Merit-Based Incentive Payment System (MIPS): Group Participation 101

May 11, 2017

Feedback Information

- A Q&A session will take place after the presentation.
  - Use the phone number provided later in the webinar to ask questions over the phone.
  - Questions posed through the Q&A chat box will also be reviewed and read aloud.
- The slides, recording, and transcript from the webinar will be posted on the Quality Payment Program website in the next week or so.
- The speakers will answer as many questions as time allows. Any questions not answered on the phone should be directed to the QPP Service Center at: qpp@cms.hhs.gov or 1-866-288-8292.

Topics

- Introduction
- Individual vs. Group Participation
- Group Participation Requirements
- Performance Category Measures
- Data Submission Mechanisms/Checklists
- Important MIPS Participation Dates
- Q&A

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Introduction

Quality Payment Program

Merit-based Incentive Payment System

The Quality Payment Program

Clinicians can choose how they want to participate in the Quality Payment Program based on their practice size, specialty, location, or patient population.

Two tracks to choose from:

Advanced Alternative Payment Models (APMs)
If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.

or

The Merit-based Incentive Payment System (MIPS)
If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS.

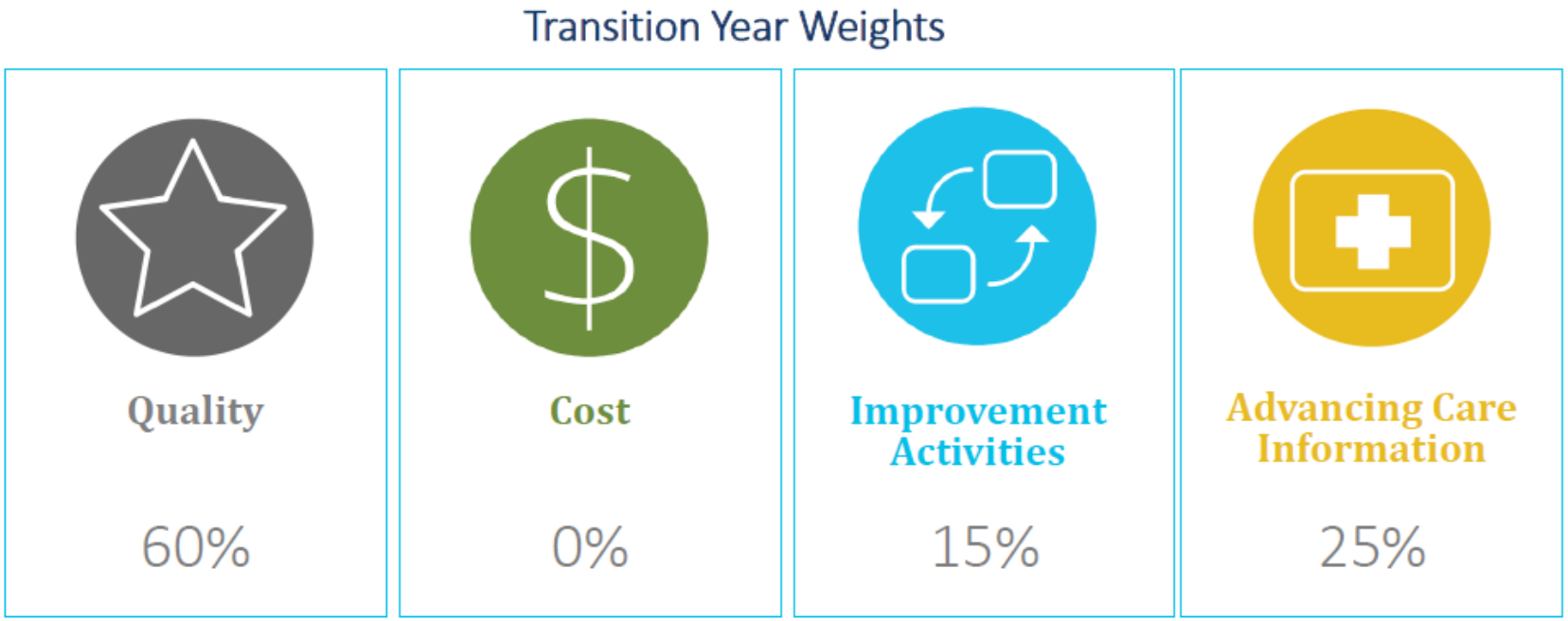
What is the Merit-based Incentive Payment System?

