An Overview of the Quality Payment Program Year 2 (2018) and Year 3 (2019) Proposed Rule

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SEPTEMBER 27, 2018

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

Quality Payment Program (QPP) Objectives

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

1. **Identify the background, purpose and framework paths of the QPP-MACRA**
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 high level changes from the proposed rule for Year 3 (2019).**
5. **Identify steps to prepare for the QPP within the IHS.**

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Update: Proposed Rule Year 3 (2019)

On July 12, 2018, the CMS released its proposed rule for Year 3 (2019) of the Quality Payment Program Notice of Proposed Rulemaking (NPRM).

- **CMS sought formal comment on the Notice of Proposed Rule Making (NPRM) – Deadline was September 10, 2018.**

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Origin of the Quality Payment Program (QPP)

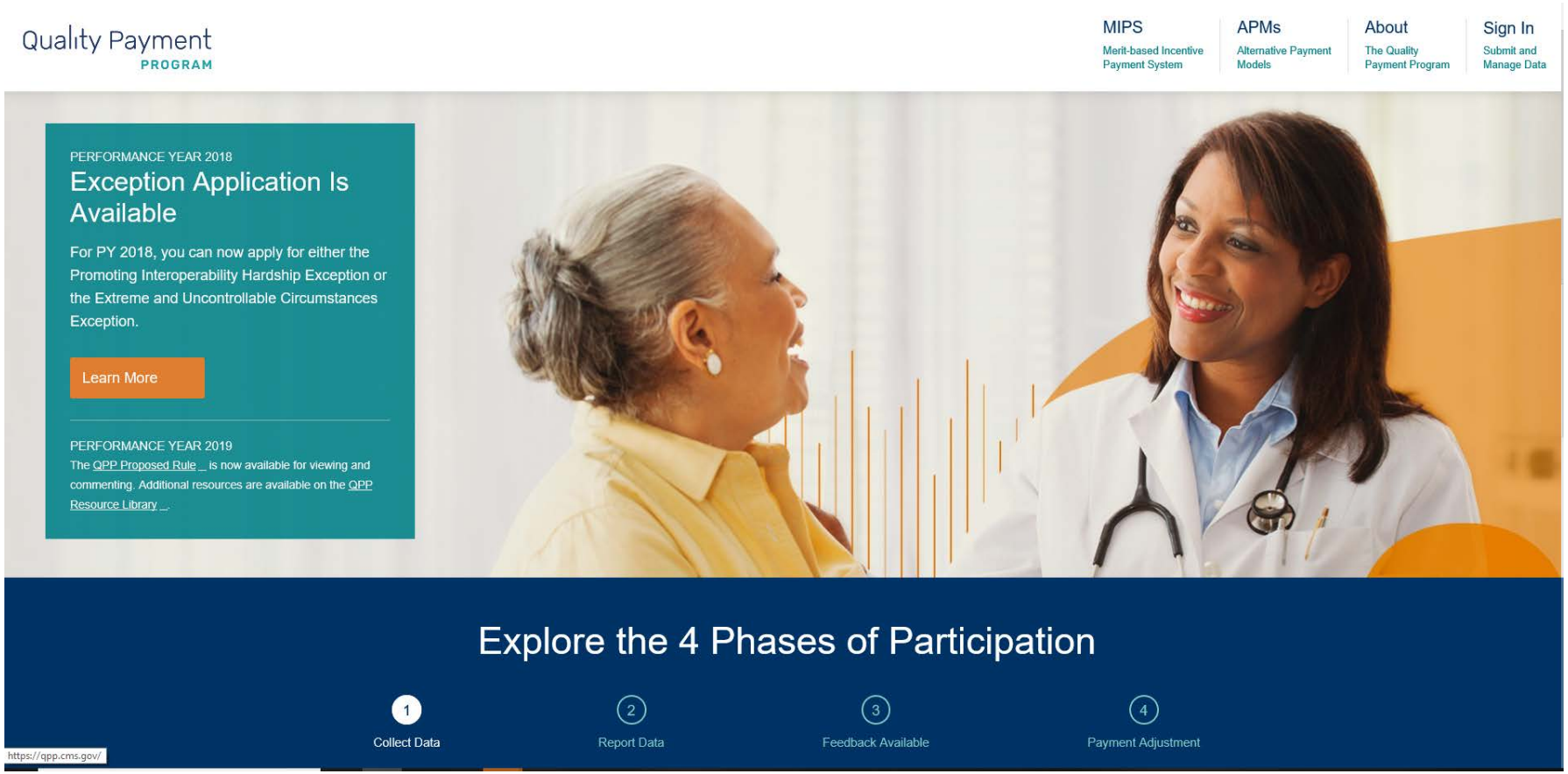
- Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
- Bipartisan Legislation
- **Repeals** the Sustainable Growth Rate (SGR) Formula
- Increases focus on quality of care and value of care delivered
- Moving toward patient-centric healthcare system
  - Delivers better care
  - Smarter spending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

Quality Payment Program Aims

Considerations

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

QPP Landing Page



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

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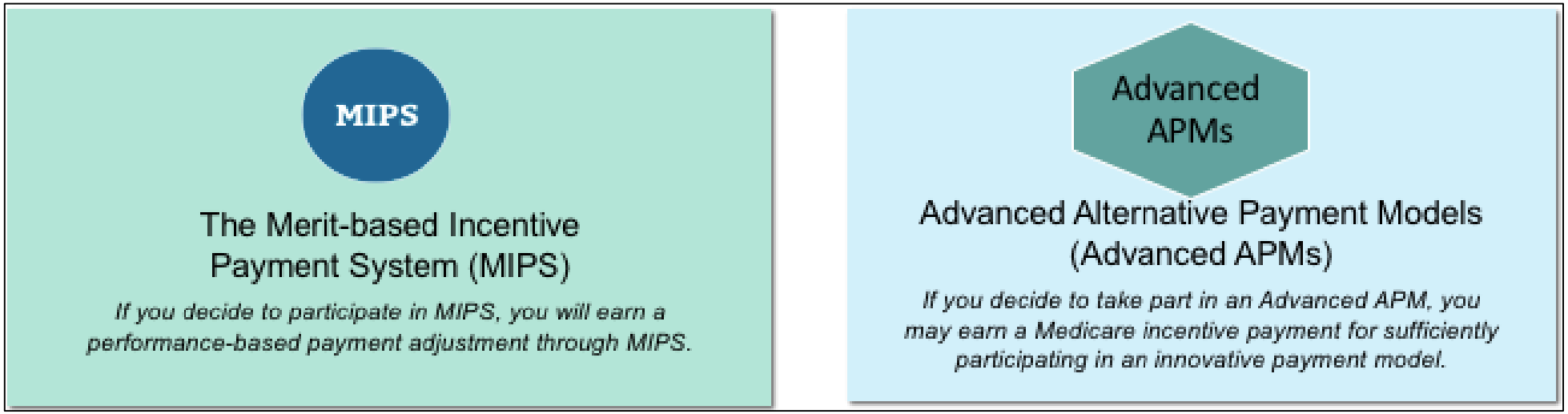
Quality Payment Program: Two Participation Tracks

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)



Merit-based Incentive Payment system (MIPs)

