Medicare Physician Payment: QPP Requirements for 2018

December 2017
Some general observations

• QPP created by MACRA is complex

• Most of the “new” requirements are really revisions to the legacy FFS programs
  • Perceptions/understanding shaped by participation in legacy programs
  • Those who chose to accept penalties before may still decline to participate
    • Penalties less severe than combined legacy programs

• One goal of MACRA was to simplify administrative processes for physicians
  • Many improvements in effect now

• There is more work to do
  • Improving the practice environment is a high priority for the AMA
MACRA established two Medicare paths for physicians

- MACRA was designed to offer physicians a choice between two payment pathways:
  - A modified fee-for-service model (MIPS)
  - New payment models that reduce costs of care and/or support high-value services not typically covered under the Medicare fee schedule (APMs)
- In short-term, most are expected to participate in MIPS
- CMS named the physician payment system created by the Medicare Access and CHIP Reauthorization Act (MACRA) law the Quality Payment Program (QPP)
QPP eligibility

• Eligible clinicians include:
  • Physicians (includes dentists, podiatrists, optometrists, some chiropractors)
  • Physician Assistants
  • NPs, CRNAs, Clinical Nurse Specialists

• Exempt clinicians include:
  • Those in first year billing Medicare
  • Participants who receive 25% Medicare payments or see 20% Medicare patients through Advanced APMs
  • Those below a low-volume threshold (LVT)

• LVT raised in 2018, from $30,000 or 100 patients to $90,000 or 200 patients

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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>All Medicare clinicians billing Part B</td>
<td>1,380,209</td>
<td>1,548,022</td>
</tr>
<tr>
<td>MIPS ineligible types</td>
<td>-199,308</td>
<td>-233,289</td>
</tr>
<tr>
<td>Newly enrolled</td>
<td>-85,268</td>
<td>-81,954</td>
</tr>
<tr>
<td>Low volume</td>
<td>-383,514</td>
<td>-540,347</td>
</tr>
<tr>
<td>Qualifying APM participants</td>
<td>-70K-120K</td>
<td>-70,732</td>
</tr>
<tr>
<td>Eligible clinicians who can report under MIPS</td>
<td>43-47%</td>
<td>621,700 (40%)</td>
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</table>
Low-volume threshold exemption

- Clinicians with annual Medicare allowed charges of $90,000 or less, or 200 or fewer Medicare patients exempt from QPP
  - Threshold increased from 2017 levels of $30,000/100 patients

- Eligibility calculated by CMS
  - Based on 12-month historical data (previous September-August)
  - Includes Part B drug costs, but not Part D
  - Visit www.qpp.cms.gov, enter your NPI to check eligibility for the current year

- For group reporting: low-volume physicians who are members of a group that exceeds the threshold must still participate in MIPS

- Exempted physicians receive annual fee schedule updates, but no bonuses or penalties
Accommodations for small practices

In effect for 2017

- Pick your pace MIPS transition (reporting a single quality measure provided exemption from penalties)
- Low-volume threshold $30K/100 patients
- Scores for IA reporting doubled
- $100 million in grants for technical assistance via QIOs and regional health improvement collaboratives

2018 accommodations

- Low-volume threshold raised to $90K/200 patients
- Doubled IA scores continued
- Technical assistance grants continued
- Virtual group option created
- ACI hardship exemption for small practices
- Favorable Quality scoring
- Bonus points added to final score for small practices

https://qpp.cms.gov/about/small-underserved-rural-practices
Merit-based Incentive Payment System (MIPS)
MIPS components and scoring weights

50% Quality Reporting (was PQRS)
10% Cost (was Value-based Modifier)
25% Advancing Care Information (was MU)
15% Improvement Activities

MIPS aims:

- Align 3 current independent programs
- Add 4th component to promote improvement and innovation
- Provide more flexibility and choice of measures
- Retain a fee-for-service payment option

2018 changes:
- Quality weight decreased from 60% to 50% (will be 30% in 2019)
- Cost weight increased from 0% to 10% (will be 30% in 2019)
## MIPS Quality component—full year reporting

