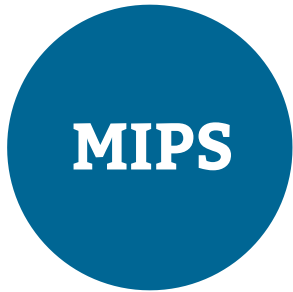**The Merit-based Incentive Payment System:**
Advancing Care Information and Improvement Activities Performance Categories

December 13, 2016

Major Topics Covered

MIPS

The Merit-based Incentive Payment System at-a-glance

Overview of Advancing Care Information and Improvement Activities

What is the Merit-based Incentive Payment System?

Performance Categories

Quality	Cost	Improvement Activities	Advancing Care Information

- 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 based on a 1 to 100 point scale
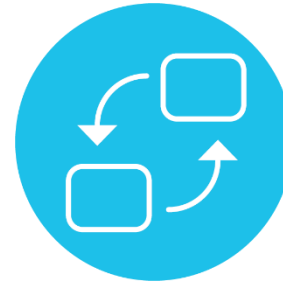
Transition Year Weights

Quality	Cost	Improvement Activities	Advancing Care Information
60%	0%	15%	25%

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

Eligible Clinicians:

- Medicare Part B clinicians billing more than $30,000 a year **AND** providing care for more than 100 Medicare patients a year.

These clinicians include:

Physicians	Physician Assistants	Nurse Practitioner	Clinical Nurse Specialist	Certified Registered Nurse Anesthetists

Non-Patient Facing Clinicians

- Non-patient facing clinicians are eligible to participate in MIPS as long as they exceed the low-volume threshold, are not newly enrolled, and are not a qualifying APM participant (QP) or partial QP that elects not to report data to MIPS

- The non-patient facing MIPS-eligible clinician threshold for individual MIPS-eligible clinicians is $\leq$ 100 patient facing encounters in a designated period

- A group is non-patient facing if > 75% of NPIs billing under the group's TIN during a performance period are labeled as non-patient facing

- There are special reporting requirements for non-patient facing clinicians

Who is excluded from MIPS?

Clinicians who are:

Newly-enrolled in Medicare	Below the low-volume threshold	Significantly participating in Advanced APMs
• Enrolled in Medicare for the first time during the performance period (exempt until following performance year)	• Medicare Part B allowed charges less than or equal to $30,000 a year OR • See 100 or fewer Medicare Part B patients a year	• Receive 25% of your Medicare payments OR • See 20% of your Medicare patients through an Advanced APM

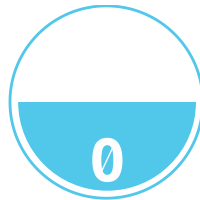# Pick Your Pace for Participation for the Transition Year

Participate in an Advanced Alternative Payment Model

MIPS

Test

Submit Something

Partial Year

Submit a Partial Year

Full Year

Submit a Full Year

Some practices may choose to participate in an Advanced Alternative Payment Model in 2017

- Submit **some** data after January 1, 2017

- Neutral or small payment adjustment
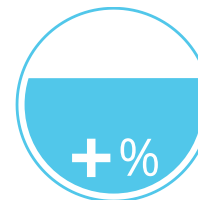
- Report for 90-day period after January 1, 2017

- Small positive payment adjustment
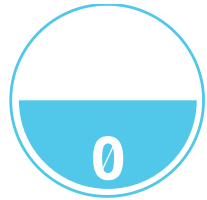
- Fully participate starting January 1, 2017

- Modest positive payment adjustment

Not participating in the Quality Payment Program for the Transition Year will result in a negative 4% payment adjustment.

