



Navigating Medicare's Quality Payment Program: A Comprehensive Primer for Physicians

Physicians Advocacy Institute
MACRA Educational Series
April 2017



About the Physicians Advocacy Institute

The Physicians Advocacy Institute (PAI) is a not-for-profit organization that was established to advance fair and transparent policies in the health care system to sustain the profession of medicine for the benefit of patients.

As part of this mission, PAI seeks to better understand the challenges facing physicians and their patients and also educate policymakers about these challenges.

PAI also develops tools to help physicians prepare for and respond to policies and marketplace trends that impact their ability to practice medicine.

Information about PAI can be found at physiciansadvocacyinstitute.org.

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Guide to the PAI MACRA Educational Series

- **Overall purpose** – Program of materials and resources that provide context, an overview of core concepts and requirements, and an in-depth discussion of important topics
- **MACRA overview** – Foundational presentation and associated webinars to include a focus on meeting requirements for the 2017 transition period. Includes different sections on aspects of MACRA's Quality Payment Program.
- **Follow-on products in early 2017** – In-depth one-pagers and monographs focused on topics such as the MIPS scoring system and strategies for reporting
- **In development** – Guide to additional resources in physician communities

Acronyms

- ACI – Advancing Care Information Category
- APMs – Alternative Payment Models
- CEHRT – Certified EHR Technology
- EHR/EMR – Electronic Health Registry; Electronic Medical Record
- MACRA – Medicare Access and CHIP Reauthorization Act
- MIPS – Merit-Based Incentive Payment System
- PQ – Partially Qualifying Advanced APM Participant
- QCDR – Qualified Clinical Data Registry
- QP - Qualifying Advanced APM Participant
- QPP – Quality Payment Program

What to find in this presentation . . .

- 1) MACRA at 30,000 feet
- 2) 2017 transition year minimum reporting options
- 3) Pathway 1: Merit-based Incentive Payment System (MIPS)
 - Exemptions and reporting options
 - Overview of approach to performance measurement and payment incentives
 - Detail on performance categories
 - Reporting and timelines
- 4) Pathway 2: Advanced Alternative Payment Models (Advanced APMs) – requirements and thresholds for participation
- 5) MIPS APMs – options for physicians who participate in APMs but do not meet Advanced APM thresholds
- 6) Next steps and looking forward

MACRA's QPP at 30,000 feet

From SGR to MACRA

- MACRA = Medicare Access and CHIP Reauthorization Act of 2015
- Next phase of Medicare fee-for-service payments under Part B
- What does the new system do?
 - Replaces annual updates under Sustainable Growth Rate (SGR) with the Quality Payment Program (QPP)
 - Introduces new opportunities for positive and negative payment adjustments of Medicare Part B payments
 - Combines three quality performance programs (PQRS, value-based payment modifier, meaningful use) into a single program under the QPP
- Regulations finalized in November 2016; final rule went into effect January 1, 2017
- Payment changes begin in 2019 (based on 2017 performance)

Goals of the new payment system

1. Create a new Medicare payment system for physicians (and certain other eligible clinicians) across all specialties that is meaningful and flexible
2. Improve patient outcomes and engage patients
3. Encourage physicians to improve performance with “carrots and sticks”
4. Increase the availability of and participation in risk-based models of care
5. Support broad physician participation, including small/solo practices
6. Simplify complex and multiple reporting and performance systems

Source: CMS MIPS and APM final rule

Two pathways for physicians to choose from

Merit-based Incentive Payment System (MIPS)

- Fee-for-service annual updates
- New set of positive and negative payment adjustments
- 4 performance categories
 - Cost
 - Quality
 - Improvement activities
 - Advancing care information
- Opportunities to participate in alternative payment models (MIPS APMs)

Advanced Alternative Payment Models (APMs)

- Enhanced fee-for-service annual updates
- Exempt from MIPS participation
- Payment incentive for participation in risk-based payment models
 - CMS has identified eligible models
 - More models to evolve
- May earn a 5% payment incentive each year 2019-2024
- May earn a 0.75% annual Medicare Part B physician fee schedule update for successful participation in Advanced APMs beginning 2026
 - Those who do not participate successfully in Advanced APMs would receive a 0.25% annual update and may also be subject to MIPS reporting requirements and payment adjustments

Medicare payment adjustments depend on the pathway selected...

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Annual fee schedule updates* (all physicians)	+0.5%	+0.5%	+0.5%							Non-APM: 0.25%	Non-APM: 0.25%
										APM: 0.75%	APM: 0.75%
MIPS**			+/- 4%	+/- 5%	+/- 7%	+/- 9%	+/- 9%	+/- 9%	+/- 9%	+/- 9%	+/- 9%
Advanced APMs (Qualifying Participants)			+5%	+5%	+5%	+5%	+5%	+5%			

*Annual physician fee schedule updates may be downwardly adjusted by other budgetary requirements

**Due to CMS transition relief policies in 2017, available funds may be insufficient to grant a full 4% incentive payment in 2019; additionally, physicians have the potential to receive an additional positive payment adjustment for exceptional performance for payment years 2019-2024

Concerns heard from PAI members

- **Disconnect between MACRA and everyday practice**
- **Unclear nexus between program/reporting requirements and clinical quality improvement.** Physicians feel burdened with meeting the program requirements, but fail to see how the requirements translate into improved patient care and quality in their practices.
- **Uncertainty about how to implement.** What do practices want to be measured on? How to measure and integrate into office workflow? How to do claims-based filing, participate in registries, attestation?
- **Investment costs vs. returns.** Concern over the cost of investing to succeed under QPP, and frustration that “QPP investment” doesn’t necessarily mean better patient care
- **Wide range of needs across physician practice types and specialties**
- **Leveraging incentives/managing risks.** Uncertainty on incentive side and concerns about measurement that accounts for risk
- **Sustainability of small practices.** The current environment under QPP makes it difficult for small and rural practices to thrive
- **Limited APM participation options.** In some markets, this may define possible pathways for physicians
- **EMR vendors adding to confusion, seen as part of the problem**
- **Lack of interest and engagement.** Physicians who don’t understand the complexity are considering opting out of Medicare, retiring in two years, or just taking the hit of the penalty
- **Patients.** Perceived absence of greater flexibility to engage patients under Medicare rules....

Practical challenges with measurement and reporting

Benchmarks and relative scale

- Benchmarks and the performance threshold change annually and are “budget neutral” – the amount of payment adjustments are uncertain
- Physicians do not know how they compare to peers
- No benchmarks for new measures (so they receive less weight)

Availability and relevance of quality measures

- The availability of applicable and relevant measures varies depending on a physician’s specialty
- The measures used for the cost category are hospital-focused; often viewed as inappropriate for assessing physician performance
- Both outcome and process performance measures may be affected by differences in patient demographics

Continuity and problems with previous reporting programs

- Many physicians submitted their data but did not review their QRURs to assess/improve their performance
- Difficulty in accessing and understanding QRURs, and CMS’s scoring methodology
- Also – reporting requirements have changed from the previous programs, which will cause confusion

Reporting submission process and errors

- Lack of real-time feedback to correct reporting errors – notification of incorrect submissions occurs months after the end of the reporting period
- Vendors – concern over accountability for reporting errors due to incorrect submissions
- Costs associated with multiple data submission methods/vendors with no guarantee in a positive return on investment

Merit-based Incentive Payment System (MIPS)

2017 transition year minimum reporting options

2017 “Transition Year” – Opportunities for easy participation

Don't Participate

- Submit no data
- -4% payment adjustment in 2019

Test – Submit Something

- Submit a minimum amount of data
- Avoid negative payment adjustment

Partial – Submit Partial Year

- Submit 90-days worth of data
- Avoid negative payment adjustment
- Eligible for maximum positive payment adjustment

Full – Submit Full Year

- Submit data for all 2017
- Avoid negative payment adjustment
- Eligible for maximum positive payment adjustment

A negative payment adjustment can be avoided by reporting just a minimum amount of data!

Options for minimal “test” participation in 2017

Submit something – avoid a -4% payment adjustment with a minimum amount of data

Three options:

- Quality – report data for 1 patient for 1 quality measure (can be reported through claims),
 - Practice Tip: It is recommended that additional data (more than 1 patient) be reported for the quality category to better ensure that the penalty is avoided
- **OR** Improvement Activities – report 1 improvement activity (can be completed through attestation),
- **OR** Advancing Care Information – report the required base measures (4 or 5 based on 2014 or 2015 certified EHR technology) for at least 1 patient for each measure

Other approaches - With both the partial (90-day) and full-year participation options, physicians are eligible to receive the maximum positive payment adjustment for reporting the full requirements for each category, if the number of cases is sufficient to be scored

Pathway 1: Merit-based Incentive Payment System (MIPS)

Exemptions and reporting options

MIPS performance categories - overview

Quality

- Builds off Physician Quality Reporting System
- Report 6 measures, including 1 outcomes measure or a specialty-specific measures set
- Primary factor early on -- 60% of score for 2019 payment adjustment

Cost

- Builds off Value-based Modifier
- New cost measures being developed for 2018
- No data reported; CMS uses administrative claims data to assess performance
- Implementation eased as costs are 0% of score for 2019 payment adjustment

MIPS

Advancing Care Information

- Builds off Meaningful Use and encourages greater use of health information technology
- Report required 4 or 5 measures for base score
- 25% of score for 2019 payment adjustment
- Challenging area for many physicians

Improvement Activities

- New category
- Rewarding engagement in clinical practice improvement activities
- Report any combination of high and medium weight activities to achieve 40 total points
- 15% of score for 2019 payment adjustment

Who does QPP affect and who is required to participate in MIPS?

- The program will eventually include almost all clinicians who bill for Medicare Part B services; this will be phased in over time
- **“Eligible Clinicians” subject to MIPS in 2017:**
 - Physicians
 - Physician means doctor of: medicine, osteopathy, dental surgery, dental medicine, podiatric medicine, optometry, and, with respect to certain specified treatment, doctor of chiropractic legally authorized to practice by a State in which he/she performs this function
 - Physician Assistants
 - Nurse Practitioners
 - Clinical Nurse Specialists
 - Certified Registered Nurse Anesthetists
- **“Eligible Clinicians” may be expanded in 2019 to also include:**
 - Physical or occupational therapists
 - Speech language pathologists
 - Audiologists
 - Nurse midwives
 - Clinical social workers
 - Clinical psychologists
 - Dieticians or nutrition professionals

Some eligible clinicians are exempt from MIPS. . .

Exempted from MIPS

- Newly-enrolled Medicare physicians, who enroll in Medicare for the first time during the performance year
- Physicians and groups that are below the low-volume threshold:
 - Who have Medicare Part B allowed charges \leq \$30,000
OR
 - Who provide care to 100 or fewer Medicare Part B patients
- Physicians who are participating in Advanced APMs

CMS estimates - CMS estimates that 32.5% of eligible clinicians will be exempt from MIPS in 2017 because of the low-volume threshold

CMS will make available an NPI-level lookup tool on its QPP website later this year to assist physicians and other clinicians in determining if they are below the low-volume threshold, and therefore excluded from MIPS participation in 2017

- Practice Tip: Physicians should keep a record of the eligibility/exemption status provided by CMS

Participation options for physicians

- Physicians can participate either as individuals or as a group, but they must participate the same way across all four categories
- As an individual
 - Physicians would report under an NPI number and the tax identification number (TIN) of the practice to which they reassign their benefits
- As a group
 - 2 or more physicians (2 or more NPIs) who are part of the same practice with the same TIN
 - Specific reporting requirements and certain reporting options are available for groups of 25 or more physicians
 - All physicians in the group would receive the same aggregated scoring and corresponding payment adjustment across the group
- Additionally, all physicians in a practice must participate the same way – either individually, or as a group
 - For example, in a practice of 10 physicians all under the same TIN, the practice can elect to participate at the group level (the group of 10 physicians would collectively have to meet the specific requirements for each category) or decide that each of the 10 physicians would report as individual physicians (each physician would have to meet the specific requirements for each category)

Reporting mechanisms and options

Category	Reporting Options	
Quality	Individual	Claims, QCDR, Qualified Registry, EHR
	Group	QCDR, Qualified Registry EHR , CMS Web Interface (groups of 25 or more eligible clinicians), CMS-approved survey vendor for CAHPS (used in conjunction with another reporting mechanism), Administrative Claims
Improvement Activities & Advancing Care Information	Individual	Attestation, QCDR, Qualified Registry, EHR
	Group	Attestation, QCDR, Qualified Registry, EHR, CMS Web Interface (groups of 25 or more eligible clinicians)
Cost	Individual	No submission required. CMS will use administrative claims data.
	Group	

Selecting the best option...