<table>
<thead>
<tr>
<th>Legacy PQRS</th>
<th>2017 Quality</th>
<th>2018 changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>9 measures</td>
<td>6 measures (or one specialty set)</td>
<td>2017 modifications mostly retained</td>
</tr>
<tr>
<td>Pass/fail approach</td>
<td>Partial credit allowed</td>
<td>Completeness threshold raised from 50% to 60%</td>
</tr>
<tr>
<td>2% penalties, no bonuses</td>
<td>Flexibility in measure choice</td>
<td>Incomplete measures earn 1 point (3 for small practices)</td>
</tr>
<tr>
<td>Measures must fall across multiple domains</td>
<td>No domains or cross-cutting measures required</td>
<td>New and modified specialty measure sets available</td>
</tr>
<tr>
<td>One cross cutting measure required</td>
<td>Bonuses for electronic reporting</td>
<td>Cross cutting measures removed from most sets (except IM, FM, Ped)</td>
</tr>
<tr>
<td>50% data completeness required for successful measure reporting</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### MIPS ACI requirements—90-day reporting

<table>
<thead>
<tr>
<th>Legacy Meaningful Use</th>
<th>2017 ACI</th>
<th>2018 changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 100% score required on all measures</td>
<td>• Pass/fail replaced with base and performance scoring</td>
<td>• 2017 improvements retained</td>
</tr>
<tr>
<td>• Included redundant quality measures</td>
<td>• 4 base measures required, partial credit allowed for performance measures</td>
<td>• Will not require updates to 2015 CEHRT in 2018 (10% bonus if using)</td>
</tr>
<tr>
<td>• Included problematic CPOE, CDS measures</td>
<td>• Fewer measures; no CPOE, CDC, or clinical quality measures</td>
<td>• May report modified MU stage 2 measures instead of advancing to new stage 3 measures</td>
</tr>
<tr>
<td>• Full-year reporting (although twice reduced in Q4)</td>
<td>• Performance score thresholds eliminated</td>
<td>• Increased opportunities for bonus points</td>
</tr>
<tr>
<td></td>
<td>• 90-day reporting</td>
<td>• Hardship exemptions created for small practices, physicians with decertified EHRs, hospital-based clinicians (including off-campus), ASC-based clinicians</td>
</tr>
<tr>
<td></td>
<td>• Bonuses available for registry reporting and use of CEHRT in IA</td>
<td></td>
</tr>
</tbody>
</table>
MIPS Cost component (calculated by CMS via claims)

<table>
<thead>
<tr>
<th>Legacy value-based modifier</th>
<th>2017 Cost</th>
<th>2018 changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Included both quality and resource-use measures</td>
<td>• Focus solely on cost</td>
<td>• 2017 structural improvements maintained</td>
</tr>
<tr>
<td>• Double jeopardy; PQRS failure penalized twice</td>
<td>• No double-jeopardy</td>
<td>• Weight increased to 10%</td>
</tr>
<tr>
<td>• Measured total cost of care per capita and Medicare spending per (hospitalized) beneficiary</td>
<td>• 10 contractor-developed episode measures added</td>
<td>• 10 episode groups eliminated</td>
</tr>
<tr>
<td>• Part B (but not Part D) drugs included in calculation</td>
<td>• Contractors and clinical panels developing others</td>
<td>• Clinical panels working to develop and refine others</td>
</tr>
<tr>
<td>• Flawed measures with poor risk adjustment penalized those treating sickest patients</td>
<td>• Drug calculations unchanged</td>
<td>• Cost scores based on two legacy measures</td>
</tr>
<tr>
<td>• No statutory limits on penalty risk</td>
<td>• 0% MIPS component weight in 2017; informational reports on legacy measures provided FYI only</td>
<td>• Part B drugs included in calculations and subject to MIPS-related pay adjustments</td>
</tr>
</tbody>
</table>
MIPS Improvement Activities (no legacy program)—90-day reporting

### 2017 IAs

- Intended to give credit for practice innovations that improve access and quality
- 92 activities across 8 categories
- No required categories
- 40 points needed for larger practices (2-4 activities)
- 1-2 activities required for groups of 15 or less, rural and HPSA practices, non-patient facing specialists (most physicians fall into these categories)
- Participation in MIPS APMs and certified PCMHs earn full score in 2017

### 2018 changes

- Requirements and scoring unchanged
- More activities added for total of 112, including NDPP referrals
- CPC+ added to the MIPS APM models that earn full score in 2018
- 50% of practice sites within a TIN must be recognized as certified PCMHs to receive full IA credit
# MIPS reporting and scoring at a glance

