An Overview of the Quality Payment Program: Year 2 (2018) & New Medicare Card Rollout

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Some slides are courtesy of CMS from various CMS webinars and presentations about the Quality Payment Program.

For the New Medicare Card Initiative, **all slides** are courtesy of Centers for Medicare & Medicaid Services (CMS) from CMS presentations or from CMS Website (with the exception of slides noted prepared by IHS).

Quality Payment Program Objectives

At the end of this session participants should be able to:

1. Identify the background, purpose and framework paths of the Quality Payment Program (QPP): Medicare Access and CHIP Reauthorization Act (MACRA) of 2015.
2. Discuss payment adjustments and bonuses related to Merit Based Incentive Payment Systems (MIPS) and Advanced Alternative Payment Models (APMs).
3. Discuss **Final Rule with comments Year 2 (Performance Year 2018).**
4. Identify steps to prepare for the QPP within the IHS.

New Medicare Rollout Objectives

At the end of this session participants should be able to:

1. Identify why CMS is replacing the old Medicare Card's
2. Identify the difference between the Health Insurance Claim Number (HICN) and Medicare Beneficiary Identifier (MBI) number
3. Discuss CMS's Mailing Strategy for the New Medicare Cards
4. Discuss Resource and Patient Management System (RPMS) changes
5. Participate in Questions and Answers

Slide prepared by IHS

Quality Payment Program Overview

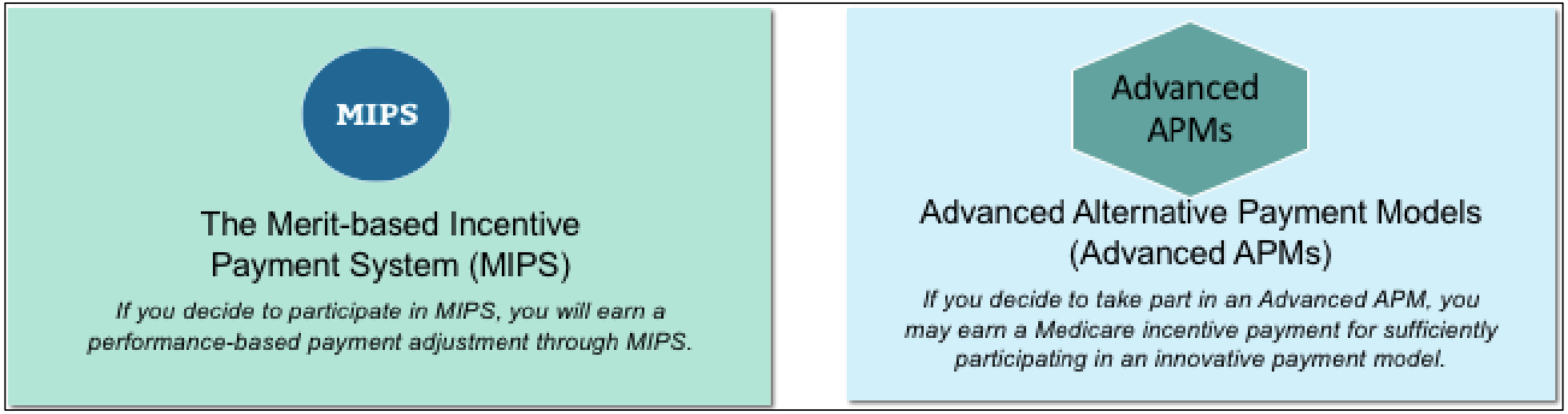
Origin of the Quality Payment Program (QPP)

- Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
- Bipartisan Legislation
- **Repeals** the Sustainable Growth Rate (SGR) Formula
- Increases focus on quality of care and value of care delivered
- Moving toward patient-centric healthcare system
  - Delivers better care
  - Smarter spending
  - Healthier People
- **Offers two tracks of participation**

Quality Payment Program: Two Participation Tracks

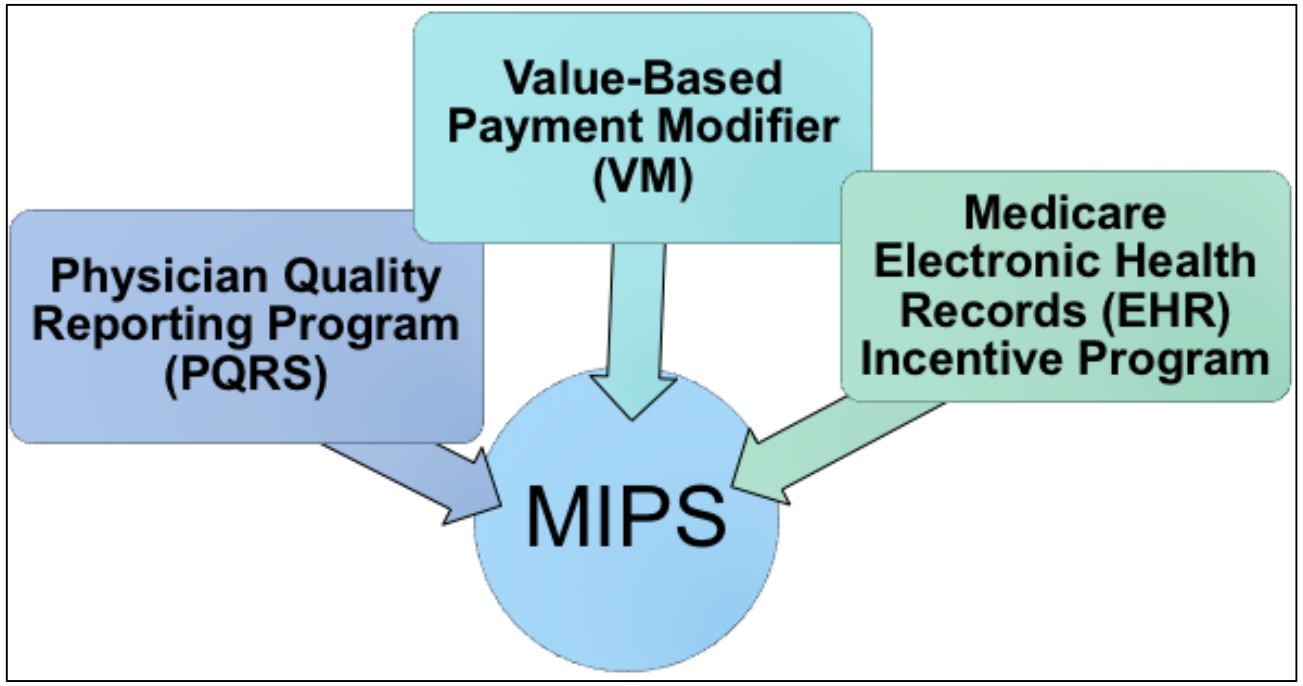
Healthcare providers can take part in CMS's quality programs in one of two ways:

1. Merit-Based Incentive Payment System (MIPS)
2. Advanced Alternative Payment Models (**Advanced** APMs)

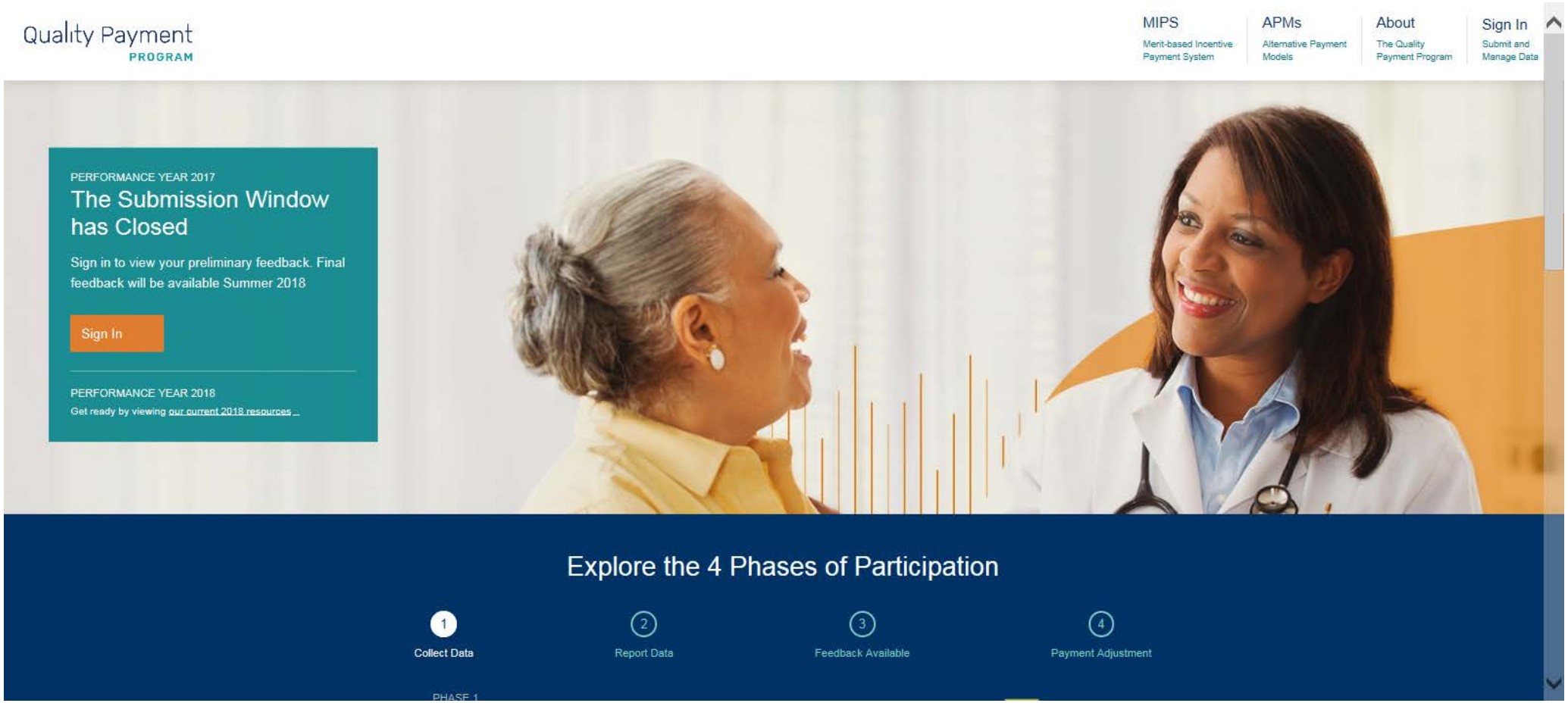


What Is MIPS?

- Currently there are **multiple quality and value reporting programs** for Medicare clinicians.
- **The Quality Payment Program/MACRA** streamlines (combines) legacy programs into a single, improved reporting program: **MIPS**



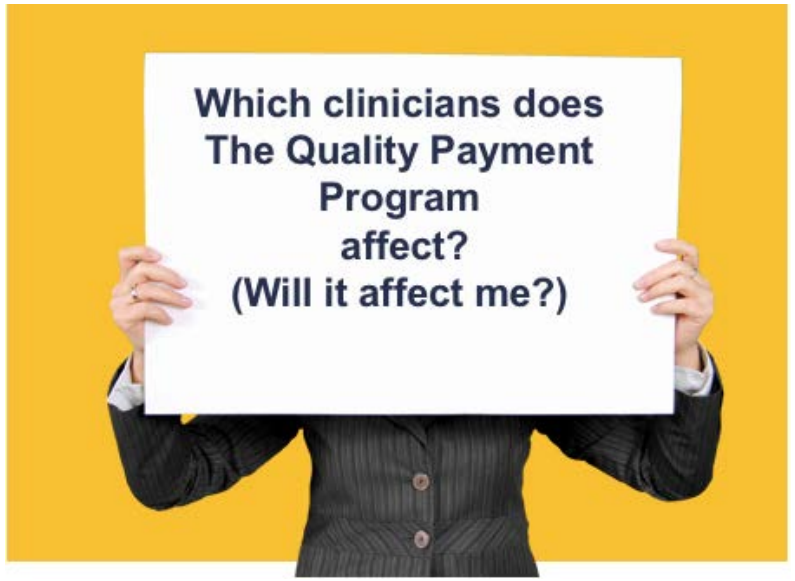
QPP Landing Page



Clinician Impact

Which clinicians does The Quality Payment Program affect? Will it affect me?