OVERVIEW

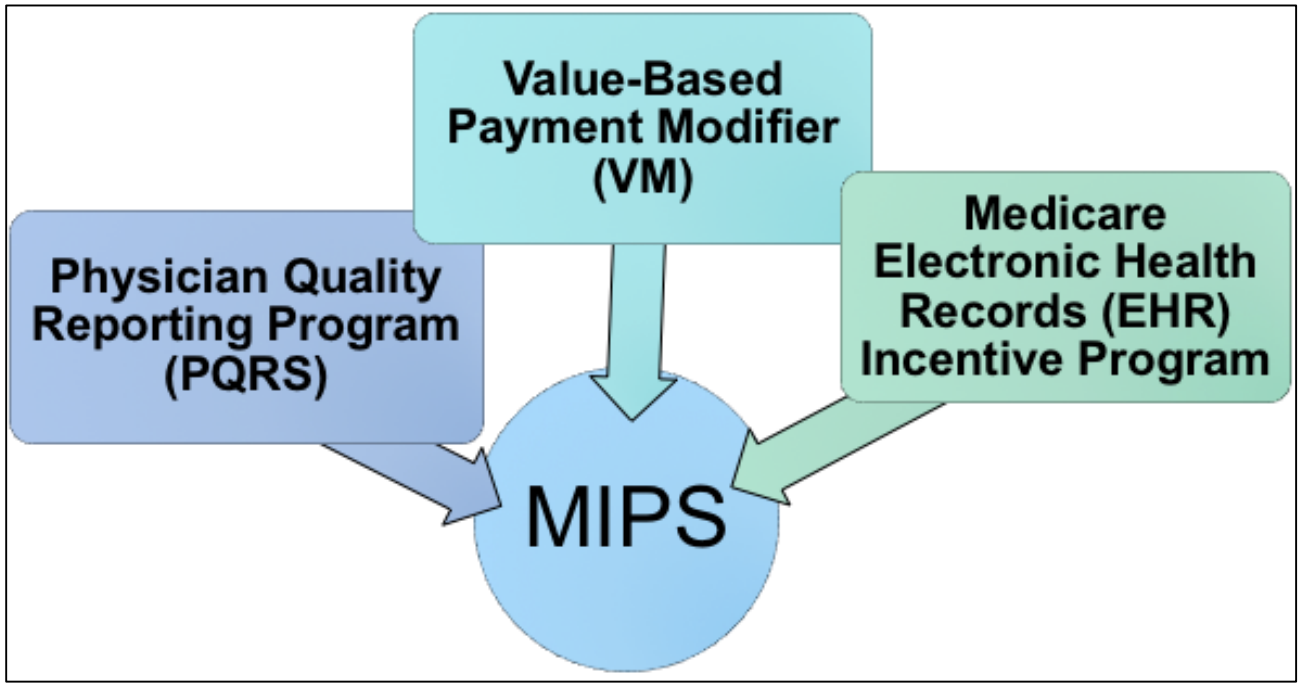
MIPS Bipartisan Budget Act of 2018

Provides additional authority to continue the gradual transition in MIPS, including:

- **Changing the application of MIPS payment adjustments, so adjustments will *not* apply to all items and services under Medicare Part B, but will now apply only to covered professional services under the Physician Fee Schedule (PFS) beginning in 2019, which is the first payment year for MIPS.**
- **Changing the way MIPS eligibility is determined with respect to low-volume threshold. Beginning in 2018 (current performance period), low-volume threshold determinations are based on allowed charges for covered professional services under the PFS, *not* all Medicare Part B allowed charges.**
- **Providing flexibility in the weighting of the Cost performance category for three additional years.**
- **Allowing flexibility in establishing the performance threshold for three additional years to ensure gradual and incremental transition to the estimated performance threshold based on the mean or median of final scores from prior year that will apply in 6th year of program.**

What Is MIPS?

- **The Quality Payment Program/MACRA** Streamlines **multiple quality and value reporting programs (legacy programs)** for Medicare clinicians into a single, improved reporting program called **MIPS**



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What Is MIPS (2018)?

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

Quality	Cost	Improvement Activity	Promoting Interoperability
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
50% of MIPS Score	10% of MIPS Score	15% of MIPS Score	25% of MIPS Score

MIPS Performance Categories Year 2 (2018)

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

On April 24, 2018, CMS renamed MIPS Advancing Care Information (ACI) 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**.

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MIPS Terms and Timelines

As a refresher…

TIN - Tax Identification Number

- Used by the Internal Revenue Service to identify an entity, such as a group medical practice, that is subject to federal taxes

NPI – National Provider Identifier

- 10-digit numeric identifier for individual clinicians

TIN/NPI

- Identifies the individual clinician and the entity/group practice through which the clinician bills services to CMS

Performance Period	Also referred to as…	Corresponding Payment Year
2017	2017 “Transition” Year	2019
2018	“Year 2”	2020
2019	“Year 3”	2021

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 Eligible Clinician Types

Year 2 (2018) eligible clinicians include:

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

****Proposed Year 3 (2019)****

Expanding the definition of MIPS eligible clinicians to include the same clinician types from Year 2 AND four new clinician types:

- **Physical therapists,**
- **Occupational therapists,**
- **Clinical social workers, and**
- **Clinical psychologists**

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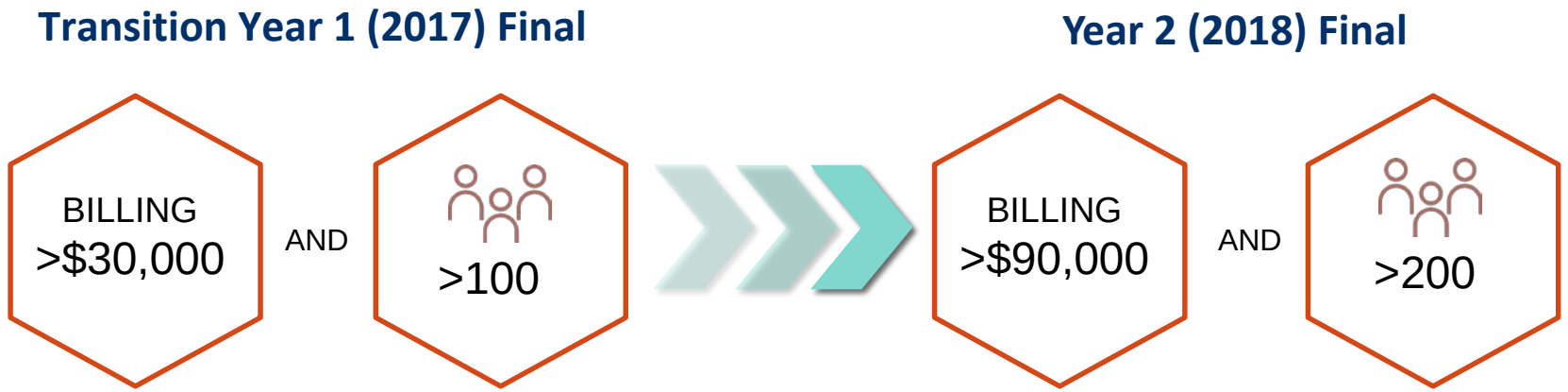
Who is included in MIPS? (2017 & 2018)

***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 for covered professional services under the Medicare Physician Fee Schedule (PFS)
AND providing care for more than 200 Medicare patients a year.



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

MIPS Year 3 (2019) Proposed
Low-Volume Threshold Criteria

Year 2 (2018) Final	Year 3 (2019) Proposed
Low-volume threshold determination criteria: ▪ **Dollar amount** ▪ **Number of beneficiaries**	Low-volume threshold determination criteria: ▪ Dollar amount ▪ Number of beneficiaries ▪ Number of services (*Newly proposed)*

MIPS Year 3 (2019) Proposed

Low-Volume Threshold Determination

Proposed low-volume threshold includes MIPS eligible clinicians billing more than **$90,000** a year in allowed charges for covered professional services under the Medicare Physician Fee Schedule **AND** furnishing covered professional services to more than **200** Medicare beneficiaries a year **AND** providing more than **200** covered professional services under the PFS. To be included, a clinician must exceed all three criterion.

Note: For MIPS APMs participants, the low-volume threshold determination will continue to be calculated at the APM Entity level.

MIPS Year 3 (2019) Proposed Opt-in Policy

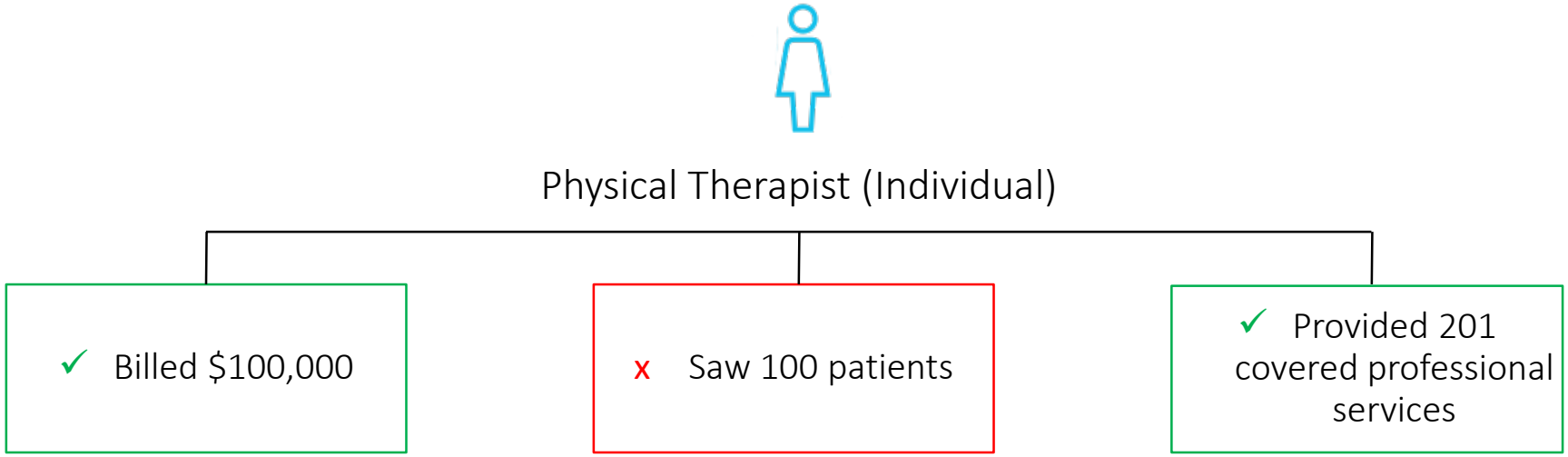
Proposing an opt-in policy for MIPS eligible clinicians who are excluded from MIPS based on the low-volume threshold determination.

