Quality Payment
PROGRAM

QUALITY PAYMENT PROGRAM YEAR 3 (2019) FINAL RULE OVERVIEW

NOVEMBER 15, 2018

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Presentation Overview

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- MIPS Year 1 (2017) Participation Results Review
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  - Overview of All-Payer Combination Option & Other Payer Advanced APMs
  - All-Payer Combination Option & Other Payer Advanced APMs Criteria and Determination Processes
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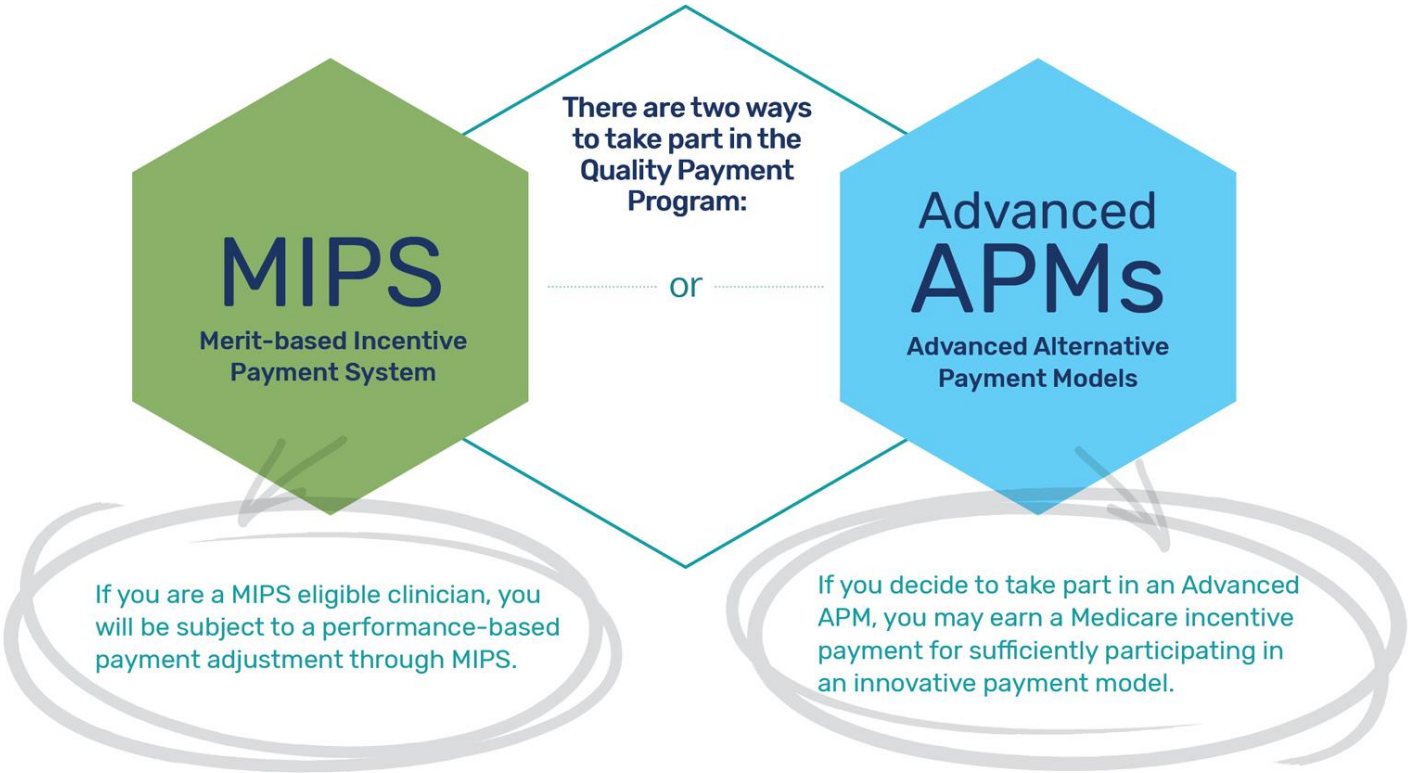
- Quality Payment Program – Help & Support

QUALITY PAYMENT PROGRAM

Overview

Quality Payment Program

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS by law to implement an incentive program, referred to as the Quality Payment Program:



Quality Payment Program

Considerations

- Improve beneficiary outcomes
- Reduce burden on clinicians
- Increase adoption of Advanced APMs
- Maximize participation
- Improve data and information sharing
- Ensure operational excellence in program implementation
- Deliver IT systems capabilities that meet the needs of users

Quick Tip: For additional information on the Quality Payment Program, please visit qpp.cms.gov

QUALITY PAYMENT PROGRAM

Year 1 (2017) Participation Results Review

QPP Year 1 (2017) Performance Data

Payment Adjustments

The 2017 performance year for the Quality Payment Program was:

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

Snapshot of Payment Adjustments for MIPS Eligible Clinicians

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

22% earned a positive payment adjustment only

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

5% received a negative payment adjustment

Payment Adjustment Highlights

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

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

General Participation in 2017:

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

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

QPP Year 1 (2017) Performance Data

Mean and Median National Final Scores

Mean and Median National Final Scores for MIPS

MEAN	MEDIAN
74.01 points (out of 100 points) was the overall **national mean score** for the MIPS 2017 performance year	**88.97 points** (out of 100 points) was the overall **national median score** for the MIPS 2017 performance year
65.71 points for clinicians participating in MIPS as individuals or groups (not through an APM)	**83.04 points** for clinicians participating in MIPS as individuals or groups (not through an APM)
87.64 points for clinicians participating in MIPS through an APM	**91.67 points** for clinicians participating in MIPS through an APM

QPP Year 1 (2017) Performance Data

Mean and Median Final Scores by Submitter Type

Mean and Median Final Scores by Submitter Type*

	INDIVIDUALS	GROUPS
MEAN	55.08 points	76.2 points
MEDIAN	60.00 points	91.04 points

*An individual is a single TIN/NPI; a group is two or more NPIs billing under a single TIN or as an APM Entity

QPP Year 1 (2017) Performance Data

Mean and Median Final Scores for Large, Small, and Rural Practices

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Overview

Merit-based Incentive Payment System (MIPS)

