MACRA, MIPS, QPP, and APMs.

Program Updates

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Medical Director – Clinical Skills Education and Testing Center

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Speaker Disclosure

I have no relevant financial relationships or affiliations to disclose.

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Speaker Disclosure

- Current appointment as a “Quality Payment Program Clinical Champion” for the Centers for Medicare & Medicaid Services
- Recently appointed member of the Technical Expert Panel (TEP) for the project entitled “Development of Inpatient Outcome Measures for the Merit-based Incentive Payment System”
- Rural Quality Advisory Panel for the Rural Quality Improvement Technical Assistance (RQITA) Program (funded by the Federal Office of Rural Health Policy)
- Co-Chair, National Quality Forum Technical Advisory Panel – Primary Care and Chronic Illness Safety Standing Committee

All are volunteer positions.
Objectives

• Explain the drivers promoting change in payment methods

• Summarize current programs designed to move to value-based payment for healthcare

• Describe the role of internal medicine as systems become accountable for costs and quality of patient outcomes
Payment reform in healthcare is inevitable.
Amazon, Berkshire Hathaway And JPMorgan Chase Launch New Health Care Company

January 30, 2018 - 8:48 AM ET

Berkshire Hathaway Chairman and CEO Warren Buffett (left) in 2017; Jeff Bezos, CEO of Amazon, in 2013; and JP Morgan Chase Chairman and CEO Jamie Dimon in 2013. Berkshire Hathaway, Amazon and JPMorgan Chase are teaming up to create a health care company announced Tuesday that is "free from profit-making incentives and constraints."

AP

Health care costs are "a hungry tapeworm on the American economy," Berkshire Hathaway Chairman and CEO Warren Buffett says, and now his firm is teaming up with Amazon and JPMorgan Chase to create a new company with the goal of providing high-quality health care for their U.S. employees at a lower cost.
Editorial: Rising healthcare costs are a cancer, not a tapeworm

By Merrill Goozner | January 31, 2018

As similes go, I have problems with using the lowly tapeworm, a subspecies of the helminth family, to understand the impact of rising healthcare costs.

"The ballooning costs of healthcare act as a hungry tapeworm on the American economy," said Berkshire Hathaway's Warren Buffett. The Oracle of Omaha, along with Jeff Bezos of Amazon and Jamie Dimon of JPMorgan Chase & Co., set the healthcare policy world atwitter with their plan to create a not-for-profit company dedicated to lowering their organizations' overall spend on health.

Let's explore this simile. The tapeworm is a parasite, an unwanted critter that lodges inside its human host. It robs its victim of the nutrients needed to thrive and grow. So far, so good.
Unnecessary Medical Care Is More Common Than You Think

A study in Washington state found that in a single year more than 600,000 patients underwent treatment they didn’t need, at an estimated cost of $282 million. “Do no harm” should include the cost of care, too, the report author says.

by Marshall Allen, Feb. 1, 5 a.m. EST
Fixing the tax code will make American businesses more competitive globally....

Study Shows Uncompetitive Tax Code Contributes to Increased Foreign Acquisition of U.S. Companies

Analysis: Competitive Corporate Income Tax Rate Would Have Kept 4,700 Companies in the United States

http://businessroundtable.org/media/news-releases/study-shows-uncompetitive-tax-code-contributes-increased-foreign-acquisition-u.s
Healthy Costs and U.S. Competitiveness

Some analysts say healthcare costs hinder U.S. industry competitiveness in the global marketplace, but it’s unclear whether proposed health reforms will offer any cost relief.

Backgrounder by Toni Johnson

Last updated March 26, 2012

Warren Buffett: Healthcare Is the Real Problem for American Business

Warren Buffett claims the biggest issue facing American businesses as they compete abroad is healthcare, not taxes.
Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care
Corporate healthcare costs – A competitive disadvantage in the global market?