MIPS: Choosing to Test for 2017

Submit Something

- Submit minimum amount of 2017 data to Medicare
- Avoid a downward adjustment

You Have Asked: *"What is a minimum amount of data?"*

| 1 Quality Measure	OR	1 Improvement Activity	OR	4 or 5 Required Advancing Care Information Measures

MIPS: Partial Participation for 2017

Submit a Partial Year

+ %

- Submit 90 days of 2017 data to Medicare

- May earn a positive payment adjustment

"So what?" - If you're not ready on January 1, you can start anytime between January 1 and October 2

JAN
1

Oct
2

Need to send performance data by **March 31, 2018**
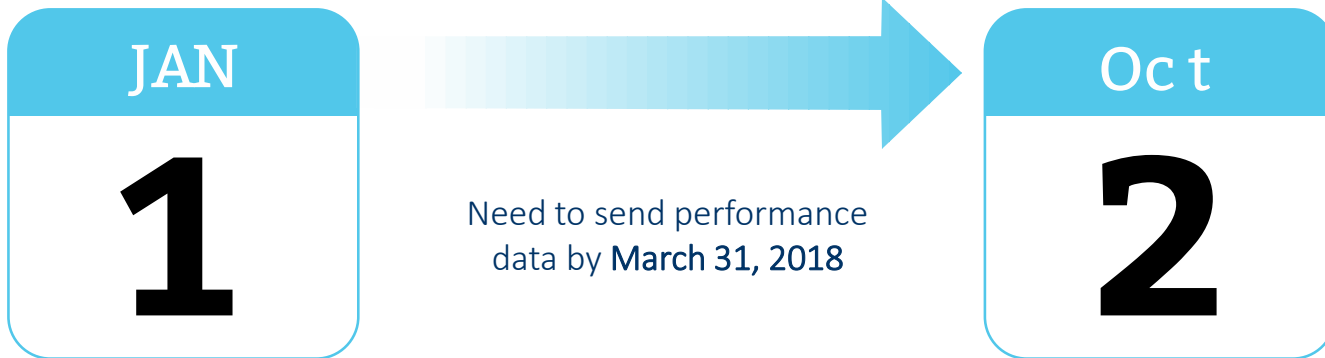
MIPS: Full Participation for 2017

Submit a Full Year

- Submit a full year of 2017 data to Medicare

- May earn a positive payment adjustment

- Best way to earn largest payment adjustment is to submit data on all MIPS performance categories

Key Takeaway:
Positive adjustments are based on the performance data on the performance information submitted, not the **amount** of information or **length of time submitted.**