- MIPS eligible clinicians who meet or exceed at least one of the low-volume threshold criteria may choose to participate in MIPS.

MIPS Opt-in Scenarios

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

MIPS Year 3 (2019) Proposed Opt-in Policy Example



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

However…

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

MIPS Year 3 (2019) Proposed Opt-in Policy

What else do I need to know?

Proposing that to make an election to opt-in (or voluntarily report), individual eligible clinicians and groups would:

- ❑ Sign-in to qpp.cms.gov
- ❑ Select the option to opt-in (or voluntarily report).

  - Once an election has been made, the decision to opt-in to MIPS would be **irrevocable** and **could not be changed**.

  - Clinicians or groups who opt-in are subject to all of the MIPS rules, special status, and MIPS payment adjustment.

  - Please note that APM Entities interested in opting-in to participate in MIPS under the APM Scoring Standard would do so at the APM Entity level.

*We encourage you to review the wireframe drawings on the three different approaches to MIPS participation on qpp.cms.gov/design-examples

MIPS Year 3 (2019) Proposed MIPS Determination Period

Year 2 (2018) Final

Low Volume Threshold Determination Period:

- First 12-month segment: Sept. 1, 2016-Aug. 31, 2017 (including 30-day claims run out)
- Second 12-month segment: Sept. 1, 2017 to Aug. 31, 2018 (including a 30-day claims run out)
- Special Status
  Use various determination periods to identify MIPS eligible clinicians with a special status and apply the designation.
  Special status includes:
  - Non-Patient Facing
  - Small Practice
  - Rural Practice
  - Health Professional Shortage Area (HPSA)
  - Hospital-based
  - Ambulatory Surgical Center-based (ASC-based)

Year 3 (2019) Proposed

Change to the MIPS Determination Period:

First 12-month segment: Oct. 1, 2017-Sept. 30, 2018 (including a 30-day claims run out)

Second 12-month segment: Oct. 1, 2018-Sept. 30, 2019 (does not include a 30-day claims run out)

Goal: consolidate the multiple timeframes and align the determination period with the fiscal year.

Goal: streamlined period will also identify MIPS eligible clinicians with the following special status:

- Non-Patient Facing
- Small Practice
- Hospital-based
- ASC-based

Note: Rural and HPSA status continue to apply in 2019

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

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

MIPS Reporting Options

YEAR 2 AND PROPOSED RULE FOR YEAR 3

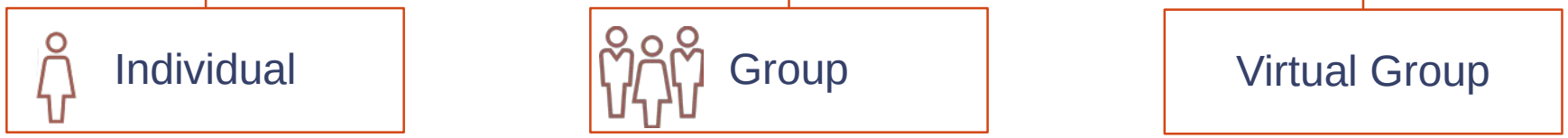
What Is a Virtual Group?

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.

MIPS Reporting Options Year 2 (2018) & Year 3 (2019)Proposed

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.

Virtual Group Elections

Year 2 (2018) Final

Virtual group elections:

Must be made by December 31 of calendar year preceding applicable performance period, and cannot be changed during performance period.

Election process broken into two stages: Stage 1 (optional) pertains to virtual group eligibility determinations, and Stage 2 pertains to virtual group formation.

Technical assistance available to help with the election process.

Year 3 (2019) Proposed

Virtual group elections:

Same requirements as Year 2, with the following changes:

- **TINs would be able to inquire about their TIN size prior to making an election during a 5-month timeframe, which would begin on August 1 and end on December 31 of a calendar year prior to the applicable performance period.**
- **TIN size inquiries would be made through the Quality Payment Program Service Center.**

Data Submission

YEAR 2 AND PROPOSED RULE FOR YEAR 3

Submission Methods: Year 2 (2018)

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 (ACI)~~ **Promoting Interoperability**	Attestation QCDR Qualified Registry EHR	Attestation QCDR Qualified Registry EHR CMS Web Interface (groups of 25 or more

MIPS Year 3 (2019) Proposed
Collection, Submission, and Submitter Types

Year 2 (2018) Final

"Submission mechanisms" used all-inclusively when referencing:

- **Method by which data is submitted (e.g., registry, EHR, attestation, etc.)**
- **Certain types of measures and activities on which data are submitted**
- **Entities submitting such data (i.e. third party intermediaries submitting on behalf of a group)**

Year 3 (2019) Proposed

To enhance clarity and reflect the user experience, we are proposing to revise existing and define additional terminology:

- **Collection Types**
- **Submission Types**
- **Submitter Types**

MIPS Year 3 (2019) Proposed Collection, Submission, and Submitter Types Definitions

Definitions for Newly Proposed Terms:

- **Collection type-** a set of quality measures with comparable specifications and data completeness criteria including, as applicable: electronic clinical quality measures (eCQMs); MIPS Clinical Quality Measures* (MIPS CQMs); Qualified Clinical Data Registry (QCDR) measures; Medicare Part B claims measures; CMS Web Interface measures; the CAHPS for MIPS survey; and administrative claims measures.
- **Submission type-** the mechanism by which a submitter type submits data to CMS, including, as applicable: direct, log in and upload, log in and attest, Medicare Part B claims, and the CMS Web Interface.
- **Submitter type-** the MIPS eligible clinician, group (including APM Entities and virtual groups), or third party intermediary acting on behalf of a MIPS eligible clinician or group, as applicable, that submits data on measures and activities.

*The term MIPS CQMs would replace what was formerly referred to as “registry measures” since entities other than registries may submit data on these measures.

**We encourage you to review the proposed terms and wireframes for the submission types on qpp.cms.gov/design-examples.

MIPS Year 3 (2019) Proposed
Collection, Submission, and Submitter Types – Individual Example

Data Submission Types for MIPS Eligible Clinicians Reporting as Individuals

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

MIPS Year 3 (2019) Proposed

Collection, Submission, and Submitter Types – Group Example

Data Submission Types for MIPS Eligible Clinicians Reporting as Groups

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

MIPS: CMS Web Interface

MIPS participation via CMS Web Interface is only available to groups with 25 or more eligible clinicians.

Registration period **was** 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 a group wanted to participate through another data submission option, they needed to "cancel" their election in the registration system (timeframe to cancel was April 1, 2018 - June 30, 2018).

Groups planning to participate in MIPS via two options noted require registration

- CMS Web Interface or Consumer Assessment of Healthcare Providers and
- Systems (CAHPS) for MIPS survey

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

Performance Categories

YEAR 2 AND PROPOSED RULE FOR YEAR 3

MIPS Performance Period Changes by Year

Year 3 (2019) Proposed – *No Change*

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	90 days
~~Advancing Care Information~~ Promoting Interoperability	90 days

MIPS Performance Category Weights

Year 1 (2017) Final

Performance Category	Performance Category Weight
Quality	60%
Cost	0% weight in the first year
Improvement Activities	15%
Promoting Interoperability	25%

Year 2 (2018) Final

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

Year 3 (2019) Proposed

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

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.