Performance Categories

- Moves Medicare Part B clinicians to a performance-based payment system.
- Provides clinicians with flexibility to choose the activities and measures that are most meaningful to their practice.
- Reporting standards align with Advanced APMs wherever possible.

What are the Performance Category Weights?

- Weights assigned to each category are based on 1 to 100 points.



Note: These are default weights; the weights can be adjusted in certain circumstances.

MIPS Eligible Clinicians:

Clinicians billing $30,000 or more in Medicare Part B allowed charges **AND** providing care for 100 or more Part B-enrolled Medicare beneficiaries during the low-volume threshold determination period (9/1/2015 – 8/31/2016; 9/1/2016 – 8/31/2017).

These clinicians include:

Physicians	Physician Assistants	Nurse Practitioners	Clinical Nurse Specialists	Certified Registered Nurse Anesthetists

Who is Exempt from MIPS?

Clinicians who are:

Newly-enrolled in Medicare

- Enrolled in Medicare for the first time during the performance period (exempt until the following performance year).

Significantly participating in Advanced APMs

- Receive 25% of their Medicare payments (Qualifying APM Participants (QPs)).

OR

- See 20% of their Medicare patients through an Advanced APM (Partial QPs who elect not to report data to MIPS).

Below the low-volume threshold

- Medicare Part B allowed charges less than or equal to $30,000 a year;

OR

- Provide care to 100 or fewer Part B-enrolled Medicare beneficiaries.

Non-Patient Facing MIPS Eligible Clinicians

- Non-patient facing MIPS clinicians participate in MIPS if they:
  - Exceed the low-volume threshold,
  - Are not newly-enrolled Medicare eligible clinicians, and
  - Are not a QP or Partial QP who elects not to report data to MIPS.
- A group is considered non-patient facing if >75% of NPIs billing under the group's TIN during the non-patient facing determination period (9/1/2015 – 8/31/2016; 9/1/2016 – 8/31/2017) are labeled as non-patient facing.

Group Participation under MIPS

Individual vs. Group Participation

OPTIONS

1. **Individual** — unique billing Taxpayer Identification Number (TIN) and National Provider Identifier (NPI) combination

2. **As a Group**
   a) Single TIN with 2 or more clinicians (NPIs) who have reassigned their billing rights to the TIN*
   b) An APM Entity

* If clinicians participate as a group, they are assessed as a group across all 4 MIPS performance categories.

Requirements for Group Participation

- Groups that choose to participate at the group level must:
  1. Meet the definition of a group during the performance period for the MIPS payment year.
  2. Aggregate their performance data across the TIN to have their performance assessed and scored as a group.

Performance Categories and Measures Overview

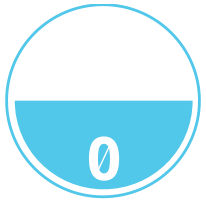
Quality, Improvement Activities, and Advancing Care Information

MIPS Performance Category: Quality

- Replaces the Physician Quality Reporting System (PQRS) and Quality portion of the Physician Value-based Payment Modifier (VM)
- *"So what?"*—Provides for an easier transition due to familiarity

MIPS Performance Category: Quality

- Requirements for the transition year:



Submit Something

- Test means...
  - Submitting a minimum amount of data for **one** measure for 2017.

Submit a Partial Year

Submit a Full Year

- Partial and Full means...
  - Submitting at least **six** quality measures, including at least one outcome measure, for 90 days or a full year.
  - ***Quality measures vary by submission mechanism.***

Note: Groups are encouraged to select the quality measures that are most appropriate for their practice and patient population.