Percent of GDP

United States (16.6%)
Switzerland (11.4%)
Sweden (11.2%)
France (11.1%)
Germany (11.0%)
Netherlands (10.9%)
Canada (10.0%)
United Kingdom (9.9%)
New Zealand (9.4%)
Norway (9.3%)
Australia (9.0%)


GM says healthcare costs add between $1,500 and $2,000 to the sticker price of every automobile it makes.
CMS projected that healthcare spending will on average rise 5.5 percent annually from 2017 to 2026 and will comprise 19.7 percent of the U.S. economy in 2026, up from 17.9 percent in 2016. By 2026, health spending is projected to reach $5.7 trillion.
Will the cost of cancer drugs break the economy?

By Elizabeth Whitman  |  March 14, 2017

If left unchecked, the rising cost of cancer drugs could have devastating implications for individuals, societies and national economies, a group of cancer physicians and researchers said.

In a new paper published Tuesday in Nature Reviews: Clinical Oncology, the cancer experts excoriated the pharmaceutical industry for pricing oncology drugs at rates that make them inaccessible and are unjustifiably high given the often scant benefit some of these drugs bring patients.
Medicare represents a growing share of the federal budget

NOTE: Pies represent total spending.
General revenue—not the Medicare payroll tax—is now the largest source of Medicare’s financing.


NOTE: “Other” includes proceeds from the taxation of Social Security benefits, which help to finance Medicare Hospital Insurance costs, as well as drug fees and state transfers. General revenues are resources that come from the General Fund of the Treasury. Numbers may not sum to 100% due to rounding.

https://www.pgpf.org/budget-basics/budget-explainer-medicare
Despite the amount of money the US spends on health care...
Per capita health expenditures and life expectancy 1970-2014

Deductible spending has risen while copayment spending has fallen

Cumulative increases in health costs, amounts paid by insurance, amounts paid for cost sharing and workers wages, 2005-2015

More out-of-pocket spending for healthcare

Widening gap between wages and out-of-pocket costs!

https://www.healthsystemtracker.org/brief/increases-in-cost-sharing-payments-have-far-outpaced-wage-growth/?_sf_s=Payments+for+cost+sharing+#item-start
Payment Reform seems Inevitable

• We have a payment system that has rewarded more care (including redundancy), regardless of the value (or quality) of that care. Fee-for-service payment is inflationary.

• Payment models have not promoted coordination of care across settings.

• Poor outcomes and disparities of care persist.
Remember when we had the SGR?

**Fee-for-service** (FFS) payment system, where clinicians are paid based on **volume** of services, not **value**.

**The Sustainable Growth Rate (SGR)**

- Established in 1997 to **control the cost of Medicare payments** to physicians

**IF**

- Overall physician costs
- Target Medicare expenditures

**THEN**

- Physician payments cut across the board

Each year, Congress passed temporary “**doc fixes**” to avert cuts (no fix in 2015 would have meant a **21% cut** in Medicare payments to clinicians)
Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

One Hundred Fourteenth Congress of the United States of America

AT THE FIRST SESSION

Begun and held at the City of Washington on Tuesday, the sixth day of January, two thousand and fifteen

An Act

To amend title XVIII of the Social Security Act to repeal the Medicare sustainable growth rate and strengthen Medicare access by improving physician payments and making other improvements, to reauthorize the Children's Health Insurance Program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the “Medicare Access and CHIP Reauthorization Act of 2015”.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—SGR REPEAL AND MEDICARE PROVIDER PAYMENT MODERNIZATION

Republican controlled Senate and House:

- Senate vote: 92 yea; 8 nay
- House vote: 392 yea; 37 nay

House sponsor: Michael C. Burgess, MD [R - Texas]

Repealed the SGR!

Very bipartisan!
MACRA moves Medicare Part B clinicians to a performance-based payment system
What is the Merit-based Incentive Payment System?

Combines legacy programs into single, improved reporting program

- PQRS
- VM
- EHR

MIPS

Legacy Program Phase Out

- Last Performance Period: 2016
- PQRS Payment End: 2018
TITLE I—SGR Repeal and Medicare Provider Payment Modernization – What happened in 2017?