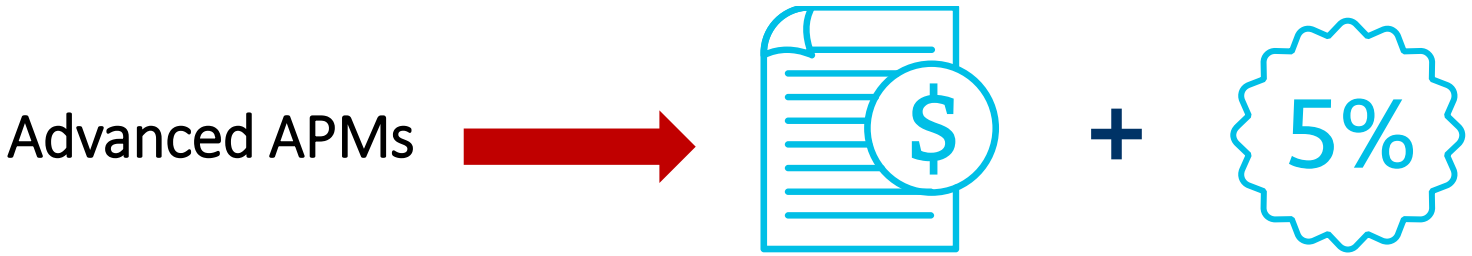
APM participants who are not Qualifying APM Participants (QPs) will receive favorable scoring under MIPS.

Only some of these APMs will be Advanced APMs.

Advanced APMs: Benefits

Clinicians and practices can:

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



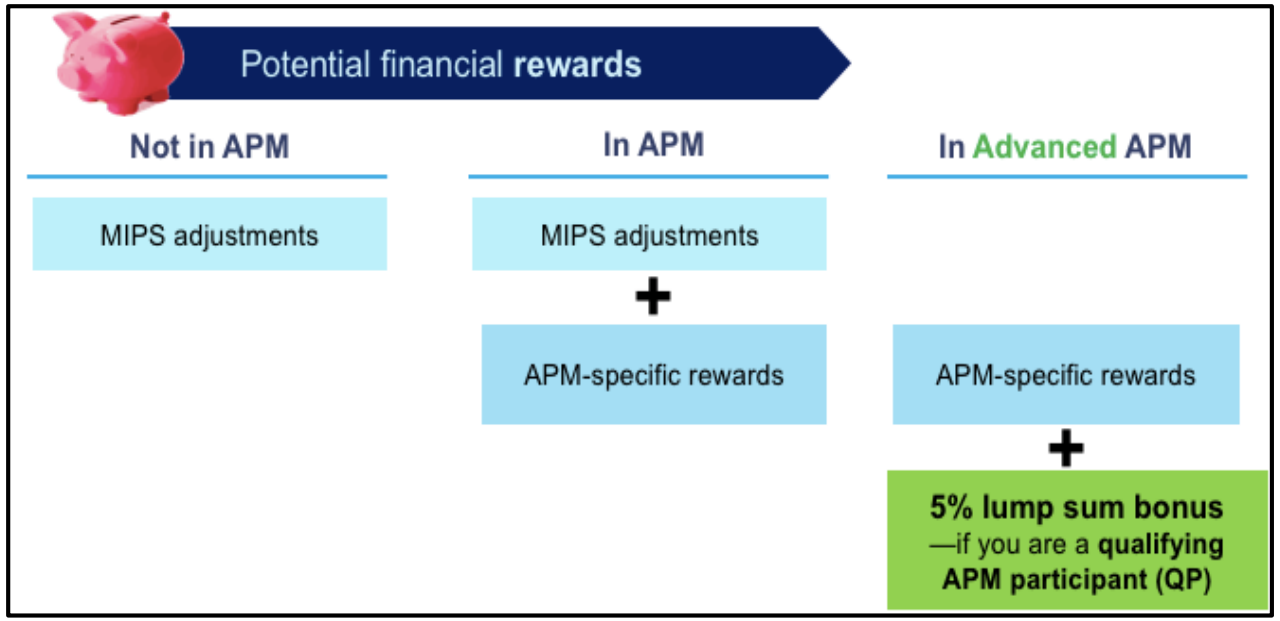
"So what?" - It is important to understand that the Quality Payment Program does not change the design of any particular APM. Instead, it creates **extra incentives** for a sufficient degree of participation in Advanced APMs.

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)

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Putting It All Together

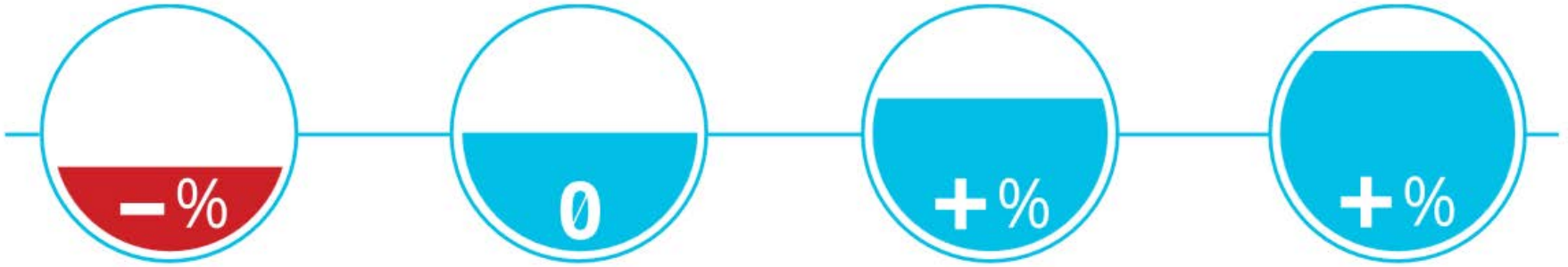
THE QUALITY PAYMENT PROGRAM

MIPS Pick Your Pace: CY 2017

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



Don't Participate | Submit Something | Submit a Partial Year | Submit a Full Year

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Quality Payment Program: CY 2018

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

CY 2018

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

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MIPS Timelines for Year 3 Proposed