Individual vs. Group Reporting

OPTIONS
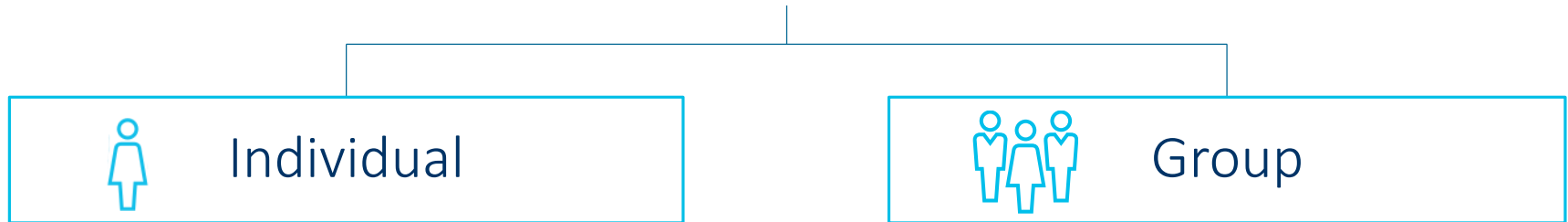
Individual	Group

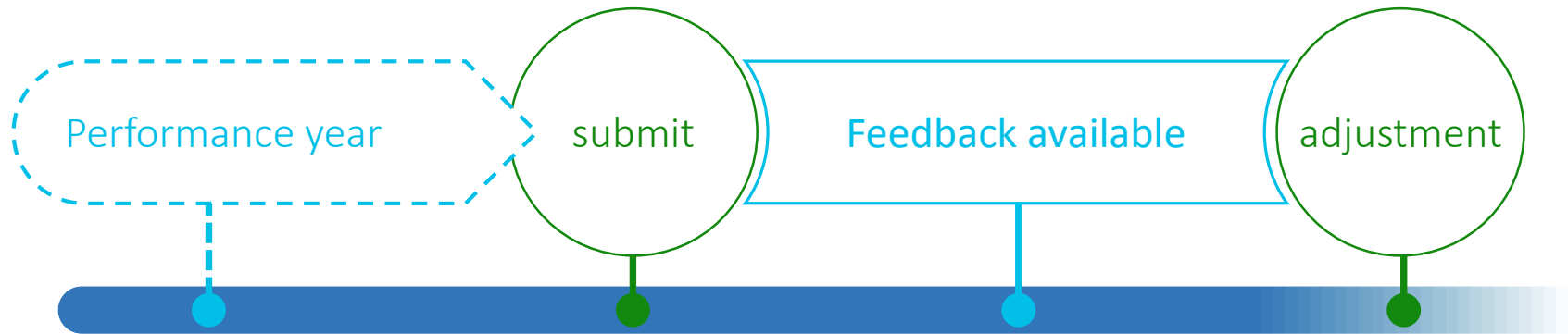1. **Individual**—under an NPI number and TIN where they reassign benefits

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

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

Get your Data to CMS

	Individual	Group
Quality	✓ QCDR *(Qualified Clinical Data Registry)* ✓ Qualified Registry ✓ EHR ✓ Claims	✓ QCDR *(Qualified Clinical Data Registry)* ✓ Qualified Registry ✓ EHR ✓ Administrative Claims ✓ CMS Web Interface (groups of 25 or more) ✓ CAHPS for MIPS Survey
Advancing Care Information	✓ Attestation ✓ QCDR ✓ Qualified Registry ✓ EHR Vendor	✓ Attestation ✓ QCDR ✓ Qualified Registry ✓ EHR Vendor ✓ CMS Web Interface (groups of 25 or more)
Improvement Activities	✓ Attestation ✓ QCDR ✓ Qualified Registry ✓ EHR Vendor	✓ Attestation ✓ QCDR ✓ Qualified Registry ✓ EHR Vendor

When Does the Merit-based Incentive Payment System Officially Begin?

| Performance year | submit | Feedback available | adjustment |

| **2017** | **March 31, 2018** | **Feedback** | **January 1, 2019** |
| Performance Year | Data Submission | | Payment Adjustment |

Performance: The first performance period opens January 1, 2017 and closes December 31, 2017. During 2017, you will record quality data and how you used technology to support your practice. If an Advanced APM fits your practice, then you can provide care during the year through that model.

Send in performance data: To potentially earn a positive payment adjustment under MIPS, send in data about the care you provided and how your practice used technology in 2017 to MIPS by the deadline, March 31, 2018. In order to earn the 5% incentive payment for participating in an Advanced APM, just send quality data through your Advanced APM.

Feedback: Medicare gives you feedback about your performance after you send your data.

Payment: You may earn a positive MIPS payment adjustment beginning January 1, 2019 if you submit 2017 data by March 31, 2018. If you participate in an Advanced APM in 2017, then you could earn 5% incentive payment in 2019.

Understanding Advancing Care Information and Improvement Activities Performance Categories
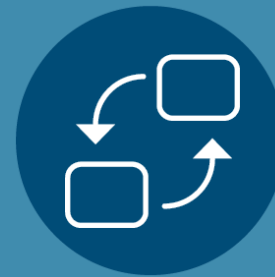
Advancing Care Information

Who can participate?