Reporting Mechanism	Pros/Cons
Claims	<p>The affordable option</p> <p>Share responsibility with billing companies</p> <p>Confusion and inaccurate reporting of codes for the quality measures</p> <p>Not available for all categories (only available for individuals for the quality category)</p>
Attestation	<p>No submission of data is required; another affordable option</p> <p>Must keep records for audit purposes</p>
QCDR/Qualified Registry	<p>These can be specialty-specific and offer more applicable quality measures; but also may be more limited in scope</p> <p>Physicians must pay a registration fee and additional fees for data integration services; however, some national specialty societies offer this option at no or low cost to members</p> <p>Difficulty linking to EHR systems and automatically extracting the data (often requires manual data entry)</p> <p>Requirement for “all-payer data”</p>
EHR	<p>Many practices already use EHRs in daily practice (but not all practices have access to EHRs)</p> <p>Vendor submits the data on your behalf, but you must trust that vendor will correctly and accurately submit the information</p> <p>Depending on the measures selected and number of applicable patients, may be more advantageous to use an EHR than a specialized registry</p> <p>Limited availability of applicable quality measures that can be reported via an EHR</p>
CMS Web Interface	<p>Only for groups of 25 or more physicians and eligible clinicians</p> <p>Higher reporting thresholds for Quality measures (must report more measures)</p> <p>Must register by June 30, 2017</p>
CAHPS	<p>Must register by June 30, 2017</p> <p>Must be reported in conjunction with another reporting mechanism</p>
Administrative Claims	<p>No submission is required</p> <p>Uncertainty about your performance and how CMS will use the data in its calculations</p>

Pathway 1: Merit-based Incentive Payment System (MIPS)

Overview of approach to performance measurement and payment incentives

MIPS – the essentials

- Combines current quality reporting and value-based programs into one program
- MIPS comprised of four categories:
 - **Quality** – builds off the current Physician Quality Reporting System (PQRS) program
 - **Advancing Care Information** – next phase of EHR Incentive Program (Meaningful Use)
 - **Cost** – based on the Value-based Payment Modifier (VM)
 - **Improvement Activities** – new category that rewards physicians for activities that improve the clinical practice and delivery of care
- MIPS participating physicians get a MIPS final score based on their total combined, weighted average score across all categories
- CMS will compare score to an overall performance threshold and then determine positive, neutral, or negative payment adjustments
- Payment adjustments must be budget neutral across all payments to physicians in program
 - There will be no winners without losers

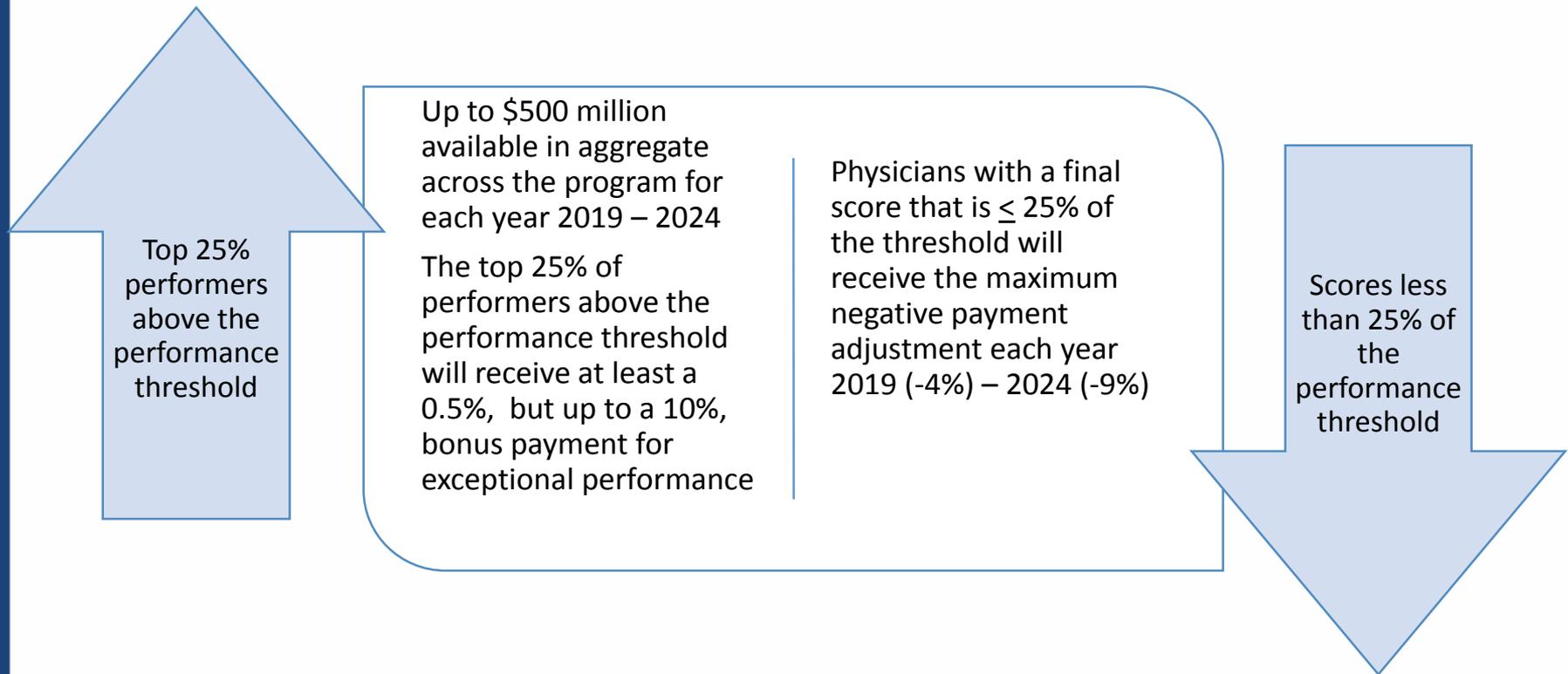
MIPS – details on performance scores and payment adjustments

- Physicians receive a score for each of the 4 performance categories
 - 2017 scores will be based on 3 performance categories (quality, improvement activities, and advancing care information)
 - 2018 onwards, scores will be based on all 4 performance categories (including cost)
- Weights apply to each category to get to a final score out of 100 points
- CMS will publish a minimum threshold of points out of 100 that physicians must achieve in their MIPS final score to avoid a negative payment adjustment
 - ***For 2017, the threshold for avoiding a negative payment adjustment is only 3/100 total points*** – this can be achieved by reporting at least 1 quality measure or improvement activity
 - For 2018 onwards, CMS will make threshold determinations using mean or median final scores from a prior period

Example (using 2018 performance year category weights):

$(\text{quality score \%} * 50\%)(100) + (\text{cost score \%} * 10\%)(100) + (\text{improvement activities score \%} * 15\%)(100) + (\text{advancing care information score \%} * 25\%)(100) \geq \text{threshold to avoid a negative payment adjustment}$

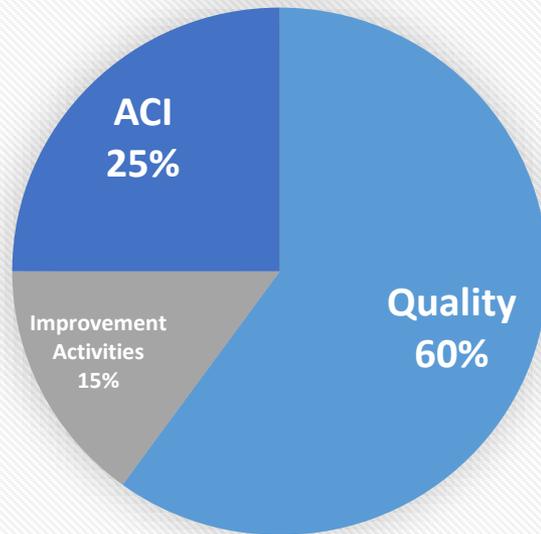
Extra bonus payments available for high MIPS performers



The threshold for the exceptional performance payment adjustment for the 2017 performance year/2019 payment year is 70 points.

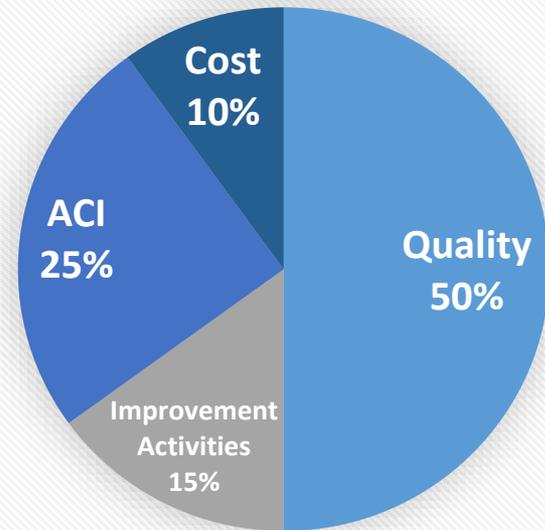
MIPS category weights behind final score calculation - and how they change over time

2017 - Category Weights



■ Quality ■ Improvement Activities ■ ACI

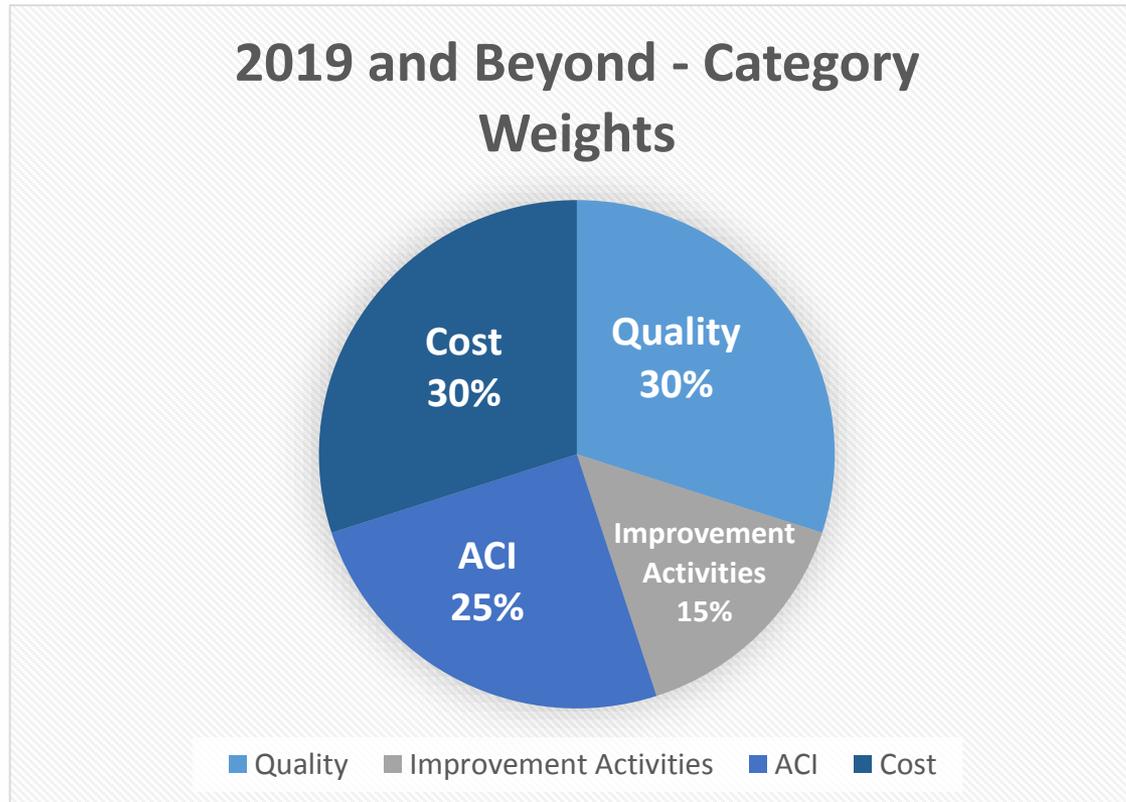
2018 - Category Weights



■ Quality ■ Improvement Activities ■ ACI ■ Cost

These are default weights that may be adjusted in certain circumstances.