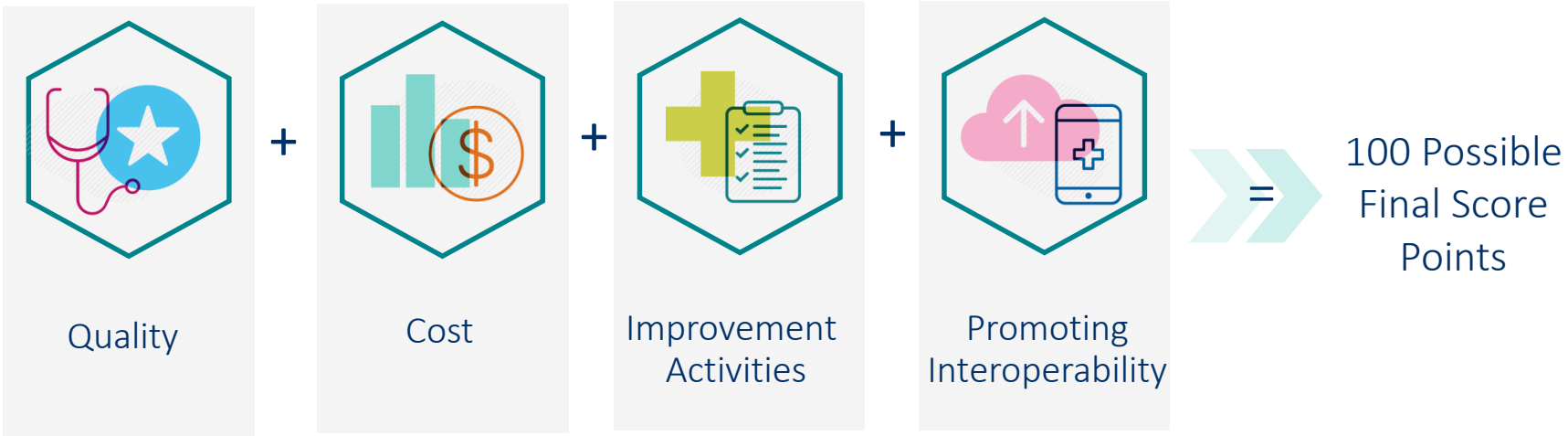
Quick Overview

Combined legacy programs into a single, improved program.

Merit-based Incentive Payment System (MIPS)

Quick Overview

MIPS Performance Categories



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

Merit-based Incentive Payment System (MIPS)

Terms to Know

As a refresher…

- TIN - Taxpayer Identification Number
  - Used by the Internal Revenue Service to identify an entity, such as a group medical practice, that is subject to federal taxes
- NPI – National Provider Identifier
  - 10-digit numeric identifier for individual clinicians
- TIN/NPI
  - Identifies the individual clinician and the entity/group practice through which the clinician bills services to CMS

Performance Period	Also referred to as…	Corresponding Payment Year	Corresponding Adjustment
2017	2017 "Transition" Year	2019	Up to +4%
2018	"Year 2"	2020	Up to +5%
2019	"Year 3"	2021	Up to +7%

Merit-based Incentive Payment System (MIPS)

Timeline

2019
Performance Year

- Performance period opens January 1, 2019
- Closes December 31, 2019
- Clinicians care for patients and record data during the year

March 31, 2020
Data Submission

- Deadline for submitting data is March 31, 2020
- Clinicians are encouraged to submit data early

Feedback

- CMS provides performance feedback after the data is submitted
- Clinicians will receive feedback before the start of the payment year

January 1, 2021
Payment Adjustment

- MIPS payment adjustments are prospectively applied to each claim beginning January 1, 2021

FINAL RULE FOR YEAR 3 (2019) - MIPS

Eligibility

MIPS Year 3 (2019) Final

MIPS Eligible Clinician Types

Year 2 (2018) Final

MIPS eligible clinicians include:

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

Year 3 (2019) Final

MIPS eligible clinicians include:

- Same five clinician types from Year 2 (2018)

AND:

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

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

MIPS Year 3 (2019) Final

Low-Volume Threshold Criteria

What do I need to know?

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

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

    - The finalized criteria now includes:

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

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

MIPS Year 3 (2019) Final

Low-Volume Threshold Determination

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

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

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

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

   AND

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

   AND

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

MIPS Year 3 (2019) Final

Low-Volume Threshold Determination

What else do I need to know?

Clinicians who:

- x **DO NOT** bill more than $90,000 a year in allowed charges for covered professional services under the Medicare Physician Fee Schedule (PFS)

OR

- x **DO NOT** furnish covered professional services to more than 200 Medicare beneficiaries

OR

- x **DO NOT** provide more than 200 covered professional services under the PFS (*New*)

Are excluded from MIPS in Year 3 (2019) and do not need to participate

Remember: To be required to participate, clinicians must:

MIPS Year 3 (2019) Final

Low-Volume Threshold Determination

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

You have two options:

1. Voluntarily participate

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

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

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

MIPS Year 3 (2019) Final

Opt-in Policy

- MIPS eligible clinicians who meet or exceed at least one, but not all, of the low-volume threshold criteria may choose to participate in MIPS

MIPS Opt-in Scenarios

Dollars	Beneficiaries	Professional Services (*New*)	Eligible for Opt-in?
≤ 90K	≤ 200	≤ 200	No – excluded
≤ 90K	≤ 200	> 200	Yes (may also voluntarily report or not participate)
> 90K	≤ 200	≤ 200	Yes (may also voluntarily report or not participate)
> 90K	≤ 200	>200	Yes (may also voluntarily report or not participate)
≤ 90K	> 200	> 200	Yes (may also voluntarily report or not participate)
> 90K	> 200	> 200	No – required to participate

MIPS Year 3 (2019) Final

Opt-in Policy – Example

Physical Therapist (Individual)

✓ Billed $100,000	x Saw 100 patients	✓ Provided 201 covered professional services

- Did not exceed **all** three elements of the low-volume threshold determination criteria, therefore exempt from MIPS in Year 3

However…

- This clinician could **opt-in** to MIPS and participate in Year 3 (2019) since the clinician met or exceeded at least **one** (in this case, two) of the low-volume threshold criteria and is also a MIPS eligible clinician type

MIPS Year 3 (2019) Final

Opt-in Policy

What else do I need to know?