<table>
<thead>
<tr>
<th>MIPS component</th>
<th>Category weight</th>
<th>Reporting period</th>
<th>Reporting options</th>
<th>Points</th>
<th>Bonuses available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>50%</td>
<td>12 months</td>
<td>Claims (individuals), EHR, qualified registry, QCDR, web interface (groups 25+)</td>
<td>3 points for complete measures 1 point for incomplete measures (special rules for topped out measures, small practices, benchmarked measures)</td>
<td>Up to 10% for high priority measures Up to 10% for end-to-end electronic reporting 10 points possible for improvement</td>
</tr>
<tr>
<td>ACI</td>
<td>25%</td>
<td>90 days</td>
<td>EHR, attestation, GCDR, qualified registry, QCDR, web interface (groups 25+)</td>
<td>100 total 50% base score Up to 10% for each performance measure</td>
<td>5% for public health or QCDR reporting 10% for using CEHRT for IA 10% bonus for using only 2015 CEHRT, Stage 3 measures</td>
</tr>
<tr>
<td>IA</td>
<td>15%</td>
<td>90 days</td>
<td>Attestation, EHR, qualified registry, QCDR, web interface (groups 25+)</td>
<td>10 points for medium 20 points for high 40 points = full score</td>
<td>Points doubled for small practices</td>
</tr>
<tr>
<td>Cost</td>
<td>10%</td>
<td>12 months</td>
<td>Calculated by CMS</td>
<td>Average of 2 measures (or 1 if both can’t be scored)</td>
<td>1 point possible for improvement</td>
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Ways clinicians can report

<table>
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<tr>
<th>Individual</th>
<th>Group</th>
<th>Virtual Group (New)</th>
</tr>
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<tr>
<td>• NPI and TIN</td>
<td>• 2 or more clinicians (NPIs) who have reassigned their rights to a single TIN</td>
<td></td>
</tr>
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<td></td>
<td>• APM entity</td>
<td>• Solo practitioners and groups of 10 or fewer EPs who come together virtually</td>
</tr>
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</table>
2018 performance year timeline

2018
- 2018 Performance Year
  - Opens Jan. 1
  - Closes Dec. 31
  - Clinicians care for patients and record data during the year

March 31, 2019
- Deadline for submitting data

2019
- CMS provides performance feedback after data submission, before start of next payment year

2020
- Payment adjustments prospectively applied to each claim starting Jan. 1
Key events in Q1 2018

• Jan. 1: Begin 12-month MIPS Quality data collection for 2018
  - During Q1, make preparations for ACI and IA data collection for 2018 (90-day reporting)

• Jan. 1 through March 31: Report 2017 MIPS data to CMS
  - Not applicable for 2017 Quality data reported via claims, including Pick Your Pace

• Spring 2018: Payment adjustments reflecting 2016 performance under legacy PQRS, MU, VBM will be made
  - These adjustments are unrelated to MACRA/ QPP
Performance thresholds and payment adjustments

<table>
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<th>2017</th>
<th>2018</th>
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<tr>
<td>• Threshold for bonuses/cuts set at 3 points</td>
<td>• Threshold for bonuses/cuts set at 15 points</td>
</tr>
<tr>
<td>• Potential adjustments in 2019 +/-4%</td>
<td>• Potential adjustments in 2020 +/- 5%</td>
</tr>
<tr>
<td>• Threshold for exceptional bonus set at 70 points</td>
<td>• Threshold for exceptional bonus remains 70 points</td>
</tr>
<tr>
<td>• Additional performance threshold starts at 0.5 and goes up to 10%</td>
<td>• Complex patient bonus up to 5 points</td>
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<td>• Small practice bonus 5 points</td>
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<td>• Adjustment applied to Medicare paid amount</td>
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15 point examples from CMS:
• Report all Improvement Activities
• Meet ACI base score and report 1 quality measure that meets data completeness criteria
• Meet ACI base score and one medium weighted Improvement Activity
• Submit 6 quality measures that meet data completeness criteria
## Bonus points

### Formerly available

- Up to 5% ACI bonus for reporting to one or more additional public health and clinical data registries
- Up to 10% ACI for reporting certain Improvement Activities via CEHRT
- Additional Quality points for: (1) electronic reporting; (2) reporting on CG-CAHPS survey measure; (3) additional outcome or high priority measure

### New for 2018

- For complex patients, up to 5 points available based on combination of Hierarchical Conditions Category (HCC) risk score and number of dual eligibles treated
- Small practice bonus of 5 points added to final score for practices of 15 or fewer
- 10% bonus for using only 2015 CEHRT
- Potential points for improvements in Cost and Quality components
# 2019 and 2020 penalty risks compared