Eligible Professional

Advanced Alternate Payment Mechanisms (APM)
- “Substantial portion” of revenues from “approved” alternate payment models
  - 5% bonus each year from 2019-2024
  - 0.75% increase per year beginning in 2026

Merit-based Incentive Payment System (MIPS)†
- Providers receive a score of 0-100
- Each year, CMS will establish a threshold score based on the median or mean composite performance scores of all providers
  - Providers scoring above the threshold will receive bonus payments (up to three times the annual penalty cap).

Quality Payment Program (QPP)

†Performance scores will be posted to Physician Compare website.
What Is MIPS?

Performance Categories:

- Reporting standards align with Alternative Payment Models when possible
- Many measures align with those being used by private insurers

Clinicians will be reimbursed under Medicare Part B based on this Performance Score

*Cost was not considered in the score for 2017.*
How much can MIPS adjust payments?

- Based on the MIPS composite performance score, physicians and practitioners will receive positive, negative, or neutral adjustments up to the percentages below.
- MIPS adjustments are budget neutral. A scaling factor may be applied to upward adjustments to make total upward and downward adjustments equal.

Adjustment to provider’s base rate of Medicare Part B payment

<table>
<thead>
<tr>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022 onwards</th>
</tr>
</thead>
<tbody>
<tr>
<td>-4%</td>
<td>-5%</td>
<td>-7%</td>
<td>-9%</td>
</tr>
</tbody>
</table>

Merit-Based Incentive Payment System (MIPS)
MIPS Scoring for Quality

Select 6 of the approximately 300 available quality measures (minimum of 90 days)
- Or a specialty set
- Or CMS Web Interface measures
- Readmission measure is included for group reporting with groups with at least 16 clinicians and sufficient cases

Clinicians receive 3 to 10 points on each quality measure based on performance against benchmarks

Failure to submit performance data for a measure = 0 points

Bonus points are available
Quality Measures

Instructions

1. Review and select measures that best fit your practice.
2. Add up to six measures from the list below, including one outcome measure. You can use the search and filters to help find the measures that meet your needs or specialty.
3. If an outcome measure is not available that is applicable to your specialty or practice, choose another high priority measure.
4. Download a CSV file of the measures you have selected for your records.

Groups in APMs qualifying for special scoring standards under MIPS, such as Shared Savings Program Track 1 or the Oncology Care Model: Report quality measures through your APM. You do not need to do anything additional for the MIPS quality category.

Note: This tool is only for informational and estimation purposes. You can't use it to submit or attest to measures or activities.

Select Measures

Search All by keyword

Search for...

SEARCH

Filter by:

High Priority Measure

Data Submission Method

Specialty Measure Set

2017 MIPS Performance

- Quality (60%)
- Advancing Care Information (25%)
- Improvement Activities (15%)
### Select Measures

**Search All by keyword**

- **Filtered**: Yes
- **Search for...**: [Input field]

**Filter by:**

- **High Priority Measure**: None
- **Data Submission Method**: None
- **Specialty Measure Set**: None

**Specialty Measure Set**

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

**Disclaimer**

*MIPS eligible clinicians or groups are expected to report on applicable measures. “Applicable” is defined as measures relevant to a particular MIPS eligible practice's clinical profile.*
Table 1: Using Data in Benchmark to Estimate Points (For Non-Inverse Measures)*

<table>
<thead>
<tr>
<th>Decile</th>
<th>Number of Points Assigned for the 2017 MIPS Performance Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below Decile 3</td>
<td>3 points</td>
</tr>
<tr>
<td>Decile 3</td>
<td>3-3.9 points</td>
</tr>
<tr>
<td>Decile 4</td>
<td>4-4.9 points</td>
</tr>
<tr>
<td>Decile 5</td>
<td>5-5.9 points</td>
</tr>
<tr>
<td>Decile 6</td>
<td>6-6.9 points</td>
</tr>
<tr>
<td>Decile 7</td>
<td>7-7.9 points</td>
</tr>
<tr>
<td>Decile 8</td>
<td>8-8.9 points</td>
</tr>
<tr>
<td>Decile 9</td>
<td>9-9.9 points</td>
</tr>
<tr>
<td>Decile 10</td>
<td>10 points</td>
</tr>
</tbody>
</table>

