

# Quality Payment PROGRAM

## QUALITY PAYMENT PROGRAM YEAR 3 (2019) FINAL RULE OVERVIEW

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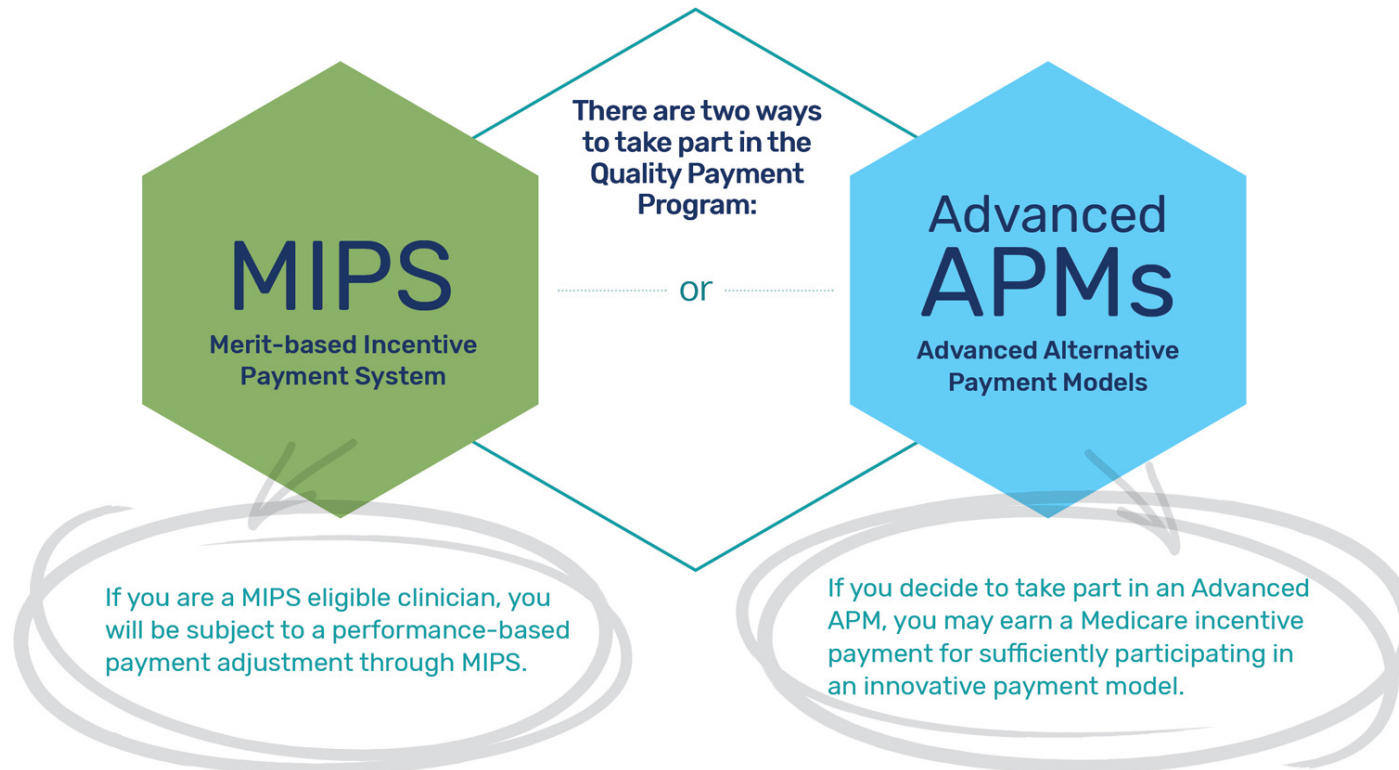
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# Quality Payment Program



The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS by law to implement an incentive program, referred to as the Quality Payment Program:

