quality, submitting a minimum amount of data -- that could be as minimal as one measure -- and then partial and full participation would mean participating more fully. So the six measures, one that would be an outcome or a high

priority. And, again, I really do encourage everyone to go to the qpp.cms.gov site to take a closer look at the measures.

Okay, next slide. So the Advancing Care Information Performance Category. The Advancing Care Information Performance Category deals with the usage of Certified Electronic Health Records. The Advancing Care Information Performance Category ends the Medicare EHR Incentive Program, which was also known as Meaningful Use, and we have restructured the way that it works under MIPS.

Please note that there are two measure sets for reporting for the transition year, and, again, that's based off of what edition of Certified Electronic Health Record Technology that you have.

So the next slide. There are some nuances of who can participate in the Advancing Care Information Performance Category, so anyone can participate, either as an individual or as a part of a group, but there is increased flexibility for those clinicians who were not previously eligible or able to participate under the sunsetting program, the Medicare, EHR Incentive Program.

So, for example, Physician Assistants, Nurse Practitioners, and Hospital-based Clinicians, they weren't always able to participate under the Meaningful Use Program. Since they weren't always able to participate under Meaningful Use, we wanted to provide flexibilities for those clinicians to choose to participate in the Advancing Care Information Performance Category for the transition year.

Next slide. So, again, the options for participation under the Advancing Care Information Performance Category deal with the edition of Certified Electronic Health Record Technology you have. If it's the 2015 edition, you would use the Advancing Care Information Objectives and Measures, and then if you have 2014 CEHRT, you would be using the 2017 Advancing Care Information Objectives and Measures.

Next slide. And so, again, for the Test Pace for the Advancing Care Performance Category, that would be submitting data on the base element. It will differ if it's four or five measures based off of your edition of CEHRT, and then partial and full participation for the Advancing Care Information Performance Category deals with submitting more than the base score in year one. So more than those required elements.

And, again, a full list of the measures are available at qpp.cms.gov.

And then next slide? The base measures are listed on this slide here for both the Advancing Care Information Objectives and Measures, as well as the Transition Objectives and Measures. You'll notice that they're mainly the same. There are just a few slight nuances across the two. And then moving on to the next slide. So the performance score measures are listed here, and, again, you'll note that there are a number of similarities across the two. There are just some slight differences on what is required based off of your edition of Certified EHR Technology you have available to you.

Next slide. So some of the flexibilities I want to highlight within the Advancing Care Information Performance Category -- first, we will automatically re-weight the Advancing Care Information Performance Category to zero for those clinicians that are hospital-based if they are considered non-patient facing. Nurse Practitioners, Physician Assistants, Certified Registered Nurse Anesthetists, and Certified Nurse Specialists.

If we do receive data from those types of specialties, we would, however, consider that that clinician is optionally deciding to participate and then, as with all the performance categories, we would assess

performance based off of the data we have available. And then for those clinicians who face a significant hardship and are unable to report the Advancing Care Information Performance Category, they can apply to have their Performance Category Score completely weighted to zero.

Some of the examples of that would be if you have very limited Internet access. If so, you would need to apply for that hardship, and then the 25 points that are available under the Advancing Care Information Performance Category would go to the Quality Category.

So next slide, it wraps up the Advancing Care Information Performance Category. So, again, we have the Base Score, the Performance Score, and then there is a Bonus Score. You'll note that that ends up being more than 100 points, so what we do is we scale. For those clinicians who have more than 100, they could still just get the 25 points available.

So let's move on to the next slide -- The Improvement Activities Performance Category. Improvement Activities is the new performance category available under MIPS that really deals with clinical improvement. Clinicians can choose from over 90 activities that fall under nine subcategories that you can see listed on the slide here.

Remember that the Improvement Activities Performance Category comprises 15% of a clinician's final score.

Next slide. And so then... high-weighted or medium-weighted.
Clinicians have the ability to choose from combinations of either high- or medium-weighted activities. So for a clinician who wants to get the full 15 points, they could do two high-weighted activities or they could do one high-weighted activity and two medium-weighted activities or four medium-weighted activities.