MIPS Performance Category: Quality

- Requirements:

60%

60% of final score

Select 6 of about 271 quality measures (minimum of 90 days to be eligible for maximum payment adjustment); 1 must be:

- Outcome measure; OR
- High-priority measure—defined as outcome measure, appropriate use measure, patient experience, patient safety, efficiency measures, or care coordination.

Different requirements for groups participating via CMS Web Interface or those in MIPS APMs

May also select specialty-specific set of measures

The all-cause hospital readmission measure will be scored for groups that have ≥ 16 clinicians and a sufficient number of cases (no requirement to submit).

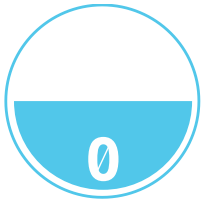
MIPS Performance Category:
Improvement Activities

- Attest to participation in activities that improve clinical practice
  - Examples: Shared decision making, patient safety, coordinating care, increasing access
- *Groups choose* from 90+ activities under 9 subcategories:

1. Expanded Practice Access	2. Population Management	3. Care Coordination
4. Beneficiary Engagement	5. Patient Safety and Practice Assessment	6. Participation in an APM
7. Achieving Health Equity	8. Integrating Behavioral and Mental Health	9. Emergency Preparedness and Response

MIPS Performance Category:
Improvement Activities

- Requirements for the transition year:



Submit Something

- Test means…
  - Submitting 1 improvement activity:
    - Activity can be high weight or medium weight.

Submit a Partial Year

Submit a Full Year

- Partial and Full means…
  - Choosing 1 of the following combinations:
    - 2 high-weighted activities.
    - 1 high-weighted activity and 2 medium-weighted activities.
    - At least 4 medium-weighted activities.

MIPS Performance Category: Improvement Activities

Activities:

- **Most groups** - Attest to completing between 2 and up to 4 improvement activities for a minimum of 90 days.
- **Groups of 15 or fewer clinicians in designated rural areas or Health Professional Shortage Areas (HPSAs)** – Attest to completing up to 2 activities for a minimum of 90 days.
- *Activities do not change for each submission mechanism under this performance category*.

MIPS Scoring for Improvement Activities
(15% of Final Score in Transition Year)

Total points = 40

Activity Weights

- Medium = 10 points
- High = 20 points

Alternate Activity Weights*

- Medium = 20 points
- High = 40 points

*For clinicians in small, designated rural area, and designated HPSA practices; and non-patient facing MIPS eligible clinicians or groups

Full credit for clinicians in a patient-centered medical home, Medical Home Model, or similar specialty practice

MIPS Scoring for Improvement Activities
(15% of Final Score in Transition Year)

Improvement Activities Performance Category Score = $\left\{ \frac{\text{Total number of points scored for completed activities}}{\text{Total maximum number of points (40)}} \right\} \times 100$

Quick Tip: Maximum score cannot exceed 100%.

MIPS Performance Category:
Advancing Care Information

Measures:

For those using EHR Technology Certified to the 2015 Edition:

Option 1	*Option 2*
Advancing Care Information Objectives and Measures	Combination of the two measure sets

For those using EHR Technology Certified to the 2014 Edition:

Option 1	*Option 2*
2017 Advancing Care Information Transition Objectives and Measures	Combination of the two measure sets

Note: Groups must use certified EHR technology to report.

MIPS Performance Category:
Advancing Care Information

- Requirements for the transition year:

Submit Something

- Test means…
  - Submitting 4 or 5 base score measures:
    - Depends on use of 2014 or 2015 Edition.
  - Reporting *all* required measures in the base score to earn any credit in the Advancing Care Information. performance category.

Submit a Partial Year

Submit a Full Year

- Partial and Full means…
  - Submitting more than the base score in year 1.