- **Short answer:** Quality Payment Program affects clinicians who participate in Medicare Part B.



MIPS Quality Payment Program Eligibility

No change in the types of clinicians eligible to participate in 2018.
For 2017 and 2018, the types of clinicians are as follows:

- Physicians
  - Doctors of Medicine
  - Doctors of Osteopathy
- Dentists
- Optometrists
- Chiropractors
- Podiatrists
- Physician assistants
- Nurse practitioners
- Clinical nurse specialists
- Certified registered nurse anesthetists

Who Is Included in MIPS? (2017 and 2018)

Change to the Low-Volume Threshold for 2018.

- **Includes** 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.
- Voluntary reporting remains an option for those clinicians who are exempt from MIPS.

What Is MIPS (2017)?

MIPS participants receive a payment adjustment based on performance in four categories.

Quality	Cost	Improvement Activity	Advancing Care Information
Replaces PQRS	Replaces Value-Based Modifier	New performance category	Replaces the EHR Incentive Program
Assesses the value of care to ensure patients get the right care at the right time.		Supports: Care coordination, Beneficiary engagement, Population management, Patient safety	Supports the secure exchange of health information and the use of certified EHR technology
60% of MIPS Score	0% of MIPS Score	15% of MIPS Score	25% of MIPS Score

MIPS Performance Categories Transition Year (2017)

Physicians and practitioners scoring under MIPS:

- A single MIPS composite performance score will factor in performance for weighted performance categories from 0–100: Quality, Cost*, Improvement Activities, and Advancing Care Information.

  * Cost = 0% weight in the first year

MIPS Performance Categories for Year 2 (2018)

Comprised of **four** performance categories in 2018.

On April 24, 2018, CMS renamed MIPS Advancing Care Information performance category to **the Promoting Interoperability** performance category.

So what? The points from each performance category are added together to give you a MIPS Final Score. Performance threshold set at 15 points.

The MIPS Final Score is compared to the MIPS performance threshold to determine if one receive a **positive**, **negative**, or **neutral payment adjustment**.

Who Is Exempt? MIPS Year 2 (2018)

- No change in Basic-Exemption Criteria—only change to low-volume threshold
- 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 Medicare patients through an Advanced APM

What Is a Virtual Group?

Year 2 (2018): Added **Virtual Groups** as a way to participate

- Solo practitioners and groups of 10 or fewer eligible clinicians who come together virtually (no matter what specialty or location) to participate in MIPS for a performance period of a year.
- Solo practitioners and small groups may only participate in a Virtual Group if they exceed the low-volume threshold.
- Are not a newly Medicare-enrolled eligible clinician, a Qualifying APM Participant (QP), or a Partial QP choosing not to participate in MIPS.
- Election period was **December 31, 2017** for the 2018 MIPS performance period.
- To learn more, see the 2018 Virtual Groups Toolkit available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/2018-Virtual-Groups-Toolkit.zip.

Reporting Options MIPS Year 2 (2018)

OPTIONS

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

2. As a Group

a) Two or more clinicians identified by their National Provider Identifier (NPIs) who have reassigned their billing rights to a single Tax Identification Number (TIN)*.

b) As an APM Entity

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

* If clinicians participate as a group, they are assessed as a group across all 4 MIPS performance categories. The same is true for clinicians participating as a Virtual Group.

MIPS Year 2 (2018) Performance Period

Change: Increase to Performance Period

Transition Year 1 (2017) Final

Performance Category	Minimum Performance Period
Quality	90-days minimum; full year (12 months) was an option
Cost	Not included. 12 months for feedback only.
Improvement Activities	90 days
Advancing Care Information	90 days

Year 2 (2018) Final

Performance Category	Minimum Performance Period
Quality	**12 months**
Cost	**12 months**
~~Improvement Activities~~ **Promoting Interoperability**	90 days
Advancing Care Information	90 days

Submission Methods

No change: All of the submission mechanisms remain the same from Year 1 to Year 2.

Performance Category	Submission Mechanisms for Individuals	Submission Mechanisms for Groups (Including Virtual Groups
Quality	QCDR Qualified Registry EHR Claims	QCDR Qualified Registry EHR CMS Web Interface (groups of 25 or more)
Cost	Administrative claims (no submission required)	Administrative claims (no submission required)
Improvement Activities	Attestation QCDR Qualified Registry EHR	Attestation QCDR Qualified Registry EHR CMS Web Interface (groups of 25 or more)
~~Advancing Care Information~~ **Promoting Interoperability**	Attestation QCDR Qualified Registry EHR	Attestation QCDR Qualified Registry EHR CMS Web Interface (groups of 25 or more

MIPS: CMS Web Interface

- MIPS participation via CMS Web Interface is only available to groups with 25 or more eligible clinicians.
- Registration period is open between April 1, 2018 through June 30, 2018.
- If your group registered for the CMS Web Interface in 2017 to report for MIPS, CMS automatically registered your group to use the CMS Web Interface in 2018 for MIPS.
- If your group would like to participate through another data submission option, you should “cancel” your election in the registration system between April 1, 2018 - June 30, 2018.
- Groups planning to participate in MIPS via two options noted require registration
  1. CMS Web Interface or Consumer Assessment of Healthcare Providers and
  2. Systems (CAHPS) for MIPS survey

Source: https://qpp.cms.gov/mips/individual-or-group-participation/about-group-registration

Incentives for Advanced APM Participation

What Is an Alternative Payment Model (APM)?

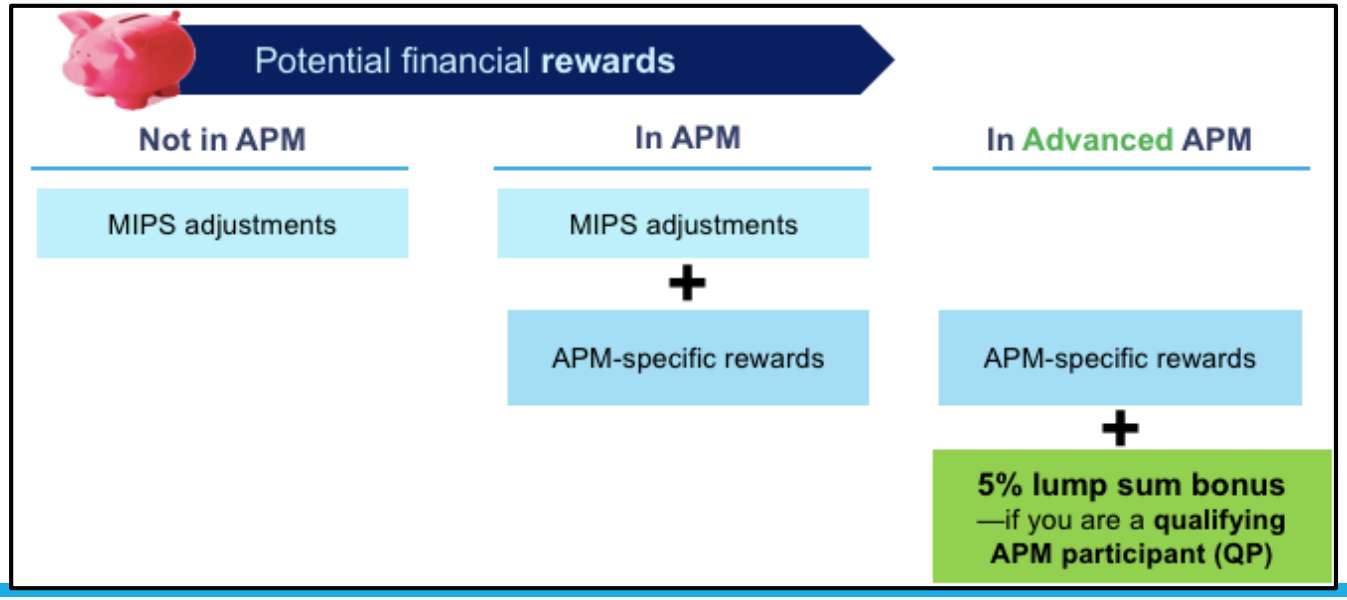
APMs are **new approaches to paying** for medical care through Medicare that **incentivize quality and value.**

- As defined by MACRA, APMs include:
  - **CMS Innovation Center Model** (under section 1115A, other than a Health Care Innovation Award)
  - **MSSP** (Medicare Shared Savings Program)
  - **Demonstration** under the Health Care Quality Demonstration Program
  - **Demonstration** required by federal law
- MACRA **does not change any particular APM rewards value**.
- APM participants who are not Qualifying **APM** Participants (**QPs**) will receive **favorable scoring under MIPS**.
- Only **some** of these APMs will be **Advanced** APMs.

Rewards for APM Participants

QPP provides **additional** rewards for participating in **APMs**.

- Potential financial rewards:
  - **Not in APM:** MIPS Adjustments
  - **In APM:** MIPS Adjustments **plus** APM-specific rewards
  - **In Advanced APM:** APM-specific rewards **plus** 5% lump-sum bonus*
    *If you are a **qualifying APM participant (QP)**



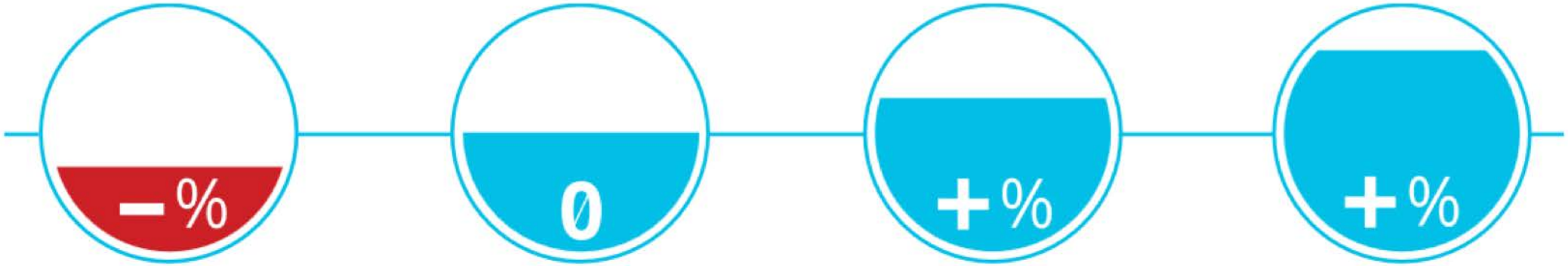
Putting It All Together

MIPS Pick Your Pace: CY 2017

This was ONLY for CY 2017

- Don’t Participate
- Submit Something
- Submit a Partial Year
- Submit a Full Year

Positive adjustments are based on performance data from the performance information submitted **— Not the amount of information or the length of times submitted**.