And then the next slide. So wrapping up the Improvement Activities Performance Category of some of the flexibilities we have available, which I've touched on earlier, are for those clinicians that are considered to be either non-patient facing or that are part of a small group, those clinicians would have to do less under this category. They would only either have to do one high-weighted activity or two medium-weighted activities.

Also, those clinicians that are part of a PCMH automatically earn the full 15 points, and those clinicians that are part of certain APMs, you will automatically receive points under this performance category.

So let's just move on to the next slide, and there's just a couple slides here on the Cost Performance Category. As I mentioned previously, we are not measuring cost for the transition year. We will, however, be providing feedback to you on how you would have performed under Cost, because we will be assessing your performance on cost in the second year.

The next slide. So some of the cost measures that we are maintaining from the Physician Value Modifier Program are the Medicare Spending per Beneficiary Measure and the Total Per-Capita Cost Measure, and then on the next slide, so, again, just to wrap up the Cost Performance Category, there's no requirement for participation in the Cost Performance Category.

We will, however, be assessing your performance on those two measures I mentioned on the previous slide, as well as on a set of 10 episode groupers that are specialty-specific. We will apply the measures

that we can apply to you, and we will provide this information in a forthcoming feedback report. So I think at this point, let's go ahead, and I'll turn it back over to you, Jamie, for a couple quick questions.

>> Yes. The first is, "What is the difference between submitting data for 90 days and 365 days?"

>> Sure. So, this deals with the partial Pick Your Pace option and the full Pick Your Pace option. So the main difference comes into play when we talk about the Quality Performance Category, and Mary will actually be talking about this in just a little bit, so I'll just give you a bit of a sneak peak, and then I know Mary will talk about this in more detail. The way that the scoring works under the Quality Performance Category and the nature of the measures, especially of those measures that require a follow-up or are outcome-based, it's not always possible to complete all the quality actions within the 90-day period, and so in those instances, we would encourage those clinicians to participate for the full year so they can receive the fullest possible points for those measures compared to measure-level benchmark. So, under a Quality Category is where the main difference between the 90- and 365-day performance period comes into play. Next question?

>> Okay. "For the ACI-portion in-transition measures, or the 10% bonus on improvement activities through Certified EHR Technology, does it only require one activity to be done through Certified EHR Technology to disclosing the referral loop to get 10% of its bonus points? Or do all the measures have to be completed via CEHRT to get the bonus points?"

>> Hi, this is Elizabeth Holland. It only requires one of the improvement activities that are listed in the chart in the final rule, so you just need to do one activity using CEHRT that's on that list, and you would get the bonus.

>> Okay, great. And I think we're going to pick up on the presentation again at Slide 49.

>> Thanks, Jamie, and this is Molly again. So at this point, I'm going to turn the presentation over to my colleague, Mary Wheatley, who will talk us through [Indistinct] under the MIPS Program. Mary.

>> Great. Thanks, Molly. So, up to this point, we've been talking about, well, who's in MIPS, what do I have to do to be compliant with MIPS, how do I get all the pieces in there?

And then somewhere -- This is what we're going to talk about now, and we're going to talk about it at just a high level because this is an overview of how to take all these things that you submitted and how do we transform that into this number that is going to be used to determine your payment adjustment.

So if you go to the next slide, please. So we'll go through and we'll start it really by each category. So if you go to the Quality Scoring. Excellent. Great. Thank you. And this slide, really, we don't have to spend too much time. This is a recap of all the things that Molly was talking about before, like what are the things that you have to do to participate, and I want to take just -- Actually, I want to take just a quick moment and, you know, make a notification that because we have so much flexibility in MIPS, there's a couple nuances, and so what we're going to go through is kind of the basic scoring, but we realize that if you're part of an APM, like all your submission requirements will be probably conducted through that APM, and the score will be kind of connected to the APM. So if you're in SSPACO, it may not be covered in this section. Also, if you are doing Web Interface, the rules for participating in Web Interface is a little different. So there are some, like, special requirements, and I'll try to hit on those as we go through it.