Final score in 2019 and beyond – cost becomes more important



These are default weights that may be adjusted in certain circumstances.

Pathway 1: Merit-based Incentive Payment System (MIPS)

Detail on performance categories

Should I select the MIPS pathway?

1. Determine whether you are exempt from MIPS participation
2. Pick your quality reporting pace for 2017 by evaluating practice readiness
3. Select the best reporting mechanism(s) by evaluating practice resources
 - Is a specialty-, diagnosis-, or treatment-specific QCDR with more applicable measures available?
 - What new processes and workflows will need to be put in place to meet the reporting requirements?
 - Do you have access to an EHR?
4. Consider whether the Advanced APM option is feasible before making the final decision

If you aren't participating in an Advanced APM:

- Review the quality category measures and improvement activities and select at least one measure or activity to avoid the negative payment adjustment
- Determine if participating for a minimum of 90 days and becoming eligible to receive a positive payment adjustment is feasible for you/your practice
- Review current 2017 and proposed 2018 Advanced APMs and determine if participating in the APM track is an option for the future

If you are participating in an Advanced APM:

- CMS will make 3 evaluations in 2017 to determine whether physicians meet QP/PQ thresholds
 - The determination periods are March 31 (decision by July 2017), June 30 (decision by October 31), and August 31 (decision by December 31)
- Check these determinations to see if you have meet the QP/PQ thresholds and are exempt from MIPS

MIPS Quality Category

Quality category – Individual and small group reporting

60% of MIPS final score in 2017

Total possible points = 10 x # of measures reported (e.g., 60 points for 6 measures)

Reporting requirements:

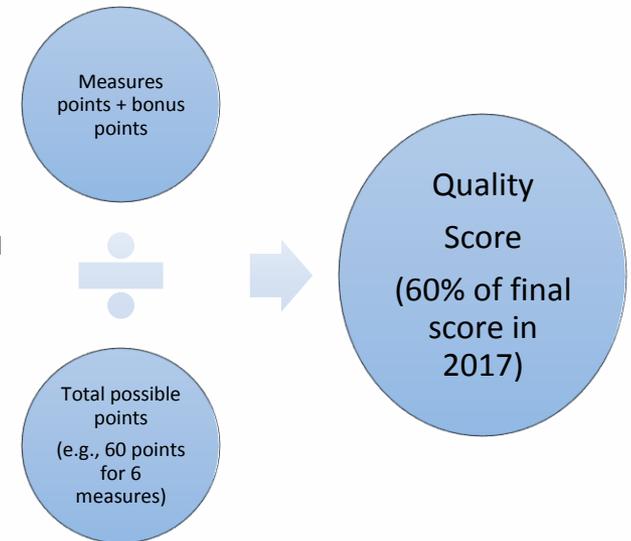
- Minimum of 6 individual measures, including one outcome measure (or a high-priority measure if an outcome measure is not available); or alternatively (to the 6 individual measures), report one specialty-specific measure set
- Report each measure for 50% of applicable patients
- For groups of 16 or more and with ≥ 200 cases that meet the all-cause readmission measure, this measure will automatically be calculated using administrative claims data and would be counted in addition to the individual measures reporting requirement
 - Thus, if a group reports 6 individual measures and satisfies the requirements for automatic calculation of the all-cause readmission measure (if it is a group of 16 or more eligible clinicians and has at least 200 cases that are eligible for the measure), then the group's quality score will be based on its performance in 7 measures out of a total of 70 points

Reporting Mechanisms:

- Claims, qualified clinical data registry (QCDR), qualified registry, EHR

Score:

- Physicians receive 3-10 points for each measure based on their performance compared to a benchmark. Physicians will automatically receive 3 points for submitting information on a measure
- More points with high performance compared to the benchmark
- Bonus points for reporting additional high-priority measures (not included in denominator for total points); reporting measures electronically using an EHR, registry, QCDR



Quality breakdown of “50% of applicable patients” requirement

Report each measure for 50% of applicable patients

“Applicable patients” means the total number of patients that meet the denominator criteria specified by CMS for each measure

“50% of applicable patients” means that, out of all the patients who met the denominator criteria, the measure is reported for at least 50% of those patients

- **E.g.**, 100 patients meet the denominator criteria for the tobacco use screening and cessation intervention measure. The “50% of applicable patients” requirement would be met if some data related to the measure is then reported for at least 50 of those 100 patients, including whether you conducted the quality activity related to the measure or not. For example, the threshold would be met if you reported that you conducted a screening and cessation intervention for 24 patients and did not conduct a screening and/or cessation for the other 26 patients (24 patients + 26 patients = 50 patients)

Do only Medicare Part B patients count towards “applicable patients” or does this include all patients from all payers?

- This depends on the reporting mechanism
 - Claims – Medicare Part B patients
 - CAHPS as part of CMS Web Interface – Medicare Part B patients
 - QCDR, qualified registry, and EHR – Patients from all payers, including Medicare (all-payer mix)

How is the “50% of applicable patients” different than the performance score?

The “50% of applicable patients” is the data completeness criteria, which must be satisfied for you to receive a performance score. The performance score is how often you completed/conducted the required quality improvement activity related to each measure.

How is the performance score determined?

- The performance score for each measure is determined by looking at the number of patients that meet the denominator criteria for whom the measure is reported and who are not excluded, and seeing for how many of those patients you performed a quality activity that could satisfy the measure (the numerator for the measure)
 - Some patients may meet the denominator criteria but may ultimately be excluded from the denominator due to the measure specifications (note: while these excluded patients would count toward the data completeness criteria, they do not count toward the performance score criteria)
 - Some measures may have more than one quality activity that can satisfy the measure, these are denoted as “performance met” activities in the CMS measures specification documents
- Your numerator/denominator performance will then be compared to the benchmark for the measure, and you will receive points for that measure based on how you performed in relation to the benchmark
 - Benchmarks for the measures have been determined using previous years’ data
 - As noted in the previous slide, you will receive a minimum of 3 points for submitting data as part of the 2017 reporting year, regardless of your actual performance in relation to the benchmark
 - For measures without a benchmark (new measures or measures without sufficient data to establish a benchmark) you will receive 3 points for the 2017 reporting year
 - Lastly, topped out measures – generally, those measures in which all physicians perform extremely well (*e.g.*, median performance is 95% or higher) – will be scored differently beginning the second year the measure is identified as topped out. This means that they will not be scored differently for the 2017 reporting year, but will be scored differently beginning with the 2018 reporting year

Quality category individual measures

- There are 271 MIPS individual measures (across all specialties and settings) available for 2017 reporting
- Physicians can use the CMS measures search tool to help filter the list down to applicable measures
- MIPS measures and the measures search tool are available on CMS's Quality Payment Program website: <https://qpp.cms.gov/measures/quality>
- There are more measures to come that will be reportable through QCDRs that are not included as part of CMS's MIPS measures list
 - Reminder: QCDRs could be specialty-, condition-, treatment-specific, etc.
 - Each QCDR will offer up to 30 measures (non-MIPS measures), in addition to the MIPS measures, and these may be more applicable and meaningful for physicians
 - A full list of QCDRs and their measures will be available this spring
- Alternatively, clinicians can report one of 30 specialty-specific measures sets (next slide)

Quality category specialty-specific measure sets

- There are 30 specialty measure sets available for 2017 reporting
- Some measure sets contain less than 6 measures, in this case you are only required to report on only those measures that are applicable
 - *E.g.*, A measures set has 5 measures, and only 3 of those 5 measures are applicable to your practice, you are only required to report those 3 measures
- Some measure sets contain more than 6 measures, in this case you are only required to report on 6 measures (one of which must be an outcome or high-priority measure – all measure sets include at least one outcome or high priority measure)

Allergy/Immunology	Emergency Medicine	Internal Medicine	Orthopedic Surgery	Preventive Medicine
Anesthesiology	Gastroenterology	Interventional Radiology	Otolaryngology	Radiation Oncology
Cardiology	General Oncology	Mental/Behavioral Health	Pathology	Rheumatology
Dermatology	General Practice	Neurology	Pediatrics	Thoracic Surgery
Diagnostic Radiology	General Surgery	Obstetrics/Gynecology	Physical Medicine	Urology
Electrophysiology Cardiac Specialist	Hospitalists	Ophthalmology	Plastic Surgery	Vascular Surgery

CMS measures search tool . . .

- MIPS measures and the measures search tool are available on CMS's Quality Payment Program website: <https://qpp.cms.gov/measures/quality>
- Option 1: determine if a specialty measure set is available
 - If a measure set is available, review the measures and determine applicability to your practice
 - If less than 6 measures, report all applicable measures
 - If more than 6 measures, select at least 6 measures and one of which is at least an outcomes measure (or high priority if an outcome measure is not available in the measure set)
- Option 2: search by the data submission method available and most convenient for your practice (claims, EHR, registry, etc.)
- Option 3: search by a key-term applicable to your specialty/practice
 - e.g., condition, diagnosis, treatment, etc.

Select Measures

Search All by keyword Filter by:

All High Priority Measure ▾ Data Submission Method ▾ Specialty Measure Set ▾

Showing 271 Measures

➤ Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy - Avoidance of Inappropriate Use

➤ Acute Otitis Externa (AOE): Topical Therapy

➤ ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication

Selected Measures

0 Measures Added

Once you select measures they will appear here

Disclaimer
*MIPS eligible clinicians or groups are expected to report on applicable measures. "Applicat

Note: This measures tool will help filter and narrow down the measures, but you will need to review the CMS specifications for each measure to determine the numerator and denominator criteria. These are available on at <https://qpp.cms.gov/resources/education>, as a zip file labeled "Quality Measures Specifications"

Quality category – CMS web interface for groups of 25 or more eligible clinicians

60% of MIPS final score in 2017

Maximum points = 110 points if all-cause readmission measure does not apply

Maximum points = 120 points if all-cause readmission measure does apply

Reporting requirements:

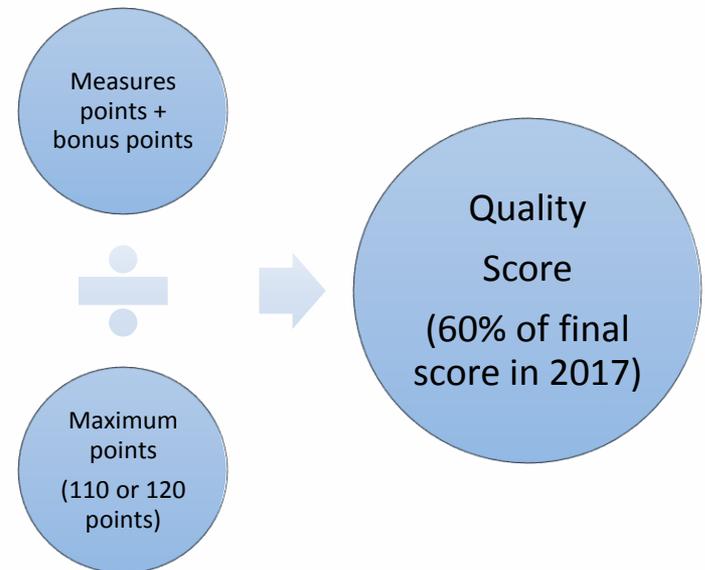
- Report up to 15 measures
- Readmission measure applies if ≥ 200 cases
- Report each measure for 50% of applicable patients