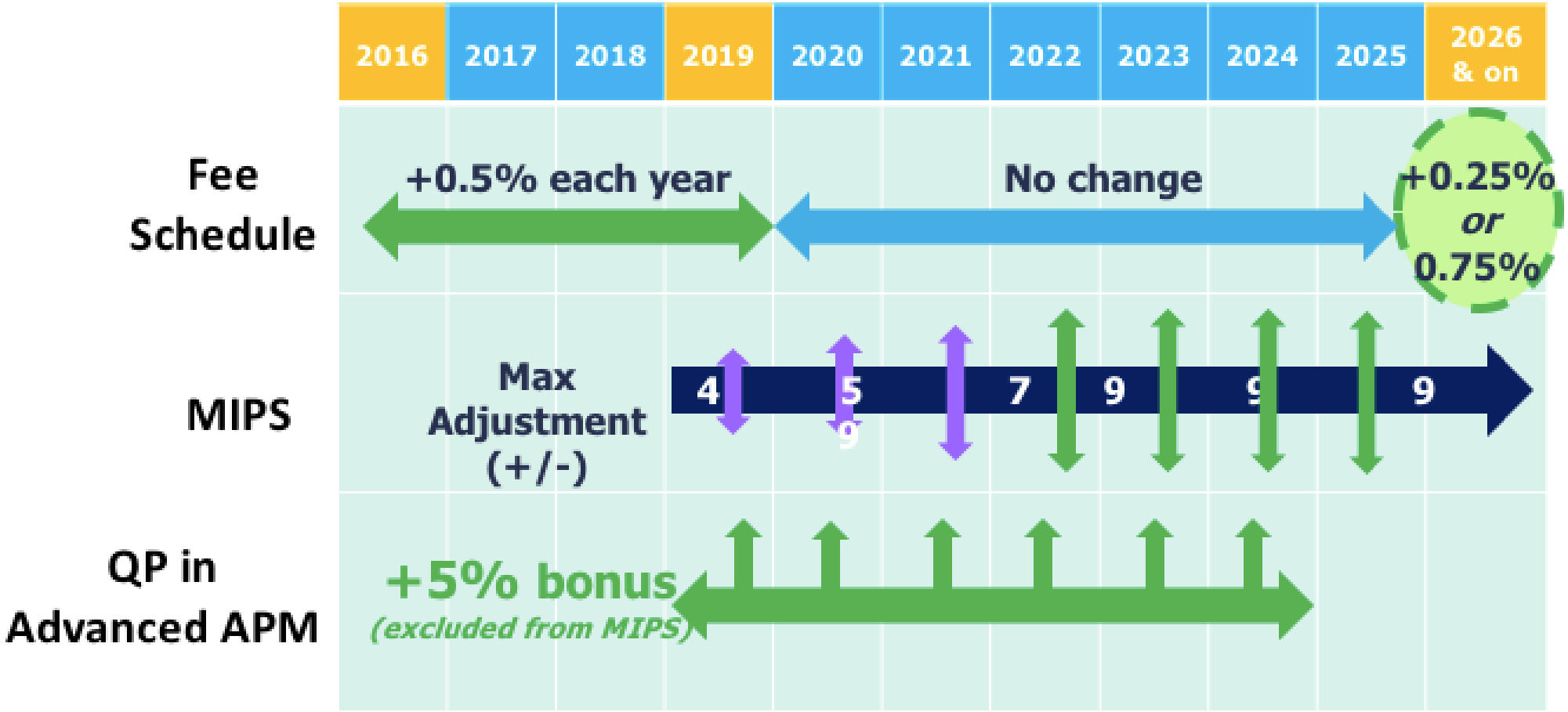
Quality Payment Program: CY 2018

MIPS Performance Year begins on January 1st and ends on December 31st each year

- CY 2017 Pick Your Pace:
  - Ready could begin January 1, 2017
  - Not Quite Ready: Start anytime between January 1, 2017 – October 2, 2017.
  - Send in Performance Data by March 31, 2018

- CY 2018
  - Increased Performance Period Reporting
  - Send in Performance Data by March 31, 2019

Putting It All Together

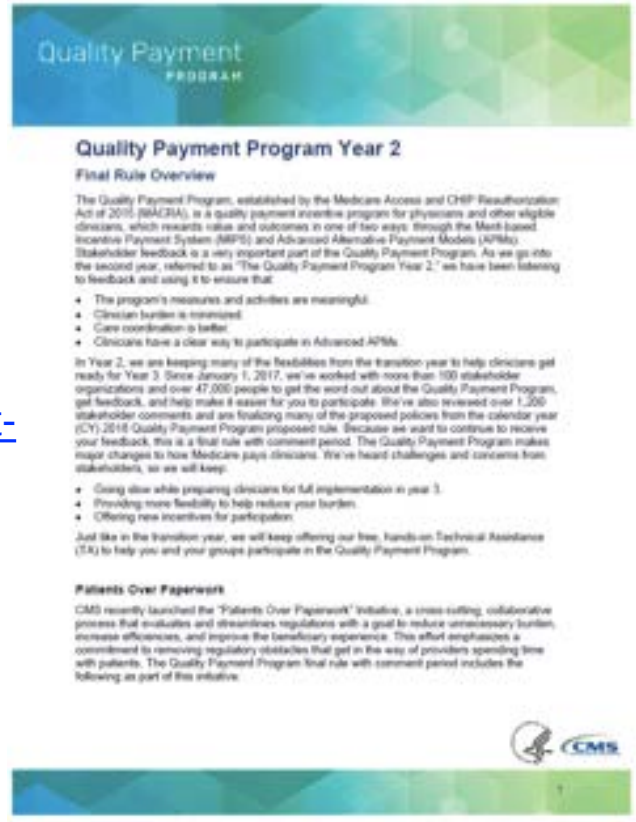


Additional Information:
Quality Payment Program Year 2 (2018)

Final Rule for QPP Year 2 (2018)

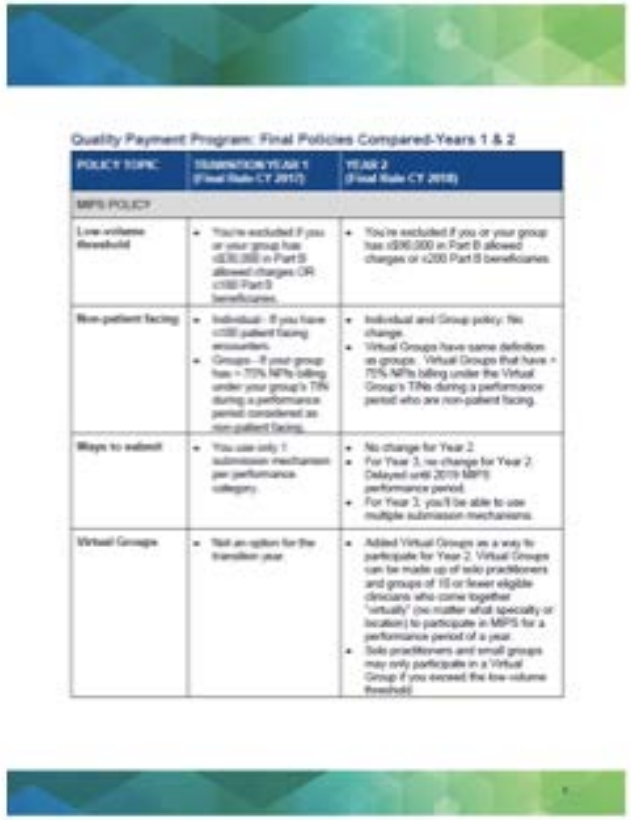
CMS Final Rule for QPP Year 2 (2018) Fact Sheet

- 26 pages
- Provides comparison summary
- Example of changes provided such as adding virtual groups for 2018.
- https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/QPP-Year-2-Final-Rule-Fact-Sheet.pdf


Quality Payment
PROGRAM

Quality Payment Program Year 2

Final Rule Overview


Quality Payment Program: Final Policies Compared-Years 1 & 2

Comparison – Quality

Topic	Transition Year 1 (2017) Final	Year 2 (2018) Final
Weight to Final Score	• 60% in 2019 payment year. • 50% in 2020 payment year. • 30% in 2021 payment year and beyond.	• 50% in 2020 payment year. • 30% in 2021 payment year and beyond—SAME
Data Completeness	Measures that do not meet the data completeness criteria receive three points.	Measures that do not meet data completeness criteria will earn one point instead of three points, except measures submitted by small practices will continue to earn three points.
Scoring	1. Three-point floor for measures scored against a benchmark. 2. Three points for measures that don't have a benchmark or don't meet case minimum requirements. 3. Bonus for additional high priority measures up to 10%. 4. Bonus for end-to-end electronic reporting up to 10% of denominator for performance category.	No change

Comparison – ACI/ Promoting Interoperability

Topic	Transition Year 1 (2017) Final	Year 2 (2018) Final
CEHRT	2014 or 2015 CEHRT Edition for the 2017 transition year and require use of 2015 CEHRT edition for 2018.	Use either the 2014 or 2015 Edition CEHRT in 2018.
Weight to Final Score	25%, made up of a base score, performance score, and bonus points for data submission on certain measures and activities.	No change for the 2020 payment year.
Bonus	• Bonus (5%) for reporting to one or more additional public health and clinical data registries. • Bonus (10%) for completion of at least one of the specified Improvement Activities using CEHRT.	• A 5% bonus score is available for submitting to an additional public health agency or clinical data registry not reported under the performance score. • Additional Improvement Activities are eligible for a 10% Advancing Care Information bonus if CEHRT used to complete at least one of the specified Improvement Activities. • A 10% bonus score for using 2015 Edition exclusively.

Comparison –
ACI/ Promoting Interoperability(continued)

Topic	Transition Year 1 (2017) Final	Year 2 (2018) Final
Reweighting/ Hardship Exceptions	Allowed reweighting of the Advancing Care Information category to zero (0), if there are insufficient measures applicable and available to MIPS eligible clinicians.	Based on authority from the 21st Century Cures Act, CMS will reweight the Advancing Care Information performance category to 0% of the final score and reallocate the performance category weight of 25% to the Quality performance category for: • A significant hardship exception • A new significant hardship exception for MIPS-eligible clinicians in small practices (15 or fewer clinicians); • An exception for hospital-based MIPS-eligible clinicians; • A new exception for MIPS-eligible clinicians whose EHR was decertified. New deadline of December 31 of the performance period for the submission of reweighting applications, beginning with the 2017 performance period.

Comparison – Improvement Activity

Topic	Transition Year 1 (2017) Final	Year 2 (2018) Final
Weight to Final Score	15% and measured based on a selection of different medium and high-weighted activities.	No change for the 2020 payment year.
Number of Activities	• 92 activities were included in the Inventory. • No more than two activities (two medium or one high-weighted activity) are needed to receive the full score for small practices, practices in rural areas, geographic HPSAs, and non-patient facing MIPS eligible clinicians. • No more than four activities (four medium or two high-weighted activities, or a combination) for all other MIPS eligible clinicians. • Total of 40 points.	• No change in number of activities to report to reach a total of 40 points. • Finalized more activities and changes to existing activities; for a total of approximately 112 activities in the inventory. • Requirements for small practices, practices in rural areas, geographic HPSAs, and non-patient facing MIPS eligible clinicians: no change

Comparison – Cost

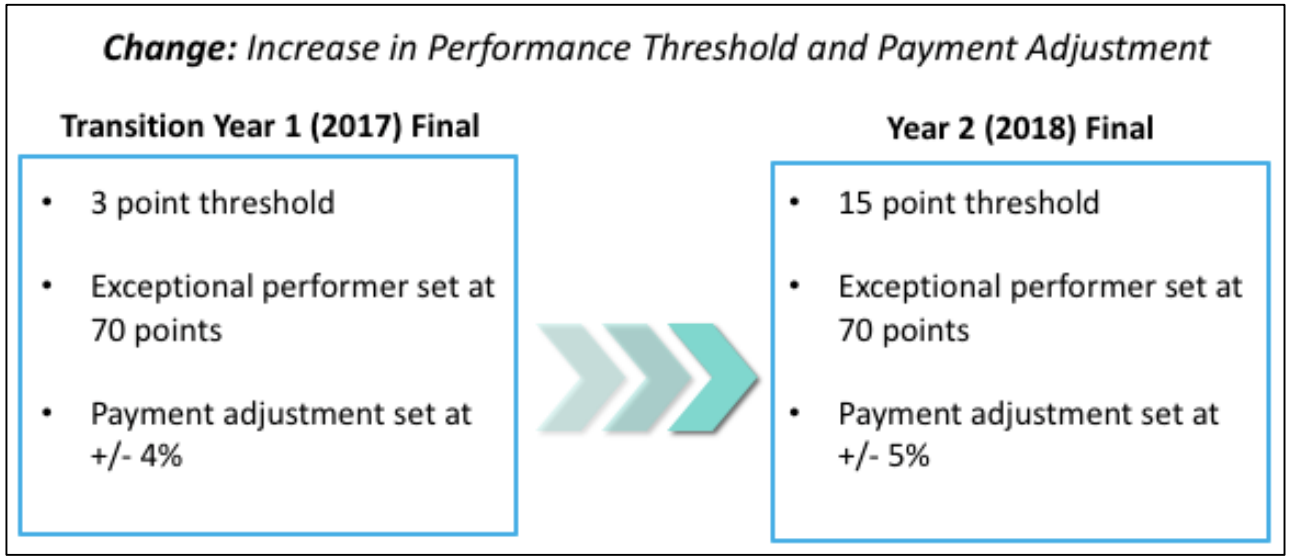
Topic	Transition Year 1 (2017) Final	Year 2 (2018) Final
Weight to final score	• 0% in 2019 payment year. • 10% in 2020 payment year. • 30% in 2021 payment year and beyond.	• 10% in 2020 MIPS payment year, but are soliciting feedback on keeping the weight at 10%. • 30% in 2021 MIPS payment year and beyond.
Measures	• Will include the Medicare Spending per Beneficiary (MSPB) and total per capita cost measures. • 10 episode-based cost measures. • Measures do not contribute to the score, feedback is provided for these measures.	• Include Medicare Spending per Beneficiary (MSPB) and total per capita cost measures in calculating Cost performance category score for the 2018 MIPS performance period. • For the 2018 MIPS performance period, CMS won't use the 10 episode-based measures adopted for the 2017 MIPS performance period. • CMS developing new episode-based measures with stakeholder input and soliciting feedback on some of these measures - Fall 2018. • Expect proposed new cost measures in the future.