*For inverse measures, the order would be reversed. Where Decile 1 starts with the highest value and decile 10 has the lowest value.
<table>
<thead>
<tr>
<th>Title</th>
<th>File Size</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learn More About Improvement Activities and APMs</td>
<td>379KB</td>
<td>December 29th, 2016</td>
</tr>
<tr>
<td>APMs: Medicaid Models and All-Payer Models</td>
<td>388KB</td>
<td>December 29th, 2016</td>
</tr>
<tr>
<td><strong>FOR REGISTRIES, QUALIFIED CLINICAL DATA REGISTRIES (QCDRS) &amp; EHR VENDORS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality Measure Specifications</td>
<td>249.3MB</td>
<td>December 29th, 2016</td>
</tr>
<tr>
<td>Quality Measure Specifications Supporting Documents</td>
<td>8.3MB</td>
<td>February 13th, 2017</td>
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<tr>
<td><strong>2017 Quality Benchmarks</strong></td>
<td>193KB</td>
<td>December 29th, 2016</td>
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<tr>
<td>Quality Measure Encounter Codes</td>
<td>131KB</td>
<td>December 29th, 2016</td>
</tr>
<tr>
<td>Advancing Care Information Measure Specifications</td>
<td>3.9MB</td>
<td>December 29th, 2016</td>
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<tr>
<td>Advancing Care Information Measure Specifications Fact Sheet</td>
<td>148KB</td>
<td>December 29th, 2016</td>
</tr>
<tr>
<td>Advancing Care Information for Vendors</td>
<td>82KB</td>
<td>December 29th, 2016</td>
</tr>
</tbody>
</table>

https://qpp.cms.gov/resources/education
Costs

• CMS will calculate from claims episode-specific measures to account for differences among specialties.
  – For cost measures, clinicians that deliver more efficient care achieve better performance and score the highest points (the most efficient resource use).

“Episodes of care” roll up all costs of inpatient and outpatient care (including imaging, laboratory, drugs, rehabilitation, etc).
MIPS Performance Category:
Improvement Activities – 15% of Score

- 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:

|-----------------------------|-------------------------|---------------------|
Select Improvement Activities

Search All by keyword

Filter by:

Showing 92 Activities

- Additional improvements in access as a result of QIN/QIO TA
- Administration of the AHRQ Survey of Patient Safety Culture
- Annual registration in the Prescription Drug Monitoring Program
- Anticoagulant management improvements
- Care coordination agreements that promote improvements in patient tracking across settings

Selected Activities

0 Activities Added

Once you select measures they will appear here

https://qpp.cms.gov/measures/ia
MIPS Scoring for Improvement Activities
(15% of Final Score in Transition Year)

Total points = 40

- Activity Weights
  - Medium = 10 points
  - High = 20 points

- Alternate Activity Weights*
  - Medium = 20 points
  - High = 40 points

*For clinicians in small, rural, and underserved practices or with non-patient facing clinicians or groups

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

Advancing Care Information

- Clinicians must use certified EHR technology to report

For those using EHR Certified to the 2015 Edition:

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

For those using 2014 Certified EHR Technology:

- Option 1: 2017 Advancing Care Information Transition Objectives and Measures
- Option 2: Combination of the two measure sets
MIPS Scoring - Advancing Care Information
(25% of Final Score): Base Score

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

Failure to meet reporting requirements will result in base score of zero, and an advancing care information performance score of zero.
## MIPS Scoring - Advancing Care Information (25% of Final Score): Performance Score