Reporting Mechanisms:

- CMS Web Interface, CAHPS
- Must register by June 30, 2017

Score:

- Clinicians receive 3-10 points for each measure based on their performance compared to a benchmark
- More points with high performance compared to the benchmark
- Bonus points for reporting additional high-priority measures (not included in denominator for total points); reporting measures electronically using an EHR, registry, QCDR



MIPS Advancing Care Information (ACI) Category

Advancing Care Information (ACI) category

25% of MIPS final score in 2017

Total points possible = 155 points

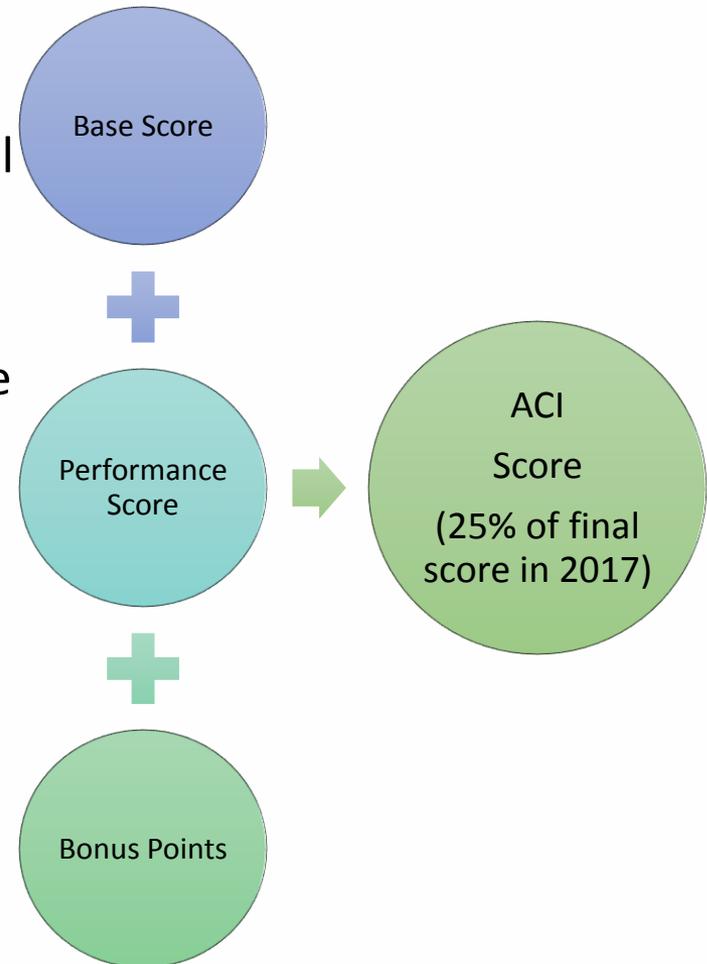
However, only 100 points are needed to earn full credit for the ACI category

Reporting Requirement:

- Report all required measures for base score (90-day reporting period)
- Report up to 9 optional measures for additional performance score
- Options for standard and transition measures, using CEHRT 2014 and/or 2015

Reporting Mechanisms:

- Attestation, QCDR, qualified registry, EHR, CMS Web Interface (groups of 25 or more eligible clinicians)



ACI scoring breakdown . . .

Base Score 50 Points



- Report yes/no or numerator/denominator for required base measures (depends CEHRT edition)
- All required base measures must be reported to earn any credit in the ACI category
- Failure to report base measures will result in a score of 0 points for ACI category
 - Performance measures will not be counted if base measures are not reported

Performance Score Up to 90 points



- Report up to 7 or 9 performance measures (depends on CEHRT edition)
- Each performance measure is worth 10-20 points
- The number of points you would receive for each measure would be determined by your performance rate for each measure
- You are not required to report all additional performance measures; any performance measures reported in addition to base measures will increase your overall ACI score

Bonus Points Up to 15 points

- 5 bonus points can be earned for reporting one or more of the following Public Health and Clinical Data Registry Reporting measures:
 - Syndromic Surveillance Reporting
 - Specialized Registry Reporting
 - Electronic Case Reporting
 - Public Health Registry Reporting
 - Clinical Data Registry Reporting
- 10 bonus points can be earned for reporting certain Improvement Activities using CEHRT

ACI measures and objectives

Measure	Required for base score	Performance score weight	Bonus
Data Registry Reporting	No	0	5 bonus points for submitting to one or more public health or clinical data registries
Clinical Information Reconciliation	No	Up to 10 points	No
Electronic Case Reporting	No	0	5 bonus points for active engagement with a public health agency to electronically submit case reporting of reportable conditions
e-Prescribing	Yes	0	No
Immunization Registry Reporting	No	0 or 10 points	No
Patient-Generated Health Data	No	Up to 10 points	No
Patient-Specific Education	No	Up to 10 points	No
Provide Patient Access	Yes	Up to 10 points	No
Public Health Registry Reporting	No	0	5 bonus points for submitting to one or more public health or clinical data registries
Request/Accept Summary of Care	Yes	Up to 10 points	No
Secure Messaging	No	Up to 10 points	No
Security Risk Analysis	Yes	0	No
Send a Summary of Care	Yes	Up to 10 points	No
Syndromic Surveillance Reporting	No	0	5 bonus points for submitting to one or more public health or clinical data registries
View, Download and Transmit	No	Up to 10 points	No

2017 ACI transition measures and objectives

Measure	Required for base	Performance Score Weight	Bonus
e-Prescribing	Yes	0	No
Health Information Exchange	Yes	Up to 20 points	No
Immunization Registry Reporting	No	0 or 10 points	No
Medication Reconciliation	No	Up to 10 points	No
Patient-Specific Education	No	Up to 10 points	No
Provide Patient Access	Yes	Up to 20 points	No
Secure Messaging	No	Up to 10 points	No
Security Risk Analysis	Yes	0	No
Specialized Registry Reporting	No	0	5 bonus points for submitting to one or more public health or clinical data registries
Syndromic Surveillance Reporting	No	0	5 bonus points for submitting to one or more public health or clinical data registries
View, Download and Transmit	No	Up to 10 points	No

Report Improvement Activities via CEHRT and earn ACI bonus – High weight activities

High weight improvement activities

Provide 24/7 access to eligible clinicians or groups who have real-time access to patient's medical record

Anticoagulant management improvement

Glycemic management services

Report Improvement Activities via CEHRT and earn ACI bonus – Medium weight activities

Medium weight improvement activities

- Chronic care and preventive care management for empaneled patients
- Implementation of methodologies for improvements in longitudinal care management for high risk patients
- Implementation of episodic care management practice improvements
- Implementation of medication management practice improvements
- Implementation or use of specialist reports back to referring clinician or group to close referral loop
- Implementation of documentation of improvements for practice/process improvements
- Implementation of practices/processes for developing regular individual care plans
- Practice improvements for bilateral exchange of patient information
- Use of certified EHR to capture patient reported outcomes
- Engagement of patients through implementation of improvements in patient portal
- Engagement of patients, family and caregivers in developing a plan of care
- Use of decision support and standardized treatment protocols
- Leveraging a QCDR to standardize processes for screening
- Implementation of integrated primary care and behavioral health (PCBH) model
- Electronic health record enhancements for behavioral health (BH) data capture

Exemption from ACI reporting

- The ACI category can be reweighted to 0% of the final score in some cases
- The 25% ACI weight would be assigned to the quality performance category



Physicians can submit an application for reweighting for one of the following hardships

- Insufficient internet connectivity
- Extreme and uncontrollable circumstances
- Lack of control over the availability of CEHRT

The following physicians qualify for automatic reweighting to 0% (however, they may report and be scored for ACI)

- Hospital-based eligible physicians
- Physicians assistants
- Nurse practitioners
- Clinical nurse specialists
- Certified registered nurse anesthetists
- Physicians who lack face-to-face interaction with patients



MIPS Improvement Activities Category

Improvement Activities category

15% of MIPS final score in 2017

Total possible points = 40 points

New category; no previous program

Reporting:

- High-weight activities: worth 20 points each
- Medium-weight activities: worth 10 points each
- 90-day reporting period

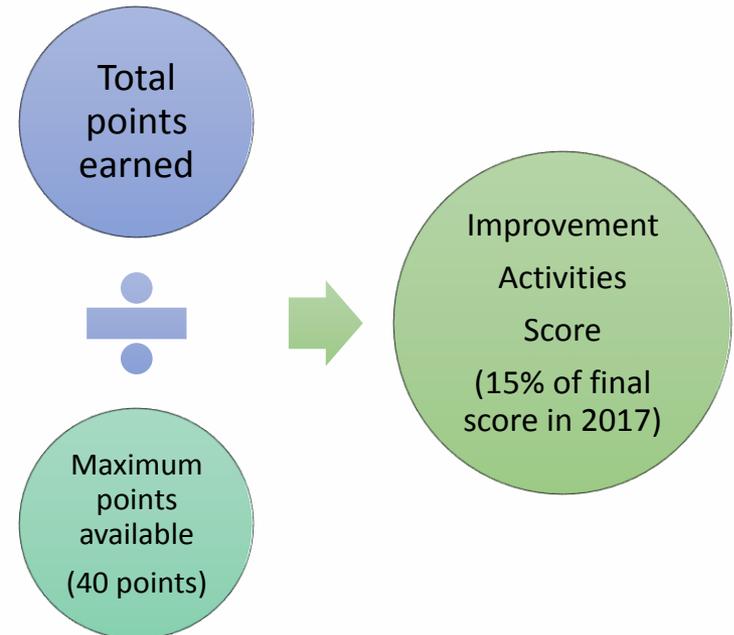
Reporting Mechanisms:

- Attestation, QCDR, qualified registry, EHR, CMS Web Interface (groups of 25 or more eligible clinicians)

Improvement Activities category scoring

Score:

- Any combination of high and medium weight activities equaling at least 40 total points
 - 2 high-weight activities ($2 \times 20 = 40$ points)
 - 4 medium-weight activities ($4 \times 10 = 40$ points)
 - 2 medium-weight activities AND 1 high-weight activity ($((2 \times 10) + (1 \times 20) = 40$ points)
- Using CEHRT to report a clinical practice improvement activity can earn bonus points towards the ACI category score



Improvement Activities category – small, rural, HPSA, and non-patient facing practices

15% of MIPS final score in 2017

Total possible points = 40 points

Eligibility:

- Solo physicians
- Groups with 15 or fewer physicians and other eligible clinicians
- Physicians in rural or health professional shortage areas (HPSAs)
- Non-patient facing physicians

Reporting – alternative scoring weights:

- High-weight activities: worth 40 points each
- Medium-weight activities: worth 20 points each
- 90-day reporting period

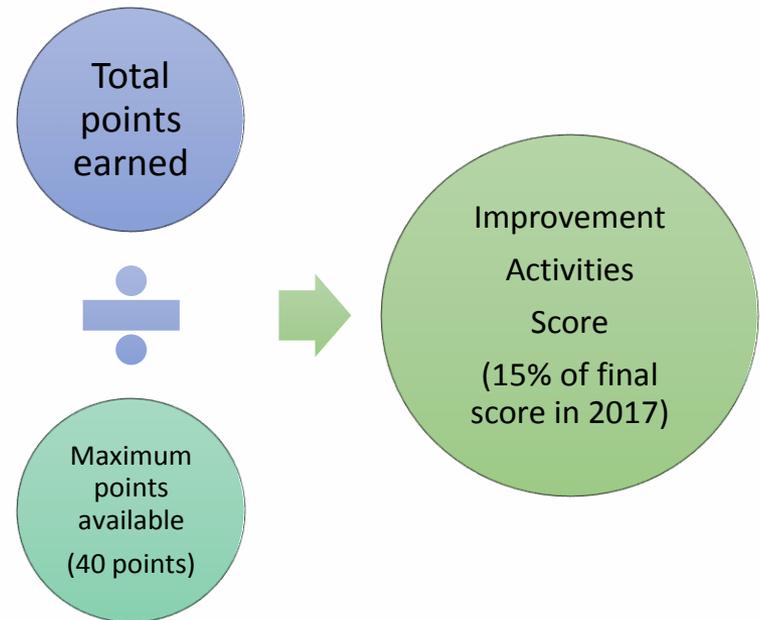
Reporting Mechanisms:

- Attestation, QCDR, qualified registry, EHR

Improvement Activities category – scoring for small, rural, HPSA, and non-patient facing practices

Score:

- Any combination of high and medium weight activities equaling at least 40 total points:
 - 2 medium-weight activities (2 x 20 = 40 points)
 - 1 high-weight activity (1 x 40 = 40 points)
- Using CEHRT to report can earn bonus for ACI score



MIPS - Improvement Activities categories

- Physicians may select from 92 clinical practice improvement activities
- List of improvement activities and activities search tool are available on CMS's website: <https://qpp.cms.gov/measures/ia>

Subcategory	Sample Activity
Achieving Health Equity	Leveraging a QCDR for use of standard questionnaires
Behavioral and Mental Health	Depression screening; diabetes screening
Beneficiary Engagement	Engagement of patients, family and caregivers in developing a plan of care
Care Coordination	Care transition documentation practice improvements
Emergency Response & Preparedness	Participation on disaster medical assistance team, registered for 6 months
Expanded Practice Access	Use of telehealth services to expand practice access
Patient Safety & Practice Assessment	Implementation of fall screening and assessment programs
Population Management	Engagement of community and health status improvement

NOTE: You are not required to perform activities in each subcategory in order to receive the highest possible score.

