QUALITY PAYMENT PROGRAM (QPP) UPDATES

Changes to the Merit-Based Incentive Program (MIPS) under the Bipartisan Budget Act of 2018

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Important to Remember

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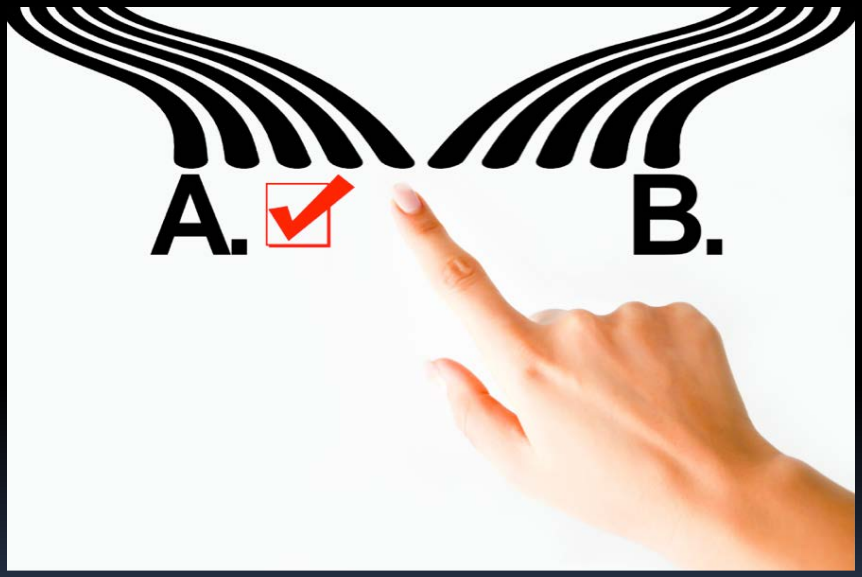
FIRST, A BRIEF REMINDER OF THE MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT (MACRA) & THE QUALITY PAYMENT PROGRAM (QPP)

Providers Choose 1 of 2 Paths



Under the Quality Payment Program (QPP), eligible providers much choose between participation in:

1. The Merit-Based Incentive Payment System (MIPS), or
2. A qualified Alternative Payment Model (APM).

Providers will be able to decide annually which program they will participate in.

ALTERNATIVE PAYMENT MODELS (APMs)

ADVANCED APMs

Alternative Payment Models (APMs)

- Alternative Payment Models (APMs) approaches to paying for medical care that incentivizes quality and value.
- MACRA defined APMs include:
  - CMS Innovation Center models
    - The Oncology Care Model (OCM) is a CMS Innovation Center payment and delivery model
  - Medicare Shared Savings Programs (MSSPs)
  - Demonstrations under the Health Care Quality Demonstration Program
  - Demonstrations required by federal law

https://innovation.cms.gov

Three Criteria for Advanced APMs

1. Require participants to use certified electronic health record technology (CEHRT);
2. Provide payment for covered professional services based on quality measures comparable to those used in the quality performance category of the Merit-based Incentive Payment System (MIPS); and
3. Either: (1) be a Medical Home Model expanded under CMS Innovation Center authority; or (2) require participating APM Entities to bear more than a nominal amount of financial risk for monetary losses.

Budget Act Changes to the PTAC

- MACRA established the Physician Focused Payment Model Technical Advisory Committee (PTAC) to review proposals for physician-focused APMs submitted by the public and to make recommendations on their implementation to CMS.
- In response to comments on the PTAC role and process, the Budget Act expands the language from the original MACRA statute and requires the panel to provide initial feedback on models and an explanation of the basis for the feedback provided.

Advanced APMs for 2018 Include:

- Comprehensive Primary Care Plus (CPC+)
- Comprehensive ESRD (CEC) Care Model (non-LDO two-sided risk & LDO arrangement)
- Bundled Payments for Care Improvement Advanced Model (BPCI Advanced)
- Medicare Accountable Care Organization (ACO Track 1+ Model)
- Medicare Shared Savings Program (MSSP ACOs Tracks 2 & 3)
- Next Generation ACO Model
- Oncology Care Model (two-sided risk)
- Vermont Medicare ACO Initiative (as part of All-Payer ACO Model)

CMS may update the list of qualified Advanced APMs based on changes in the designs of APMs or the announcement of new APMs

View the entire list of Advanced APMs at:

www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Comprehensive-List-of-APMs.pdf

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

And Updates from the Bipartisan Budget Act of 2018

Merit-Based Incentive Payment System (MIPS)

- Sunsets current Meaningful Use, Value-Based Modifier, and Physician Quality Reporting System (PQRS) penalties at the end of 2018, rolling requirements into a single program.
- Adjusts Medicare payments based on performance on a single budget-neutral payment beginning in 2019.
- Includes improvement incentives for quality and resource use categories.