Timelines

2019
Performance Year

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

March 31, 2020
Data Submission

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

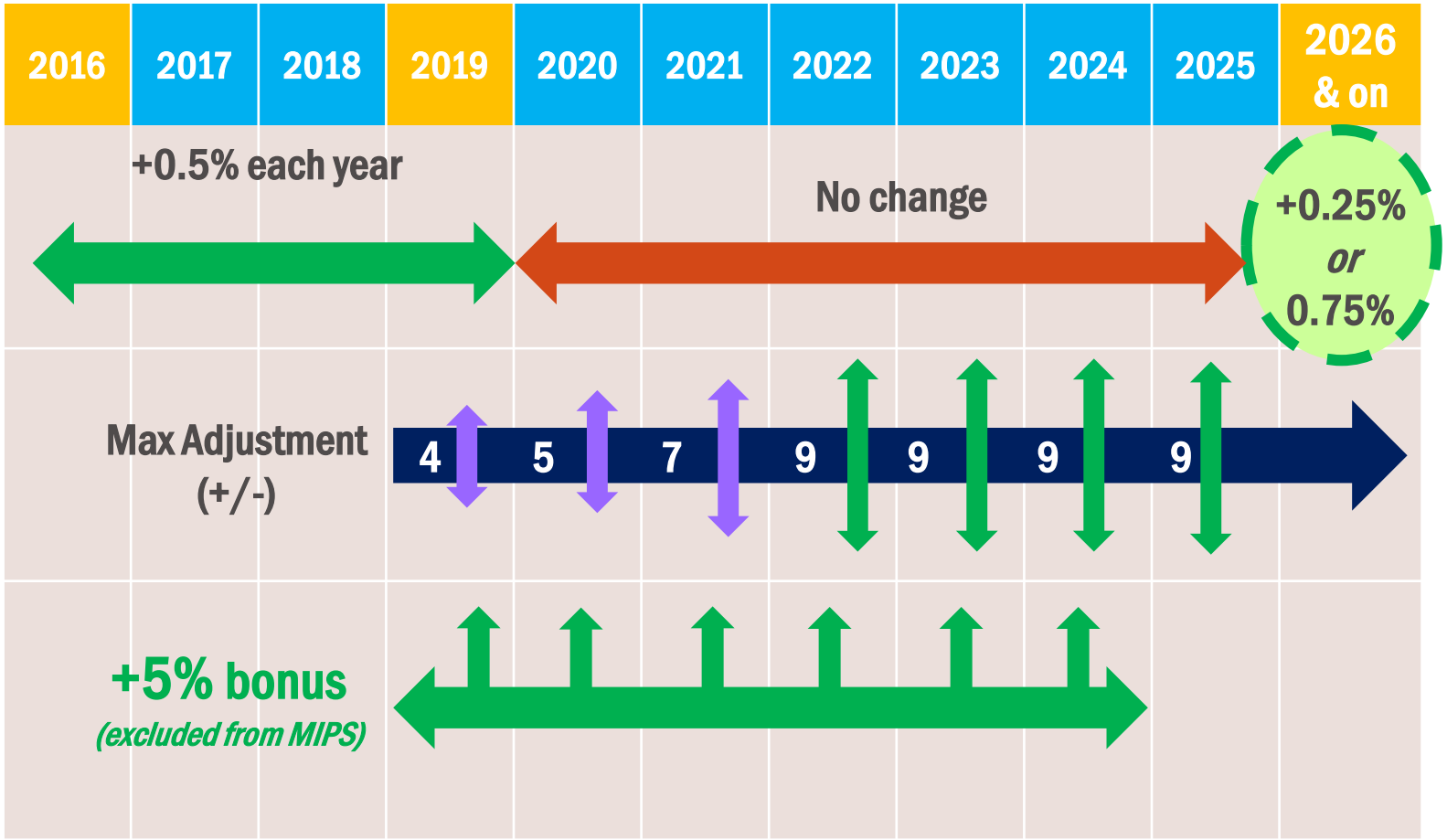
Feedback

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

January 1, 2021
Payment Adjustment

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

Putting It All Together



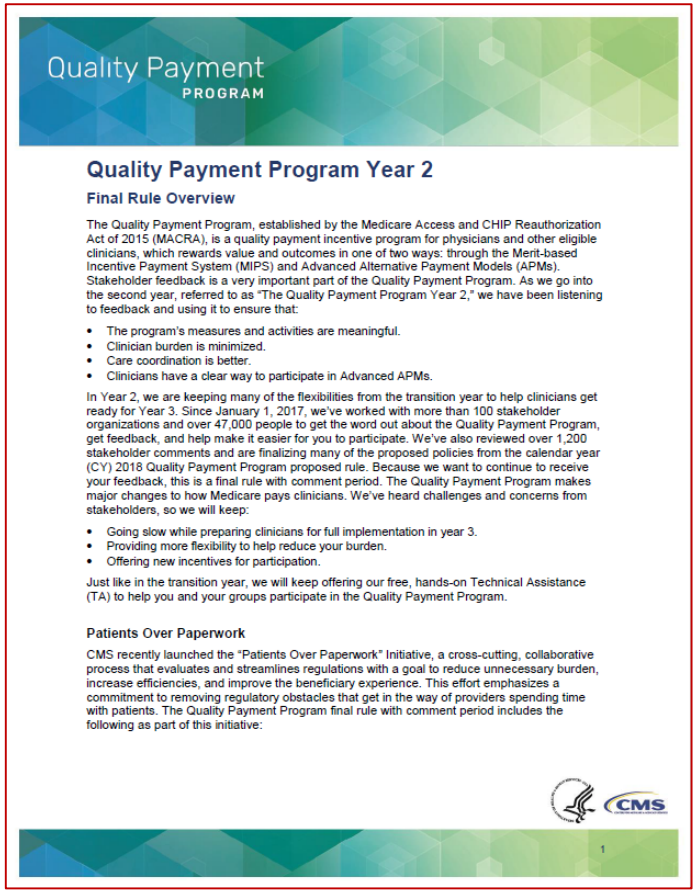
Closer Look at MIPS Categories:

QUALITY PAYMENT PROGRAM

QPP Fact Sheet: Year 2 (2018)

Fact Sheet

- 26 pages
- Provides comparison summary
- Example of changes provided such as adding virtual groups for 2018.
- Addresses Patients Over Paperwork Initiative



Quality Payment
PROGRAM

Quality Payment Program Year 2

Final Rule Overview

The Quality Payment Program, established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), is a quality payment incentive program for physicians and other eligible clinicians, which rewards value and outcomes in one of two ways: through the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). Stakeholder feedback is a very important part of the Quality Payment Program. As we go into the second year, referred to as "The Quality Payment Program Year 2," we have been listening to feedback and using it to ensure that:

- The program's measures and activities are meaningful.
- Clinician burden is minimized.
- Care coordination is better.
- Clinicians have a clear way to participate in Advanced APMs.

In Year 2, we are keeping many of the flexibilities from the transition year to help clinicians get ready for Year 3. Since January 1, 2017, we've worked with more than 100 stakeholder organizations and over 47,000 people to get the word out about the Quality Payment Program, get feedback, and help make it easier for you to participate. We've also reviewed over 1,200 stakeholder comments and are finalizing many of the proposed policies from the calendar year (CY) 2018 Quality Payment Program proposed rule. Because we want to continue to receive your feedback, this is a final rule with comment period. The Quality Payment Program makes major changes to how Medicare pays clinicians. We've heard challenges and concerns from stakeholders, so we will keep:

- Going slow while preparing clinicians for full implementation in year 3.
- Providing more flexibility to help reduce your burden.
- Offering new incentives for participation.

Just like in the transition year, we will keep offering our free, hands-on Technical Assistance (TA) to help you and your groups participate in the Quality Payment Program.

Patients Over Paperwork

CMS recently launched the "Patients Over Paperwork" Initiative, a cross-cutting, collaborative process that evaluates and streamlines regulations with a goal to reduce unnecessary burden, increase efficiencies, and improve the beneficiary experience. This effort emphasizes a commitment to removing regulatory obstacles that get in the way of providers spending time with patients. The Quality Payment Program final rule with comment period includes the following as part of this initiative:

CMS

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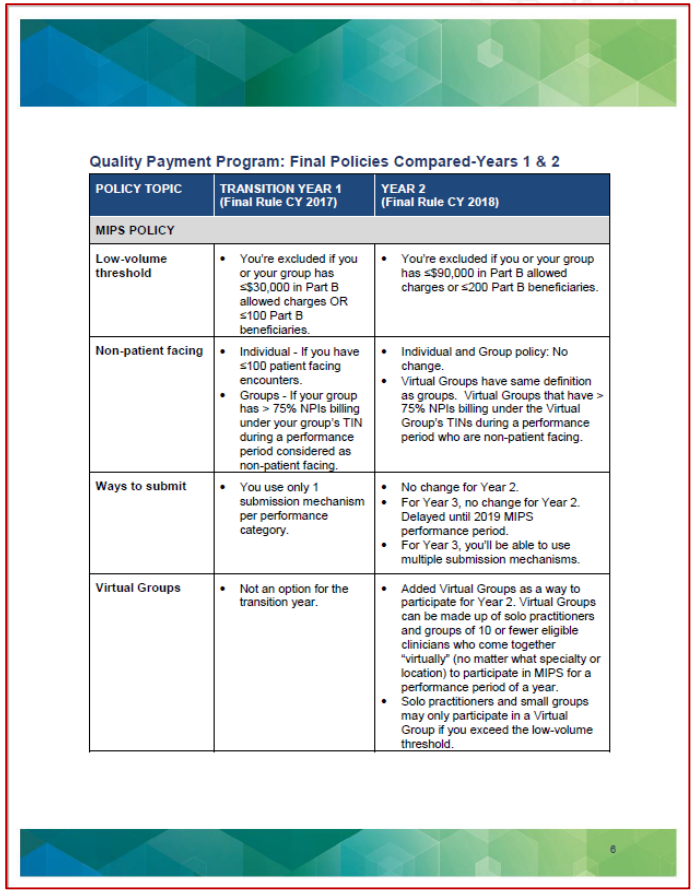

Quality Payment Program: Final Policies Compared-Years 1 & 2

POLICY TOPIC	TRANSITION YEAR 1 (Final Rule CY 2017)	YEAR 2 (Final Rule CY 2018)
MIPS POLICY		
Low-volume threshold	• You're excluded if you or your group has ≤$30,000 in Part B allowed charges OR ≤100 Part B beneficiaries.	• You're excluded if you or your group has ≤$90,000 in Part B allowed charges or ≤200 Part B beneficiaries.
Non-patient facing	• Individual - If you have ≤100 patient facing encounters. • Groups - If your group has > 75% NPIs billing under your group's TIN during a performance period considered as non-patient facing.	• Individual and Group policy: No change. • Virtual Groups have same definition as groups. Virtual Groups that have > 75% NPIs billing under the Virtual Group's TINs during a performance period who are non-patient facing.
Ways to submit	• You use only 1 submission mechanism per performance category.	• No change for Year 2. • For Year 3, no change for Year 2. Delayed until 2019 MIPS performance period. • For Year 3, you'll be able to use multiple submission mechanisms.
Virtual Groups	• Not an option for the transition year.	• Added Virtual Groups as a way to participate for Year 2. Virtual Groups can be 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 of a year. • Solo practitioners and small groups may only participate in a Virtual Group if you exceed the low-volume threshold.