MIPS Cost Category

Cost category

- In 2017 – weight of category reduced to zero percent of final score
- 2018 – category will be 10% of final score

Reporting requirements and mechanisms:

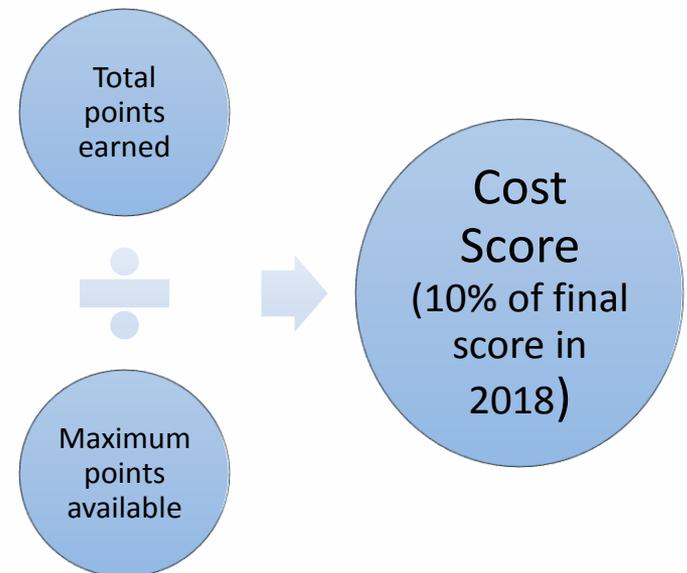
- No data is submitted on specific measures
- CMS uses administrative claims data to assess performance

Measures:

- New cost measures are being developed
- Possible measures include:
 - Medicare spending per beneficiary
 - Total per capita cost
 - Episode based measures
 - Patient condition groups and patient relationship codes

Score:

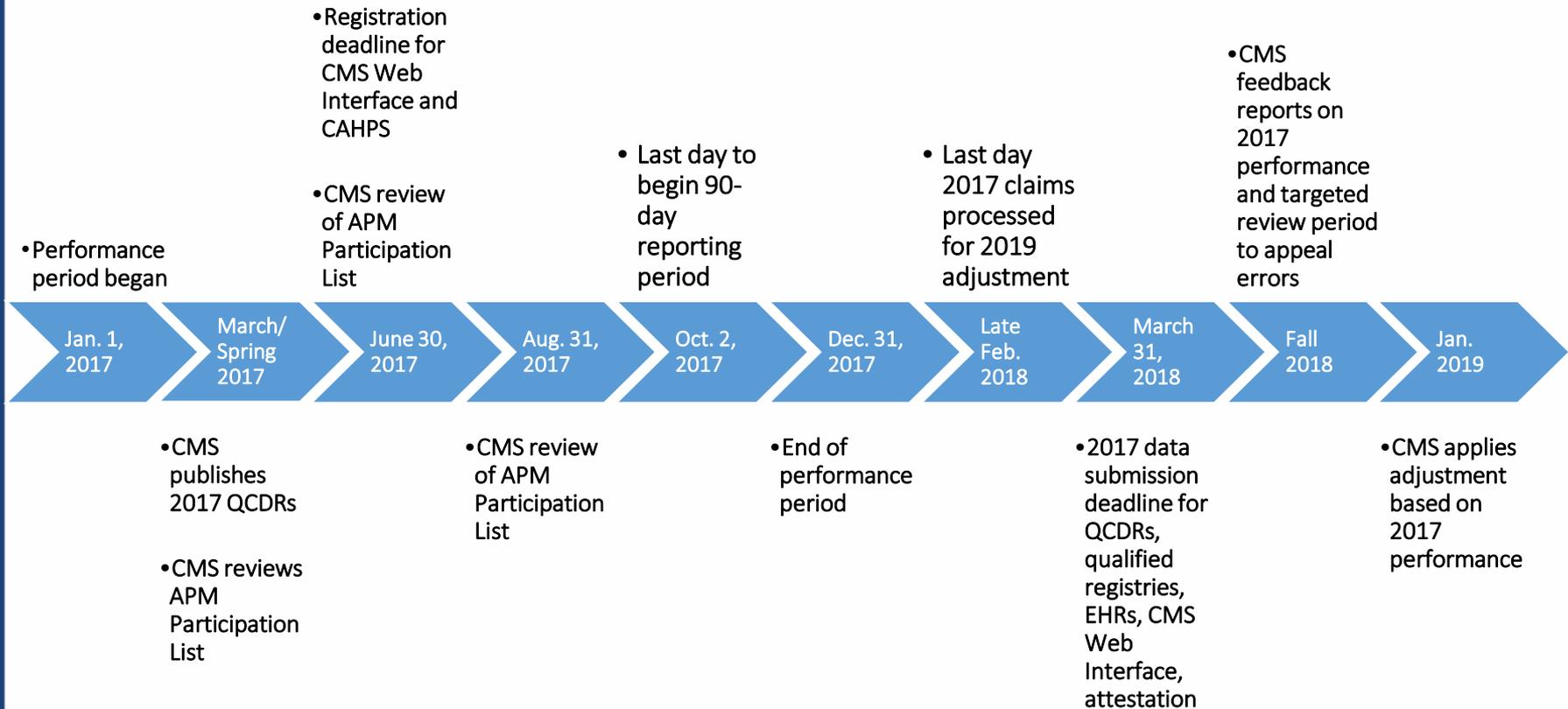
- CMS will use administrative claims data to calculate measure performance
- Although the cost category will not be scored for 2017, CMS will provide feedback on performance using administrative claims data, but it will not affect your 2017 performance score for the 2019 payment adjustment



Pathway 1: Merit-based Incentive Payment System (MIPS)

Reporting and timelines

Performance to payment timeline – submission and CMS dates for 2017 performance year



**Pathway 2:
Advanced Alternative Payment Models
(Advanced APMs)**

Should I select the Advanced APM pathway?

1. Determine if your practice qualifies for any of the approved Advanced APM options for 2017
 - Can your practice meet the APM participation requirements (these are separate and distinct from the Advanced APM criteria under the QPP)
2. Evaluate whether the practice will meet the necessary participation thresholds for QP/PQ
 - Stay alert for CMS QP/PQ determinations throughout 2017 to see if you have met the thresholds and are exempt from MIPS
 - If you meet PQ, but not QP, thresholds, determine if participating in MIPS under the MIPS APM option would position you to be eligible to earn a positive payment adjustment
3. Consider MIPS or MIPS APM options if an Advanced APM option meeting the necessary thresholds is not currently appropriate.

What are alternative payment models (APMs)?

- An APM is a payment and delivery approach where participants in the model have financial incentives to provide efficient, high-quality care
- Include elements that diverge from fee-for-service – such as bundled payments or gain-sharing – but may have fee-for service elements
- Include performance measurement and payment linked to quality and outcomes
- Participants may be at risk for some or all of the costs of care for a population or a service, but there are variations in characteristics and level of financial incentives
- May apply to services for specific conditions, episodes of care, or populations
- Primary care medical home models are often considered APMs
- There are Medicare APMs as well as commercial APMs and multi-payer APMs

What are Advanced APMs under the QPP?

- Subset of broader category of APMs
 - ***Physicians participating in Advanced APMs must meet the quality and reporting requirements that are subject to participation in the APM (this is separate and distinct from the Advanced APM criteria)***
- Characteristics and criteria for participation defined in MACRA – intention was to set a high bar for model where participants are accountable for cost and quality
- Participating physician may earn a 5% incentive payment – and are exempt from MIPS
 - ***The 5% incentive payment physicians would receive under QPP would be separate and distinct from the payments for services they receive through the APM***
- Physicians and/or their organizations (called an APM entity) decide whether to participate in the Advanced APM

What types of Advanced APMs are available under the QPP?



Medicare
Advanced
APMs

- Primary focus of QPP in short-term
- CMS has identified several for 2017 and 2018

Non-
Medicare
Other Payer
Advanced
APMs

- Will be implemented beginning with 2019 performance year
- Will potentially include APMs by private payers and state Medicaid payments arrangements and Medicare Advantage

Criteria for Medicare and Other Payer Advanced APMs

Advanced APMs

The APM is a certain CMMI, Shared Savings Program tracks, or certain federal demonstration programs

The APM requires participants to use CEHRT

The APM bases payments for services on quality measures comparable to those in MIPS

The APM is a Medical Home Model expanded under CMMI; or the APM requires participants to bear more than nominal financial risk for losses

Other Payer Advanced APMs

The APM requires participants to use CEHRT

The APM bases payments for services on quality measures comparable to those in MIPS

The APM requires participants to bear either more than nominal financial risk for losses; or the APM is a Medicaid Medical Home Model that meets criteria comparable to Medical Home Models

Advanced APM Entities must be responsible for performance and risk

- CMS requires APM Entities to take on some risk to help ensure that participants have a vested interest in costs and quality
- To qualify under the QPP, an APM Entity must take on payment risks for years when the APM Entity's actual expenditures under the Advanced APM exceed its expected expenditures
- Level of risk:
 - The level of risk taken on by the APM Entity must be more than nominal
 - The more than nominal risk determination is based on total Medicare Parts A and B revenues or expenditures



Note – The APM Entity, as a whole, is responsible for taking on the risk; not each individual physician in the APM Entity. The QPP establishes criteria for determining when an APM qualifies as an Advanced APM. How the APM functions in relation to e.g., risk adjustment or related topics of calculated savings/losses is governed by the underlying APM's rules

Financial risk standard for an APM Entity

To qualify under the QPP, an APM Entity must assume responsibility for performance years when actual expenditures exceed expected expenditures.