All MIPS Eligible Clinicians → Participating as an…

Individual **or** Group

Optional for 2017 → Hospital-based MIPS clinicians, Nurse Practitioners, Physician Assistants, Clinical Nurse Specialists, CRNAs

Not Eligible → Facilities (i.e. Skilled Nursing facilities)

MIPS Performance Category:
Advancing Care Information

- Promotes patient engagement and the electronic exchange of information using certified EHR technology

- Ends and replaces the Medicare EHR Incentive Program (also known as Medicare Meaningful Use)

- Greater flexibility in choosing measures

- In 2017, there are *2 measure sets for reporting based on EHR* edition:

Advancing Care Information Objectives and Measures	2017 Advancing Care Information Transition Objectives and Measures

MIPS Performance Category:
Advancing Care Information

- Clinicians must use certified EHR technology to report

For those using EHR Technology Certified to the 2015 Edition:		For those using EHR Technology Certified to the 2014 Edition:	
Option 1	*Option 2*	*Option 1*	*Option 2*
Advancing Care Information Objectives and Measures	Combination of the two measure sets	2017 Advancing Care Information Transition Objectives and Measures	Combination of the two measure sets

Advancing Care Information Requirements for the Transition Year
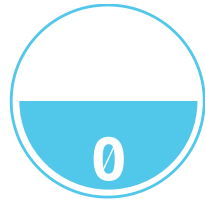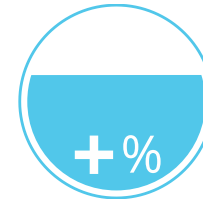
Test means…

- 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 Something — 0

Partial and full participation means…

- Submitting more than the base score in year 1

Submit a Partial Year — +%

Submit a Full Year — +%

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

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

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
- 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 Advancing Care Information Bonus Score

Improvement Activity Performance Category Subcategory	Activity Name	Improvement Activity Performance Category 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

Advancing Care Information: Flexibility

1 CMS will automatically reweight the Advancing Care Information performance category to zero for Hospital-based MIPS clinicians, clinicians who lack of Face-to-Face Patient Interaction, NP, PA, CRNAs and CNS

- Reporting is optional although if clinicians choose to report, they will be scored.

2 A clinician can apply to have their performance category score weighted to zero and the 25% will be assigned to the Quality category for the following reasons:

1. Insufficient internet connectivity
2. Extreme and uncontrollable circumstances
3. Lack of control over the availability of CEHRT

Advancing Care Information: Flexibility

3

- Hospital-based MIPS eligible clinicians qualify for an automatic reweighting of the Advancing Care Information Performance category.
  - 75% or more of Medicare services performed in the inpatient, on campus outpatient department or emergency department

- CMS will reweight the category to 0 and assign the 25% to the quality performance category to offset the difference in the MIPS Final Score.

- If data is submitted, CMS will score their performance and weight their Advancing Care Information performance accordingly.

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:
Improvement Activities

- Attest to participation in activities that improve clinical practice

  - Examples: Shared decision making, patient safety, coordinating care, increasing access

- *Clinicians choose* from 90+ activities under 9 subcategories:

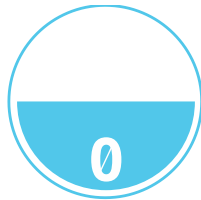| 1. Expanded Practice Access	2. Population Management	3. Care Coordination
4. Beneficiary Engagement	5. Patient Safety and Practice Assessment	6. Participation in an APM
7. Achieving Health Equity	8. Integrating Behavioral and Mental Health	9. Emergency Preparedness and Response

Improvement Activity Requirements for the Transition Year

Submit Something

Test means…

- Submitting 1 improvement activity
  - o Activity can be high weight or medium weight
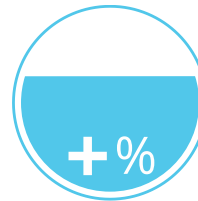
Submit a Partial Year   **Submit a Full Year**

Partial and full participation means…

- Choosing 1 of the following combinations:
  - o 2 high-weighted activities
  - o 1 high-weighted activity and 2 medium-weighted activities
  - o At least 4 medium-weighted activities

Improvement Activities: Flexibilities

Groups with 15 or fewer participants, non-patient facing clinicians, or if you are in a rural or health professional shortage area: Attest that you completed up to 2 activities for a minimum of 90 days.