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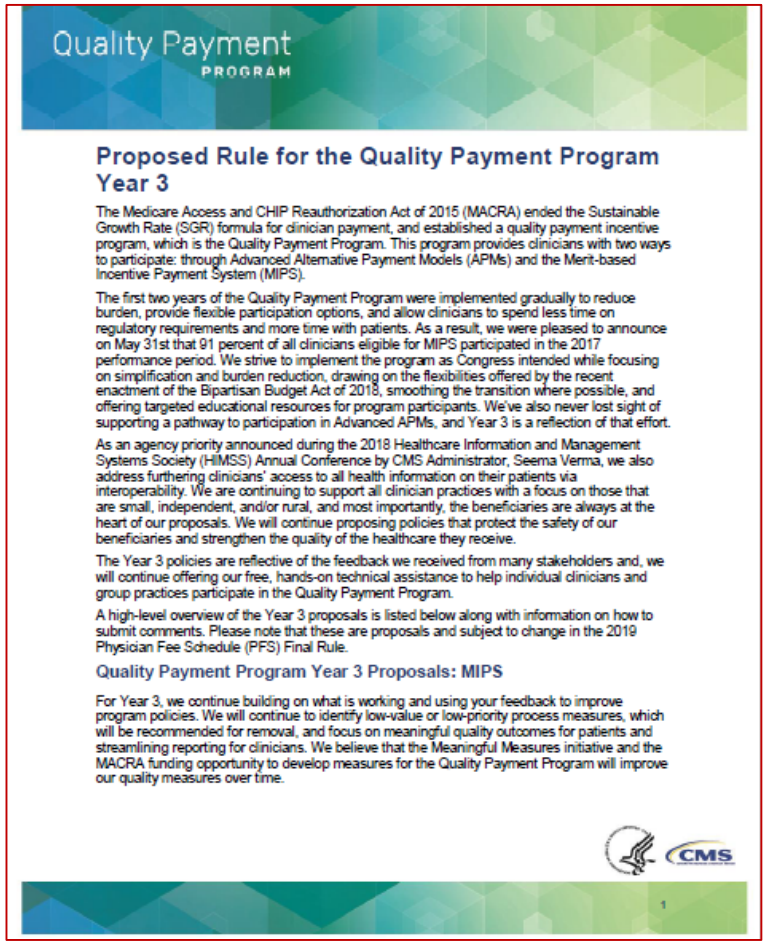
Source: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/QPP-Year-2-Final-Rule-Fact-Sheet.pdf

Slide prepared by IHS

QPP Fact Sheet: Year 3 (2019) Proposed

Fact sheet

- 28 pages
- Provides comparison of Year 2 and Proposed Year 3



Quality Payment PROGRAM

Proposed Rule for the Quality Payment Program Year 3

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula for clinician payment, and established a quality payment incentive program, which is the Quality Payment Program. This program provides clinicians with two ways to participate: through Advanced Alternative Payment Models (APMs) and the Merit-based Incentive Payment System (MIPS).

The first two years of the Quality Payment Program were implemented gradually to reduce burden, provide flexible participation options, and allow clinicians to spend less time on regulatory requirements and more time with patients. As a result, we were pleased to announce on May 31st that 91 percent of all clinicians eligible for MIPS participated in the 2017 performance period. We strive to implement the program as Congress intended while focusing on simplification and burden reduction, drawing on the flexibilities offered by the recent enactment of the Bipartisan Budget Act of 2018, smoothing the transition where possible, and offering targeted educational resources for program participants. We've also never lost sight of supporting a pathway to participation in Advanced APMs, and Year 3 is a reflection of that effort.

As an agency priority announced during the 2018 Healthcare Information and Management Systems Society (HIMSS) Annual Conference by CMS Administrator, Seema Verma, we also address furthering clinicians' access to all health information on their patients via interoperability. We are continuing to support all clinician practices with a focus on those that are small, independent, and/or rural, and most importantly, the beneficiaries are always at the heart of our proposals. We will continue proposing policies that protect the safety of our beneficiaries and strengthen the quality of the healthcare they receive.

The Year 3 policies are reflective of the feedback we received from many stakeholders and, we will continue offering our free, hands-on technical assistance to help individual clinicians and group practices participate in the Quality Payment Program.

A high-level overview of the Year 3 proposals is listed below along with information on how to submit comments. Please note that these are proposals and subject to change in the 2019 Physician Fee Schedule (PFS) Final Rule.

Quality Payment Program Year 3 Proposals: MIPS

For Year 3, we continue building on what is working and using your feedback to improve program policies. We will continue to identify low-value or low-priority process measures, which will be recommended for removal, and focus on meaningful quality outcomes for patients and streamlining reporting for clinicians. We believe that the Meaningful Measures initiative and the MACRA funding opportunity to develop measures for the Quality Payment Program will improve our quality measures over time.

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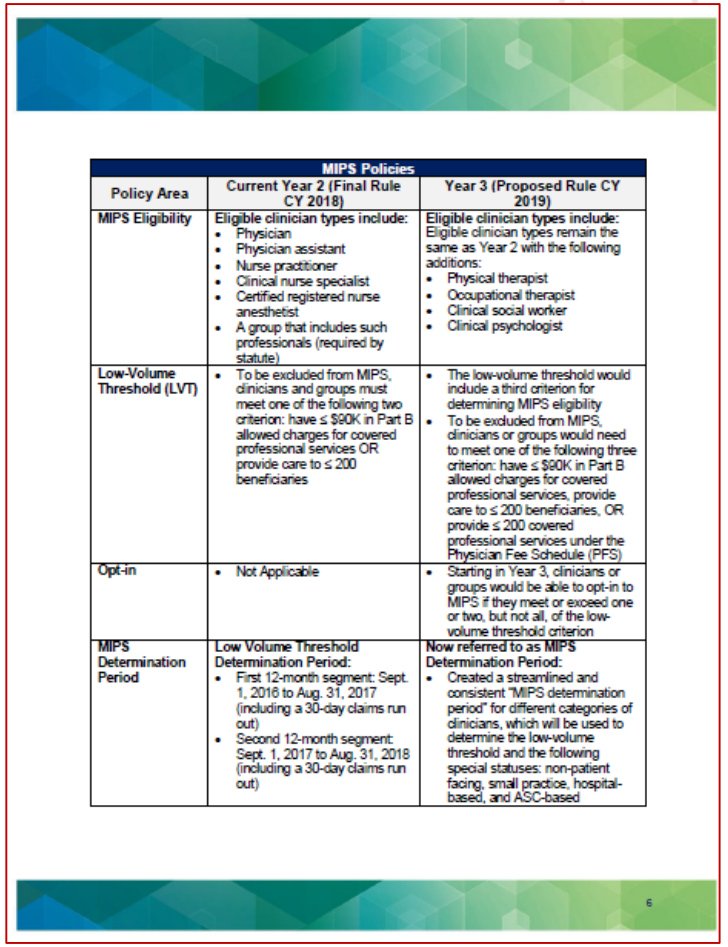

MIPS Policies

Policy Area	Current Year 2 (Final Rule CY 2018)	Year 3 (Proposed Rule CY 2019)
MIPS Eligibility	**Eligible clinician types include:** • Physician • Physician assistant • Nurse practitioner • Clinical nurse specialist • Certified registered nurse anesthetist • A group that includes such professionals (required by statute)	**Eligible clinician types include:** Eligible clinician types remain the same as Year 2 with the following additions: • Physical therapist • Occupational therapist • Clinical social worker • Clinical psychologist
Low-Volume Threshold (LVT)	• To be excluded from MIPS, clinicians and groups must meet one of the following two criterion: have ≤ $90K in Part B allowed charges for covered professional services OR provide care to ≤ 200 beneficiaries	• The low-volume threshold would include a third criterion for determining MIPS eligibility • To be excluded from MIPS, clinicians or groups would need to meet one of the following three criterion: have ≤ $90K in Part B allowed charges for covered professional services, provide care to ≤ 200 beneficiaries, OR provide ≤ 200 covered professional services under the Physician Fee Schedule (PFS)
Opt-in	• Not Applicable	• Starting in Year 3, clinicians or groups would be able to opt-in to MIPS if they meet or exceed one or two, but not all, of the low-volume threshold criterion
MIPS Determination Period	**Low Volume Threshold Determination Period:** • First 12-month segment: Sept. 1, 2016 to Aug. 31, 2017 (including a 30-day claims run out) • Second 12-month segment: Sept. 1, 2017 to Aug. 31, 2018 (including a 30-day claims run out)	**Now referred to as MIPS Determination Period:** • Created a streamlined and consistent "MIPS determination period" for different categories of clinicians, which will be used to determine the low-volume threshold and the following special statuses: non-patient facing, small practice, hospital-based, and ASC-based