But what we're going to talk about here is kind of the basic rules that apply for a selection. So if you go back to the previous slide, we just want to say again… 60%... estimate -- And in this case, we're going to focus on the six measures, and what we want to say is that if you submit these measures, you're going to get somewhere between 3 and 10 points, and we'll talk about that in a second. But you'll get somewhere between 3 and 10 points for each one of those measures that you submit. If you don't submit the measure or you don't submit the required measures -- like if you don't submit the outcome measure if one's available, then you'll get zero points for that measure. So we will score every measure that's submitted, but if you don't meet all the requirements, then we will give you zeros for the measures that are not submitted. And we do have some bonus points that are available that we'll talk about in just a second.

Next slide, please. All right. So I think we have a little bit of a delay, or it shows up as a little bit of a delay on mine, but, so, I mentioned that if you submit measures, you get somewhere between 3 and 10 points, and this is going to fall a little bit into the Pick Your Own Pace option, and so what I mean by that is that we are going to assign -- Any measure that comes in, if you just submit one measure one time, we're going to give you 3 points for submitting that measure. Everyone gets 3 points for submitting measures. However, if we can measure your -- If we can take that measure and actually score performance on that measure, we can give you up to 10 points, and to do that, you have to be scored reliably -- To be reliably scored, we think that you need to have a few things occur.

You need to have a benchmark that exists, and I'll talk about benchmarks in just a second. You need to have sufficient case volume, which means you have to have at least 20 cases for most measures -- 200 for the readmission measure. And, again, the Pick Your Pace, the longer you report, the more likely you are to get those 20 cases, and you have to have a data completeness standard that's met and that's similar to kind of the reporting rate, if you will, under PQRS, but you have to have at least 50% of the possible cases are submitted, and in that case, we feel like you've submitted the information that we need, we can reliably measure you against the benchmark, and you can get more points based on good performance on those measures.

Next slide. Can you go to Slide 52, please? Thank you. So talking about benchmarks. We have -- because we've gotten a lot of questions about benchmarks. What we have is we've said that we're going to create benchmarks for each measure and each submission mechanism that's separate. So if you submit by EHR that will be one kind of benchmark. If you submit through QCDR registries, you'll get another benchmark. If you do Web administrative claims or CAHPS benchmarks, and for Web Interface, we're actually going to be using the Medicare Shared Statements Program benchmarks that are already published.

All people who are reporting that measure, all individuals and groups regardless of specialty and practice size are combined into one benchmark, and we need at least 20 people reporting that measure in order -- At least 20 people reporting that measure in a reliable way, which, again, means that you meet a case minimum, you exceed the data completeness standard, and we've also said that you have a performance rate greater than 0%.

If you meet those criteria, then we'll create a benchmark, and we are in the process of developing these benchmarks, so you will know in advance what you have to do to -- whether a benchmark exists for your measures and what you have to do to meet to get additional points. And, again, why this matters is that not all measures will have a benchmark, at least not an historical benchmark, and if we don't have a

benchmark when you're being measured, you get 3 points, but if you're compared against a benchmark, we can see how your performance aligns, and you can get additional points for that.

Next slide. Can we move to Slide 53, please? Okay, great. So, as we mentioned before, we have some bonus points that are available. You can get a bonus point for submitting additional high-priority measures, and we'll talk about what that is in a second, and you can also get additional bonus points for using your Certified EHR Technology to submit data to CMS.

We have a cap on those, so you can get up to 10% of your score through the additional high-priority measures, and you can get an additional 10% for using end-to-end electronic reporting. You get a certain number of bonus points for -- So we'll talk about high-priority measures first. You get two additional bonus points if you report an outcome measure or a patient-experience measure above and beyond the first one that is required, and you get one bonus point for each additional high-priority measure, and if you report more than six measures, you can get additional bonus points for reporting additional measures. So it's not just restricted to the six, you can do as many as you want to submit, but we do have a cap on the amount of credit that we provide for bonus points. And for the EHR component, you can get one bonus point, again, for doing end-to-end electronic reporting, which is available for all the submission mechanisms except for clients-based reporting.