- Once an election has been made, the decision to opt-in to MIPS would be **irrevocable** and **could not be changed**
- Clinicians or groups who opt-in are subject to all of the MIPS rules, special status, and MIPS payment adjustment
- Please note that APM Entities interested in opting-in to participate in MIPS under the APM Scoring Standard would do so at the APM Entity level

User Research Opportunity:

- We're beginning a phase of user research to explore the best methods for allowing clinicians to notify us that they would like to opt-in to MIPS
- We want to hear from you
- If you're interested in helping us identify the best opt-in approaches for clinicians or groups, we encourage you to send your contact information to: CMSQPPFeedback@Ketchum.com

MIPS Year 3 (2019) Final

MIPS Determination Period

Year 2 (2018) Final

Low Volume Threshold Determination Period:

- First 12-month segment: Sept. 1, 2016-Aug. 31, 2017 (including 30-day claims run out)
- Second 12-month segment: Sept. 1, 2017 to Aug. 31, 2018 (including a 30-day claims run out)

Special Status

- Use various determination periods to identify MIPS eligible clinicians with a special status and apply the designation.
- Special status includes:
  - Non-Patient Facing
  - Small Practice
  - Rural Practice
  - Health Professional Shortage Area (HPSA)
  - Hospital-based
  - Ambulatory Surgical Center-based (ASC-based)

Year 3 (2019) Final

Change to the MIPS Determination Period:

- First 12-month segment: Oct. 1, 2017-Sept. 30, 2018 (including a 30-day claims run out)
- Second 12-month segment: Oct. 1, 2018-Sept. 30, 2019 (does not include a 30-day claims run out)
- Goal: consolidate the multiple timeframes and align the determination period with the fiscal year
- Goal: streamlined period will also identify MIPS eligible clinicians with the following special status:
  - Non-Patient Facing
  - Small Practice
  - Hospital-based
  - ASC-based

Note: Rural and HPSA status continue to apply in 2019

Quick Tip: MIPS eligible clinicians with a special status are included in MIPS and qualify for special rules. Having a special status does not exempt a clinician from MIPS.

FINAL RULE FOR YEAR 3 (2019) - MIPS

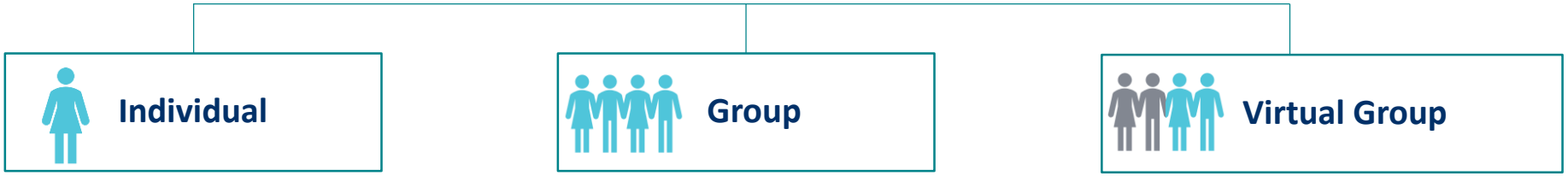
Reporting Options and Data Submission

MIPS Year 3 (2019) Final

Reporting Options

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

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



1. As an Individual—under an National Provider Identifier (NPI) number and Taxpayer Identification Number (TIN) where they reassign benefits

2. As a Group

   a) 2 or more clinicians (NPIs) who have reassigned their billing rights to a single TIN*

   b) As an APM Entity

3. As a Virtual Group – made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together "virtually" (no matter what specialty or location) to participate in MIPS for a performance period for a year

MIPS Year 3 (2019) Final

Submitting Data - Collection, Submission, and Submitter Types

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

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

Why did you make this change?

- In Year 2 (2018), we used the term "submission mechanism" all-inclusively when talking about:
  - The method by which data is submitted (e.g., registry, EHR, attestation, etc.)
  - Certain types of measures and activities on which data are submitted
  - Entities submitting such data (i.e., third party intermediaries submitting on behalf of a group)
- We found that this caused confusion for clinicians and those submitting on behalf of clinicians

MIPS Year 3 (2019) Final

Submitting Data - Collection, Submission, and Submitter Types

Definitions for Newly Finalized Terms:

- **Collection type-** a set of quality measures with comparable specifications and data completeness criteria including, as applicable, including, but not limited to: electronic clinical quality measures (eCQMs); MIPS Clinical Quality Measures* (MIPS CQMs); Qualified Clinical Data Registry (QCDR) measures; Medicare Part B claims measures; CMS Web Interface measures; the CAHPS for MIPS survey; and administrative claims measures
- **Submission type-** the mechanism by which a submitter type submits data to CMS, including, but not limited to: direct, log in and upload, log in and attest, Medicare Part B claims, and the CMS Web Interface.
    - The Medicare Part B claims submission type is for clinicians or groups in small practices only to continue providing reporting flexibility
- **Submitter type**- the MIPS eligible clinician, group, virtual group, or third party intermediary acting on behalf of a MIPS eligible clinician, group, or virtual group, as applicable, that submits data on measures and activities.

*The term MIPS CQMs would replace what was formerly referred to as “registry measures” since clinicians that don’t use a registry may submit data on these measures.

MIPS Year 3 (2019) Final

Collection, Submission, and Submitter Types - Example

Data Submission for MIPS Eligible Clinicians Reporting as Individuals

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

MIPS Year 3 (2019) Final

Collection, Submission, and Submitter Types - Example

Data Submission for MIPS Eligible Clinicians Reporting as Groups

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

FINAL RULE FOR YEAR 3 (2019) - MIPS

Performance Categories

MIPS Year 3 (2019) Final

Performance Periods

Year 2 (2018) Final

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

Year 3 (2019) Final - *No Change*

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

MIPS Year 3 (2019) Final

Performance Category Weights

Year 2 (2018) Final

Performance Category	Performance Category Weight
Quality	50%
Cost	10%
Improvement Activities	15%
Promoting Interoperability	25%

Year 3 (2019) Final

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

MIPS Year 3 (2019) Final

Quality Performance Category

Basics:

- **45%** of Final Score in 2019
- You select 6 individual measures
  - 1 must be an outcome measure
    OR
  - High-priority measure
- If less than 6 measures apply, then report on each applicable measure
- You may also select a specialty-specific set of measures

Meaningful Measures

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

MIPS Year 3 (2019) Final

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Bonus Points

Year 2 (2018) Final	Year 3 (2019) Final
• 2 points for outcome or patient experience • 1 point for other high-priority measures • 1 point for each measure submitted using electronic end-to-end reporting • Cap bonus points at 10% of category denominator	**Same requirements** as Year 2, with the following changes: • Add **small practice bonus** of **6 points** for MIPS eligible clinicians in small practices who submit data on at least 1 quality measure • Updated the definition of high-priority to include the opioid-related measures

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

MIPS Year 3 (2019) Final

Quality Performance Category

Basics:

- **45%** of Final Score in 2019
- You select 6 individual measures
  - 1 must be an outcome measure
    OR
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- If less than 6 measures apply, then report on each applicable measure
- You may also select a specialty-specific set of measures