When that happens, the APM must provide for one of the following consequences:

Withholding payments for services to the APM Entity or the APM Entity's participating clinicians; or

Reducing payment rates to the APM Entity or the APM Entity's participating clinicians; or

Requiring the APM Entity to owe payment to CMS

The financial risk must be “more than nominal”



In order to ensure that the risk an APM Entity takes on is more than nominal risk, the total amount an APM Entity potentially owes CMS, or foregoes, under an APM must be at least equal to either:

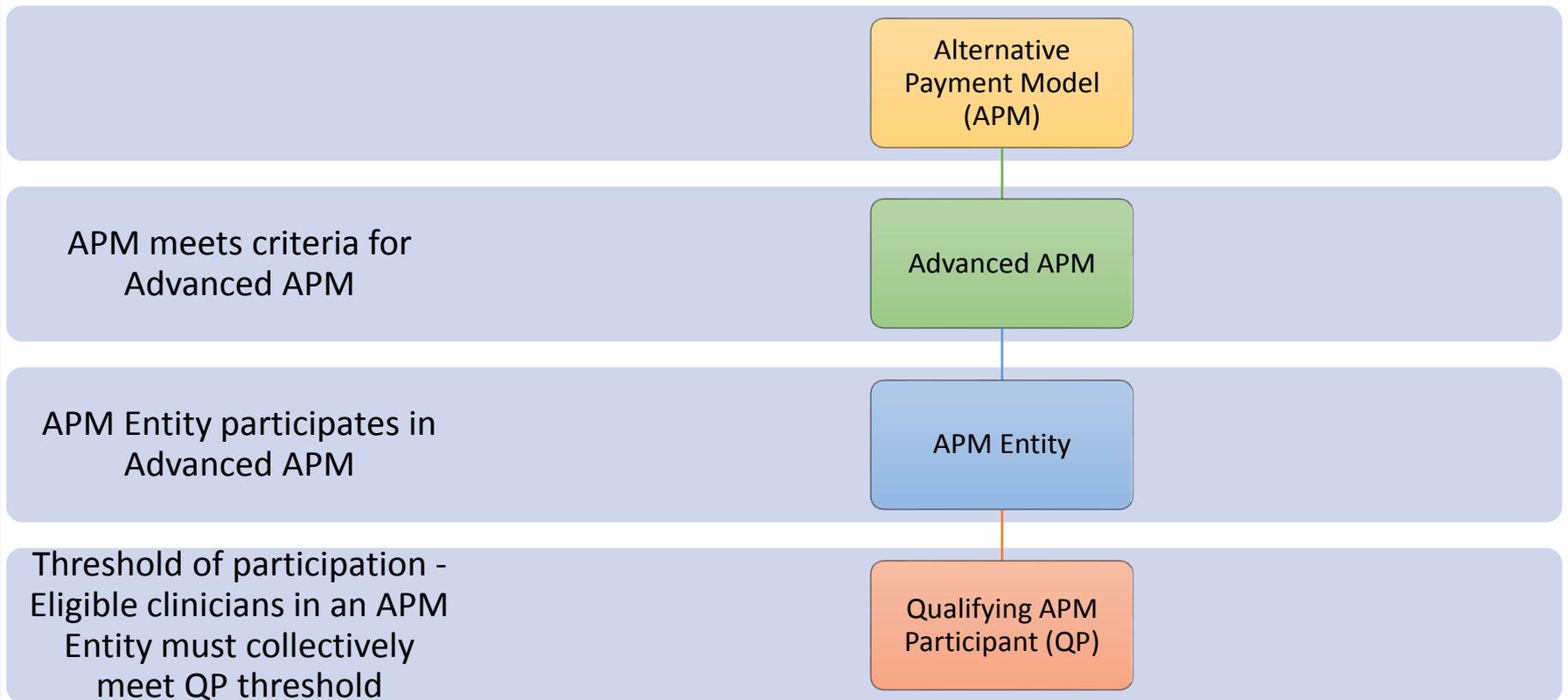


8% of the APM Entity’s average estimated total Medicare Parts A and B revenues of the APM Entity

OR

3% of the APM Entity’s expected total Parts A and B expenditures for which the APM Entity is responsible for under the Advanced APM

Required elements for receiving the Advanced APM incentive payment



Source: CMS MIPS and APM final rule

APM Entities and participation in an Advanced APM

- Participation in an Advanced APM is determined at the APM Entity level
- An APM Entity could include:
 - A sole MIPS physician (a solo practitioner);
 - An organization of physicians and other eligible clinicians with multiple tax-identification numbers (TINs) – but eligible clinicians are identified as participants by their unique APM identifier, or
 - An organization of physicians and other eligible clinicians with APM identifiers with national provider identifier(NPI)/TIN combinations; only some eligible clinicians are APM participants while others are not

When are APM Entity physicians exempt from MIPS?

- To be considered part of an APM Entity and receive credit for Advanced APM participation, physicians must be either:
 - Qualifying Advanced APM Participants (QPs)
 - **OR** Partially Qualifying Advanced APM Participants (PQs)
- QP and PQ determinations are made based on 2 methods:
 - Medicare patient count method
 - **OR** Medicare payments method
- What is the difference between QPs and PQs?
 - QPs have higher payment or patient count thresholds than PQs
 - QPs are automatically exempt from MIPS and are eligible to receive a 5% incentive payment
 - PQs have the option to be exempt from MIPS or participate in MIPS and earn a positive payment adjustment; PQs are not eligible for the 5% incentive payment

Participation thresholds

Qualifying Advanced APM Participants (QPs)

- 2017 and 2018 thresholds:
 - 25% of the APM Entity's Medicare payments through an Advanced APM
 - 20% of the APM Entity's Medicare patients through an Advanced APM
- Eligible for the 5% APM incentive payment
- Exempt from MIPS

Partially Qualifying Advanced APM Participants (PQs)

- 2017 and 2018 Thresholds:
 - 20% of the APM Entity's Medicare payments through an Advanced APM
 - 10% of the APM Entity's Medicare patients through an Advanced APM
- Exempt from MIPS but not eligible for the 5% APM incentive payment
- BUT— have the option to participate in MIPS and be eligible to receive a positive payment adjustment

Note - Participation thresholds are determined for each APM Entity as a whole. An APM Entity could comprise of a sole physician, or comprise of multiple physicians and/or other eligible clinicians under the same or different TINs

Participation threshold calculations

- Medicare Payment Count Method

- The percentage of Medicare Part B payments that are made to all the eligible clinicians in the Advanced APM Entity for all beneficiaries attributed to the Advanced APM Entity
- Aggregate of all Medicare Part B payments for the attributed beneficiaries, divided by the total Medicare Part B payments for all “attribution-eligible” beneficiaries

$$\frac{\text{Payments for Part B services to attributed beneficiaries}}{\text{Payments for Part B services to attribution-eligible beneficiaries}} \geq 25\% \text{ for QP}$$

- Medicare Patient Count Method

- The percentage of Medicare attribution-eligible beneficiaries who are actually attributed to the Advanced APM Entity
- The number of unique beneficiaries who are attributed to the Advanced APM Entity, divided by the total number of attribution-eligible beneficiaries

$$\frac{\text{\# of attributed beneficiaries provided Part B services}}{\text{\# of attribution-eligible beneficiaries provided Part B services}} \geq 20\% \text{ for QP}$$

- Attribution under each method – payment and patient – is determined by each Advanced APM’s underlying attribution rules

CMS will make 3 QP/PQ determinations throughout the year

- CMS will make 3 evaluations each performance year to determine whether physicians meet the QP thresholds
- Evaluations will be made at the APM Entity level and will be applied to each physician in the APM Entity
- The three evaluations for 2017 performance will be: March 31, June 30, and August 31
 - Will ensure that physicians who only participate in an Advanced APM and meet the QP thresholds for part of the year still receive their Advanced APM participation credit
 - APM Entities and physicians who meet the QP thresholds during any of these three review periods will be exempt from MIPS and receive the 5% incentive payment
- If an APM Entity meets only PQ thresholds, then the APM Entity can elect whether to be subject to MIPS (using the APM scoring standard for MIPS APMs), or be exempt
- If an APM Entity does not meet QP or PQ thresholds, then they will be subject to the MIPS APM scoring method

How do we know what Advanced APMs are available?

- 
- CMS posted on its website a list of all Advanced APMs for the 2017 performance period
 - At intervals no less than annually, CMS will update the Advanced APM list on its website
 - CMS will include notice of whether a new APM is an Advanced APM in the first public notice of the new APM

The list of Advanced APMs is available on the CMS Quality Payment Program website: <https://qpp.cms.gov/learn/apms>

Advanced APMs available in 2017

Physicians who have 25% of their Medicare payments or 20% of their Medicare patients through one of the following Advanced APMs will qualify for the 5% APM incentive payment

Comprehensive ESRD Care Model

- LDO and Non-LDO two-sided risk arrangements

CPC+

Medicare Shared Savings Program ACOs
– Tracks 2 & 3

Next Generation ACO Model

Oncology Care Model

- Two-sided risk arrangement

Comprehensive Care for Joint Replacement (CJR) Payment Model

- Track 1 – CEHRT

2018 Proposed Advanced APMs

Comprehensive ESRD
Care Model

CPC+

Medicare Shared
Savings Program ACOs
– Track 2

Medicare Shared
Savings Program ACOs
– Track 3

Next Generation ACO
Model

Oncology Care Model

ACO Track 1+

Cardiac Rehabilitation
(CR) Incentive Payment
Model

Comprehensive Care
for Joint Replacement
(CJR) Payment Model

Advancing Care
Coordination through
Episode Payment
Models Tracks 1 & 2

Vermont Medicare ACO
Initiative

Acute Myocardial
Infarction (AMI) Model
(Track 1 – CEHRT)

Medicare-Medicaid
Accountable Care
Organization Model
(MMACO Tracks 2 and
3)

Surgical Hip/Femur
Fracture Treatment
(SHFFT) Model (Track 1
– CEHRT)

Coronary Artery Bypass
Graft (CABG) Model
(Track 1 – CEHRT)

Next Steps: I AM participating in an Advanced APM

If you are participating in an Advanced APM:

- CMS will make 3 evaluations in 2017 to determine whether physicians meet QP/PQ thresholds
 - The determination periods are March 31 (decision by July 2017), June 30 (decision by October 31), and August 31 (decision by December 31)
- Check these determinations to see if you have meet the QP/PQ thresholds and are exempt from MIPS
- If you meet the QP thresholds, you are exempt from MIPS participation
- If you meet the PQ thresholds, then the APM Entity you are part of could elect to participate in the MIPS APM option