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## MIPS factors

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<tr>
<th>MIPS factors</th>
<th>2019 scoring</th>
<th>2020 scoring</th>
</tr>
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<tbody>
<tr>
<td>Quality measurement</td>
<td>60% of score</td>
<td>50% of score</td>
</tr>
<tr>
<td>Advancing Care Info.</td>
<td>25% of score</td>
<td>No change</td>
</tr>
<tr>
<td>Cost</td>
<td>0% of score</td>
<td>10% of score</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>15% of score</td>
<td>No change</td>
</tr>
<tr>
<td><strong>Total penalty risk</strong></td>
<td>Max of -4%</td>
<td>Max of -5%</td>
</tr>
<tr>
<td>Bonus potential</td>
<td>Max of 4%, plus potential 10% for high performers</td>
<td>Max of 5%, plus potential 10% for high performers; bonus points available for complex patients, small practices</td>
</tr>
</tbody>
</table>

*VBM was in effect for 3 years before MACRA passed, and penalty risk was increased in each of these years; there were no ceilings or floors on penalties and bonuses, only a budget neutrality requirement.*
## Payment adjustments 2019 and 2020

### 2017 final score | 2019 payment adjustment
--- | ---
> 70 points | • Positive adjustment  
• Eligible for exceptional performance bonus of at least 0.5%
4-69 points | • Positive adjustment  
• Not eligible for exceptional performance bonus
3 points | • No adjustment
0 points | • -4% negative adjustment

### 2018 final score | 2020 payment adjustment
--- | ---
> 70 points | • Positive adjustment  
• Eligible for exceptional performance bonus of at least 0.5%
15.01-69.99 points | • Positive adjustment  
• Not eligible for exceptional performance bonus
15 points | • No adjustment
3.76-14.99 points | • Negative adjustment between 0% to -5%
0-3.75 points | • -5% negative adjustment
New provision: Improvement scoring for Quality and Cost

- MACRA calls for rewarding improvement as well as overall score
  - Second year of QPP provides first opportunity

- For Quality: improvement score based on rate of improvement in total Quality score
  - Greater improvement results in more points; lower performance in transition year could produce highest improvement score
  - Up to 10 percentage points available

- For Cost: score based on statistically significant changes at the measure level
  - Up to 1 percentage point available

- If data are insufficient in either category, improvement score will be 0 percentage points

- Only positive adjustments are possible. No penalties for falling scores.
New provision: Virtual Groups

• Must include at least 2 solo and small group (≤10) clinicians
  • No restrictions on locations or specialties or number of TINs that may participate
  • MIPS Virtual Group Identifiers will be created by CMS; individual clinicians identified through combination of VGI, TIN, and NPI

• All practices in virtual groups must be eligible for MIPS
  • A participating group may include a clinician who is not eligible (e.g., does not meet LVT), but group as a whole must be eligible
  • All eligible clinicians under the TIN would be included in the virtual group

• Requirements
  • Formal written agreement between each virtual group member (model agreement being developed)
  • Must elect by December prior to performance year (for 2018, election process ran from 10/11-12/31)
  • May only participate in one virtual group during a performance period
Potential advantages of virtual groups

• Share burden of MIPS reporting
  • Combine credit for MIPS categories like Improvement Activities

• Combine patient counts in quality reporting for more reliable sample sizes

• Maintaining independence

• Take advantage of group reporting options
  • Non-patient facing MIPS clinician and small practice, rural area, and HPSA designation would apply

• CMS will provide technical assistance

• Challenges:
  • IT infrastructure lacking
  • Different EHR systems
  • Workflow and staff training changes
Alternative Payment Models (APMs)
APMs participation options as outlined by CMS

- **“Advanced” APMs** have greatest risks and offer potential for greatest rewards
- **Qualified Medical Homes** have different risk structure but otherwise will be treated as Advanced APMs
- **MIPS APMs** receive favorable MIPS scoring
- **Physician-focused APMs** are under development
CMS criteria for Advanced APMs

- 50% of participants must use certified EHR technology
- Must report and at least partially base clinician payments on quality measures comparable to MIPS
- Bear “more than nominal risk” for monetary losses
  - Defined as the lesser of 8% of total Medicare revenues or 3% of total Medicare expenditures (through 2020)
  - Primary Care Medical Home models with < 50 clinicians have different standards (2.5%-5% total Medicare revenues in annual steps until 2021)
    - Round 1 CPC+ practices may exceed 50 clinicians
    - First-year 2.5% risk maintained in 2018, delaying originally scheduled 2020 max date
- APM participation may now begin or end mid-year; future payments based on dates of participation (at least 60 continuous days)
MACRA incentives for Advanced APM participation

Model design

- APMs have shared savings, flexible payment bundles and other desirable features

Bonuses

- In 2019-2024, 5% bonus payments made to physicians participating in Advanced APMs