Participants in certified patient-centered medical homes, comparable specialty practices, or an APM designated as a Medical Home Model: You will automatically earn full credit.

Shared Savings Program Track 1 or the Oncology Care Model: You will automatically receive points based on the requirements of participating in the APM. For all current APMs under the APM scoring standard, this assigned score will be full credit. For all future APMs under the APM scoring standard, the assigned score will be at least half credit.

Improvement Activities Study

- Beginning January 1, 2017 CMS will begin recruiting participants for a study aimed at reducing the burdens associated with data submission for quality measurement

- Participants will be selected based on the criteria laid out in the final QPP rule

- Each participating Clinician or Group will submit a minimum of three MIPS clinical quality measures relevant for their practice of which one of these measures must be an outcome measure or a high-value measure and one must be a crosscutting measure, as required by MACRA/MIPS

- Each participating Clinician or Group will also be expected to participate in survey questionnaires, focus groups and monthly calls with the project team

- Successful participation will result in a full 40 points towards the Clinician or Group's Improvement Activities Score

- The first round of the study will last for 1 year after which new participants will be recruited.

What is the Scoring Methodology for Advancing Care Information and Improvement Activities?

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

50% Base score (worth 50%)

Clinicians must submit a numerator/denominator or Yes/No response for each of the following required measures:

Advancing Care Information Measures

- Security Risk Analysis
- e-Prescribing
- Provide Patient Access
- Send a Summary of Care
- Request/Accept a Summary of Care

2017 Advancing Care Information Transition Measures

- Security Risk Analysis
- e-Prescribing
- Provide Patient Access
- Health Information Exchange

0% Failure to meet reporting requirements will result in base score of zero, and an advancing care information performance score of zero.

32

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

Advancing Care Information Measures	
Measure	**Performance Score**
Provide Patient Access	Up to 10%
Patient-Specific Education	Up to 10%
View, Download and Transmit (VDT)	Up to 10%
Secure Messaging	Up to 10%
Patient-Generated Health Data	Up to 10%
Send a Summary of Care	Up to 10%
Request/Accept a Summary of Care	Up to 10%
Clinical Information Reconciliation	Up to 10%
Immunization Registry Reporting	0 or 10%

Advancing Care Information Transitional Measures	
Measure	**Performance Score**
Provide Patient Access	Up to 20%
Health Information Exchange	Up to 20%
View, Download, or Transmit	Up to 10%
Patient-Specific Education	Up to 10%
Secure Messaging	Up to 10%
Medication Reconciliation	Up to 10%
Immunization Registry Reporting	0 or 10%

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

5% BONUS

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

- Syndromic Surveillance Reporting
- 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

35

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

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

Total points = 40

Activity Weights	Alternate Activity Weights*	Full credit for clinicians in a patient-centered medical home, Medical Home Model, or similar specialty practice
- Medium = 10 points - High = 20 points	- Medium = 20 points - High = 40 points *For clinicians in small, rural, and underserved practices or with non-patient facing clinicians or groups	

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

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

Quick Tip: Maximum score cannot exceed 100%

Calculating the Final Score Under MIPS

Final Score =

$$
\left[\begin{array}{c} \text{Clinician Quality performance category score } \mathbf{x} \text{ actual } \mathbf{Quality} \text{ performance category weight} \end{array} \right] + \left[\begin{array}{c} \text{Clinician } \mathbf{Cost} \text{ performance category score } \mathbf{x} \text{ actual Cost performance category weight} \end{array} \right] + \left[\begin{array}{c} \textbf{Improvement Activities} \text{ performance category score } \mathbf{x} \text{ actual Improvement Activities performance category weight} \end{array} \right] + \left[\begin{array}{c} \textbf{Advancing Care Information} \text{ performance category score } \mathbf{x} \text{ actual Advancing Care Information performance category weight} \end{array} \right] \times 100
$$

Beyond the transition year...