Next Steps: I am NOT participating in an Advanced APM

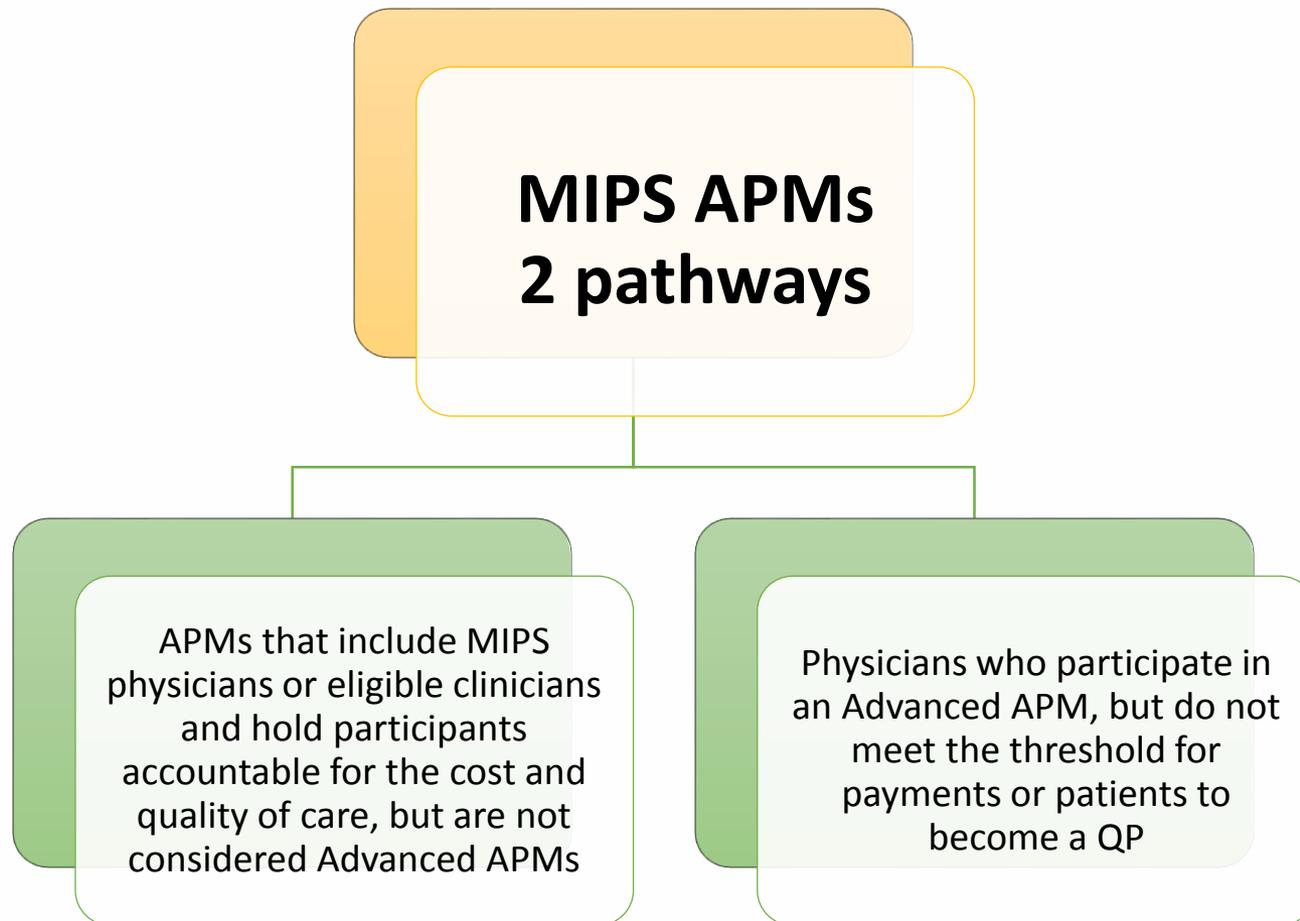
- Determine whether you are exempt from MIPS participation
- Pick your quality reporting pace for 2017 by evaluating practice readiness
 - Determine if participating for a minimum of 90 days and becoming eligible to receive a positive payment adjustment is feasible for you/your practice
- Select the best reporting mechanism(s) by evaluating practice resources
 - Is a specialty-, diagnosis-, or treatment-specific QCDR with more applicable measures available?
 - What new processes and workflows will need to be put in place to meet the reporting requirements?
 - Do you have access to an EHR?
- Consider whether the Advanced APM option is feasible before making the final decision

MIPS APMs

Should I select the MIPS APM option?

1. Evaluate practice readiness for APM participation
2. Consider advantages of the MIPS APM v. traditional MIPS reporting pathway before making final decision
 - Remember, participation for the quality and ACI categories is determined at an aggregate level (at the APM Entity or APM level depending on the model, e.g., medical homes, shared savings ACOs, Next Gen ACOs, bundled payment models)– determine how the performance of others in the APM and/or APM entity may affect the aggregate scores under the MIPS APM scoring methodology
3. Determine eligibility for a MIPS APM
 - Do you participate in an Advanced APM?
 - Check the QP/PQ determinations by CMS to see if you have met the QP thresholds and are exempt from MIPS participation
 - If you have met PQ, but not QP, thresholds, determine whether it may be advantageous to participate in MIPS using the MIPS APM option to be eligible to earn a positive payment adjustment
 - If you have not met the QP or PQ thresholds, you will be subject to the MIPS APM scoring methodology
 - Are you participating in an APM not an Advanced APM?
 - Check CMS list of MIPS APMs which is more inclusive of other APMs that may not meet the criteria for Advanced APMs (e.g., one-sided risk models)

Don't meet the QP thresholds? Not in the right kind of APM?

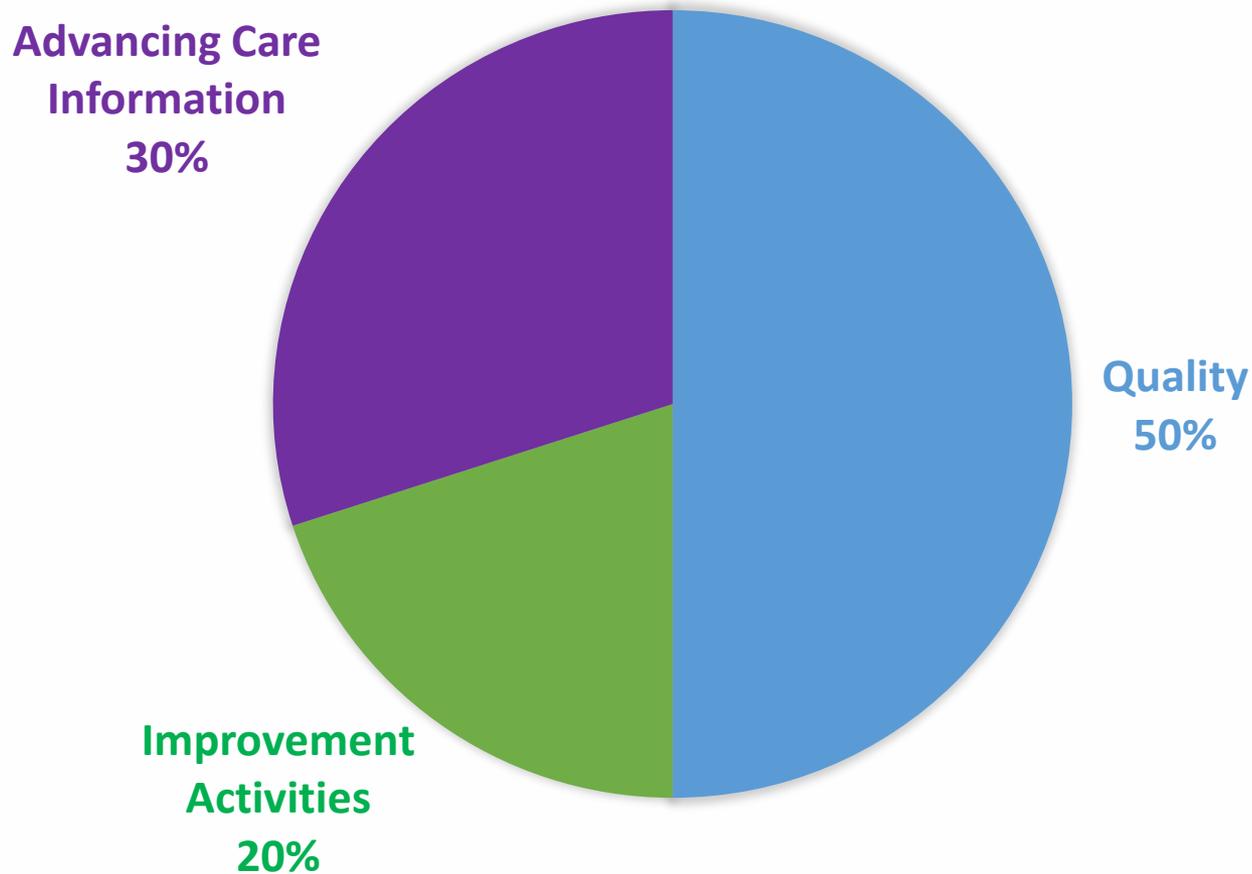


What is the MIPS APM scoring standard?

- APM Entities will receive a score for some of the 4 MIPS categories
- APM Entities will not be scored for the cost category
- All MIPS APMs for 2017 automatically meet the requirements for the Improvement Activities category and will earn full credit for that category
- Weights apply to each category to get to a final score
- Weights for each category depend on the type of MIPS APM

2017 Medicare Shared Savings Program MIPS APM Scoring – Tracks 1, 2, & 3

WEIGHT OF CATEGORIES

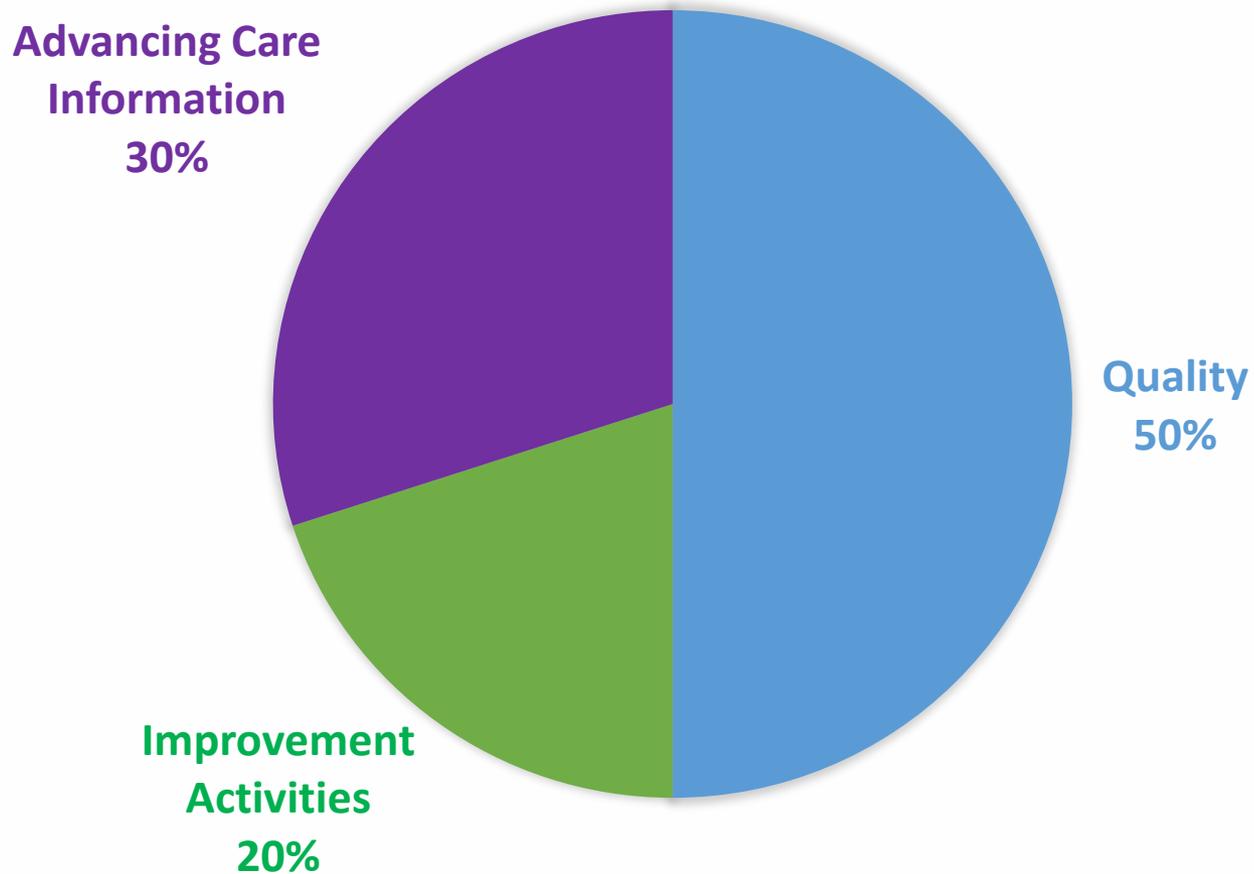


2017 Medicare Shared Savings Program MIPS APM Scoring – Tracks 1, 2, & 3

MIPS Performance Category	APM Entity Submission Requirement	Performance Score
Quality	<p>ACOs submit quality measures to the CMS Web Interface on behalf of their participating physicians and other eligible clinicians</p> <p>Note: the burden of reporting is not on the individual physicians or group TIN level</p>	<p>The MIPS quality performance category requirements and benchmarks will be used to determine the MIPS quality score at the ACO level</p> <p>Note: aggregate scoring is at the overall APM Entity level, which may be advantageous /disadvantageous</p>
Improvement Activities	<p>CMS has reviewed the MIPS APM's participation agreements, assigned scores to the improvement activities, and has determined that all APM Entities participating in MIPS APMs will receive the full score of 40 points for this category</p>	
Advancing Care Information	<p>All ACO participant TINs in the ACOs submit under this category according to the MIPS group reporting requirements</p> <p>Note: the burden of reporting is at the TIN level according to group reporting requirements</p>	<p>All of the ACO participant TIN scores will be aggregated as a weighted average based on the number of physicians and other eligible clinicians in each TIN, to yield one APM Entity score</p> <p>Note: even though reporting is at the group TIN level, aggregate scoring is at the APM Entity level, so the performance of all others will affect your overall score</p>