For a full list of measures, please visit qpp.cms.gov

MIPS Scoring for Advancing Care Information (25% of Final Score)

Advancing Care Information Performance Category Score =

Base Score + Performance Score + Bonus Score

MIPS Performance Category:
Advancing Care Information

Advancing Care Information Objectives and Measures:

Base Score Required Measures

Objective	*Measure*
Protect Patient Health Information	Security Risk Analysis
Electronic Prescribing	e-Prescribing
Patient Electronic Access	Provide Patient Access
Health Information Exchange	Send a Summary of Care
Health Information Exchange	Request/Accept a Summary of Care

2017 Advancing Care Information Transition Objectives and Measures:

Base Score Required Measures

Objective	*Measure*
Protect Patient Health Information	Security Risk Analysis
Electronic Prescribing	e-Prescribing
Patient Electronic Access	Provide Patient Access
Health Information Exchange	Health Information Exchange

MIPS Performance Category:
Advancing Care Information

How to Fulfill the Base Score:

Advancing Care Information Objectives and Measures:

Base Score Required Measures

Measure	*Result*
Security Risk Analysis	yes
e-Prescribing	1 patient
Provide Patient Access	1 patient
Send a Summary of Care	1 patient
Request/Accept a Summary of Care	1 patient

2017 Advancing Care Information Transition Objectives and Measures:

Base Score Required Measures

Measure	*Result*
Security Risk Analysis	yes
e-Prescribing	1 patient
Provide Patient Access	1 patient
Health Information Exchange	1 patient

MIPS Scoring for Advancing Care Information (25% of Final Score): Performance Score

90% Performance Score (worth up to 90%)

- Report up to **9** Advancing Care Information measures

OR

- Report up to **7** 2017 Advancing Care Information Transition Measures

Each measure is worth 10-20%.
The percentage score is based on the performance rate for each measure:

Performance Rate > 1-10	1%
Performance Rate 11-20	2%
Performance Rate 21-30	3%
Performance Rate 31-40	4%
Performance Rate 41-50	5%
Performance Rate 51-60	6%
Performance Rate 61-70	7%
Performance Rate 71-80	8%
Performance Rate 81-90	9%
Performance Rate 91-100	10%

MIPS Performance Category:
Advancing Care Information

Advancing Care Information Objectives and Measures:

Performance Score* Measures

Objective	*Measure*
Patient Electronic Access	Provide Patient Access*
Patient Electronic Access	Patient-Specific Education
Coordination of Care through Patient Engagement	View, Download and Transmit (VDT)
Coordination of Care through Patient Engagement	Secure Messaging
Coordination of Care through Patient Engagement	Patient-Generated Health Data
Health Information Exchange	Send a Summary of Care*
Health Information Exchange	Request/Accept a Summary of Care*
Health Information Exchange	Clinical Information Reconciliation
Public Health and Clinical Data Registry Reporting	Immunization Registry Reporting

2017 Advancing Care Information Transition Objectives and Measures:

Performance Score Measures

Objective	*Measure*
Patient Electronic Access	Provide Patient Access*
Patient Electronic Access	View, Download and Transmit (VDT)
Patient-Specific Education	Patient-Specific Education
Secure Messaging	Secure Messaging
Health Information Exchange	Health Information Exchange*
Medication Reconciliation	Medication Reconciliation
Public Health Reporting	Immunization Registry Reporting

***Performance Score:** Additional achievement on measures above the base score requirements

Advancing Care Information Bonus Score

5% BONUS

For reporting on one or more of the following Public Health and Clinical Data Registry Reporting measures:

- Syndromic Surveillance Reporting (14 and 15)
- Specialized Registry Reporting (14)
- Electronic Case Reporting (15)
- Public Health Registry Reporting (15)
- Clinical Data Registry Reporting(15)