Cost Performance Category

Transition year (2017)	**Year 2 (2018)**
CMS used a 0% weight for the Cost performance category when they calculated groups or EC MIPS final score for the transition year (2017 MIPS performance period). The cost category was given a 0% weight in the 2017 calculations to give everyone the chance to understand the attribution and scoring methods.	CMS finalized a weight of 10% for the 2018 MIPS performance period to help groups or EC get ready for a higher weighting in the future. The 10% cost weight will help participants: • Have an easier transition to the 30% cost weight MACRA requires starting with the 2019 MIPS performance period. • Urge everyone to review and understand their performance on cost measures.

Resource: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Cost-Performance-Category-Fact-Sheet.pdf

MIPS Year 2 (2018) MIPS:
Performance Threshold and Payment Adjustment



How can I achieve 15 points?

- Report all required Improvement Activities.
- Meet the Advancing Care Information base score and submit one Quality measure that meets data completeness.
- Meet the Advancing Care Information base score, by reporting the five base measures, and submit one medium-weighted Improvement Activity.
- Submit six Quality measures that meet data completeness criteria.

MIPS Year 2 (2018)
Extreme and Uncontrollable Circumstances

- CMS knows that areas affected by the recent hurricanes, specifically Hurricanes Harvey, Irma, and Maria, have experienced devastating disruptions in infrastructure and clinicians face challenges in submitting data under the Quality Payment Program.
- CMS has issued an **Interim Final Rule** with an automatic extreme and uncontrollable circumstances policy where clinicians are exempt from the Quality, Improvement Activities, and Advancing Care Information performance categories ***without*** submitting a hardship exception application.

What does the Interim Final Rule mean for me in the Transition Year (2017)?

- CMS will automatically reweight the Quality, Improvement Activities, and Advancing Care Information performance categories.
- This will result in the clinician receiving a MIPS Final Score equal to the performance threshold, unless the MIPS-eligible clinician submits data.
- Clinicians who do submit data (as an individual or group) will be scored on their submitted data.
- This policy does not apply to APMs.

MIPS Year 2 (2018)
Extreme and Uncontrollable Circumstances (2)

Extreme and Uncontrollable Circumstances in Year 2 (2018):

- The Final Rule with Comment Period for Year 2 **extends** the Transition Year hardship exception reweighting policy for the Advancing Care Information performance category to now include Quality, Cost, and Improvement Activities.
- This policy applies to all of the 2018 MIPS performance categories.
- **A hardship exception application is required**.
- The hardship exception application **deadline** is **December 31, 2018**.

Steps to Prepare for the Quality Payment Program

Getting Ready to Participate in MIPS 2018

- Determine participants' eligibility status
  - New eligibility criteria
  - Use CMS website to confirm eligibility on
- Choose if participants are reporting as an individual or a group (Virtual Group)
- Choose participants' submission mechanism and verify its capabilities
  - Decide if working with a third party intermediary (e.g. Qualified Registries)
  - Attestation – CMS's Data Submission Tool

Getting Ready to Participate in MIPS 2018 (2)

- Choose measure(s) and activities
  - Use CMS resources (website) to explore options on which measures to use
- Follow reporting requirements (2018)
  - Follow reporting durations for performance categories (e.g., 12 months for Quality and Cost Performance Period)
  - Verify the information needed to report successfully
- Record data based on participants' care for patients
- Submit data

QPP/MACRA – Next Steps for IHS

Operationalize the Quality Payment Program

- IHS's Quality Payment Program – MACRA National Working Group
- Encourage using resources – IHS Website and LISTSERV
- Provide Community Outreach – training and education
  - Webinar
  - Utilize CMS resources for technical assistance
  - Address care coordination

Future Plans for RPMS

- Perform Market Research
  - Explore what products can interface with EHR to submit CQMs
- Update Clinical Quality Measures (CQM) Logic
  - Workgroup completed initial review (high level analysis)

Claims Based Information

How You Can Help (CY 2018)

How can Patient Registration and Benefits Coordination assist with QPP?

- Capture Data and Billing in a timely manner will also determine whether a group or individual provider can be exempt from reporting (less than $90,000 billed approved charges OR less than 200 Medicare Part B patients seen).
- There is a “Cost” component to the calculation that have a positive/negative impact.
- Capture if beneficiary has new Medicare card number (Medicare Beneficiary Identifier).

Additional Resource Information

Steps to Prepare for the Quality Payment Program

Utilize Quality Payment Program Resources:

- Centers for Medicare & Medicaid Services (CMS): https://qpp.cms.gov
  - Help and Support: https://qpp.cms.gov/about/help-and-support
  - QPP Resource Library: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Resource-library.html
- IHS Resources: https://www.ihs.gov/qpp/

Technical Assistance Support

Technical Assistance Resource Guide

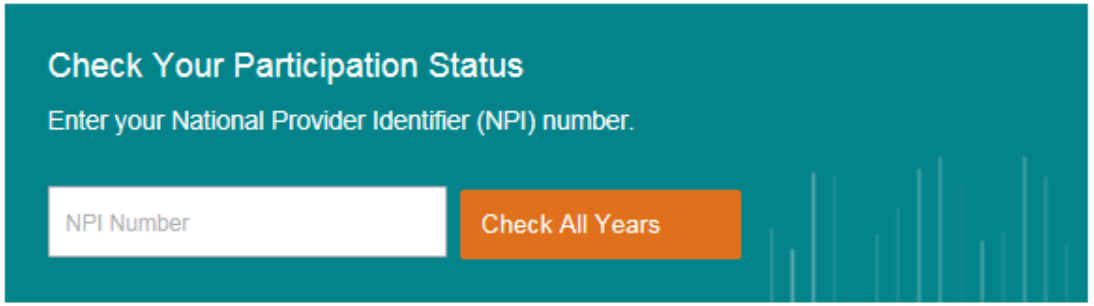
- Small, Underserved, & Rural Support (SURS)
  - Small practices of 15 or fewer clinicians
  - Practices in rural locations, health professional shortages areas (HPSAs), and medically underserved areas (MUAs)
- Quality Innovation Networks – Quality Improvement Organizations (QIN-QIOs)
  - Large practice of more than 15 clinicians
- Transforming Clinical Practice Initiative (TCPI)

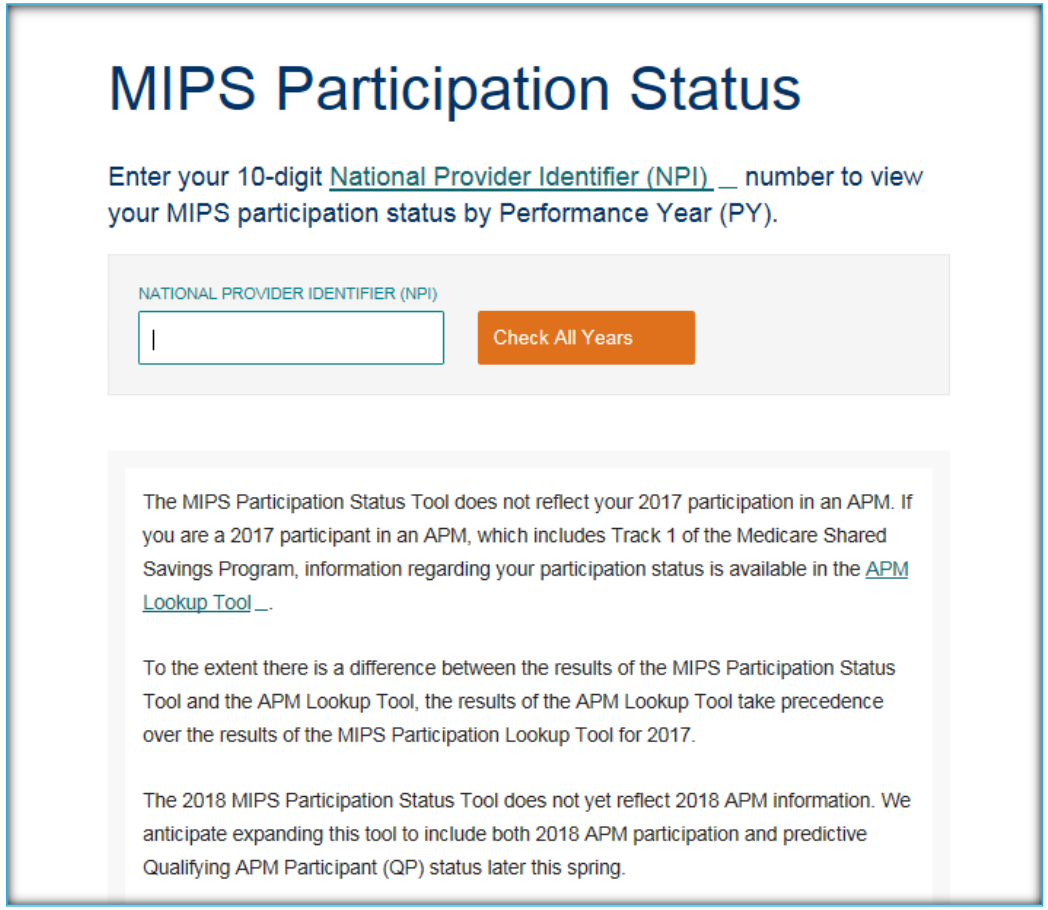
Source:
https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Technical-Assistance-Resource-Guide.pdf

Map of organizations providing small, underserved, and rural support

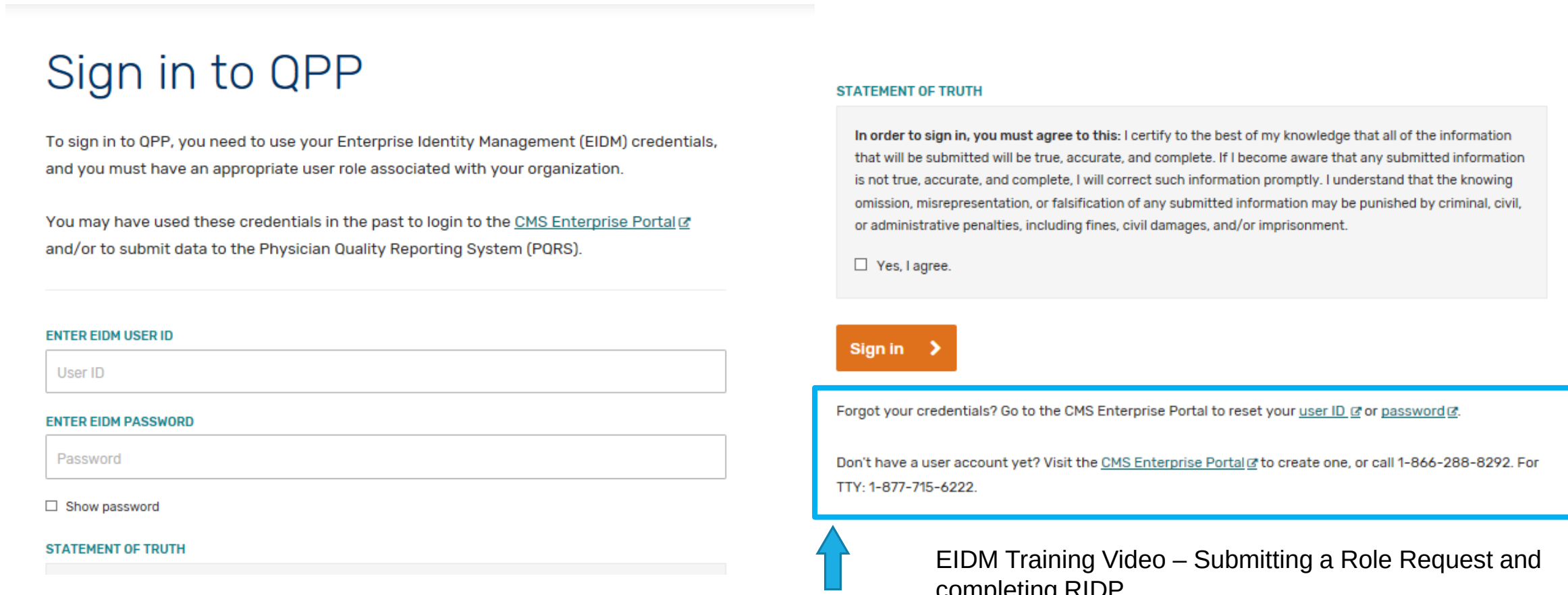
Eligibility:
Check MIPS Participation Status