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

<table>
<thead>
<tr>
<th>Advancing Care Information Transitional Measures</th>
<th>Measure</th>
<th>Performance Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Provide Patient Access</td>
<td>Up to 20%</td>
</tr>
<tr>
<td></td>
<td>Health Information Exchange</td>
<td>Up to 20%</td>
</tr>
<tr>
<td></td>
<td>View, Download, or Transmit</td>
<td>Up to 10%</td>
</tr>
<tr>
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<tr>
<td></td>
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<tr>
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<td>Medication Reconciliation</td>
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</tr>
<tr>
<td></td>
<td>Immunization Registry Reporting</td>
<td>0 or 10%</td>
</tr>
</tbody>
</table>
MIPS Scoring for 2017

- Sliding scale positive adjustment
- Sliding scale negative adjustment
- Top performance - Additional "Exceptional Performance" Incentive
  - 0.5% - 70 points
  - No more than 10% - 100 points
  (will be scaled based on the number of providers that score more than 70 points)
- Threshold* (No Payment Adjustment)
  - 4% in 2019

Maximum Penalty

- Threshold* (No Payment Adjustment)
  - Maximum Penalty
  - 4% in 2019
Payment incentives must be budget neutral for scores above and below the annual threshold.

However, Congress set aside $500 million (not budget neutral) to be distributed among the “exceptional performers”. It cannot exceed 10% (for a score of 100), but will be scaled based on the number of practices that achieve at least 70 points.

CMS will start applying the MIPS payment adjustments in 2019. They will be applied throughout the year to each claim that you submit.
Alternate Payment Models (APMs)

- “Substantial portion” of revenues* from “approved” alternate payment models
  - For now, very few “approved” APMs
  - Not subject to MIPS
- Receive 5% lump sum bonus payments for years 2019-2024
- Receive a higher fee schedule update from 2026 onward
Alternate Payment Models

• Advanced APMs defined as those that meet criteria for linking payments to quality measures, using EHRs, and nominal risk.

Only participants in Advanced APMs at MACRA thresholds qualify for 5% lump sum payments.

• Current models that meet Advanced APM criteria are Track 2 & 3 ACOs, Next Generation ACOs, Comprehensive Primary Care Plus (CPC+), some Comprehensive ESRD Care organizations (ESCOs).

– 6 (1%) MSSP ACOs are in Track 2 and 16 (4%) are in Track 3
– There are 13 ESCOs and 18 Next Gen ACOs
– CPC+ just announced three weeks ago

The practice must bear more than nominal financial risk!

✓ Base payment on quality measures comparable to those in MIPS
✓ Require use of certified EHR technology
✓ Either (1) bear more than nominal financial risk for monetary losses OR (2) be a medical home model expanded under CMMI authority

What is an eligible APM?
Qualifying Advanced APMs

What models are Advanced APMs?
In 2017, the following models are Advanced APMs:

- Comprehensive ESRD Care (CEC) - Two-Sided Risk
- Comprehensive Primary Care Plus (CPC+)
- Next Generation ACO Model
- Shared Savings Program - Track 2
- Shared Savings Program - Track 3
- Oncology Care Model (OCM) - Two-Sided Risk
- Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1- CEHRT)
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)
**Advanced APM – to avoid MIPS**

<table>
<thead>
<tr>
<th>Performance Year</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022 and later</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of Medicare Payments through an Advanced APM</td>
<td>25%</td>
<td>25%</td>
<td>50%</td>
<td>50%</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Percentage of Medicare Patients through an Advanced APM</td>
<td>20%</td>
<td>20%</td>
<td>35%</td>
<td>35%</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>
Quality Payment Program

FINAL RULE WITH COMMENT PERIOD FOR QUALITY PAYMENT PROGRAM YEAR 2 (2018)

https://qpp.cms.gov/
MIPS Year 2 (2018)
Who is Included?

No change in the types of clinicians eligible to participate in 2018

MIPS eligible clinicians include:

- Physicians
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
MIPS Year 2 (2018)
Who is Included?

Change to the Low-Volume Threshold for 2018. Include MIPS eligible clinicians billing more than $90,000 a year in Medicare Part B allowed charges AND providing care for more than 200 Medicare patients a year.