10% BONUS

For using **CEHRT** to report certain Improvement Activities

Improvement Activities Eligible for ACI Bonus Score

Improvement Activity Performance Category Subcategory	Activity Name	Weight
Expanded Practice Access	Provide 24/7 access to eligible clinicians or groups who have real-time access to patient's medical record	High
Population Management	Anticoagulant management improvements	High
Population Management	Glycemic management services	High
Population Management	Chronic care and preventative care management for empanelled patients	Medium
Population Management	Implementation of methodologies for improvements in longitudinal care management for high risk patients	Medium
Population Management	Implementation of episodic care management practice improvements	Medium
Population Management	Implementation of medication management practice improvements	Medium
Care Coordination	Implementation of use of specialist reports back to referring clinician or group to close referral loop	Medium
Care Coordination	Implementation of documentation improvements for practice/process improvements	Medium
Care Coordination	Implementation of practices/processes for developing regular individual care plans	Medium
Care Coordination	Practice improvements for bilateral exchange of patient information	Medium
Beneficiary Engagement	Use of certified EHR to capture patient reported outcomes	Medium
Beneficiary Engagement	Engagement of patients through implementation of improvements in patient portal	Medium
Beneficiary Engagement	Engagement of patients, family and caregivers in developing a plan of care	Medium
Patient Safety and Practice Assessment	Use of decision support and standardized treatment protocols	Medium
Achieving Health Equity	Leveraging a QCDR to standardize processes for screening	Medium
Integrated Behavioral and Mental Health	Implementation of integrated PCBH model	High
Integrated Behavioral and Mental Health	Electronic Health Record Enhancements for BH data capture	Medium

MIPS Performance Category:
Advancing Care Information

BASE SCORE	+	PERFORMANCE SCORE	+	BONUS SCORE	=	FINAL SCORE
Account for **50%** of the **total Advancing Care Information Performance** Category Score		Account for up to **90%** of the total **Advancing Care Information Performance** Category Score		Account for up to **15%** of the total **Advancing Care Information Performance** Category Score		Earn 100 or more percent and receive **FULL 25 points** of the total **Advancing Care Information** Performance Category Final Score

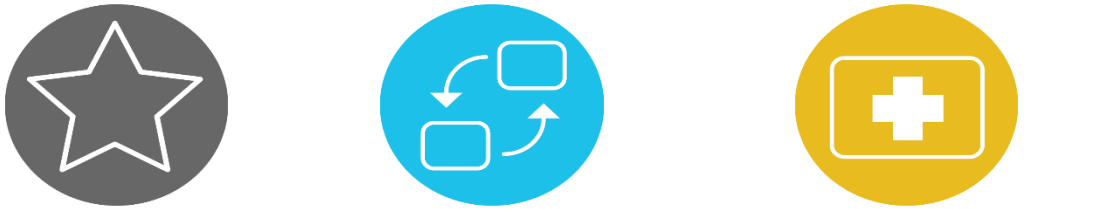
The overall Advancing Care Information score would be made up of a base score, a performance score, and a bonus score for a maximum score of 100 percentage points

Data Submission Mechanisms for Groups

Quality, Improvement Activities, and Advancing Care Information

Data Submission Mechanisms

- Groups have the option to choose a different submission mechanism for each performance category:



- *Note*: There is no reporting requirement for the Cost performance category in 2017.

Data Submission Mechanisms for Groups

	Group Participation Options
Quality	• Qualified Clinical Data Registry (QCDR) • Qualified Registry • EHR • Administrative Claims • CMS Web Interface (groups of 25+) • Consumer Assessment of Health Providers and Systems (CAHPS) for MIPS Survey *
Improvement Activities	• QCDR • Qualified Registry • EHR • Attestation • CMS Web Interface (groups of 25+)
Advancing Care Information	• QCDR • Qualified Registry • EHR • Attestation • CMS Web Interface (groups of 25+)

*Note: Groups of any size can administer the CAHPS for MIPS survey (in conjunction with the utilization of a submission mechanism).

Data Submission Mechanisms - Explained

Submission Mechanism	How Does It Work?
Qualified Clinical Data Registry (QCDR)	A QCDR is a CMS-approved entity that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients. Each QCDR typically provides tailored instructions on data submission for eligible clinicians.
Qualified Registry	A Qualified Registry collects clinical data from an eligible clinician or group of eligible clinicians and submits it to CMS on their behalf.
Electronic Health Record (EHR)	Eligible clinicians submit data directly through the use of an EHR system that is considered certified EHR technology (CEHRT). Alternatively, clinicians may work with a qualified EHR data submission vendor (DSV) who submits on behalf of the clinician or group.
Attestation	Eligible clinicians prove (attest) that they have completed measures or activities.
CMS Web Interface	A secure internet based data submission option for groups of 25 or more eligible clinicians reporting quality data to CMS. The CMS Web Interface is partially pre-populated with claims data from the group's Medicare Part A and B beneficiaries who have been assigned to the group. The group then completes data for the pre-populated Medicare patients.
Administrative Claims	***Only available for Quality reporting.*** Administrative claims submissions require no separate data submissions to CMS. These measures do not allow for any selection of measures or require any action by groups. CMS calculates the se measures based on data available from administrative claims.
CAHPS for MIPS Survey	CMS-approved survey vendor that collects and submits data about the experience of care at the practice on behalf of the group.