Higher updates

- Annual baseline payment updates will be higher (0.75%) for Advanced APM participants than for MIPS participants (0.25%) starting 2026

MIPS exemption

- Advanced APM participants do not have to participate in MIPS (models include their own EHR use and quality reporting requirements)
Advanced APMs anticipated for 2018

- Comprehensive ESRD Care Model
- Comprehensive Primary Care Plus
- ACO Track 1 Plus
- ACO Track 2
- ACO Track 3
- Next Generation ACO Model
- Oncology Care Model Track 2
Timeline for determining eligibility and bonuses

• Qualified Medicare APM participants identified by CMS via 3 “snapshots”: March 31, June 30, August 31
  • Physicians listed as participants on one of those dates will be considered participants for that performance year
  • Performance of all participants in an APM entity to be judged as a whole
  • New flexibility provided to allow start-up APMs to participate
    • Performance score based on at least 60 continuous days of participation

• Performance year ends August 31
  • Provides time for MIPS reporting for those not meeting thresholds

• 5% bonus will be calculated on Medicare revenues for second calendar year
  • Lump sum payment provided in third calendar year

Example of bonus calculation timeline:
• 2017 performance year determines eligibility (as of August 31)
• 2018 year-end revenues provide base for calculating bonus
• Lump sum bonus payment mid-2019 after all 2018 claims are submitted
New all-payer APM combination option

• Available beginning 2019 performance year

• Option only for clinicians who fail to become qualified APM participants under the Medicare only APM pathway

• Clinician, EPM entity or payers must submit applications to CMS
  • Medicaid, Medicare Advantage, and CMMI multi-payer models may submit arrangements
    • Will be expanded to commercial payers and other non-Medicare/Medicaid plans in future years

• Model requirements similar to Medicare advanced APMs

• Eligible clinicians have option of being assessed at individual or APM entity level
  • Score will be based on Medicare-weighted threshold at group level, if entity score is higher than individual EP score
# MIPS APMs

## Criteria
- APM entity participates in a model under an agreement with CMS
- Entity includes at least one MIPS eligible clinician on a participant list
- Payment incentives based on performance on cost and quality measures (either on entity or individual clinician level)

## 2017 qualified models
- MSSP Track 1 counts

## Advanced APM benefits do not apply
- Must participate in MIPS to receive any favorable payment adjustments
- Do not qualify for 5% APM bonus payments 2019-2024
- Not eligible for higher baseline annual updates beginning 2026

## Other benefits
- 2017 MIPS APMs receive full Improvement Activities credit (could vary in future years)
- Models have different MIPS reporting (no Cost score; Quality is 50%, IA is 20%, ACI 30%)
- APM-specific rewards (e.g., shared savings, guaranteed payments)
- Eligible for annual MIPS bonuses, which continue indefinitely (vs. 6 years for 5% APM bonuses)
MIPS APMs: All Advanced APMs below threshold PLUS

- ACO Track 1 (438, 91% of total)
- Oncology Care Model Track 1
- Comprehensive ESRD Care Model 1-sided risk
Resources
CMS resources

TCPI and SAN networks
- Technical assistance in 50 states for primary care and specialists

Small, Underserved, and Rural Support
- Assistance tailored to needs
- 11 SURS providing assistance in all states, DC, PR, VI
- https://qpp.cms.gov/about/small-underserved-rural-practices

QIN-QIO
- Support for large practices (over 15 clinicians)
- 14 QIN-QIOs in all 50 states, DC, PR, VI
- www.qioprogram.org
AMA resources on quality payment program

www.ama-assn.org/medicare-payment

Links and tabs to:
- 10 Step MIPS Action Plan
- Pick Your Pace video and instructions
- Detailed info on MIPS and APMs
- STEPSForward modules
- AMA Payment Model Evaluator
- Podcasts from ReachMD
- Links to specialty and state society MACRA resources
- Link to qpp.cms.gov
- Other MACRA resources, links, and news stories, as well as AMA comments and recommendations
Navigating the Payment Process

Essential Tools & Resources

- Prior Authorization and Utilization Management Reform Principles
- MIPS Action Plan
- "Pick Your Pace" Options Under the CMS Quality Payment Program
- 2018 Quality Payment Program Final Rule Highlights
- 2018 Medicare Physician Fee Schedule Final Rule Highlights
- Payment Model Evaluator
- OPP Resources for Small Practices
- Physician Payment Resource Center

IN FOCUS: THE YEAR IN REVIEW

Top stories detailed efforts to help doctors avoid pay penalties

Physician advocacy regarding the time and administrative burden of...
Your MISSION is Our MISSION