Data Completeness

Year 2 (2018) Final	Year 3 (2019) Final
• 60% for submission mechanisms except for Web Interface and CAHPS • Measures that do not meet the data completeness criteria earn 1 point • Small practices continue to receive 3 points	**Same requirements** as Year 2

MIPS Year 3 (2019) Final

Quality Performance Category

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- You select 6 individual measures
  - 1 must be an outcome measure
    OR
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- If less than 6 measures apply, then report on each applicable measure
- You may also select a specialty-specific set of measures

Special Scoring Considerations

Measures Impacted by Clinical Guideline Changes

- CMS will identify measures for which following the guidelines in the existing measure specification could result in patient harm or otherwise provide misleading results as to good quality care
- Clinicians who are following the revised clinical guidelines will still need to submit the impacted measure
- The total available measure achievement points in the denominator will be reduced by 10 points and the numerator of the impacted measure will result in zero points

Groups Registered to Report the CAHPS for MIPS Survey

- If the sample size was not sufficient and if the group doesn't select another measure, the total available measure achievement points will be reduced by 10 and the measures will receive zero points

MIPS Year 3 (2019) Final

Quality Performance Category

Basics:

- **45%** of Final Score in 2019
- You select 6 individual measures
  - 1 must be an outcome measure
    OR
  - High-priority measure
- If less than 6 measures apply, then report on each applicable measure
- You may also select a specialty-specific set of measures

Improvement Scoring

Year 2 (2018) Final	Year 3 (2019) Final
• Eligible clinicians must fully participate (i.e. submit all required measures and have met data completeness criteria) for the performance period • If the eligible clinician has a previous year Quality performance category score less than or equal to 30%, we would compare 2018 performance to an assumed 2017 Quality performance category score of 30%	• **Same requirements** as Year 2

MIPS Year 3 (2019) Final

Quality Performance Category

Basics:

- **45%** of Final Score in 2019
- You select 6 individual measures
  - 1 must be an outcome measure
    OR
  - High-priority measure
- If less than 6 measures apply, then report on each applicable measure
- You may also select a specialty-specific set of measures

Topped-out Measures

Year 2 (2018) Final	Year 3 (2019) Final
• A topped out measure is when performance is so high and unwavering that meaningful distinctions and improvement in performance can no longer be made • 4-year lifecycle to identify and remove topped out measures • Scoring cap of 7 points for topped out measures	**Same requirements** as Year 2, with the following changes: • Extremely Topped-Out Measures: – A measure attains extremely topped-out status when the average mean performance is within the 98th to 100th percentile range – CMS may propose removing the measure in the next rulemaking cycle • QCDR measures are excluded from the topped out measure lifecycle and special scoring policies

MIPS Year 3 (2019) Final

Cost Performance Category

Basics:

- **15%** of Final Score in 2019
- Measures:
  - Medicare Spending Per Beneficiary (MSPB)
  - Total Per Capita Cost
  - **Adding** 8 episode-based measures
- No reporting requirement; data pulled from administrative claims
- No improvement scoring in Year 3

Measure Case Minimums

Year 2 (2018) Final	Year 3 (2019) Final
• Case minimum of 20 for Total per Capita Cost measure and 35 for MSPB	**Same requirements** as Year 2, with the following additions: • Case minimum of 10 for procedural episodes • Case minimum of 20 for acute inpatient medical condition episodes

MIPS Year 3 (2019) Final

Cost Performance Category

Basics:

- **15%** of Final Score in 2019
- Measures:
  - Medicare Spending Per Beneficiary (MSPB)
  - Total Per Capita Cost
  - **Adding** 8 episode-based measures
- No reporting requirement; data pulled from administrative claims
- No improvement scoring in Year 3

Measure Attribution

Year 2 (2018) Final	Year 3 (2019) Final
• Plurality of primary care services rendered by the clinician to determine attribution for the Total per Capita Cost measure • Plurality of Part B services billed during the index admission to determination attribution for the MSPB measure • Added two CPT codes to the list of primary care services used to determine attribution under the Total per Capita Cost measure	**Same requirements** as Year 2, with the following additions: • For procedural episodes: CMS will attribute episodes to the clinician that performs the procedure • For acute inpatient medical condition episodes: CMS will attribute episodes to each clinician who bills inpatient evaluation and management (E&M) claim lines during a trigger inpatient hospitalization under a TIN that renders at least 30 percent of the inpatient E&M claim lines in that hospitalization

MIPS Year 3 (2019) Final

Facility-based Quality and Cost Performance Measures

What is it?

- Facility-based scoring is an option for clinicians that meet certain criteria beginning with the 2019 performance period
  - CMS finalized this policy for the 2019 performance period in the 2018 Final Rule
  - Facility-based scoring allows for certain clinicians to have their Quality and Cost performance category scores based on the performance of the hospitals at which they work

MIPS Year 3 (2019) Final

Facility-based Quality and Cost Performance Measures

Applicability: Individual

- MIPS eligible clinician furnishes 75% or more of their covered professional services in inpatient hospital (Place of Service code 21), on-campus outpatient hospital (POS 22), or an emergency room (POS 23), based on claims for a period prior to the performance period

- Clinician would be required to have at least a single service billed with POS code used for inpatient hospital or emergency room

Applicability: Group

- Facility-based group would be one in which 75% or more of eligible clinicians billing under the group's TIN are eligible for facility-based measurement as individuals

MIPS Year 3 (2019) Final

Facility-based Quality and Cost Performance Measures

Attribution

- Facility-based clinician would be attributed to hospital where they provide services to most patients
- Facility-based group would be attributed to hospital where most facility-based clinicians are attributed
- If unable to identify facility with the Hospital Value-based Purchasing (VBP) score to attribute clinician's performance, that clinician would not be eligible for facility-based measurement and would have to participate in MIPS via other methods

Election

- Automatically apply facility-based measurement to MIPS eligible clinicians and groups who are eligible for facility-based measurement and who would benefit by having a higher combined Quality and Cost score
- No submission requirements for individual clinicians in facility-based measurement, but a group would need to submit data for the Improvement Activities or Promoting Interoperability performance categories in order to be measured as a facility-based group

MIPS Year 3 (2019) Final

Facility-based Quality and Cost Performance Measures

Measurement

- For facility-based measurement, the measure set for the fiscal year Hospital VBP Program that begins during the applicable MIPS performance period would be used for facility-based clinicians

- Example: For the 2019 MIPS performance period (Year 3), the measures used would be those for the 2020 Hospital VBP Program along with the associated benchmarks and performance periods