Building on a User Centric Approach

We are committed to building on our lessons learned and stakeholder feedback to continuously improve the program. Here are some opportunities to get involved:

Performance feedback.

We are planning to work with stakeholders to determine a new look and feel for the 2018 performance feedback. If you are interested in providing suggested ideas, then please send your thoughts to Partnership@cms.hhs.gov

Implementation of virtual groups.

Details coming soon

CMS is Currently Seeking Formal Comment on..

- <u>Virtual Groups</u>: Overall Implementation

- <u>Non-Patient-Facing</u>: Alternative terminology that could be used to reference such clinicians.

- <u>Low-Volume Threshold</u>: Approaches for Clinicians that do not meet the threshold to opt-in.

- <u>Groups</u>: Approaches for groups with eligible clinicians and non-eligible clinicians such as therapists and new Medicare-enrolled clinicians to participate

- <u>Quality Performance Category</u>: cross-cutting measure requirement for future years

- <u>Advancing Care Information Performance Category</u>: Improvement activities bonus in ACI; future measures

- <u>MIPS Scoring</u>:
  - Approaches for Non-scoreable measures (measures that are below the case min, lack a benchmark or don't meet data complete quality measure benchmark based on specialty and/or practice size
  - Scoring approach for less criteria) in future years.
  - Stratifying the Year 2

When and where do I submit comments?

- Submit comments referring to file code **CMS-5517-FC** by **December 19, 2016**

- Comments must be submitted in one of the following ways:

    Electronically through Regulations.gov

    By regular mail

    By express or overnight mail

    By hand or courier

- *Note: Final Rule with comment includes changes not reviewed in this presentation. Presentation feedback not considered formal comments on the rule.*

For additional information, please go to: QPP.CMS.GOV
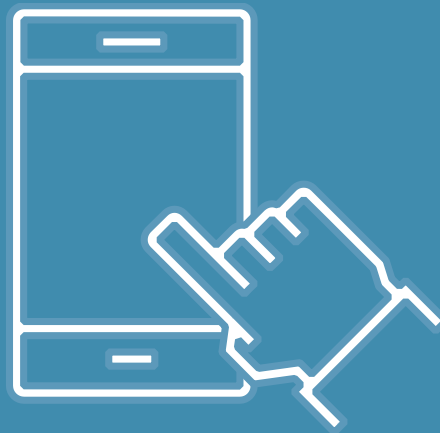
Where can I go to learn more?

Technical Assistance

CMS has organizations on the ground to provide help to clinicians who are eligible for the Quality Payment Program:

[Quality Payment Program Portal](#)
- Learn about the Quality Payment Program, explore the measures, and find educational tools and resources.

[Transforming Clinical Practice Initiative (TCPI):](#)
- Designed to support more than 140,000 clinician practices over the next 4 years in sharing, adapting, and further developing their comprehensive quality improvement strategies.

[Quality Innovation Network (QIN)-Quality Improvement Organizations (QIOs):](#)
- Includes 14 QIN-QIOs
- Promotes data-driven initiatives that increase patient safety, make communities healthier, better coordinate post-hospital care, and improve clinical quality.

The [Innovation Center's](#) Learning Systems provides specialized information on:
- Successful Advanced APM participation
- The benefits of APM participation under MIPS

Do you need technical assistance to help you participate in the Quality Payment Program? The Centers for Medicare & Medicaid Services has specialized programs and resources for eligible clinicians across the country.

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.

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

SMALL & SOLO PRACTICES
Small, Underserved Rural Support Technical Assistance

- 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.
  - Organizations selected to provide this technical assistance will be available in late 2016.

LARGE PRACTICES
Quality Innovation Network-Quality Improvement Organizations (QIN-QIO) Education and Support

- 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

Advanced Alternative Payment Model (APM) Learning Networks
Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs.

Q&A Session Information

- All questions will be taken through the Q&A box.

- 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: QPP@cms.hhs.gov.