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Source: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2019-QPP-proposed-rule-fact-sheet.pdf

MIPS Comparison: Quality

Topic	Transition Year 1 (2017) Final	Year 2 (2018) Final	Year 3 (2019) Proposed
Weight to Final Score	▪ 60% in 2019 payment year. ▪ 50% in 2020 payment year.	▪ 50% in 2020 payment year.	▪ 45% in 2021 payment year.
Data Completeness	Measures that do not meet the data completeness criteria receive three points.	▪ 60% for submission mechanisms except for Web Interface and CAHPS ▪ Measures that do not meet the data completeness criteria earn 1 point ▪ Small practices continue to receive 3 points	Same requirements as Year 2
Scoring	▪ Three-point floor for measures scored against a benchmark. ▪ Three points for measures that don't have a benchmark or don't meet case minimum requirements. ▪ Bonus for additional high priority measures up to 10%. ▪ Bonus for end-to-end electronic reporting up to 10% of denominator for performance category.	▪ No change ▪ Eligible clinicians must fully participate (i.e. submit all required measures and have met data completeness criteria) for the performance period ▪ If the eligible clinician has a previous year Quality performance category score less than or equal to 30%, we would compare 2018 performance to an assumed 2017 Quality performance category score of 30%	Same requirements as Year 2 Additional special scoring considerations for: ▪ Measures impacted by clinical guideline changes ▪ Groups Registered to Report the CAHPS for MIPS Survey

MIPS Comparison: Quality Year 3 Proposed

Basics:

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

Bonus Points

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

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

MIPS 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.	▪ 10% in 2020 MIPS payment year, but are soliciting feedback on keeping the weight at 10%.
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.

MIPS Comparison: Cost Year 3 Proposed

Basics:

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

Measure Case Minimums

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

MIPS Comparison: ACI/ Promoting Interoperability (PI)

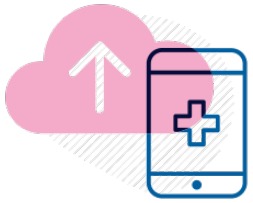
Topic	Transition Year 1 (2017) Final	Year 2 (2018) Final
CEHRT	2014 or 2015 CEHRT Edition for the 2017 transition year and require use of 2015 CEHRT edition for 2018.	Use either the 2014 or 2015 Edition CEHRT in 2018.
Weight to Final Score	25%, made up of a base score, performance score, and bonus points 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.

MIPS Comparison: ACI/ PI (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 Promoting Interoperability 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.

Note: You'll need to submit a hardship application by December 31, 2018 in order to have the PI performance category reweighted to 0%.

PI Performance Category Year 3 (2019) Proposed: Objectives and Measures



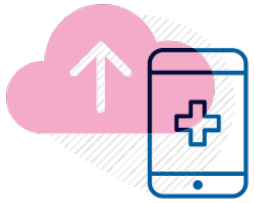
Basics:

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

Objectives and Measures

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

PI Performance Category Year 3 (2019) Proposed: Scoring



Basics:

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

Scoring

Year 2 (2018) Final	Year 3 (2019) Proposed
▪ Fulfill the base score (worth 50%) by submitting at least a 1 in the numerator of certain measures AND submit "yes" for the Security Risk Analysis measure ▪ Performance score (worth 90%) is determined by a performance rate for each submitted measure ▪ Bonus score (worth 10%) is available ▪ Maximum score is 165%, but is capped at 100%	▪ Performance-based scoring at the individual measure level ▪ Each measure would be scored on performance for that measure based on the submission of a numerator or denominator, or a "yes or no" o Must submit a numerator of at least one or a "yes" to fulfill the required measures ▪ The scores for each of the individual measures would be added together to calculate a final score ▪ If exclusions are claimed, the points would be allocated to other measures

PI Performance Category Year 3 (2019) Proposed: Reweighting

Basics:

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

Reweighting

Year 2 (2018) Final	Year 3 (2019) Proposed
▪ Automatic reweighting for the following MIPS eligible clinicians: Non-Patient Facing, Hospital-based, Ambulatory Surgical Center-based, PAs, NPs, Clinical Nurse Specialists, and CRNAs ▪ Application based reweighting also available for certain circumstances • Example: clinicians who are in small practices	**Same requirements** as Year 2, with the following additions: ▪ Extend the automatic reweighting to Physical Therapists, Occupational Therapists, Clinical Social Workers, and Clinical Psychologists

PI Performance Category Year 3 (2019) Proposed: Objectives, Measures and Points

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

MIPS 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

Improvement Activities Performance Category: Year 3 (2019) Proposed

Basics:

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

Activity Inventory

- Adding 6 new Improvement Activities
- Modifying 5 existing Improvement Activities
- Removing 1 existing Improvement Activity

CEHRT Bonus

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

**Contingent upon the new Promoting Interoperability scoring methodology being finalized*

Proposed Rule for Year 3 - MIPS

PERFORMANCE THRESHOLD AND PAYMENT ADJUSTMENTS

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

Change: *Increase in Performance Threshold and Payment Adjustment*

Transition Year 1 (2017) Final	Year 2 (2018) Final
• 3 point threshold	• 15 point threshold
• Exceptional performer set at 70 points	• Exceptional performer set at 70 points
• Payment adjustment set at +/- 4%	• Payment adjustment set at +/- 5%

Year 3 (2019) Proposed

- The proposed 30 points threshold
- Exceptional performance bonus set at 80 points
- Payment adjustment could be set at +/- 7%*
- Payment adjustment (and exceptional performer bonus) is based on comparing final score to performance threshold and additional performance threshold for exceptional performance

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

CY 2018- How can I achieve 15 points?

- **Report all required Improvement Activities.**
- **Meet the PI base score and submit one Quality measure that meets data completeness.**
- **Meet the PI 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 3 (2019) Proposed: Performance Threshold and Payment Adjustments

Year 2 (2018) Final

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

Year 3 (2019) Proposed

Final Score 2018	Payment Adjustment 2020
≥80 points	▪ Positive adjustment greater than 0% ▪ Eligible for exceptional performance bonus—minimum of additional 0.5%
30.01-79.99 points	▪ Positive adjustment greater than 0% ▪ Not eligible for exceptional performance bonus
30 points	▪ Neutral payment adjustment
7.51-29.99	▪ Negative payment adjustment greater than -7% and less than 0%
0-7.5 points	▪ Negative payment adjustment of -7%

MIPS Year 2 (2018)
Extreme and Uncontrollable Circumstances

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 Promoting Interoperability 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 FOR 2018 REPORTING

Getting Ready to Participate in MIPS 2018

- **Determine participants' eligibility status**
  - New eligibility criteria
  - Use CMS website to confirm eligibility
- **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
    - Obtain your Enterprise Identity Management (EIDM) credentials

Slide prepared by IHS

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**

Slide prepared by IHS

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
  - Data call to address challenges from 2017 reporting
  - Address care coordination utilizing technology

Slide prepared by IHS

Future Plans for RPMS

Perform Market Research

- Explore what products (e.g. registries) can interface with EHR to submit CQMs

Update Clinical Quality Measures (CQM) Logic for 2018 reporting

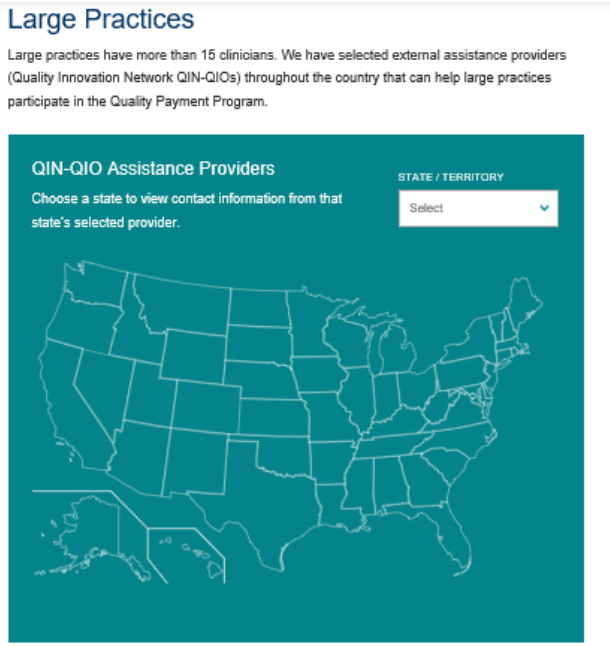
- Workgroup developing and certifying measures