2017 Next Gen ACO MIPS APM Scoring

WEIGHT OF CATEGORIES

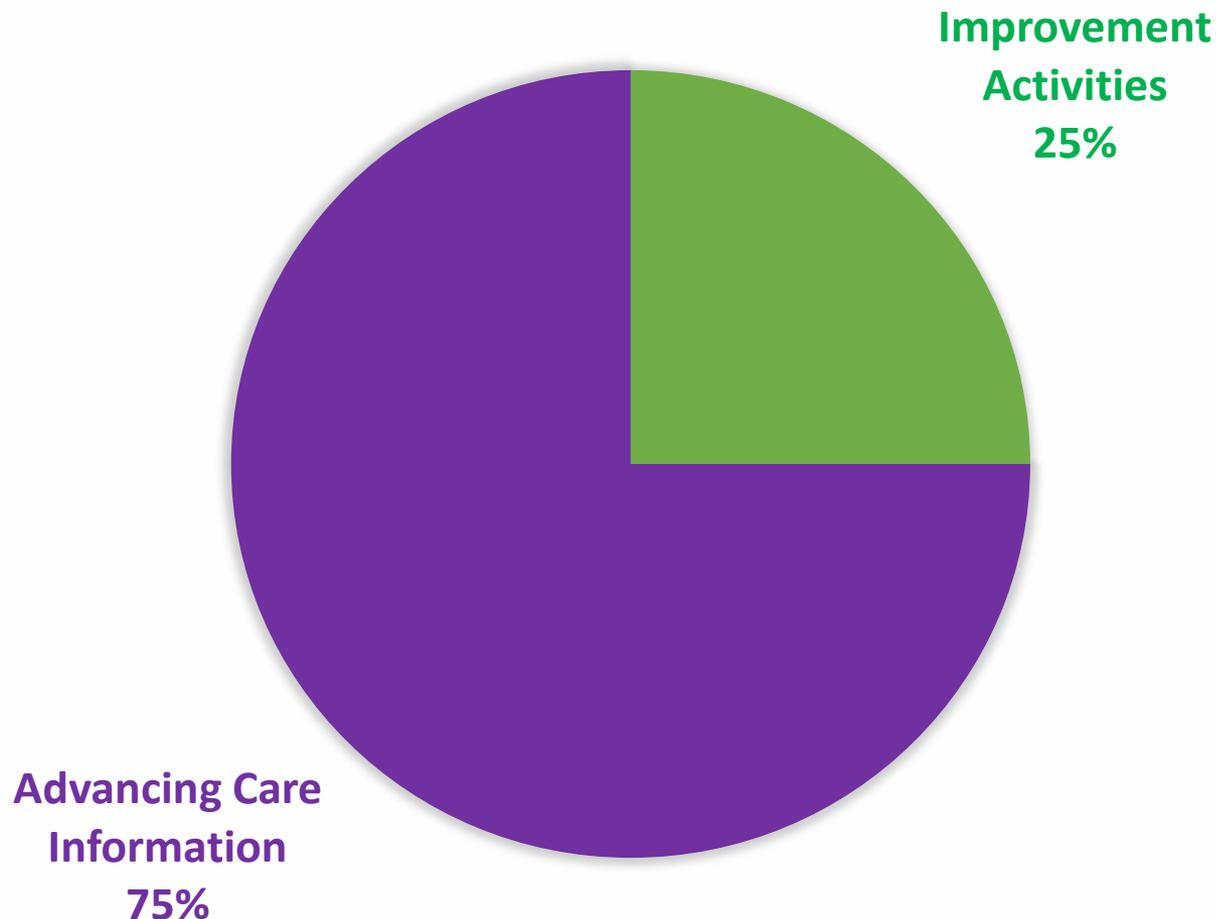


2017 Next Gen ACO MIPS APM Scoring

MIPS Performance Category	APM Entity Submission Requirement	Performance Score
Quality	<p>ACOs submit quality measures to the CMS Web Interface on behalf of their participating physicians</p> <p>Note: the burden of reporting is not on the individual physicians or group TIN level</p>	<p>The MIPS quality performance category requirements and benchmarks will be used to determine the MIPS quality score at the ACO level</p> <p>Note: aggregate scoring is at the overall APM Entity level, which may be advantageous /disadvantageous</p>
Improvement Activities	<p>CMS has reviewed the MIPS APM's participation agreements, assigned scores to the improvement activities, and has determined that all APM Entities participating in MIPS APMs will receive the full score of 40 points for this category</p>	
Advancing Care Information	<p>Each physician in the APM Entity reports ACI to MIPS through either group reporting at the TIN level or individual reporting</p> <p>Note: burden of reporting is at the group or individual physician level</p>	<p>CMS will attribute one score to each MIPS eligible clinicians in the APM Entity, which will be the highest score attributable to the NPI/TIN combination of each MIPS eligible clinician (derived from either group or individual reporting). CMS will then aggregate and average the scores to yield a single score for the APM Entity.</p> <p>Note: although the highest score is attributed at the individual level, the aggregate scoring could result in an overall score which may be advantageous /disadvantageous</p>

2017 Non-ACO MIPS APM Scoring: e.g., CPC+, Comprehensive ESRD Care Model, and Oncology Care Model

WEIGHT OF CATEGORIES



2017 Non-ACO MIPS APM Scoring: e.g., CPC+, Comprehensive ESRD Care Model, and Oncology Care Model

MIPS Performance Category	APM Entity Submission Requirement	Performance Score
Quality	<p>The APM Entity will not be assessed on quality under MIPS. The APM Entity will submit quality measures to CMS as required by the APM</p> <p>Note: burden of reporting is at the APM Entity level per the APM's quality measures</p>	N/A
Improvement Activities	<p>CMS has reviewed the MIPS APM's participation agreements, assigned scores to the improvement activities, and has determined that all APM Entities participating in MIPS APMs will receive the full score of 40 points for this category</p>	
Advancing Care Information	<p>Each MIPS eligible clinician in the APM Entity reports ACI to MIPS through either group reporting at the TIN level or individual reporting</p> <p>Note: burden of reporting is at the group TIN or individual physician level</p>	<p>CMS will attribute one score to each MIPS eligible clinicians in the APM Entity, which will be the highest score attributable to the NPI/TIN combination of each MIPS eligible clinician (derived from either group or individual reporting). CMS will then aggregate and average the scores to yield a single score for the APM Entity.</p> <p>Note: although the highest score is attributed at the individual level, the aggregate scoring could result in an overall score which may be advantageous /disadvantageous</p>

Next steps and looking forward

Next Steps: Should I select the MIPS pathway?

1. Determine whether you are exempt from MIPS participation
2. Pick your quality reporting pace for 2017 by evaluating practice readiness
3. Select the best reporting mechanism(s) by evaluating practice resources
 - Is a specialty-, diagnosis-, or treatment-specific QCDR with more applicable measures available?
 - What new processes and workflows will need to be put in place to meet the reporting requirements?
 - Do you have access to an EHR?
4. Consider whether the Advanced APM option is feasible before making the final decision

If you aren't participating in an Advanced APM:

- Review the quality category measures and improvement activities and select at least one measure or activity to avoid the negative payment adjustment
- Determine if participating for a minimum of 90 days and becoming eligible to receive a positive payment adjustment is feasible for you/your practice
- Review current 2017 and proposed 2018 Advanced APMs and determine if participating in the APM track is an option for the future

If you are participating in an Advanced APM:

- CMS will make 3 evaluations in 2017 to determine whether physicians meet QP/PQ thresholds
 - The determination periods are March 31 (decision by July 2017), June 30 (decision by October 31), and August 31 (decision by December 31)
- Check these determinations to see if you have meet the QP/PQ thresholds and are exempt from MIPS

Next Steps: Should I select the Advanced APM pathway?

1. Determine if your practice qualifies for any of the approved Advanced APM options for 2017
 - Can your practice meet the APM participation requirements (these are separate and distinct from the Advanced APM criteria under the QPP)
2. Evaluate whether the practice will meet the necessary participation thresholds for QP/PQ
 - Stay alert for CMS QP/PQ determinations throughout 2017 to see if you have met the thresholds and are exempt from MIPS
 - If you meet PQ, but not QP, thresholds, determine if participating in MIPS under the MIPS APM option would position you to be eligible to earn a positive payment adjustment
3. Consider MIPS or MIPS APM options if an Advanced APM option meeting the necessary thresholds is not currently appropriate.

Next Steps: I AM participating in an Advanced APM

If you are participating in an Advanced APM:

- CMS will make 3 evaluations in 2017 to determine whether physicians meet QP/PQ thresholds
 - The determination periods are March 31 (decision by July 2017), June 30 (decision by October 31), and August 31 (decision by December 31)
- Check these determinations to see if you have meet the QP/PQ thresholds and are exempt from MIPS
- If you meet the QP thresholds, you are exempt from MIPS participation
- If you meet the PQ thresholds, then the APM Entity you are part of could elect to participate in the MIPS APM option

Next Steps: I am NOT participating in an Advanced APM

- Determine whether you are exempt from MIPS participation
- Pick your quality reporting pace for 2017 by evaluating practice readiness
 - Determine if participating for a minimum of 90 days and becoming eligible to receive a positive payment adjustment is feasible for you/your practice
- Select the best reporting mechanism(s) by evaluating practice resources
 - Is a specialty-, diagnosis-, or treatment-specific QCDR with more applicable measures available?
 - What new processes and workflows will need to be put in place to meet the reporting requirements?
 - Do you have access to an EHR?
- Consider whether the Advanced APM option is feasible before making the final decision

What is the MIPS APM scoring standard?

- APM Entities will receive a score for some of the 4 MIPS categories
- APM Entities will not be scored for the cost category
- All MIPS APMs for 2017 automatically meet the requirements for the Improvement Activities category and will earn full credit for that category
- Weights apply to each category to get to a final score
- Weights for each category depend on the type of MIPS APM

Practical challenges with measurement and reporting

Benchmarks and relative scale

- Benchmarks and the performance threshold change annually and are “budget neutral” – the amount of payment adjustments are uncertain
- Physicians do not know how they compare to peers
- No benchmarks for new measures (so they receive less weight)

Availability and relevance of quality measures

- The availability of applicable and relevant measures varies depending on a physician’s specialty
- The measures used for the cost category are hospital-focused; often viewed as inappropriate for assessing physician performance
- Both outcome and process performance measures may be affected by differences in patient demographics

Continuity and problems with previous reporting programs

- Many physicians submitted their data but did not review their QRURs to assess/improve their performance
- Difficulty in accessing and understanding QRURs, and CMS’s scoring methodology
- Also – reporting requirements have changed from the previous programs, which will cause confusion

Reporting submission process and errors

- Lack of real-time feedback to correct reporting errors – notification of incorrect submissions occurs months after the end of the reporting period
- Vendors – concern over accountability for reporting errors due to incorrect submissions
- Costs associated with multiple data submission methods/vendors with no guarantee in a positive return on investment

What PAI-Healthsperien resources will be available to help?

- **Follow-on products in early 2017** – In-depth one-pagers and monographs focused on topics such as the MIPS scoring system and strategies for reporting and how to meet the minimum reporting requirements for 2017
- **In development** – Guide to additional resources in physician communities
- **FAQ document** – updated on a continuous and ongoing basis with important questions
- **Regular e-mail updates** – Emails will provide updates on new information, materials, and tools available from PAI, Healthsperien, as well as CMS and other organizations

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