Next slide. And, again, we're working on additional material to describe this in more detail. Can we move to slide -- Next slide, please -- 54? Thank you. So when we calculate the quality score, what we're going to do is we're going to take all the points that you get, which would be at least 3 points for each submitted measure, but you're going to get all the points for the measures that are submitted. If you submit more than six, we'll take the top six scores, and then we'll add bonus points, and we're going to divide by the maximum number of points for the performance category, and –

Go to the next slide. And so you may ask, "Well, what are the maximum number of points?" And, again, part of --

If you move to the next slide, Slide 55. Thank you. Part of -- Again, with the flexibility of MIPS, people will have a different number of maximum points. So for some submission mechanisms, if you're doing Web Interface, you have to report all the measures that are in the measure set. So you'll have either 120 points if the readmission measure applies or 110 points if the readmission measure doesn't apply.

If you're reporting six measures, and the readmission measure doesn't apply, you'll have 60 points. So it's basically the number of measures you have that are required times the number of -- times 10 points. And, again, that number, for most people, will probably be 60 if the readmission measure doesn't apply, or 70 points if the readmission measure does apply.

The next slide. And it's important to note, while we talk about the scoring for all these performance categories, you know, we offer bonus points, we offer other things, but you can't get a score -- the maximum score for each of these performance categories is 100%, so we offer multiple ways to get to the maximum score, but you can't ever go over 100%.

So just keep that in mind for all these performance categories.

So now for Improvement Activities, the total number of points, which, again, is generally 15% of your final score. The total number of points is 40 that we're trying to get at, and for -- In most cases, each activity that you report is going to be worth 10 points with the medium weight in.

There are few activities in the inventory that are weighted as a high activity, and you get 20 points for those. So, again, if you go to the QPP website, you can find out a list of the different activities and what they're weighed in.

For some practices, specifically clinicians that are in small, rural, underserved practices or non-patient facing clinicians or groups, there are small alternative activity weights, and so you can report the same activities, but they're worth more points, if you will, so that you can get that maximum of 40 points faster than you would otherwise. And for those who are participating in patient-centered medical home, Medical Home Model, or similar specialty practice, you can get full credit for your improvement activities, and, again, we haven't talked about APMs, but those who are participating in an APM will be receiving their improvement activities through the APM model that they're in.

Next slide. So, if you go to Slide 57, please. So when you look at the Improvement Activities Performance Score, what we're going to do is take the number of points for the completed activities that you've submitted and divide it by the total maximum number of points and multiply that by 100. So, again, if you report four medium-weighted activities, that gets you 40 points. If you report more, you can't get over 100%, but that's how we're going to calculate your activities. We're just going to sum up the points, and as soon as you get to 40, then you've gotten the maximum number of points you can get for the Improvement Activities Points.

Next slide. Okay. So the next one, we're talking about the Advancing Care Information.

If you can move to Slide 58, please. Thank you.

So you go to Advancing Care Information -- and Molly touched on this a lot, that we have a Base Score and Performance Category Scores. What we do want to make sure that -- again, to make it clear that if you want to get any points in the Advancing Care Information Scoring Model, then you have to meet the Base Score, which is worth 50% of your entire score, and to do that, we have on the slide the measures that you need to meet depending on which version of certification that you need to -- depending on which certification your EHR is under.

If you fail to meet these reporting requirements, then you will get zero points for the Advancing Care Information Category, and the Performance Category and the Bonus Points do not apply.

Next slide. On Slide 59, we describe how you get performance points. Again, please advance to Slide 59. Thank you. So, again, depending on which certification you're using for your EHR, you can get additional points for your performance rate, and it's a pretty straightforward way. We take your performance rate, and we're going to give you a certain percentage based on where your performance rate falls in the category.

So, for example, if your performance rate is in the mid 50's, we would give you a 6%, and we would add that 6% to the 50.

Next slide. And because there are additional activities -- Again, there's many ways you can get over 100% with that. We also have additional bonus points for reporting on public health registries and for using your Certified EHR Technology for certain improvement activities.

And on Slide 61 -- next slide. So, again, the way we calculate your score is we take your Base Score plus your Performance Score plus the Bonus Score, assuming that you meet the Base Score, and the maximum score is -- It capped at 100%.

Next slide. And then -- So then -- So now I've talked briefly, and I realize it was a very brief overview of the scoring methodology for all these different categories, but what we do at the end to consolidate these is that we take the score that you have for each of the performance categories, and it's going to be somewhere between 0% and 100%, and we multiply it by the weight of the Performance Category. So if you got 100% on the Quality Category, and the Quality Categories were 60% of your score, then you would get 60 points toward your final score of 100. We do that for all the different categories.