MIPS

- MIPS measures Medicare Part B providers to develop an annual MIPS score and payment update based on 4 categories:

1. Quality,
2. Cost,
3. Improvement Activities, and
4. Advancing Care Information

2017 was the first performance year for MIPS and 2019 the first payment year

Who is Included in MIPS?

- For Year 2 (2018) you're included in MIPS if you bill Medicare Part B more than $90,000 a year in allowable charges and provide care for more than 200 Medicare patients a year, and are a:
  - Physician
  - Physician assistant (PA)
  - Nurse practitioner (NP)
  - Clinical nurse specialist (CNS)
  - Certified registered nurse anesthetist (CRNA)

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

Who is Excluded From MIPS in 2018?

- Clinicians who are:
  - Enrolled in Medicare for the first time during the performance period (exempt until following performance year), or
  - Below the low-volume threshold of allowed charges for covered professional services of less than or equal to $90,000 a year* or see 200 or fewer Medicare Part B patients a year, or
  - Significantly participating in Advanced APMs, receiving 25% of Medicare payments or seeing 20% of Medicare patients through an Advanced APM.

The Budget Act removes the cost of Part B drugs in the calculation of the low-volume threshold.

Letter to Congress

On January 18, 109 organizations sent a letter to the leaders of the Senate Finance Committee, House Energy and Commerce Committee, and the House Ways and Means Committee addressing the issue of including Part B drugs in the MIPS payment adjustment stating:

"It will significantly amplify the range of bonuses and penalties intended by MACRA, only for certain specialties."

Budget Act
MIPS Modifications – Part B Drugs

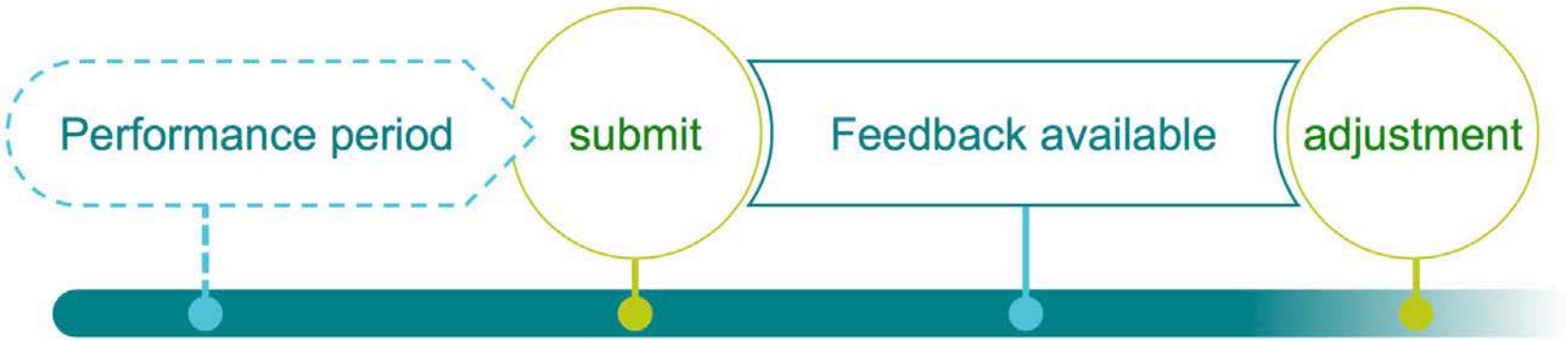
- Congress responded to commenters concerns that certain specialties administer more Part B drugs than others and would be exposed to significant financial risk by excluding Part B drug costs.

- The Budget Act modified MACRA to exclude Medicare Part B drug costs from:
  - MIPS cost calculations,
  - MIPS payment adjustments, and
  - The low-volume threshold determination of MIPS eligibility.

https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.pdf

MIPS Year 2 (2018)

Timeline for Year 2



2018
Performance Year

- Performance period opens January 1, 2018.
- Closes December 31, 2018.
- Clinicians care for patients and record data during the year.