Benchmarks

- Benchmarks for facility-based measurement are those that are adopted under the hospital VBP Program of the facility for the year specified

MIPS Year 3 (2019) Final

Facility-based Quality and Cost Performance Measures

Assigning MIPS Category Scores

- The Quality and Cost performance category scores (which are separate scores) for facility-based clinicians are based on how well the clinician's hospital performs in comparison to other hospitals in the Hospital VBP Program

Scoring – Special Rules

- Some hospitals do not receive a Total Performance Score in a given year in the Hospital VBP Program, whether due to insufficient quality measure data, failure to meet requirements under the Hospital In-patient Quality Reporting (IQR) Program, or other reasons
- In these cases, we would be unable to calculate a facility-based score based on the hospital's performance, and facility-based clinicians would be required to participate in MIPS via another method

MIPS Year 3 (2019) Final

Improvement Activities Performance Category

Basics:

- **15%** of Final Score in 2019
- Select Improvement Activities and attest "yes" to completing
- Activity weights remain the same:
  - Medium = 10 points
  - High = 20 points
- **Small practices, non-patient facing clinicians, and/or clinicians located in rural or HPSAs** continue to receive double-weight and report on no more than 2 activities to receive the highest score

Activity Inventory

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

CEHRT Bonus

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

MIPS Year 3 (2019) Final

Promoting Interoperability Performance Category

Basics:

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

Reporting Requirements

Year 2 (2018) Final	Year 3 (2019) Final
• Comprised of a base, performance, and bonus score • Must fulfill the base score requirements to earn a Promoting Interoperability score	• Eliminated the base, performance, and bonus scores • **New performance-based scoring** at the individual measure level • Must report the required measures under each Objective, or claim the exclusions if applicable

MIPS Year 3 (2019) Final

Promoting Interoperability Performance Category

Basics:

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

Objectives and Measures

Year 2 (2018) Final	Year 3 (2019) Final
• Two measure set options for reporting based on the MIPS eligible clinician's edition of CEHRT (either 2014 or 2015)	• One set of Objectives and Measures based on 2015 Edition CEHRT • Four Objectives: e-Prescribing, Health Information Exchange, Provider to Patient Exchange, and Public Health and Clinical Data Exchange • Added two new measures to the e-Prescribing Objective: Query of Prescription Drug Monitoring Program (PDMP) and Verify Opioid Treatment Agreement

MIPS Year 3 (2019) Final

Promoting Interoperability Performance Category – Point Value

Objectives	Measures	Maximum Points
e-Prescribing	• e-Prescribing	• 10 points
	• Query of Prescription Drug Monitoring Program (PDMP) (new)	• 5 bonus points
	• Verify Opioid Treatment Agreement (new)	• 5 bonus points
Health Information Exchange	• Support Electronic Referral Loops by Sending Health Information (formerly Send a Summary of Care)	• 20 points
	• Support Electronic Referral Loops by Receiving and Incorporating Health Information (new)	• 20 points
Provider to Patient Exchange	• Provide Patients Electronic Access to their Health Information (formerly Provide Patient Access)	• 40 points
Public Health and Clinical Data Exchange	• Immunization Registry Reporting • Electronic Case Reporting • Public Health Registry Reporting • Clinical Data Registry Reporting • Syndromic Surveillance Reporting	• 10 points

MIPS Year 3 (2019) Final

Promoting Interoperability Performance Category

Basics:

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

Scoring

To earn a score for the Promoting Interoperability Performance Category, a MIPS eligible clinician must:

1. User CEHRT for the performance period (90-days or greater)
2. Submit a "yes" to the Prevention of Information Blocking Attestation
3. Submit a "yes" to the ONC Direct Review Attestation
4. Submit a "yes" for the security risk analysis measure
5. Report the required measures under each Objective, or claim the exclusions if applicable

MIPS Year 3 (2019) Final

Promoting Interoperability Performance Category

Basics:

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

Scoring

Year 2 (2018) Final	Year 3 (2019) Final
• Fulfill the base score (worth 50%) by submitting at least a 1 in the numerator of certain measures AND submit "yes" for the Security Risk Analysis measure • Performance score (worth 90%) is determined by a performance rate for each submitted measure • Bonus score (worth 25%) is available • Maximum score is 165%, but is capped at 100%	• Performance-based scoring at the individual measure level • Each measure will be scored on performance for that measure based on the submission of a numerator and denominator, or a "yes or no" – Must submit a numerator of at least one or a "yes" to fulfill the required measures • The scores for each of the individual measures will be added together to calculate a final score • If exclusions are claimed, the points will be allocated to other measures

MIPS Year 3 (2019) Final

Promoting Interoperability Performance Category – Scoring Example

Objectives	Measures	Maximum Points	Numerator/ Denominator	Performance Rate	Score
e-Prescribing	• e-Prescribing	• 10 points	200/250	80%	10 x 0.8 = 8 points
Health Information Exchange	• Support Electronic Referral Loops by Sending Health Information	• 20 points	135/185	73%	20 x 0.73 = 15 points
	• Support Electronic Referral Loops by Receiving and Incorporating Health Information	• 20 points	145/175	83%	20 x 0.83 = 17 points
Provider to Patient Exchange	• Provide Patients Electronic Access to their Health Information	• 40 points	350/500	70%	40 x 0.70 = 28 points
Public Health and Clinical Data Exchange	• Immunization Registry Reporting • Public Health Registry Reporting	• 10 points	• Yes • Yes	N/A	10 points
				Total	78 Points

MIPS Year 3 (2019) Final

Promoting Interoperability Performance Category – Scoring Example

Total Score (from previous slide)	78 points
Calculate the contribution to MIPS Final Score	78 x .25 (the category value) = 19.5 performance category points
Final Performance Category Score	**19.5 points out of the 25 performance category points**

MIPS Year 3 (2019) Final

Promoting Interoperability Performance Category

Basics:

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

Reweighting

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

• Automatic reweighting for the following MIPS eligible clinicians: Non-Patient Facing, Hospital-based, Ambulatory Surgical Center-based, PAs, NPs, Clinical Nurse Specialists, and CRNAs
 	
• Application based reweighting also available for certain circumstances
  • Example: clinicians who are in small practices
	Same requirements as Year 2, with the following additions:
	
	• Extended the automatic reweighting for:
	  • Physical Therapists
	  • Occupational Therapists
	  • Clinical Psychologists
	  • Speech-Language Pathologists
	  • Audiologists
	  • Registered Dieticians or Nutrition Professionals