Again, the cost category in that transition year is 0%. So that's why sometimes you'll hear people talk about 60 points for Quality, 25 points for Advancing Care Information, 15 points for Improvement Activities. That's the total number of points to your final score after you take your individual category score and weight it to the final.

For those who don't have Advancing Care Information, it doesn't apply to you, then the 25 points that would normally be in that category would got to Quality. So you would have the 85% in the Quality Category and 15% in the Improvement Activities Category.

And when you get that final number, you'll get a number between 0% and 100%, and that is going to be the number that is used when we determine your payment adjustments, and as Molly has said before, if you report one measure one time or you participate in any of these, you're going to get a score that will be high enough to avoid the negative payment adjustment.

>> Yes. One question is, "What happens if fewer than six measures apply?"

>> So it's a great question. So, like I said, we were going kind of -- and this would be in the Quality Performance Category, so if fewer than six measures apply to you, and we have some processes that will verify that fewer than six measures apply to you -- because there is a process in place for that -- then we will make the adjustment and the scoring model.

So instead of saying you have to get -- Out of 60 points, how many points did you get out of 60?, we would say, well, how many points did you get out of 40?

So we will adjust the denominator so that you can still get a maximum score even if you have fewer measures that you can report.

>> Great. Thank you. I think we're going to keep moving through the slides since we're running out of time.

>> Okay, thanks. So this is Molly again. So I will go over the next few slides. So let's move on to slide 64, Public Reporting. So, Public Reporting. For those of you who have participated in our prior Quality Program, you'll know that we do post some amount of data on the Physician Compare Website.

We will post information related to clinician's performance under the MIPS Program for the applicable performance category, as well as the final score on the Physician Compare Website. We will, of course, only post information that meet our Public Reporting standards and that resonate with consumers. So there will be more information available later on as the program progresses of what specifically will be posted on Physician Compare, but generally we will post information related to the MIPS Program, as well as the final score for the Performance Category, but, again, it must meet our Public Reporting standard and have gone through user testing.

So let's move on to the next slide. So we have just a few more slides in the presentation. So let's talk about what will happen after the transition year.

Let's move on to the next slide again. Okay. So -- Thank you. Let's move on to the next slide again. So both Mary and I have touched on a number of items related to how the program will work for year one, and we've also touched on some of the pieces that we would potentially work differently for the second year. I also know I noted in a couple instances areas where the final rule that was issued was a final rule with comment, and we're seeking input on some additional areas. So if you notice on the slide there are certain areas where we are seeking additional feedback on.

This is part of our overall user-centric approach, not only of the way that we develop the technical processes and operational processes, but also the way that we really develop our policy. We want to ensure that our policies resonate with clinicians and that it doesn't distract from ensuring that improved patient outcomes are occurring.

So you'll note on the slide, there's a number of areas that we're seeking more comment on. If you want to submit any comment, the information on how to do that is available on the next slide.

Please not that all comments must be received by no later than December 19th.

And then we can move on to Slide 69. And at this point, I will turn the rest of the presentation back over to Ashley Spence to wrap things up for us. Thanks.

>> Sure. So thanks, Molly, and thank you, Mary, for the presentation. So as we wind down and open up for questions, a couple questions, I just wanted to note that we do have resources available.

Next slide, please. So one of the resources available to you right now, we refer to as Technical Assistance, and so what you have on the slide is a listing of assistance that you can access immediately. So the Quality Payment Program portal, which is where the educational resources for this call and many other resources are located. So you are welcome to go there.

We also have our Transforming Clinical Practice Initiative, which is available for assistance, as well as our QUIN-QIO. So we do list those in our Innovation Center aligning systems, which is available for participants and advanced APM.

And so we do list those there with the hyperlinks that will take you directly to the site. So each has a bit of a requirement for the different -- for those that are eligible to participate in those different options, and so the hyperlink will take you to those individual pages.

Next slide, please. And so the next slide just provides you with a map that we provide at the end of all of our presentations because the technical assistance that we offer is nationwide and should cover most practices regardless of size and specialty, and so also the resource. This slide will also serve as a resource with hyperlinks as you are seeking out services.