March 31, 2019
Data Submission

- Deadline for submitting data is March 31, 2019.
- 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, 2020
Payment Adjustment

- MIPS payment adjustments are prospectively applied to each claim beginning January 1, 2020.

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

QPP Year 2: MIPS Highlights

- The performance threshold is raised to 15 points in Year 2 (from 3 points in the 2017 transition year).
- Allows the use of 2014 Edition and/or 2015 Certified Electronic Health Record Technology (CEHRT) in Year 2, with a bonus for using only 2015 CEHRT.
- Earn up to 5 bonus points on your final score for treatment of complex patients.
- Clinicians impacted by hurricanes Irma, Harvey & Maria and other natural disasters:
  - CMS will automatically weight the Quality, Advancing Care Information, and Improvement Activities
  - Performance categories will be set at 0% of the final score for clinicians impacted by hurricanes Irma, Harvey and Maria and other natural disasters.

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

QPP Year 2: MIPS Highlights

- For small practices of 15 or fewer clinicians:
  - 5 bonus points are to be added to the final scores of small practices
  - Solo practitioners and small practices may choice to form or join a Virtual Group to participate with other practices.
  - Will continue to award small practices 3 points for measures in the Quality performance category that don’t meet data completeness requirements.

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

MIPS Modifications - Performance Thresholds

- Providers must exceed a "performance threshold" to avoid payment reductions.
- Under original MACRA policy, CMS would have been required to establish the performance threshold for avoiding a penalty under MIPS at the mean or median performance of all participants beginning in 2019 (resulting in approximately half of all clinicians falling below the threshold and subject to the MIPS payment reduction).
- In the Budget Act, Congress extended the flexibility for CMS to establish a threshold other than the mean or median for an additional three years (until 2022) as physician practices adapt to the new value- based payment program and CMS reduces administrative burden and provides feedback.
- Currently, the 2018 threshold is set at 15
- CMS has not yet determined the threshold for years 2019- 2021.

https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.pdf

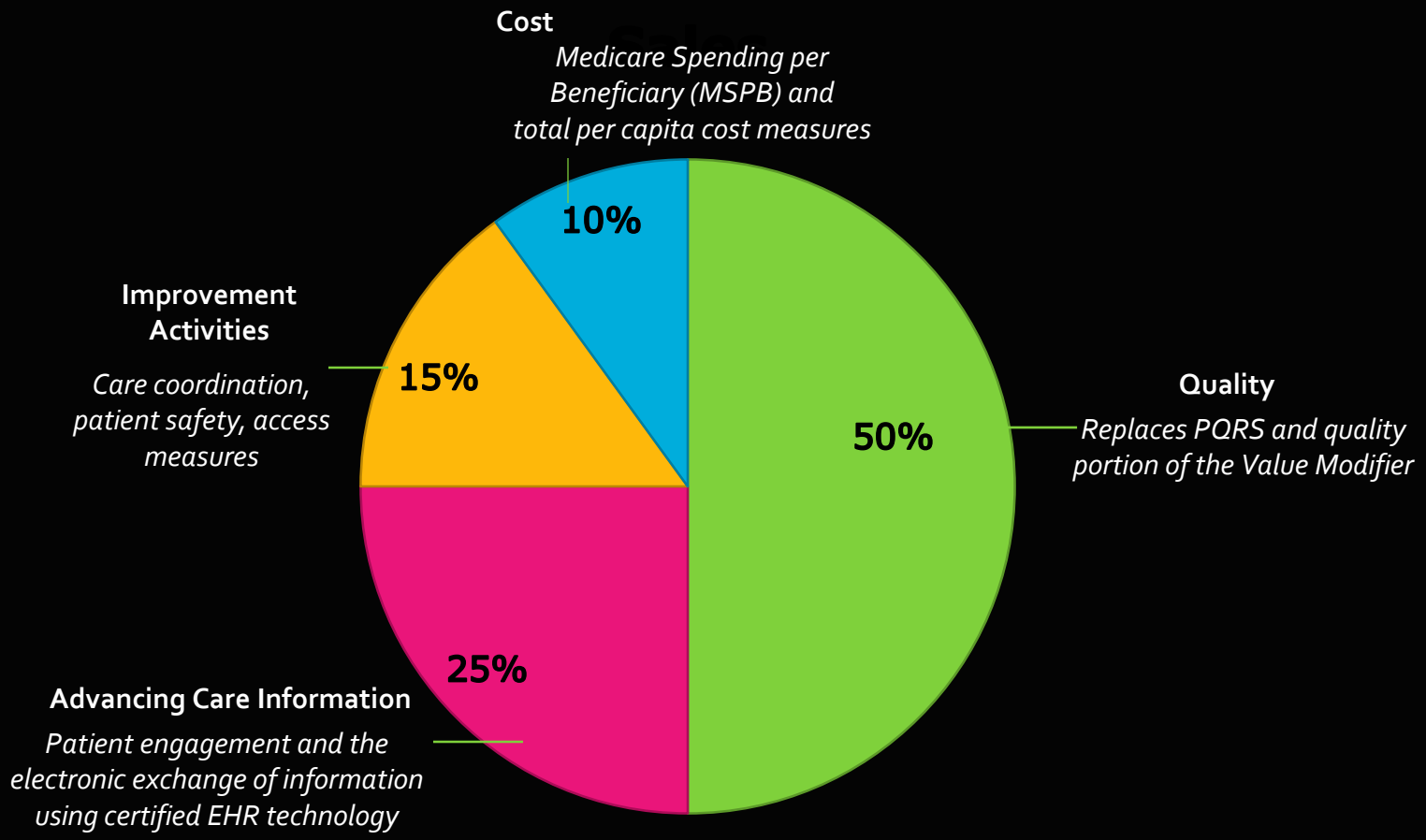
Comparison of 2017 Transition Year and 2018 Final Rule for Year 2