FINAL RULE FOR YEAR 3 (2019) - MIPS

Additional Bonuses, Performance Threshold, and Payment Adjustments

MIPS Year 3 (2019) Final

Complex Patient Bonus

Same requirements as Year 2:

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

MIPS Year 3 (2019) Final

Performance Threshold and Payment Adjustments

Year 2 (2018) Final

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

Year 3 (2019) Final

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

**To ensure budget neutrality, positive MIPS payment adjustment factors are likely to be increased or decreased by an amount called a "scaling factor." The amount of the scaling factor depends on the distribution of final scores across all MIPS eligible clinicians.*

MIPS Year 3 (2019) Final

Performance Threshold and Payment Adjustments

Year 2 (2018) Final

Final Score 2018	Payment Adjustment 2020
≥70 points	• Positive adjustment greater than 0% • Eligible for additional payment for exceptional performance —minimum of additional 0.5%
15.01-69.99 points	• Positive adjustment greater than 0% • Not eligible for additional payment for exceptional performance
15 points	• Neutral payment adjustment
3.76-14.99	• Negative payment adjustment greater than -5% and less than 0%
0-3.75 points	• Negative payment adjustment of -5%

Year 3 (2019) Final

Final Score 2019	Payment Adjustment 2021
≥75 points	• Positive adjustment greater than 0% • Eligible for additional payment for exceptional performance —minimum of additional 0.5%
30.01-74.99 points	• Positive adjustment greater than 0% • Not eligible for additional payment for exceptional performance
30 points	• Neutral payment adjustment
7.51-29.99	• Negative payment adjustment greater than -7% and less than 0%
0-7.5 points	• Negative payment adjustment of -7%

ADVANCED APMs

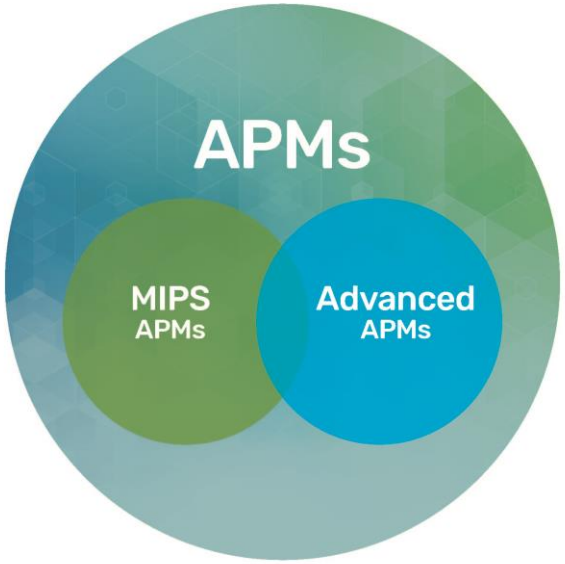
Overview

Alternative Payment Models (APMs)

Overview

- A payment approach that provides added incentives to clinicians to provide high-quality and cost-efficient care
- Can apply to a specific condition, care episode or population
- May offer significant opportunities for eligible clinicians who are not ready to participate in Advanced APMs

Advanced APMs are a Subset of APMs



Advanced APMs

Benefits

Clinicians and practices can:

- Receive **greater rewards** for taking on some risk related to patient outcomes.

"So what?" - It is important to understand that the Quality Payment Program does not change the design of any particular APM. Instead, it creates **extra incentives** for a sufficient degree of participation in Advanced APMs.

Advanced APMs

Advanced APM Criteria

To be an Advanced APM, the following three requirements must be met.

The APM:

1. Requires participants to use **certified EHR technology**;

2. Provides payment for covered professional services based on **quality measures** comparable to those used in the MIPS quality performance category; and

3. **Either**: (1) is a **Medical Home Model expanded** under CMS Innovation Center authority OR (2) requires **participants to bear a more than nominal amount of financial risk.**

Advanced APMs

Terms to Know

- **APM Entity** - An entity that participates in an APM or payment arrangement with a non-Medicare payer through a direct agreement or through Federal or State law or regulation.
- **Advanced APM** – Advanced APMs must meet three specific criteria: Require CEHRT use, base payment on MIPS-comparable quality measures, and either be a Medicare Medical Home or require participants to bear a more than nominal amount of risk.
- **Affiliated Practitioner** - An eligible clinician identified by a unique APM participant identifier on a CMS-maintained list who has a contractual relationship with the Advanced APM Entity for the purposes of supporting the Advanced APM Entity's quality or cost goals under the Advanced APM.
- **Affiliated Practitioner List** - The list of Affiliated Practitioners of an APM Entity that is compiled from a CMS-maintained list.
- **MIPS APM –** Most Advanced APMs are also MIPS APMs so that if an eligible clinician participating in the Advanced APM does not meet the threshold for sufficient payments or patients through an Advanced APM in order to become a Qualifying APM Participant (QP), thereby being excluded from MIPS, the MIPS eligible clinician will be scored under MIPS according to the APM scoring standard. The APM scoring standard is designed to account for activities already required by the APM.
- **Participation List** - The list of participants in an APM Entity that is participating in an Advanced APM, compiled from a CMS-maintained list.
- **Qualifying APM Participant (QP)** - An eligible clinician determined by CMS to have met or exceeded the relevant QP payment amount or QP patient count threshold for a year based on participation in an Advanced APM Entity.

Advanced APMs

Current List of Advanced APMs for 2019

- Bundled Payments for Care Improvement (BPCI) Advanced Model*
- Comprehensive Care for Joint Replacement Model
- Comprehensive ESRD Care Model (LDO Arrangement)
- Comprehensive ESRD Care Model (non-LDO Two-sided Risk Arrangement)
- Comprehensive Primary Care Plus (CPC+) Model
- Medicare Accountable Care Organization (ACO) Track 1+ Model
- Maryland Total Cost of Care Model (Care Redesign Program)
- Maryland Total Cost of Care Model (Maryland Primary Care Program)
- Next Generation ACO Model
- Shared Savings Program – Track 2
- Shared Savings Program – Track 3
- Oncology Care Model (OCM) – Two-Sided Risk Arrangement
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)

*BPCI Advanced began in October 2018, and participants will have an opportunity to achieve QP status, or be scored under the APM scoring standard for MIPS, starting in performance year 2019.