Approved Qualified Registries and QCDRs

- Groups who use qualified registries and QCDRs must choose from **the list approved by CMS** to ensure the entity meets CMS submission standards and criteria.
- Approved lists of qualified registries and QCDRs are available on the CMS QPP website: https://qpp.cms.gov/.

QCDR: Submission Mechanism Checklist

- ✓ Choose a CMS approved QCDR.
- ✓ Ensure the QCDR has an Enterprise Identity Management account.
- ✓ Determine how you will participate (e.g., Pick Your Pace options: Test, Partial year, or Full year).
- ✓ Choose measures and/or activities.
- ✓ Obtain consent of clinicians in group before submission.
- ✓ Report data for the 2017 calendar year (e.g., test, partial year, or full year).
- ✓ Test the submission of the aggregated data in the XML file by using the Submission Engine Validation Tool.
- ✓ Use Medicare Claims to verify TIN combination; ensure group's TIN combination is correct on file submission.
- ✓ Work directly with a QCDR to submit 2017 data by March 31, 2018.
- ✓ Obtain consent of clinicians in group before submission.
- ✓ Data must be submitted in the CDR XML format or QRDA III formats to be accepted.

Qualified Registry: Submission Mechanism Checklist

- ✓ Choose a CMS qualified registry.
- ✓ Ensure the qualified registry has an Enterprise Identity Management Account.
- ✓ Determine how you will participate (e.g., test, partial year, or full year).
- ✓ Choose measures and/or activities.
- ✓ Obtain consent of clinicians in group before submission.
- ✓ Report data for the 2017 calendar year (e.g., Pick Your Pace options: Test, Partial year, or Full year).
- ✓ Test the submission of the aggregated data in the XML file by using the Submission Engine Validation Tool.
- ✓ Use Medicare Claims to verify TIN combination; ensure group's TIN combination is correct on file submission.
- ✓ Obtain consent of clinicians in group before submission.
- ✓ Work directly with a registry to submit 2017 data by March 31, 2018.
- ✓ Data must be submitted in one of the approved Qualified Registry XML formats include on the Education page of qpp.cms.gov.

Electronic Health Record: Submission Mechanism Checklist

- ✓ Determine how you will participate (e.g., test, partial year, or full year).
- ✓ Obtain consent of clinicians in group before submission.
- ✓ Choose measures and/or activities.
- ✓ Report data for the 2017 calendar year (e.g., test, partial year, or full year).
- ✓ Use Medicare claims to verify TIN combination; ensure group's TIN combination is correct on file submission.
- ✓ Obtain consent of clinicians in group before submission.
- ✓ Work directly with a certified EHR to submit 2017 data by March 31, 2018.
- ✓ Submit measure data:
  - If the data is exported or extracted from CEHRT, the health IT vendor or third party must be able to indicate this data source; and
  - Transmit the data electronically exported or extracted from the CEHRT to us directly or through a data intermediary in the CMS-specified form and manner.

Attestation: Submission Mechanism Checklist

- ✓ Determine how you will participate (e.g., test, partial year, or full year).
- ✓ Choose measures and/or activities for one or each category depending on your group's MIPS performance period.
- ✓ Obtain consent of clinicians in group before submission.
- ✓ Report data for the 2017 calendar year (e.g., test, partial year, or full year).
- ✓ Use Medicare Claims to verify TIN combination; ensure group's TIN combination is correct on file submission.
- ✓ Obtain consent of clinicians in group before submission.
- ✓ Submit measure data extracted from your CEHRT by March 31, 2018. Note: Not all attestation data is from CEHRT.