	2017 Pick-Your-Pace	%	**2018 Final Rule**	%
	Performance Threshold: 3 Points		Performance Threshold: 15 Points	
Quality	1. Minimal: 1 measure, 1 patient/chart 1. Partial: 90 consecutive days, 50% of all patients 2. Full: 6 measures; at least 90 consecutive days, 50% of all patients	60	• 6 Measures • Full calendar year • 60% of all patients	50
Advancing Care Information	Minimal: base score only-5 measures; for 90 consecutive days No performance thresholds used in scoring	25	• At least 90 consecutive days • Hardship exemption for small practices • 2014 Edition CEHRT	25

Comparison of 2017 Transition Year and 2018 Final Rule for Year 2

	2017 Pick-Your-Pace	%	**2018 Final Rule**	%
	Performance Threshold: 3 Points		Performance Threshold: 15 Points	
Improvement Activities	Minimal: 1 activity for 90 consecutive days Full: 1-4 activities for at least 90 consecutive days	15	• At least 90 consecutive days • 1-4 activities • Reduced reporting for small/rural practices	15
Cost	Full year; Calculated automatically by CMS	0	Full year; Calculated automatically by CMS	10
Low-Volume Threshold	Criteria ≤ $30,000 in Part B allowed charges, or ≤ 100 Part B beneficiaries		Criteria ≤ $90,000 in Part B allowed charges, or ≤ 200 Part B beneficiaries	
Other			Virtual Groups added Bonus points for small practices; complex patients and exclusive use of 2015 CEHRT use	

MIPS Performance Category Weights Year 2 - 2018



MIPS Year 2 (2018)

Calculating the Final Score

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

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

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

MIPS Year 2 (2018) Reporting Options

Three Options for MIPS Reporting in 2018

1 INDIVIDUAL	2 GROUP	3 VIRTUAL GROUP
Individual Under an National Provider Identifier (NPI) number and Taxpayer Identification Number (TIN) where they reassign benefits	As a Group a) 2 or more clinicians (NPIs) who have reassigned their billing rights to a single TIN* b) As an APM entity	As a Virtual Group Solo practitioners & 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

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

Decide How You Will Participate

Individual

Eligible Clinicians (EC):

- Submit individual EC data for each of the MIPS categories
- Payment adjustment is based on individual MIPS Score
- Report data through EHR, Registry, a Qualified Clinical Data Registry, or Medicare Part B claims.