FINAL RULE FOR YEAR 3 (2019) – ADVANCED APMs

Advanced APM Criteria

Advanced APMs (2019) Final

Advanced APM Criteria – CEHRT Use

Years 1 & 2 (2017 &2018) Final

Minimum CEHRT Use Threshold:

- To qualify as an Advanced APM (across both Medicare and other payers), a payment arrangement must satisfy the criterion of requiring that at least 50% of the eligible clinicians in each APM Entity use CEHRT

Year 3 (2019) Final

Minimum CEHRT Use Threshold:

- Increase the CEHRT use threshold for Advanced APMs
- An Advanced APM must require at least **75%** of eligible clinicians in each APM Entity use CEHRT

Advanced APMs (2019) Final

Advanced APM Criteria – MIPS Comparable Measures

Years 1 & 2 (2017 &2018) Final

MIPS Comparable Measures:

- Quality measures upon which an Advanced APM bases payment must be reliable, evidence-based, and valid and meet one of the following criteria:

1. On the MIPS final list;
2. Endorsed by a consensus-based entity (NQF);
3. Submitted in the annual call for quality measures;
4. Developed using QPP Measure Development funds; or
5. Otherwise, determined by CMS to be reliable, evidence-based, and valid

Year 3 (2019) Final

MIPS Comparable Measures:

- Beginning in 2020, streamline the quality measure criteria to state that at least one of the quality measures upon which an Advanced APM bases payment must be:

1. On the MIPS final list;
2. Endorsed by a consensus-based entity; or
3. Otherwise be determined to be evidence-based, reliable, and valid by CMS

Advanced APMs (2019) Final

Advanced APM Criteria – Outcome Measures

Years 1 & 2 (2017 &2018) Final

Outcome Measures:

- The quality measures upon which an Advanced APM bases payment must include at least one outcome measure, unless CMS determines that there are no available or applicable outcome measures included in the MIPS quality measures list for the Advanced APM's QP Performance Period

Year 3 (2019) Final

Outcome Measures:

- Beginning in 2020, amend the Advanced APM quality criterion to require that the outcome measure used must be evidenced-based, reliable, and valid by meeting one of the following criteria:
- On the MIPS final list;
- Endorsed by a consensus-based entity; or
- Otherwise determined to be evidence-based, reliable, and valid by CMS

Advanced APMs (2019) Final

Advanced APM Criteria – Revenue-based Nominal Amount Standard

Year 2 (2018) Final

Revenue-based Nominal Amount Standard:

- For performance periods 2019 and 2020, the revenue-based nominal amount standard is set at 8% of the average estimated Parts A and B revenue of providers in participating APM Entities

Year 3 (2019) Final

Revenue-based Nominal Amount Standard:

- No Change
- Maintained the 8% revenue-based nominal amount standard through performance period 2024

ADVANCED APMs

Overview of All-Payer Combination Option & Other Payer Advanced APMs

All-Payer Combination Option

Overview

The MACRA law created two options to allow eligible clinicians to become QPs:

Medicare Option

- Available for all performance years
- Eligible clinicians achieve QP status exclusively based on participation in Advanced APMs with Medicare

All-Payer Combination Option

- Available starting in Performance Year 2019
- Eligible clinicians achieve QP status based on a combination of participation in:
  - Advanced APMs with Medicare; and
  - Other Payer Advanced APMs offered by other payers

All-Payer Combination Option

All-Payer Combination Option & Other Payer Advanced APMs

Other Payer Advanced APMs are non-Medicare payment arrangements that meet criteria that are similar to Advanced APMs under Medicare.

Payer types that may have payment arrangements that qualify **as Other Payer Advanced APMs** include:

- ✓ Title XIX (Medicaid)
- ✓ Medicare Health Plans (including Medicare Advantage)
- ✓ Payment arrangements aligned with CMS Multi-Payer Models
- ✓ Other commercial and private payers

All-Payer Combination Option

Other Payer Advanced APM Criteria

The criteria for determining whether a payment arrangement qualifies as an Other Payer Advanced APM are similar, but not identical, to the comparable criteria used for Advanced APMs under Medicare:

1. Requires at least 50 percent of eligible clinicians to **use certified EHR technology** to document and communicate clinical care information

2. Base payments on **quality measures that are comparable to those used in the MIPS** quality performance category

3. Either: (1) is a Medicaid Medical Home Model that meets criteria that are comparable to a **Medical Home Model expanded** under CMS Innovation Center authority, OR (2) requires **participants to bear more than nominal amount of financial risk if actual aggregate expenditures exceed expected aggregate expenditures**

FINAL RULE FOR YEAR 3 (2019) – ADVANCED APMs

All-Payer Combination Option & Other Payer Advanced APMs Criteria and Determination Processes

Advanced APMs (2019) Final

Other Payer Criteria – CEHRT Use

Years 1 & 2 (2017 &2018) Final

Minimum CEHRT Use Threshold:

- To qualify as an Advanced APM (across both Medicare and other payers), a payment arrangement must satisfy the criterion of requiring that at least 50% of the eligible clinicians in each APM Entity use CEHRT

Year 3 (2019) Final

Minimum CEHRT Use Threshold:

- Increased the CEHRT use criterion threshold for Other Payer Advanced APMs so that in order to qualify as an Other Payer Advanced APM as of January 1, 2020, CEHRT must be used by at least **75%** of eligible clinicians in the other payer arrangement.

Advanced APMs (2019) Final

Other Payer Criteria – CEHRT Use for Other Payer Advanced APMs

Years 1 & 2 (2017 &2018) Final

CEHRT Use Requirement:

- Previously finalized that CMS would presume that an other payer arrangement would satisfy the CEHRT use criterion if we receive information and documentation from the eligible clinician through the Eligible Clinician Initiated Process showing that the other payer arrangement requires the requesting eligible clinician(s) to use CEHRT to document and communicate clinician information

Year 3 (2019) Final

CEHRT Use Requirement:

- Modified the CEHRT use criterion for Other Payer Advanced APMs to allow **either payers or eligible clinicians** to submit evidence that CEHRT is actually used at the required threshold, whether or not CEHRT use is explicitly required under the terms of the other payer arrangement.

Advanced APMs (2019) Final

Other Payer Criteria – Revenue-based Nominal Amount Standard

Year 2 (2018) Final

Revenue-based Nominal Amount Standard:

- The revenue-based nominal amount standard for Other Payer Advanced APMs parallels to the revenue-based nominal amount standard for Advanced APMs.
- Payer arrangements would meet the revenue-based nominal amount standard for performance periods 2019 and 2020 if **risk is at least 8%** of the total combined revenues from the payer of providers and supplies in participating APM Entities.

Year 3 (2019) Final

Revenue-based Nominal Amount Standard:

- No change
- Maintained the revenue-based nominal amount standard for Other Payer Advanced APMs at **8%** through performance period 2024.