Next slide, please. And so the very last slide that you see here is that, again -- and I mentioned this at the top of the Webinar that we were and are accepting Q&A via the chat box. What we can't answer we do apologize that we can't get to all of it, but we do provide the e-mail for the service center on the slide.

So you can still get your questions addressed from CMS experts by e-mailing our Quality Payment Program Service Center, and the e-mail address is there at qpp@cms.hhs.gov.

With that, we still have about five minutes, so I think we can take two questions or so. So I'll turn it back to the moderator.

>> Hi. Yes. A couple people have asked if you can re-explain readmissions measures.

>> Sure. This is Molly. I'll start. And then, Mary, please feel free to jump in here if I get anything wrong. So the readmission measure, it's a quality measure, and we calculate that measure based off of what we call administrative claims data, and what that is is that we just calculate that measure purely based off of the claims that we receive and house here at CMS. No separate codes are required that a doctor or your practice manager would need to add to the claim. We can just calculate that quality measure based off of what we receive on claims. We will be calculating that quality measure for clinicians that are part of a group, and if that group is the size of 16 or greater -- so if they are not a small group. And do you want to add anything else for that, Mary?

>> No, other than to say this measure has been used previously in the Value Modifier Program, so groups who are in the Value Modifier should have some experience with that measure.

>> Thank you. Next question.

>> The next question is, "When will there be definitions, clarifications, or benchmarks given for the measures?"

>> Can you repeat that one more time, Jamie?

>> Right. "When will there be definitions, clarifications, or benchmarks for the measures?"

>> Oh, sure. So, we have -- So, I'll try to make this a short answer. Sometimes my answers are not always short, so I apologize in advance. So I would recommend that folks go to the qpp.cms.gov website, and if you click on at the top, there's an "Explore Measures" button. That will take you to our Measures Shopping Cart, and that Measures Shopping Cart is the ability to really explore the measures that we have available.

Within the Shopping Cart, there's the ability to kind of sort and filter the measures based off of your specialty if the measure is an outcome or high-priority measure, et cetera. Within that Shopping Cart, when you add the measures, and when you click on them, you can get more high-level information on what the measure is, who the measure steward is, if it's part of a specialty measures set.

More details relate to the measure specifications themselves. They have been added to the qpp.cms.gov site under the Education & Tools tab. We're still exploring whether we actually want to integrate in the measure specification into the Measure Shopping Cart, so if anyone has any opinions on that, whether they are supportive of that or not supportive, I would recommend that you go ahead and leave us a comment in the Chat, and that will help us determine how we want to proceed with it, but if you are under the Education & Tools section, about halfway down the page, there's "Learn More About the Merit-Based Incentive Payment System Program, and there are measure specifications, a fact sheet, and implementation guide, as well as all of the measure specifications themselves, and within those measure specifications themselves, those have the detailed pieces related to how Measure Spec works, what codes are associated with it, who is in the denominator, who's in the numerator.

>> Thank you, and I think we have time, probably, for one more question.

>> Sorry. Before we jump into that last question, I also just wanted to remind you, the participants today, to complete the post poll. I know we're nearing the end, and folks will have to hop off, so you should see the poll on your screen any second, and want to ask you to give us your honest opinion, you know, to the fact of this Webinar being useful. So has your knowledge improved since we started an hour and a half ago? So thank you for today.

>> And we can go ahead and still take that one last question, Jamie.

>> Okay. The question is, "Do you need to enroll or register for MIPS? And if you're participating as a group, do you need to register?"

>> Great question. If you are participating as an individual, you do not have to enroll or register at all. If you are participating as a group, you only have to register for two specific submission mechanisms. That includes the CMS Web Interface and if you are using CAHPS for MIPS, but in all other instances, registration is not required, which is a change from the way things previously worked under the PQRS or the VM Program. So if you want to participate as a group using a QCDR, you do not have to register for that under the MIPS Program.

>> Thank you.

>> And thank you, everyone, for attending the call today. Jamie, we'll turn it over to you to wrap things up. Thank you.

>> Yes. We did just want to tell everyone that these slides will be posted on qpp@cms.gov/education in the next few days. And thanks, everyone, for participating.

>> Thank you. This concludes your Webinar. You may now disconnect.