Groups (including Virtual Groups):

- Submit group-level data for each of the MIPS categories
- Individual EC payment adjustments are based on the group's performance
- Report data through EHR, Registry or a Qualified Clinical Data Registry
- Groups of 25 or more can report through CMS Web Interface

MIPS Year 2 (2018)

Submission Mechanisms

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	Attestation QCDR Qualified Registry EHR	Attestation QCDR Qualified Registry EHR CMS Web Interface (groups of 25 or more)

Please note:

- Continue with the use of **1** submission mechanism per performance category in Year 2 (2018). Same policy as Year 1.
- The **use of multiple submission mechanisms** per performance category is deferred to Year 3 (2019).

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

MIPS Modifications – Cost Category

- Weighted at 10% for 2018 performance year (2020 payment year).
- Budget Act:
  - Allows CMS discretion to determine the weight of the cost category (within a range of 10%-30%) through 2021. Prior to passage of this bill the cost weight was scheduled to account for 30% of performance scores by 2021.
  - Removes the cost of Part B drugs from MIPS calculations and MIPS payment adjustments.
- Part B* and Part D drugs are not included in the cost calculation for the 2018 performance year.

*The Budget Act removed the cost of Part B drugs from the Cost category calculation

https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.pdf

MIPS Modifications – Cost Category

- CMS will evaluate two measures in the Cost category for 2018: the Medicare Spending per Beneficiary (MSPB) and the Total Per Capita Costs for All Attributed Beneficiaries (TPCC) measures.
- The MSPB clinician measure assesses the cost to Medicare of services performed by an individual clinician during an MSPB episode.
- The TPCC measure is a payment-standardized, annualized, risk-adjusted, and specialty-adjusted measure that evaluates the overall cost of care provided to beneficiaries attributed to clinicians.
- The Budget Act eliminated year-over-year improvement scoring for the cost category during reporting years 2018-2021.
- CMS will continue to develop and test new measures.

https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.pdf

Improvement Activity (IA)

- **15%** of Final Score in 2018 112 activities available in the inventory.
- Medium and High Weights remain the same from 2017:
  - Medium = 10 points High = 20 points
- A simple “yes” is all that is required to attest to completing an IA.
- Group reporting: only 1 MIPS eligible clinician in a TIN must perform the IA for the TIN to receive credit.
- Virtual group reporting: only 1 MIPS eligible clinician in a virtual group must perform the IA for the TIN to receive credit .

*2018 Improvement Activities are available on the CMS QPP Resources Page

https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Resources.html

Advancing Care Information (ACI)

- 2 Measures sets available based on EHR Edition*
- No change to the base score requirements for 2018.
- Performance score: MIPS eligible clinicians and groups earn 10% for reporting to any one of the Public Health and Clinical Data Registry Reporting measures as part of the performance score.
- Bonus score: 5% bonus score is available for reporting to an additional registry not reported under the performance score.
- Additional Improvement Activities are eligible for a 10% ACI bonus for completion of at least 1 of the specified Improvement Activities using CEHRT.
- A 10% bonus is available for using only 2015 Edition CEHRT.
- Total bonus score available is 25%

*2018 ACI measures are available in the QPP Resource Library:
https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Resources.html

Qualified Registries
2018 Performance Period

Vendor	Quality	Improvement Activities	Advancing Care Information
Pulse Qualified Registry	X	X	X
QOPI® Reporting Registry (Qualified Registry)	X	X	X
QPP Navigator	X	X	X
QPP Registry	X	X	X
Quantician	X	X	X
QVision Healthcare LLC	X	X	X
RCM Registry	X	X	
Registry Clearinghouse	X		
Registry One	X	X	X
ReportingMD	X	X	X
Roji Health Intelligence LLC	X	X	X
SaferMD SuncoastRHIO Collaborative	X	X	X
Seva Health MIPS Registry	X	X	X
SM Outpatient Therapy Registry	X		
SolvEdge Inc.	X		
Sovereign Health Registry	X	X	X
Specialty Benchmarks Registry	X	X	
SpectraMedix eMeasures360 Registry	X	X	X
SPH Analytics Qualified Registry	X	X	X
Submit2CMS	X	X	X