Advanced APMs (2019) Final

Other Payer – Payer-Initiated Process for Remaining Other Payers

Year 2 (2018) Final

Payer-Initiated Process:

- CMS established a process to allow select payers to submit payment arrangements for consideration as Other Payer Advanced APMs, starting in 2018 (for the 2019 All-Payer QP Performance Period)
- Also finalized the intent to allow remaining other payers to request that CMS determine whether other payer arrangements are Other Payer Advanced APMs starting in 2019 (for the 2020 All-Payer QP Performance Period) and annually each year thereafter

Year 3 (2019) Final

Payer-Initiated Process:

- Allow all payer types to be included in the 2019 Payer Initiated Process for the 2020 QP Performance Period

Advanced APMs (2019) Final

Other Payer – Multi-Year Other Payer Determinations

Year 2 (2018) Final

Multi-Year Other Payer Determinations:

- Payers and eligible clinicians with payment arrangements determined to be Other Payer Advanced APM to re-submit all information for CMS review and redetermination on an annual basis

Year 3 (2019) Final

Multi-Year Other Payer Determinations:

- Maintained annual submissions, but streamlined the process for multi-year arrangements
- When initial submissions are made, the payer and/or eligible clinician provide information on the length of the agreement, and attest at the outset that they would submit for redetermination if the payment arrangement underwent any changes during its duration
- In subsequent years, if there are no changes to the payment arrangement, the payer and/or eligible clinician would not have to annually attest or resubmit the payment arrangement for determination

Advanced APMs (2019) Final

All-Payer Combination Option – TIN Level QP Determinations

Year 2 (2018) Final

TIN Level QP Determinations:

- Conduct All-Payer QP determinations at the individual eligible clinician level

Year 3 (2019) Final

TIN Level QP Determination:

- Beginning in 2019, allow for QP determinations under the All-Payer Option to be requested at the TIN level in addition to the APM Entity and individual eligible clinician levels

FINAL RULE FOR YEAR 3 (2019) – ADVANCED APMs

MIPS APMs & the APM Scoring Standard

Advanced APMs (2019) Final

MIPS APMs – Criteria

Years 1 & 2 (2017 &2018) Final

MIPS APM Criteria:

- Currently, one of the MIPS APM criteria is that an APM "bases payment on cost/utilization and quality measures"
- We did not intend to limit an APM's ability to meet the cost/utilization part of this criterion solely by having a cost/utilization measure

Year 3 (2019) Final

MIPS APM Criteria:

- Reordered the wording of this criterion to state that the APM "bases payment on quality measures and cost/utilization"
- This would clarify that the cost/utilization part of the policy is broader than specifically requiring the use of a cost/utilization measure

Advanced APMs (2019) Final

MIPS APMs – Aligning PI under the APM Scoring Standard

Years 1 & 2 (2017 &2018) Final

MIPS APM Criteria:

- Under previously finalized policy for the APM scoring standard, Shared Savings Program ACOs are required to report Promoting Interoperability (PI) at the participant TIN level
- This differs from all other MIPS APMs, which allow MIPS eligible clinicians to report PI in any manner permissible under MIPS (i.e., at either the individual or group level)

Year 3 (2019) Final

MIPS APM Criteria:

- Align PI reporting requirements under the APM scoring standard so that MIPS eligible clinicians in any MIPS APMs, including the Shared Savings Program, can report PI in any manner permissible under MIPS (i.e., at either the individual or group level)

QUALITY PAYMENT PROGRAM

Help & Support

Technical Assistance

Available Resources

CMS has free resources and organizations on the ground to provide help to clinicians who are participating in the Quality Payment Program:

PRIMARY CARE & SPECIALIST PHYSICIANS

Transforming Clinical Practice Initiative

- Supports more than 140,000 clinician practices through active, collaborative and peer-based learning networks over 4 years.
- **Practice Transformation Networks (PTNs) and Support Alignment Networks (SANs)** are located in all 50 states to provide comprehensive technical assistance, as well as tools, data, and resources to improve quality of care and reduce costs.
- The goal is to help practices transform over time and move toward Advanced Alternative Payment Models.
- Contact TCPI.ISC@TruvenHealth.com for extra assistance.

Locate the PTN(s) and SAN(s) in your state

SMALL & SOLO PRACTICES

Small, Underserved, and Rural Support (SURS)

- Provides outreach, guidance, and direct technical assistance to clinicians in **solo or small practices (15 or fewer), particularly those in rural and underserved areas**, to promote successful health IT adoption, optimization, and delivery system reform activities.
  - Assistance will be tailored to the needs of the clinicians.
  - There are 11 SURS organizations providing assistance to small practices in all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands.
  - For more information or for assistance getting connected, contact QPPSURS@IMPAQINT.COM.

LARGE PRACTICES

Quality Innovation Networks-Quality Improvement Organizations (QIN-QIO)

- Supports clinicians in **large practices (more than 15 clinicians)** in meeting Merit- Based Incentive Payment System requirements through customized technical assistance.
- Includes one-on-one assistance when needed.
- There are 14 QIN-QIOs that serve all 50 states, the District of Columbia, Guam, Puerto Rico, and Virgin Islands.

Locate the QIN-QIO that serves your state

Quality Innovation Network (QIN) Directory

TECHNICAL SUPPORT

All Eligible Clinicians Are Supported By:

Quality Payment Program Website: qpp.cms.gov
Serves as a starting point for information on the Quality Payment Program.

Quality Payment Program Service Center
Assists with all Quality Payment Program questions.
1-866-288-8292 TTY: 1-877-715-6222 QPP@cms.hhs.gov

Center for Medicare & Medicaid Innovation (CMMI) Learning Systems
Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs. More information about the Learning Systems is available through your model's support inbox.

Learn more about technical assistance: https://qpp.cms.gov/about/help-and-support#technical-assistance

Help CMS Improve the Quality Payment Program

Interested in providing feedback to CMS as we continue to improve the Quality Payment Program experience?

We're looking for participants to collaborate with us to provide feedback on all aspects related to qpp.cms.gov, including:

- Products
- Services
- Educational Materials
- Website Content

These feedback sessions typically range from 30-60 minutes and can be done over the phone, via video conference, or through email.

Email cmsqppfeedback@ketchum.com to participate in our feedback sessions!

Q&A Session

To ask a question, please dial:

1-866-452-7887

If prompted, use passcode: 6993775

Press ***1** to be added to the question queue.

You may also submit questions via the chat box.

Speakers will answer as many questions as time allows.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