- CMS website
- CMS MIPS Participation Status
  - Sources:
    https://qpp.cms.gov/
    https://qpp.cms.gov/participation-lookup





Sign into QPP with Enterprise Identity Management (EIDM) Credentials



EIDM User Account Help

EIDM Training Video – Submitting a Role Request and completing RIDP
https://www.youtube.com/watch?v=OmL4JOOQ7Rc

IHS QPP – MACRA Resources

- IHS Website: https://www.ihs.gov/qpp/
- LISTSERV Email: MACRA@listserv.ihs.gov
- Subscribe URL: https://www.ihs.gov/listserv/topics/signup/?list_id=357

The New Medicare Card Initiative Rollout

Presented by Susy Postal DNP, RN-BC , Chief Health Informatics Officer

Presentation developed with Marni Land, CMS Federal Partners Liaison

Background

- The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015
  - The legislation mandates the removal of Social Security Numbers (SSN) from all Medicare cards.
- New Medicare Card Initiative
  - A fraud prevention initiative to combat identity theft and illegal use of Medicare benefits.
  - A new Medicare Beneficiary Identifier (MBI) will replace the SSN-based Health Insurance Claim Number (HICN) on the new Medicare cards.
  - The MBI to replace HICN for Medicare transactions such as billing, processing claims and determining eligibility for services across multiple entities (Example include: Social Security Administration (SSA), Railroad Retirement Board (RRB), States, Medicare providers, and health plans).
  - CMS to mail out new Medicare cards with a new MBI by April 2019 (legislative mandate).
  - People with Medicare may start using their new Medicare cards as soon as they get them.

Slide prepared by IHS

Operations: Three Steps to the New MBI

1. **Generate MBI for all beneficiaries:** Includes existing (currently active, deceased, or archived) and people new to Medicare
2. **Issue new, redesigned Medicare cards:** New cards containing the new MBI to existing and new people with Medicare
3. **Modify systems and business processes**: Required updates to accommodate receipt, transmission, display, and processing of the new MBI

Comparison of Different Identifiers

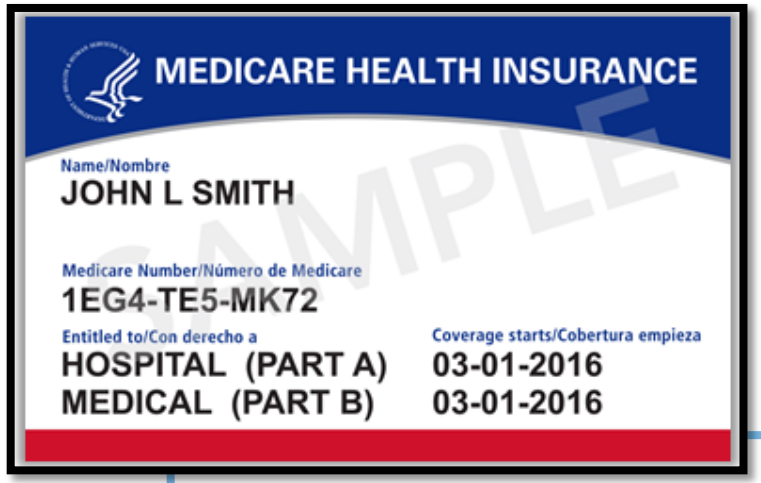
NOTE: Identifiers are Fictitious

KEY	Example
SSN	123-75-9812
CAN	123-75-9812-A
HICN	123-75-9812-A
RRB Post April 1964	A-123-75-9812 (prior years it is A-000000 – not based on SSN)
New MBI	1EG4-TE5-MK73

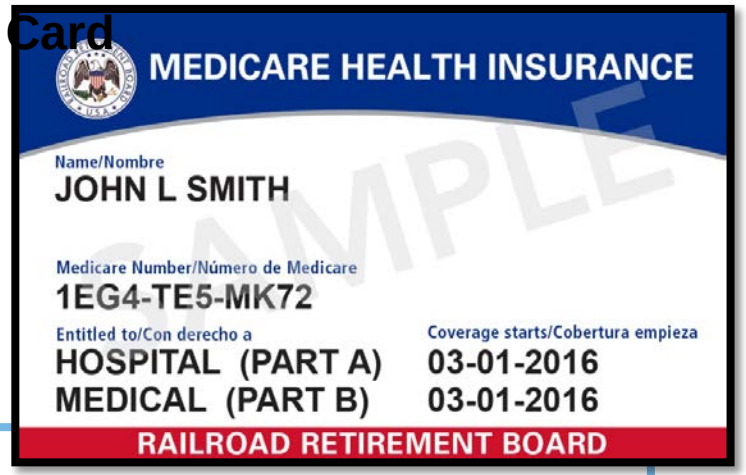
NOTE: Dashes are for display purposes only. They will not be stored in the database nor used in file formats.

Example of New Card: New Unique Medicare Number

New CMS Medicare Card



New Railroad Retirement Board Card



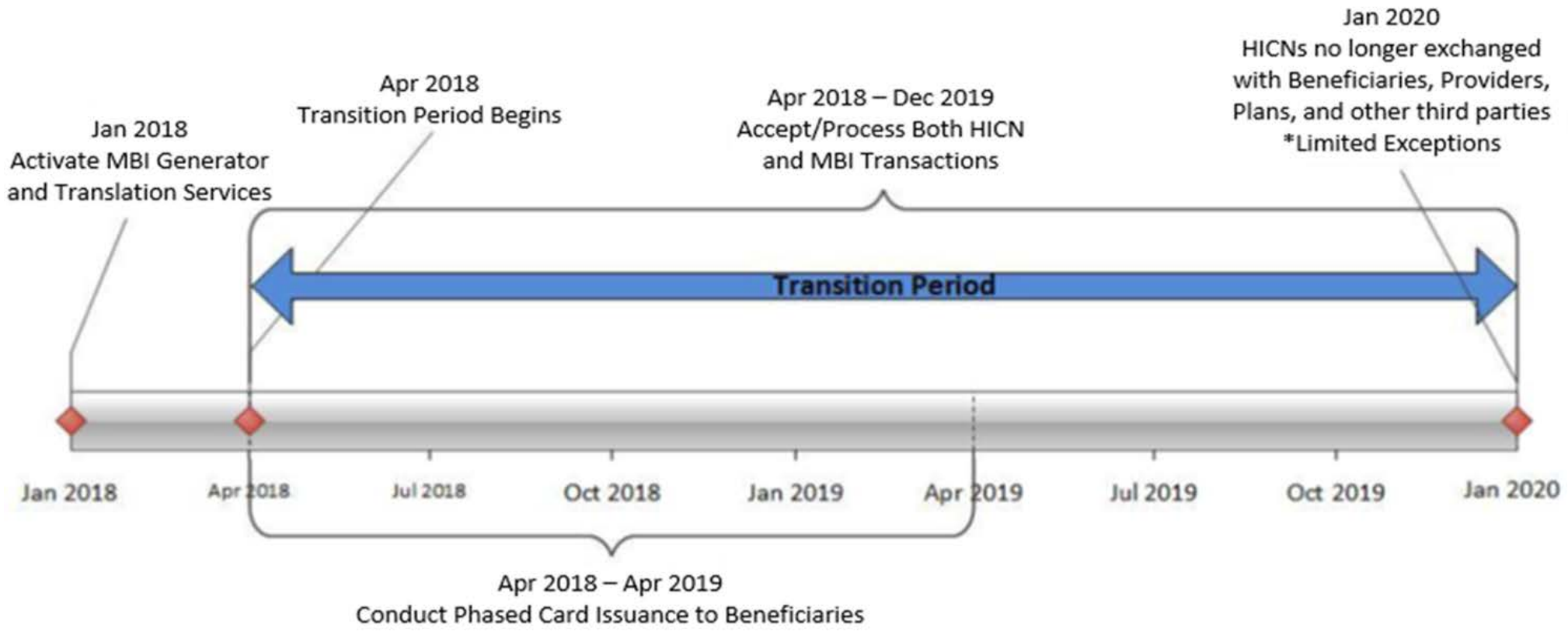
Key Characteristics

- The same number of characters as the current HICN (11), but will be visibly distinguishable from the HICN
- Contain uppercase alphabetic and numeric characters throughout the 11-digit identifier
- Occupy the same field as the HICN on transactions
- Be unique to each beneficiary (e.g., husband and wife will have their own MBI)
- Be easy to read and limit the possibility of letters being interpreted as numbers (e.g., alphabetic characters are upper case only and will exclude S, L, O, I, B, Z)
- Not contain any embedded intelligence or special characters
- The gender and signature line are removed from the new Medicare cards

Using the New Medicare Number: During Transition

- The transition period will run from April 2018 through December 31, 2019
- CMS will complete its system and process updates to be ready to accept and return the MBI on April 1, 2018
- All stakeholders who submit or receive transactions containing the HICN must modify their processes and systems to be ready to submit or exchange the MBI by April 1, 2018. Stakeholders may submit either the MBI or HICN during the transition period
- CMS will accept, use for processing, and return to stakeholders **either** the MBI **or** HICN, whichever is submitted on the claim, during the transition period
- CMS will actively monitor use of HICNs and MBIs during the transition period to ensure that everyone is ready to use only MBIs by January 1, 2020

CMS Operations: Transition Period



New Medicare Number Exceptions After the Transition Period

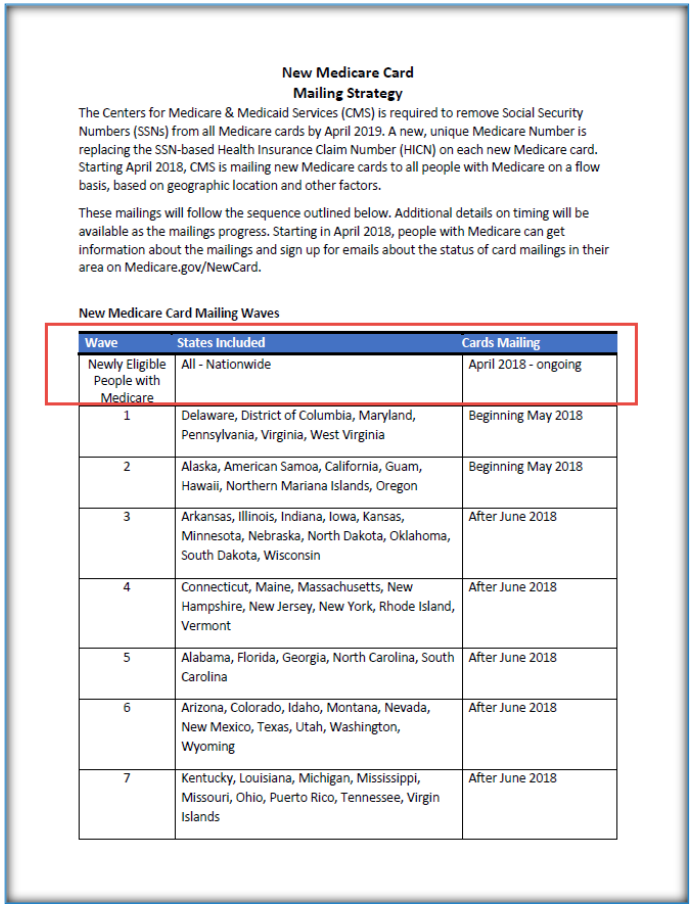
Beneficiaries, providers, and plans will no longer use the HICN for internal and most external purposes.