Transition Year 1 (2017) Final

BILLING =>$30,000 AND >100

Year 2 (2018) Final

BILLING =>$90,000 AND >200

Voluntary reporting remains an option for those clinicians who are exempt from MIPS.
MIPS Year 2 (2018)
Who is Exempt?

No Change in Basic Exemption Criteria*

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

- Below the low-volume threshold
  - Medicare Part B allowed charges less than or equal to $90,000 a year OR
  - See 200 or fewer Medicare Part B patients a year

- Significantly participating in Advanced APMs
  - Receive 25% of their Medicare payments OR
  - See 20% of their Medicare patients through an Advanced APM

*Only Change to Low-volume Threshold
### MIPS Year 2 (2018)
Performance Period

**Change:** Increase to Performance Period

#### Transition Year 1 (2017) Final

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Minimum Performance Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>90-days minimum; full year (12 months) was an option</td>
</tr>
<tr>
<td>Cost</td>
<td>Not included. 12-months for feedback only.</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>90-days</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>90-days</td>
</tr>
</tbody>
</table>

#### Year 2 (2018) Final

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Minimum Performance Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>12-months</td>
</tr>
<tr>
<td>Cost</td>
<td>12-months</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>90-days</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>90-days</td>
</tr>
</tbody>
</table>
MIPS Year 2 (2018)
Calculating the Final Score

Quality + Cost + Improvement Activities + Advancing Care Information = 100 Possible Final Points

50 + 10 + 15 + 25

Remember: All of the performance category points are added together to give you a MIPS Final Score.

The MIPS Final Score is compared to the MIPS performance threshold to determine if you receive a positive, negative, or neutral payment adjustment.
MIPS Year 2 (2018)
MIPS: Performance Threshold & Payment Adjustment

**Change:** Increase in Performance Threshold and Payment Adjustment

**Transition Year 1 (2017) Final**
- 3 point threshold
- Exceptional performer set at 70 points
- Payment adjustment set at +/- 4%

**Year 2 (2018) Final**
- 15 point threshold
- Exceptional performer set at 70 points
- Payment adjustment set at +/- 5%

**How can I achieve 15 points?**
- Report all required Improvement Activities.
- Meet the Advancing Care Information base score and submit 1 Quality measure that meets data completeness.
- Meet the Advancing Care Information base score, by reporting the 5 base measures, and submit one medium-weighted Improvement Activity.
- Submit 6 Quality measures that meet data completeness criteria.
Scoring for MIPS - 2018

- **Top performance - Additional “Bonus” Incentive**
  - Points: 100
  - Sliding scale positive adjustment (budget neutral)
  - Threshold* (No Payment Adjustment)
    - Points: 70
    - Sliding scale negative adjustment (budget neutral)
    - Maximum Penalty
      - 4% in 2017, 5% in 2018, 7% in 2019, and 9% in 2020 to 2023
Performance Threshold = 15

“Pit of Despair” Threshold = 15 * 25% = 3.75
Advanced APMs
Overview: All-Payer Combination Option

- The All-Payer Combination Option is, along with the Medicare Option, one of two pathways through which eligible clinicians can become a QP for a year.

- The All-Payer Combination Option is available beginning in the 2019 QP Performance Period.
Technical Assistance for Clinicians

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

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

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

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

**TECHNICAL SUPPORT**
All Eligible Clinicians Are Supported By:
- Quality Payment Program Website: qpp.cms.gov
  Serves as a starting point for information on the Quality Payment Program.
- Quality Payment Program Service Center
  Assists with all Quality Payment Program questions.
  1-866-288-8292 TTY: 1-877-715-6222 QPP@cms.hhs.gov
- Center for Medicare & Medicaid Innovation (CMMI) Learning Systems
  Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs. More information about the Learning Systems is available through your model's support inbox.

To learn more, view the Technical Assistance Resource Guide: https://qpp.cms.gov/resources/education
dale-bratzler@ouhsc.edu