www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Resources.html

Qualified Clinical Data Registries (QCDRs) 2018 Performance Period

Vendor	Quality	Improvement Activities	Advancing Care Information
Oncology QCDR Powered by Premier, Inc.	x	x	x
Ortho[m]atrix	x	x	x
Outpatient Endovascular and Interventional Society National Registry	x		
Pathologists Quality Registry	x	x	
Persivia, Inc.	x	x	x
Philips Wellcentive	x	x	x
Physical Therapy Outcomes Registry	x	x	x
Physician Compass	x	x	x
PINNACLE Registry and Diabetes Collaborative Registry	x	x	x
POLARIS	x	x	x
PPRNet	x	x	x
PPS Analytics LLC	x	x	x
Practice Fusion, Inc.	x	x	x
Practice Insights by McKesson Specialty Health in Collaboration with The US Oncology Network	x	x	x
Premier Clinician Performance Registry	x	x	x
PsychPRO	x	x	x
QCMETRIX QCDR	x		
QOPI® Reporting Registry (QCDR) Brought to you by ASCO and ASTRO	x	x	x
Quality Outcomes Database (QOD)	x		

www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Resources.html

Quality Scoring - How you Report

- Key: Only 1 Submission method will be allowed for the Quality category
- Quality measures can be submitted via Electronic Health Records (EHRs), Qualified Registries, Qualified Clinical Data Registries (QCDRs), Claims, CMS Web Interface, and CAHPS for MIPS Survey submission methods.
- Quality measures are worth up to 10 points
- Scoring for the Quality measure may differ depending on the submission method
- Benchmarking for each measure is also uniquely determined by each submission method - a measure that is available to report via multiple submission methods may have a benchmark for one submission method, but not for the other.
  - Measures without a benchmark can only earn a maximum of 3 points (unless the measure is a high priority or outcome measure which may be worth 1 or 2 additional bonus points).

Submission_Method	Measure_Type	Benchmark	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10	Topped Out
Claims	Process	Y	39.78 - 51.32	51.33 - 61.67	61.68 - 70.47	70.48 - 77.77	77.78 - 84.49	84.50 - 91.99	92.00 - 99.06	>= 99.07	No
EHR	Process	Y	14.13 - 23.25	23.26 - 33.02	33.03 - 43.58	43.59 - 53.96	53.97 - 63.60	63.61 - 74.54	74.55 - 85.52	>= 85.53	No
Registry/QCDR	Process	Y	12.24 - 24.02	24.03 - 36.34	36.35 - 48.51	48.52 - 58.95	58.96 - 68.05	68.06 - 77.77	77.78 - 90.19	>= 90.20	No

Quality Scoring – What you Report

- CMS will award bonus points to providers who report “high priority” measures:
  - Two bonus points for each additional outcome measure reported beyond the required one OR
  - One bonus point for each additional high priority measure.
- Bonus points for reporting additional high priority and outcome measures are capped at 10% of the total available points in the Quality performance category for providers. For example, if a provider is in a small practice and can score up to 60 points, the total bonus points that can be awarded is 6.

MEASURE NAME	QUALITY ID	HIGH PRIORITY MEASURE	DATA SUBMISSION METHOD	SPECIALTY MEASURE SET
HER2 Negative or Undocumented Breast Cancer Patients Spared Treatment with HER2-Targeted Therapies	449	Yes	Registry	General Oncology
Oncology: Medical and Radiation - Pain Intensity Quantified	143	Yes	EHR	General Oncology,Radiation Oncology
Patients with Metastatic Colorectal Cancer and KRAS Gene Mutation Spared Treatment with Anti-epidermal Growth Factor Receptor (EGFR) Monoclonal Antibodies	452	Yes	Registry	General Oncology
Proportion Admitted to Hospice for less than 3 days	457	Yes	Registry	General Oncology
Proportion Admitted to the Intensive Care Unit (ICU) in the Last 30 Days of Life	455	Yes	Registry	General Oncology
Proportion Not Admitted To Hospice	456	Yes	Registry	General Oncology
Proportion of Patients who Died from Cancer with more than One Emergency Department Visit in the Last 30 Days of Life	454	Yes	Registry	General Oncology
Proportion Receiving Chemotherapy in the Last 14 Days of Life	453	Yes	Registry	General Oncology
Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	102	Yes	EHR	General Oncology,Radiation Oncology,Urology
Trastuzumab Received By Patients With AJCC Stage I (T1c) - III And HER2 Positive Breast Cancer Receiving Adjuvant Chemotherapy	450	Yes	Registry	General Oncology