However, once the transition period is over, you'll still be able to use the HICN in these situations:

- **Medicare plan exceptions:**
- **Appeals –** You can use either the HICN or the MBI for claims appeals and related forms
- **Adjustments** – You can use the HICN indefinitely for some systems (Drug Data Processing, Risk Adjustment Processing, and Encounter Data) and for all records, not just adjustments
- **Reports** – CMS will use the HICN on these reports until further notice:
  - Incoming to CMS (quality reporting, Disproportionate Share Hospital data requests, etc.)
  - Outgoing from us (Provider Statistical & Reimbursement Report, Accountable Care Organization reports, etc.)

New MBI, New Card Issuance & Mailing

- CMS will begin mailing new cards in April 2018 and will meet the congressional deadline for replacing all Medicare cards by April 2019.
- The gender and signature line will be removed from the new Medicare cards.
- The Railroad Retirement Board will issue their new cards to RRB beneficiaries.
- CMS will work with states that currently include the HICN on Medicaid cards to remove the Medicare ID or replace it with a new MBI.
- CMS will conduct intensive education and outreach to all people with Medicare, their families, caregivers, and advocates to help prepare for this change.



New Medicare Card
Mailing Strategy

The Centers for Medicare & Medicaid Services (CMS) is required to remove Social Security Numbers (SSNs) from all Medicare cards by April 2019. A new, unique Medicare Number is replacing the SSN-based Health Insurance Claim Number (HICN) on each new Medicare card. Starting April 2018, CMS is mailing new Medicare cards to all people with Medicare on a flow basis, based on geographic location and other factors.

These mailings will follow the sequence outlined below. Additional details on timing will be available as the mailings progress. Starting in April 2018, people with Medicare can get information about the mailings and sign up for emails about the status of card mailings in their area on Medicare.gov/NewCard.

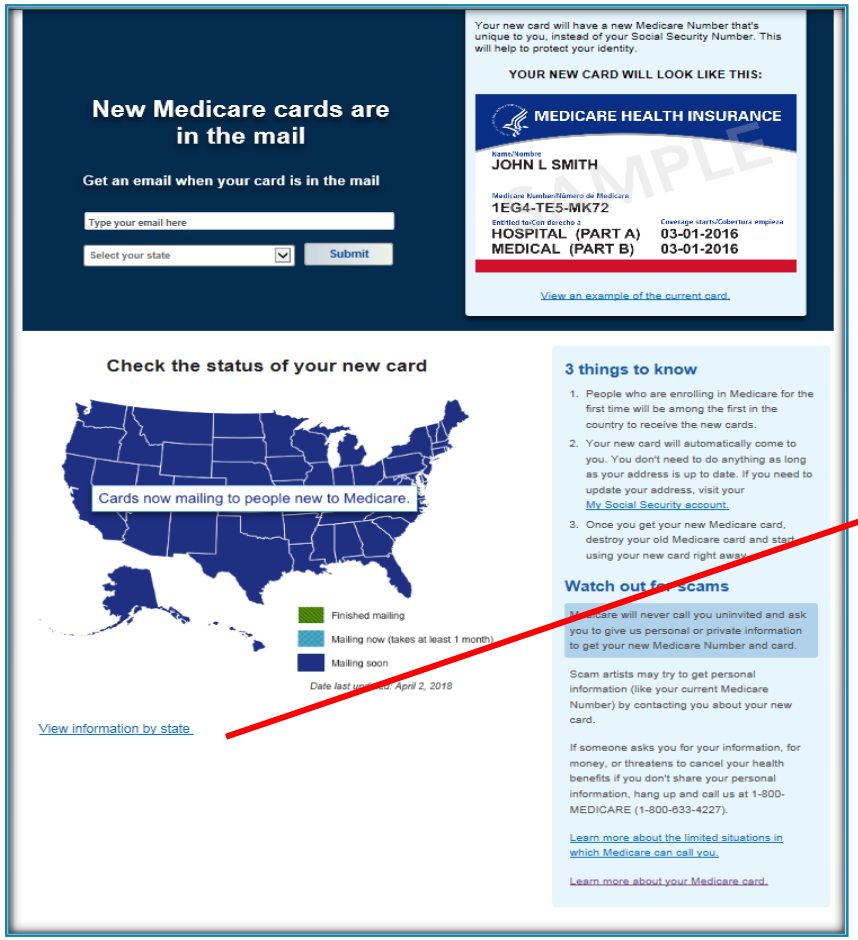
New Medicare Card Mailing Waves

Wave	States Included	Cards Mailing
Newly Eligible People with Medicare	All - Nationwide	April 2018 - ongoing
1	Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia	Beginning May 2018
2	Alaska, American Samoa, California, Guam, Hawaii, Northern Mariana Islands, Oregon	Beginning May 2018
3	Arkansas, Illinois, Indiana, Iowa, Kansas, Minnesota, Nebraska, North Dakota, Oklahoma, South Dakota, Wisconsin	After June 2018
4	Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Rhode Island, Vermont	After June 2018
5	Alabama, Florida, Georgia, North Carolina, South Carolina	After June 2018
6	Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Texas, Utah, Washington, Wyoming	After June 2018
7	Kentucky, Louisiana, Michigan, Mississippi, Missouri, Ohio, Puerto Rico, Tennessee, Virgin Islands	After June 2018

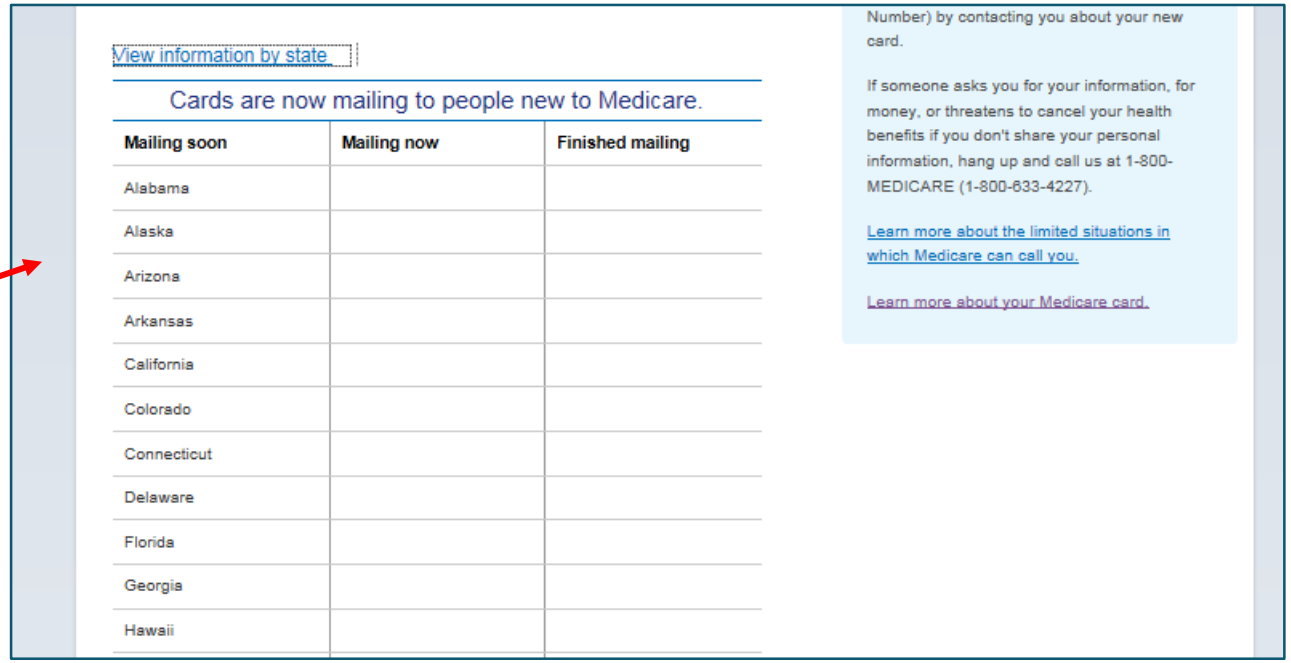
Source: https://www.cms.gov/Medicare/New-Medicare-Card/NMC-Mailing-Strategy.pdf

Slide prepared by IHS

Check the Status of New Card Mailing



View Information by State



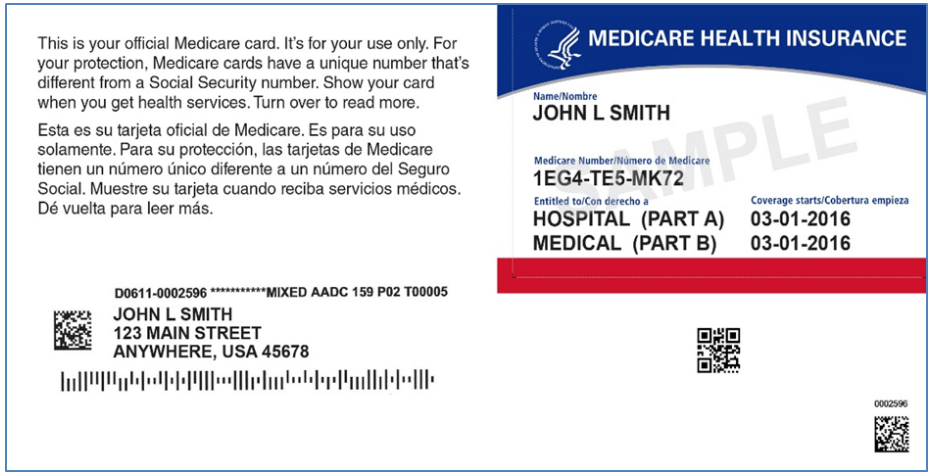
Source: https://www.medicare.gov/newcard/

New Medicare Card Mailing: Envelope and Insert

front

back

Envelope

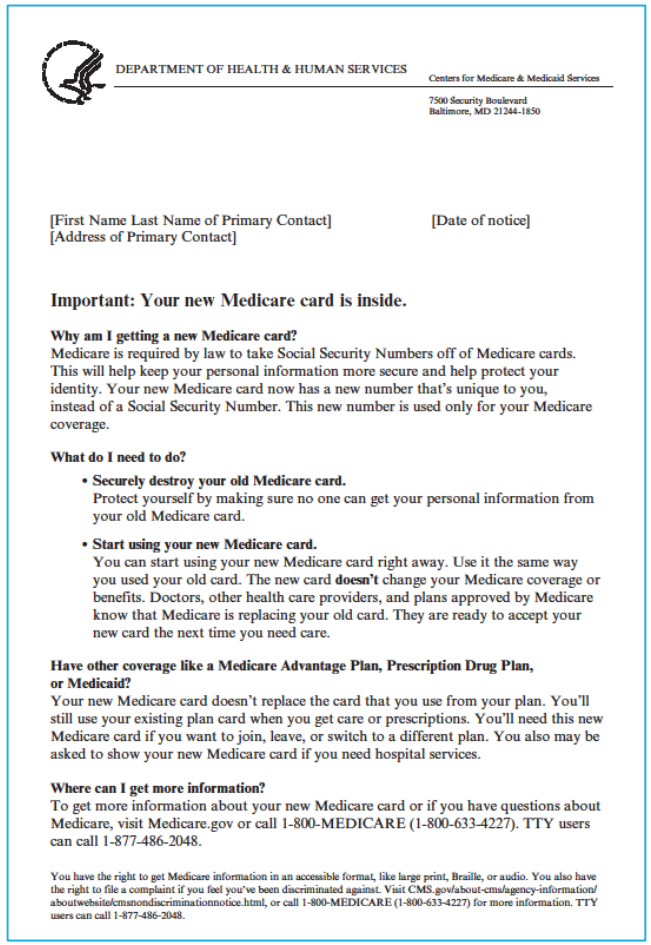


Insert

Slide prepared by IHS

New Medicare Card Mailing - Letter

front



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

7500 Security Boulevard
Baltimore, MD 21244-1850

[First Name Last Name of Primary Contact]
[Address of Primary Contact]

[Date of notice]

Important: Your new Medicare card is inside.

Why am I getting a new Medicare card?
Medicare is required by law to take Social Security Numbers off of Medicare cards. This will help keep your personal information more secure and help protect your identity. Your new Medicare card now has a new number that's unique to you, instead of a Social Security Number. This new number is used only for your Medicare coverage.

What do I need to do?