CMS Web Interface: Submission Mechanism Checklist

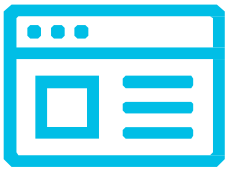
- ✓ Register with the CMS Enterprise Portal by June 30, 2017.
- ✓ Ensure the group has an Enterprise Identity Management account.
- ✓ Determine how you will participate (e.g., test, partial, or full).
- ✓ Obtain consent of clinicians in group before submission.
- ✓ Report data for the 2017 calendar year.
- ✓ Use Medicare Claims to verify TIN combination; ensure group's TIN combination is correct on file submission.
- ✓ Obtain consent of clinicians in group before submission.
- ✓ In early 2018, report data for the 2017 calendar year.
- ✓ Data can either be manually entered or uploaded into the CMS Web Interface via an XML file, which can be populated by a certified EHR.

CAHPS for MIPS Survey Checklist

- ✓ Register with the CMS Enterprise Portal by June 30, 2017.
- ✓ Select and authorize a CMS-approved survey vendor (from a list published by CMS) to collect and report your survey data to CMS.
- ✓ Obtain consent of clinicians in your group before submission.
- ✓ Be responsible for your vendor costs to collect and report the survey.
- ✓ Monitor your vendor's performance during survey administration.
- ✓ Receive your CAHPS for MIPS survey scores from CMS.
- ✓ Have your CAHPS for MIPS survey scores available for public reporting on Physician Compare.

Group Registration

Registration is required for eligible clinicians participating as a group that wish to



Utilize the
CMS Web Interface

Administer the
CAHPS for MIPS Survey

- *Groups that intend to report via the CMS Web Interface or administer the CAHPS for MIPS survey must register by* ***June 30, 2017****.*

Payment Adjustments

How are payment adjustments applied?

- The group will get one MIPS payment adjustment based on the group's performance.
- CMS assigns the MIPS payment adjustments to the combination of the TIN/NPI, regardless of whether performance was measured at the individual or group level.
- Any individual (NPI) included in the TIN, but excluded from MIPS because they are identified as a new Medicare-enrolled clinician, a QP, or Partial QP, would not receive a MIPS payment adjustment regardless of their MIPS participation.
- CMS will only apply the MIPS payment adjustments to Medicare Part B allowed charges.
- If a MIPS eligible clinician is part of a group that is reporting at the group level and reports at the individual level, such MIPS eligible clinician would have a final score based on the group's (TIN) performance and a final score based on their individual (TIN/NPI) performance; however, the MIPS payment adjustment would be applied to higher final score.

Dates to Remember

Important MIPS Participation Dates

Date	Milestone
January 1, 2017	2017 MIPS performance period begins
April 1, 2017	Registration period began for the CMS Web Interface and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS survey
June 30, 2017	Registration deadline for the CMS Web Interface and CAHPS for MIPS survey
October 2, 2017	Last day to begin partial (90 day) participation
December 31, 2017	2017 MIPS performance period ends
January 1 , 2018 – March 31, 2018	MIPS data submission period for the 2017 program year

Question & Answer (Q&A) Session

Q&A Session Information

- Please dial **1-866-452-7887** to ask a question.
  - If prompted, use passcode: 3865522.
- You may also ask your question using the Q&A chat feature of the webinar platform.
- The speakers will answer 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 or 1-866-288-8292.

Participate in QPP Website Testing!

- CMS would like the Quality Payment Program website to meet the needs of the clinician community, by providing streamlined access to information and minimizing undue burdens for program participation.

- CMS invites representatives from organizations of all sizes to assess current and future functionality of the website, as well as make recommendations for improvements. CMS is looking for:
  - Medicare clinicians;
  - Practice managers;
  - Administrative staff; and
  - EHR and Registry vendors.

- If interested, **please email** Partnership@cms.hhs.gov to participate in a one-on-one feedback session.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