Performance Period 2018:Topped Out Measures

- Topped out measures with measure benchmarks that have been topped out for *at least 2 consecutive years* will only receive up to 7 points.
- For Performance Period 2018 the topped out measures include:

1. Perioperative Care: Selection of Prophylactic Antibiotic-First or Second Generation Cephalosporin. (Quality Measure ID: 21)
2. Melanoma: Overutilization of Imaging Studies in Melanoma.(Quality Measure ID: 224)
3. Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients). (Quality Measure ID: 23)
4. Image Confirmation of Successful Excision of Image-Localized Breast Lesion. (Quality Measure ID: 262)
5. Optimizing Patient Exposure to Ionizing Radiation: Utilization of a Standardized Nomenclature for Computerized Tomography (CT) Imaging Description (Quality Measure ID: 359)
6. Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy (Quality Measure ID: 52)

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

Tip:
Questions to Ask – Registries & QCDRs

- **What internal workflow changes will need to occur and what changes will you have to adopt at your practice?** The collection of data or how quality data codes are recorded could change with registry reporting.
- **How often will you receive output reports/feedback analysis on your measures?** The regular delivery of feedback reports is dependent on your registry vendor partner.
- **Does the registry have knowledge on provider-specific or TIN-specific potential incentives or penalties?** Evaluate the difference between specialty based registries and multi-specialty registries and their options for individuals and groups.
- **Does the registry support individual and group reporting**? How will the vendor collect and submit data if you decide to use group reporting.
- **Are there cost and fees associated with using the registry or QCDR? Do you have to be a member or purchase a membership?**
- **What technical modifications will need to be made to collect, submit and validate registry data?**

http://www.mckesson.com/bps/blog/six-things-to-consider-when-choosing-a-qcdr/

Maximum MIPS Financial Impact by Payment Year

Payment Year	2019	2020	2021	2022
Performance Year	2017	2018	2019	2020
Maximum Payment Adjustment	± 4%	± 5%	± 7%	± 9%

Payment adjustments are applied to Medicare physician fee schedule payments for services*

*The Budget Act removed Part B drugs from the payment adjustment

Technical Assistance

Available Resources

CMS has **free** resources and organizations on the ground to provide help to eligible clinicians included in the Quality Payment Program:

PRIMARY CARE & SPECIALIST PHYSICIANS

Transforming Clinical Practice Initiative

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

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

SMALL & SOLO PRACTICES

Small, Underserved, and Rural Support (SURS)

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

LARGE PRACTICES

Quality Innovation Networks-
Quality Improvement Organizations (QIN-QIO)

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

Locate the QIN-QIO that serves your state

Quality Innovation Network (QIN) Directory

TECHNICAL SUPPORT

All Eligible Clinicians Are Supported By:

Quality Payment Program Website: qpp.cms.gov
Serves as a starting point for information on the Quality Payment Program.

Quality Payment Program Service Center
Assists with all Quality Payment Program questions.
1-866-288-8292 TTY: 1-877-715-6222 QPP@cms.hhs.gov

Center for Medicare & Medicaid Innovation (CMMI) Learning Systems
Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs. More information about the Learning Systems is available through your model's support inbox.

To learn more, view the Technical Assistance Resource Guide: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Technical-Assistance-Resource-Guide.pdf

SUMMARY

- Not all Quality Measures (QMs) are available with all Registries
- QMs are worth up to 10 points each
- QM points may differ based on your method of reporting
- Reporting additional High Priority and Outcome QMs are worth 1 bonus point each – capped at 10% of the Quality score
- QMs that have been “topped out” for 2 consecutive years will earn a maximum of 7 points
- Benchmarks for a QM may vary based on method of reporting
- QMs that do not have benchmarks or do not meet case minimum have a ceiling of 3 points
- QMs with benchmarks have a floor of 3 points
- Earn additional points by attesting to High Weight Improvement Activities
- Earn a 10% bonus in the Advancing Care Information category by using only 2015 Edition CEHRT
- Review your QRUR Cost Report

Resources

- CMS QPP Website
  https://qpp.cms.gov

- Quality Payment Program Year 2 – Final Rule Overview

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

- MIPS Virtual Groups Webinar

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Virtual-Groups-Public-Webinar-slides.pdf

Resources

QPP Resource Library

https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Resource-library.html

Budget Act

https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.pdf

THANK YOU

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Best Practices Review is available on the iPad®

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