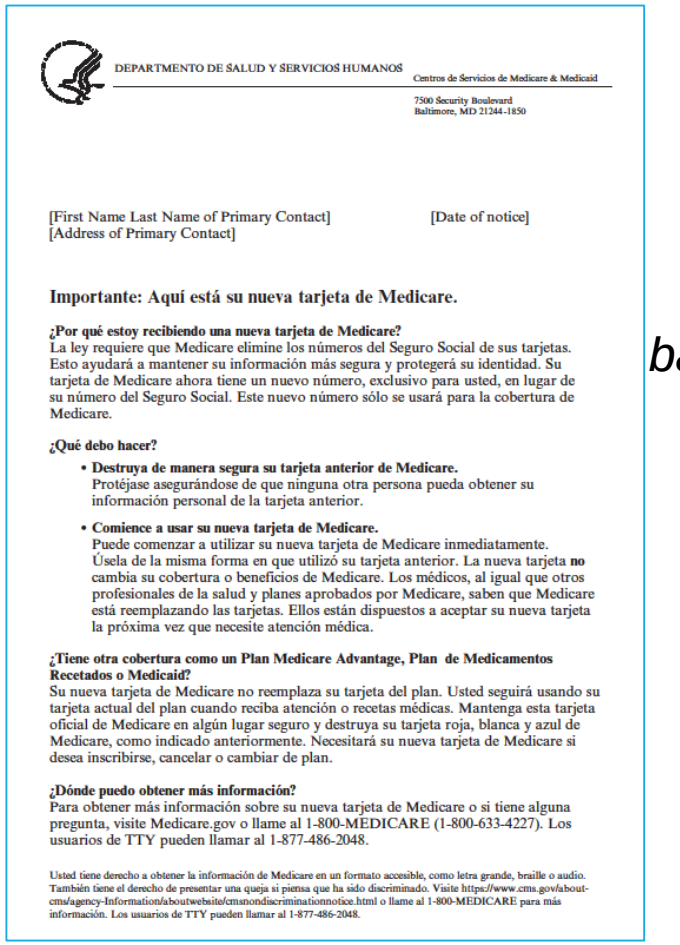
- **Securely destroy your old Medicare card.**
  Protect yourself by making sure no one can get your personal information from your old Medicare card.
- **Start using your new Medicare card.**
  You can start using your new Medicare card right away. Use it the same way you used your old card. The new card **doesn't** change your Medicare coverage or benefits. Doctors, other health care providers, and plans approved by Medicare know that Medicare is replacing your old card. They are ready to accept your new card the next time you need care.

Have other coverage like a Medicare Advantage Plan, Prescription Drug Plan, or Medicaid?
Your new Medicare card doesn't replace the card that you use from your plan. You'll still use your existing plan card when you get care or prescriptions. You'll need this new Medicare card if you want to join, leave, or switch to a different plan. You also may be asked to show your new Medicare card if you need hospital services.

Where can I get more information?
To get more information about your new Medicare card or if you have questions about Medicare, visit Medicare.gov or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit CMS.gov/about-cms/agency-information/aboutwebsite/cmsnondiscriminationnotice.html, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

back



DEPARTMENTO DE SALUD Y SERVICIOS HUMANOS

Centros de Servicios de Medicare & Medicaid

7500 Security Boulevard
Baltimore, MD 21244-1850

[First Name Last Name of Primary Contact]
[Address of Primary Contact]

[Date of notice]

Importante: Aquí está su nueva tarjeta de Medicare.

¿Por qué estoy recibiendo una nueva tarjeta de Medicare?
La ley requiere que Medicare elimine los números del Seguro Social de sus tarjetas. Esto ayudará a mantener su información más segura y protegerá su identidad. Su tarjeta de Medicare ahora tiene un nuevo número, exclusivo para usted, en lugar de su número del Seguro Social. Este nuevo número sólo se usará para la cobertura de Medicare.

¿Qué debo hacer?

- **Destruya de manera segura su tarjeta anterior de Medicare.**
  Protéjase asegurándose de que ninguna otra persona pueda obtener su información personal de la tarjeta anterior.
- **Comience a usar su nueva tarjeta de Medicare.**
  Puede comenzar a utilizar su nueva tarjeta de Medicare inmediatamente. Úsela de la misma forma en que utilizó su tarjeta anterior. La nueva tarjeta **no** cambia su cobertura o beneficios de Medicare. Los médicos, al igual que otros profesionales de la salud y planes aprobados por Medicare, saben que Medicare está reemplazando las tarjetas. Ellos están dispuestos a aceptar su nueva tarjeta la próxima vez que necesite atención médica.

¿Tiene otra cobertura como un Plan Medicare Advantage, Plan de Medicamentos Recetados o Medicaid?
Su nueva tarjeta de Medicare no reemplaza su tarjeta del plan. Usted seguirá usando su tarjeta actual del plan cuando reciba atención o recetas médicas. Mantenga esta tarjeta oficial de Medicare en algún lugar seguro y destruya su tarjeta roja, blanca y azul de Medicare, como indicado anteriormente. Necesitará su nueva tarjeta de Medicare si desea inscribirse, cancelar o cambiar de plan.

¿Dónde puedo obtener más información?
Para obtener más información sobre su nueva tarjeta de Medicare o si tiene alguna pregunta, visite Medicare.gov o llame al 1-800-MEDICARE (1-800-633-4227). Los usuarios de TTY pueden llamar al 1-877-486-2048.

Usted tiene derecho a obtener la información de Medicare en un formato accesible, como letra grande, braille o audio. También tiene el derecho de presentar una queja si piensa que ha sido discriminado. Visite https://www.cms.gov/about-cms/agency-Information/aboutwebsite/cmsnondiscriminationnotice.html o llame al 1-800-MEDICARE para más información. Los usuarios de TTY pueden llamar al 1-877-486-2048.

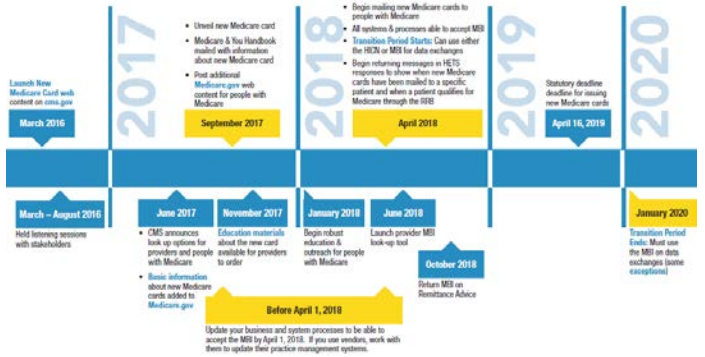
Outreach and Education

- CMS will provide outreach and education to:
  - Approximately 60 million beneficiaries, their families, advocacy groups, and caregivers
  - Health Plans
  - The provider community (1.5M providers)
    - All Provider Letter and Fact Sheet
    - Quarterly Open Door Forums
  - States and Territories
  - Other business partners, including vendors
- CMS will involve all business partners in our outreach and education efforts through their existing vehicles for communication (e.g., Open Door Forums, HPMS notices, MLN Connects)
- CMS is also working to develop a secure way for beneficiaries to be able to access their new Medicare number when needed.
- Medicare benefits will not change and ones Social Security Number (SSN) will not change.

Outreach and Education Resources

A Flyer to Distribute

A Full Timeline for Your Records



A Poster for Providers' Offices

Tear-offs for Patients

- Resources to help you communicate with people with Medicare are available on CMS website https://www.cms.gov/newcard to print and/or order

Conference Cards for Beneficiaries

New Medicare Card: Spotlight on Indian Health Service

IHS Outreach and Education

A few examples of outreach:

Calendar Year 2017

August

- IHS Partnerships Conference: August 22 & 23
- National Indian Health Board (NIHB) Tribal Technical Advisory Group (TTAG): August 23

September

- Outreach to IHS, Tribal and Urban Partners
- Information System Advisory Council: September 19
- NIHB National Tribal Health Conference: September 25

October

- IHS National Business Office Committee Meeting: October 25

November

- NIHB TTAG: November 1

December

- EHR for Health Information Management Training: December 12

Calendar Year 2018

February

- New Medicare Card posted on IHS.gov website
- NIHB TTAG: February 21
- Long Term Service and Support Technical Assistance for AI/AN February 28

March

- General Staff Meeting: March 1
- ISAC: March 14
- Alaska Tribal Health Pre-Negotiations: March 20

April

- CMS Open Forum: April 5
- Purchased/ Referred Care Officers Meeting: April 24

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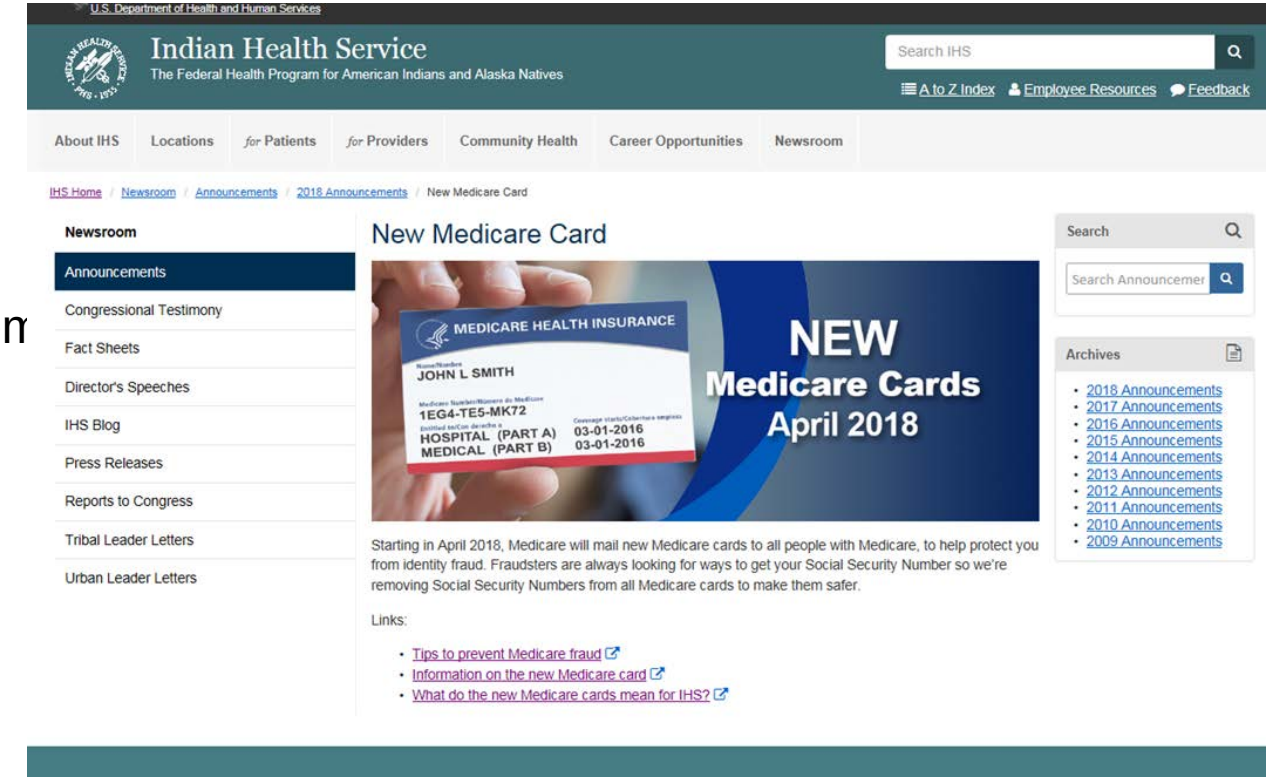
IHS Communication

- Website: www.IHS.gov
- Social Media
  - Facebook: IHS Home page
  - Twitter
- Office of Resource Access and Partnership (ORAP), Division of Business Office Enhancem (DBOE)
  - Guidance for IHS Business Office Staff:
    - Patient Registration
    - Patient Benefit Coordinators
    - Purchased /Referred Care (PRC)
    - Third Party Billing Staff
    - Accounts Receivable Staff
    - Health Information Management (HIM) Staff
- RPMS Training (application update)



Slide prepared by IHS

IHS Preparation Prior to April 1, 2018 Rollout

- **IHS addressed impacted applications**
  - Resource and Patient Management System (RPMS)
  - National Patient Information Reporting System (NPIRS) - National Data Warehouse
- **OIT Project team formed**
  - Meeting
  - Developed Project plan
  - Addressed communication
  - Addressed data flow of information
  - Addressed need for future enhancements to accept MBI number before April 1, 2018
  - Future initiatives proactive planning (Phase II)