Slide prepared by IHS

Additional Resource Information

Technical Assistance Support

- **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)**
- **Learn more about technical assistance:**
  - https://qpp.cms.gov/about/help-and-support#technical-assistance
  - https://qpp.cms.gov/about/small-underserved-rural-practices



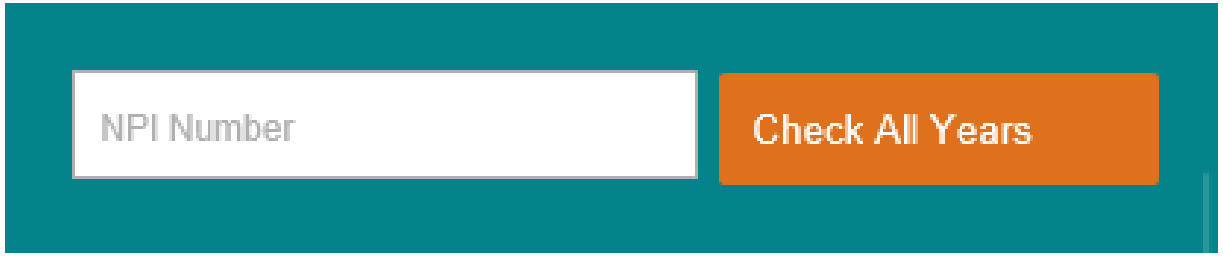
Slide prepared by IHS

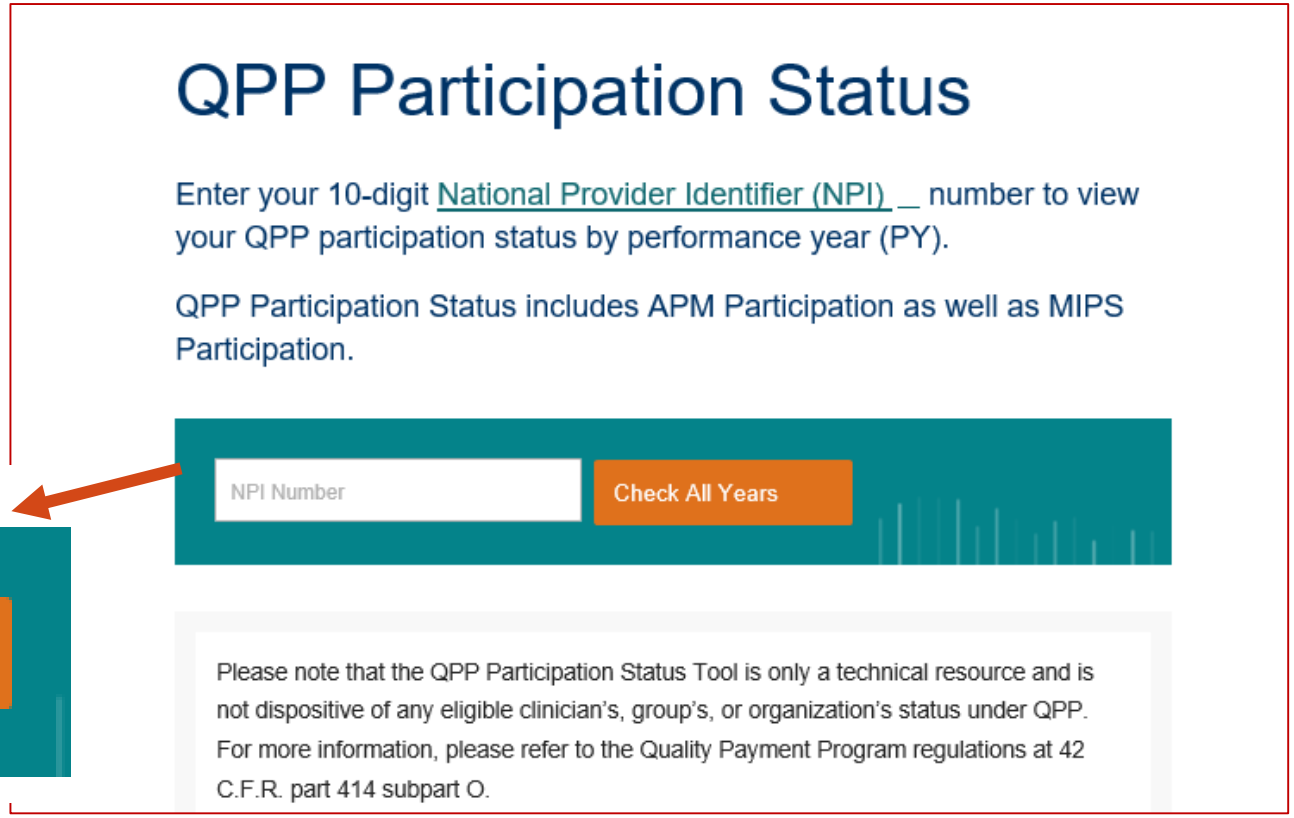
Eligibility: MIPS Participation Status

CMS website

CMS MIPS Participation Status

- Sources:
  https://qpp.cms.gov/
  https://qpp.cms.gov/participation-lookup





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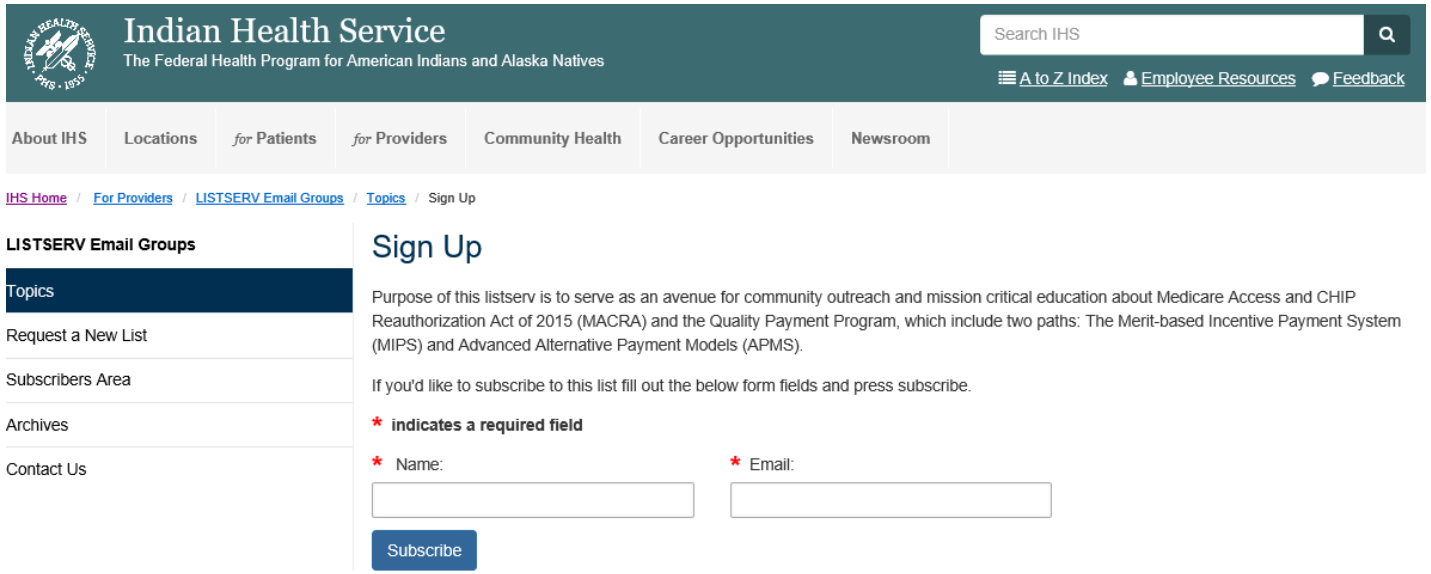
IHS QPP – MACRA Resources

- **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**



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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/

Slide prepared by IHS

QPP Resources

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. 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

Centers for Medicare & Medicaid Services. (October 27, 2016) Medicare Shared Savings Program 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

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:Quality payment program year 3 proposed rule overview. (July 17, 2018) (slide deck- webinar).

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. Proposed Rule for the Quality Payment Program Year 3. Available at: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2019-QPP-proposed-rule-fact-sheet.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 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.

Federal Register. Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year. (November 16, 2017). Available at https://www.federalregister.gov/documents/2017/11/16/2017-24067/medicare-program-cy-2018-updates-to-the-quality-payment-program-and-quality-payment-program-extreme

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