Slide prepared by IHS

Impacted Applications

The current plan released the following updates on March 29, 2018 (FY18 Q2 release):

- Third Party Billing (ABM) v2.6 p26
- Point of Sale (ABSP) v1.0 p50
- Contract Health Management System (ACHS) v3.1 p27
- Patient Registration (AG) v7.1 p13
- IHS Dictionaries (Patient) + IHS PCC Suite (AUPN) v99.1 p26
- Accounts Receivable (BAR) 1.8 p27
- Practice Management Suite (BPRM) v3.0 p6

Note: Information is accurate pending there are no changes from CMS

Slide prepared by IHS

Timeline for RPMS Application Development

High Level Schedule:

- Alpha – 2/5/2018 – 2/16/2018
- Beta – 2/20/2018 – 3/19/2018
- National Release – 3/29/2018
- Go live April 1, 2018

- Training Sessions:
- 3/27/18 for all impacted applications – 1 hour session which will be recorded. Completed
- 4/6/18 Completed
- 4/13/18 Completed

Slide prepared by IHS

What IHS Federal, Tribal, and Urban Facilities Need to Know to Get Ready for the New MBI

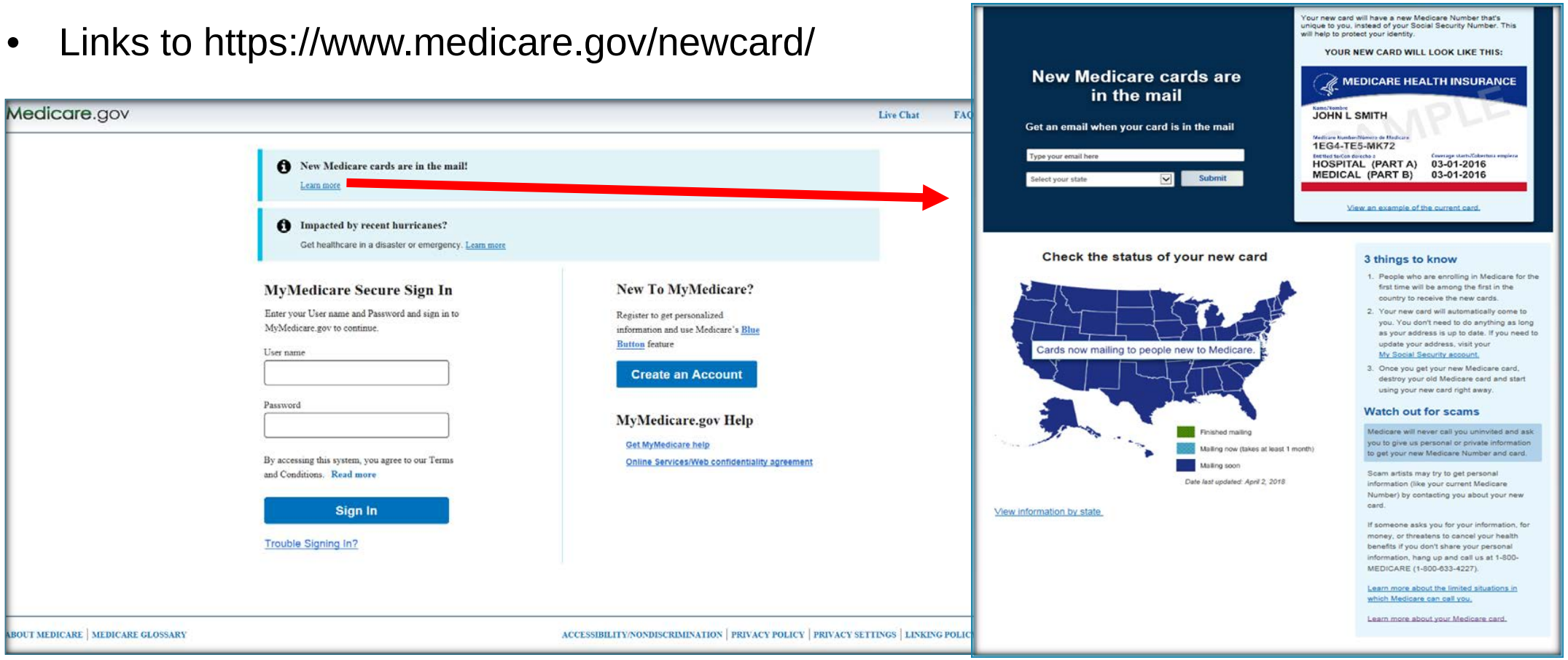
1. **Get ready to use the new MBI format (when beneficiaries present with the new cards)**
   - Ask your billing and office staff if your practice management system is now able to accept the 11 digit alpha numeric MBI.
   - If you use vendors to bill Medicare, ask them about their new MBI practice management system changes and make sure changes have been made.
   - Encourage practices and health care facilities to visit the CMS website at **https://www.cms.gov/newcard.**

2. **Help your patients get ready**
   - If the **address** you have on file is different than the address you get in electronic eligibility transaction responses, encourage your patients to correct their address in Medicare's records at SSA using **ssa.gov/myaccount**
     (this may require coordination between your billing and office staff)**.**
   - Remind people with Medicare that Medicare will never contact them and request personal information. They should protect their new MBI like a credit card and only share it with those they trust.

Medicare Beneficiary Education

MyMedicare.gov Login Page – Regular User

- Informs beneficiaries the Medicare cards are in the mail
- Links to https://www.medicare.gov/newcard/



MyMedicare – Dashboard Page

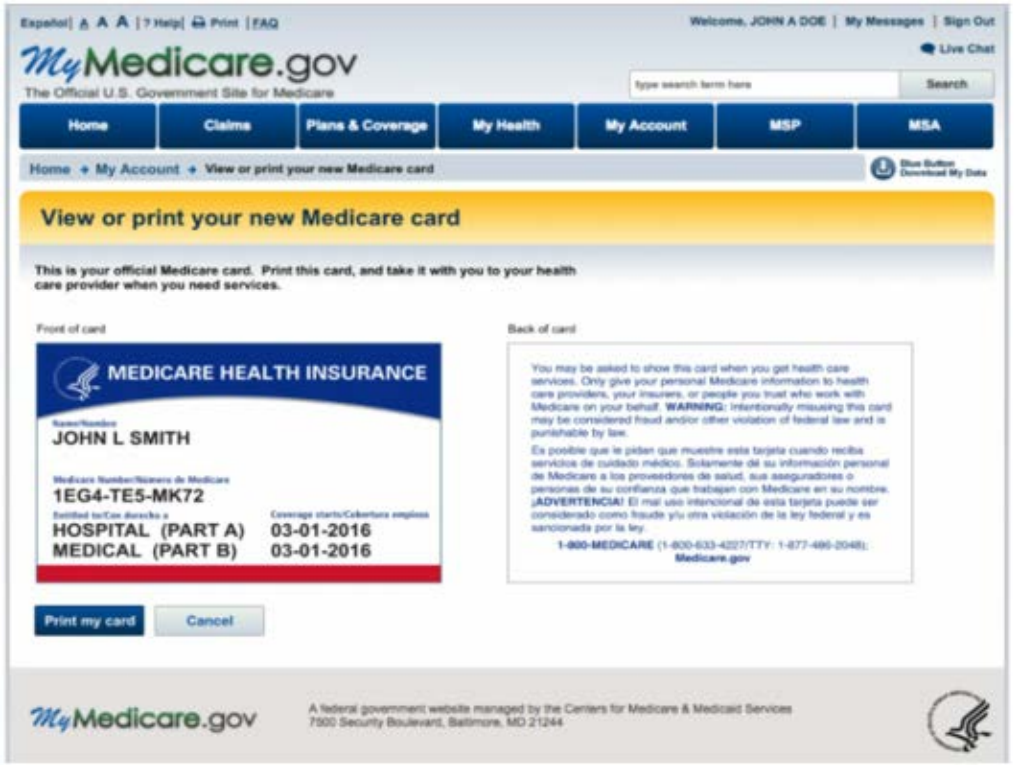
Section for New Medicare Card with Links

- “Learn more about your new card” and
- “View or Print Medicare Card.”
  - View or Print links **only** displays for beneficiaries who have had their card mailed and have an MBI.

MyMedicare – View or Print Card

Beneficiaries' New Medicare card displays (front and back)

- Part A and Part B display if available
- Print my card button available
- RRB card will display for RRB beneficiaries
- Webpage can be accessed with mobile devices



CMS Resources: New Medicare Card

Additional technical information, detailed updates, training opportunities, and materials to share available at: https://www.cms.gov/newcard

CMS Open Forum Resource Materials at https://www.cms.gov/Medicare/New-Medicare-Card/Open-Door-Forums.html

CMS welcomes comments and questions! Send to: NewMedicareCardSSNRemoval@cms.hhs.gov

Information for people with Medicare: go.medicare.gov/newcard

Outreach & Education Video: https://youtu.be/DusRmgzQnLY

Slide prepared by IHS

QPP Resources

- American Medical Association. **Quality Payment Program (QPP) Specifics**. Available at: http://www.ama-assn.org/ama/pub/advocacy/topics/medicare-physician-payment-reform.page.
- Centers for Medicare & Medicaid Services. A. Abrams. **Group and/or Individual data submission for MIPS** (January 2, 2018). (video) Available at https://www.youtube.com/watch?v=q0Cvke6fnrg
- Centers for Medicare & Medicaid Services. **2017 Merit-based Incentive Payment System (MIPS): CMS Web Interface Fact Sheet.** (April, 12, 2017) Available at https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/CMS-Web-Interface-Fact-Sheet-2.pdf.
- Centers for Medicare & Medicaid Services. **2018 Merit-based Incentive Payment System (MIPS) Cost Performance Category Fact Sheet.** (March 27, 2018). Available at https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Cost-Performance-Category-Fact-Sheet.pdf
- Centers for Medicare & Medicaid Services. (October 27, 2016) **Advanced Alternative Payment Models (APMs) in The Quality Payment Program** (slide deck) Available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/APMs-in-The-Quality-Payment-Program-for-Shared-Savings-Program-SSP-webinar-slides.pdf.
- Centers for Medicare & Medicaid Services. **MACRA: What's MACRA**. Available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html.

QPP Resources (2)

- Centers for Medicare & Medicaid Services. **Merit-Based Incentive Payment System: Advancing Care Information Performance Category**. Available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Advancing-Care-Information-Presentation.pdf.
- Centers for Medicare & Medicaid Services. **The Merit-Based Incentive Payment Systems (MIPS)**. Available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-MIPS-NPRM-Slides.pdf.
- Centers for Medicare & Medicaid Services. **Merit-Based Incentive Payment System (MIPS): 2017 CMS-Approved Qualified Registries.** (November 28, 2017) Available at https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2017-Qualified-Registries.pdf.
- Centers for Medicare & Medicaid Services. Executive Summary **Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year.** Available at https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/QPP-Year-2-Executive-Summary.pdf.
- Centers for Medicare & Medicaid Services. Quality Payment Program: **Modernizing Medicare to provide better care and smarter spending for a healthier America**. Available at https://qpp.cms.gov/.
- Centers for Medicare & Medicaid Services. (November 8, 2017). Quality Payment Program: **FINAL RULE with Comment Period for Quality Payment Program Year 2** (2018) (slide deck—CMS Train the trainer).

QPP Resources (3)

- Centers for Medicare & Medicaid Services. **Quality Payment Program** (slide deck). Available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-MACRA-NPRM-Slides.pdf.
- Centers for Medicare & Medicaid Services. Quality Payment Program: **Resource Library**. Available at https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Resource-library.html.
- Centers for Medicare & Medicaid Services. Quality Payment Program: **Technical Assistance Resource Guide.** (May 10, 2017) Available at https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Technical-Assistance-Resource-Guide.pdf.
- Centers for Medicare & Medicaid Services. Quality Payment Program **Year 2 Final Rule Overview**. (November 28, 2017). Available at https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/QPP-Year-2-Final-Rule-Fact-Sheet.pdf.
- Federal Register. **Final Rule with Comments** 42 CFR Parts 414 and 495. Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models. (November 4, 2016) Available at https://www.federalregister.gov/documents/2016/11/04/2016-25240/medicare-program-merit-based-incentive-payment-system-mips-and-alternative-payment-model-apm.

Questions

Contact: susy.postal@IHS.gov