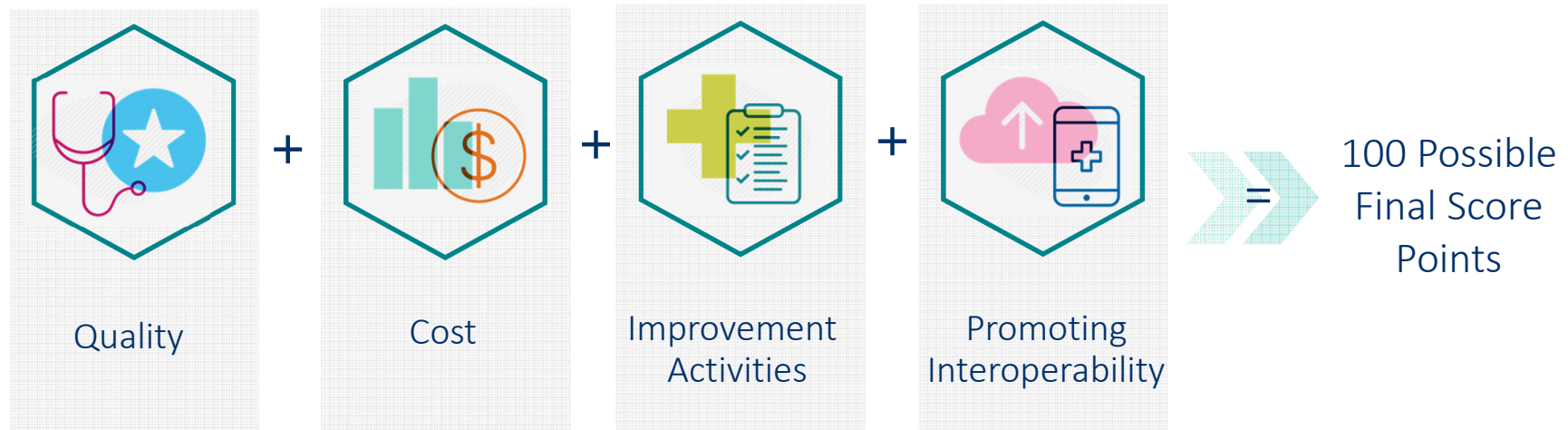


# Merit-based Incentive Payment System (MIPS)



## Quick Overview

### MIPS Performance Categories



- Comprised of **four** performance categories
- **So what?** *The points from each performance category are added together to give you a MIPS Final Score*
- The MIPS Final Score is compared to the MIPS performance threshold to determine if you receive a **positive, negative, or neutral payment adjustment**



# MIPS Year 3 (2019) Final

## MIPS Eligible Clinician Types



### Year 2 (2018) Final

#### MIPS eligible clinicians include:

- Physicians
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
- Groups of such clinicians



### Year 3 (2019) Final

#### MIPS eligible clinicians include:

- Same five clinician types from Year 2 (2018)

#### AND:

- Clinical Psychologists
- Physical Therapists
- Occupational Therapists
- Speech-Language Pathologists\*
- Audiologists\*
- Registered Dietitians or Nutrition Professionals\*

\*We modified our proposals to add these additional clinician types for Year 3 as a result of the significant support we received during the comment period

# MIPS Year 3 (2019) Final

## Low-Volume Threshold Criteria



### *What do I need to know?*

1. Threshold amounts **remain the same** as in Year 2 (2018)
2. Added a third element – Number of Services – to the low-volume threshold determination criteria
  - The finalized criteria now includes:
    - Dollar amount - \$90,000 in covered professional services under the Physician Fee Schedule (PFS)
    - Number of beneficiaries – 200 Medicare Part B beneficiaries
    - Number of services\* (*New*) – 200 covered professional services under the PFS

\*When we say “service,” we are equating one professional claim line with positive allowed charges to one covered professional service

# MIPS Year 3 (2019) Final

## Low-Volume Threshold Determination



*What happens if I am excluded, but want to participate in MIPS?*

You have two options:

1. Voluntarily participate

- You'll submit data to CMS and receive performance feedback
- You will not receive a MIPS payment adjustment

2. Opt-in (*Newly added for Year 3*)

- If you are a MIPS eligible clinician and meet or exceed at least one, but not all, of the low-volume threshold criteria, you may opt-in to MIPS
- If you opt-in, you'll be subject to the MIPS performance requirements, MIPS payment adjustment, etc.

# MIPS Year 3 (2019) Final

## Opt-in Policy



- Opt-in is available 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, but not all, of the low-volume threshold criteria may choose to participate in MIPS

### MIPS Opt-in Scenarios

Dollars	Beneficiaries	Professional Services ( <i>New</i> )	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	Yes (may also voluntarily report or not participate)
> 90K	> 200	> 200	No – required to participate



# MIPS Year 3 (2019) Final

## Opt-in Policy



### *What else do I need to know?*

- 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.

### *User Research Opportunity:*

- We're beginning a phase of user research to explore the best methods for allowing clinicians to notify us that they would like to opt-in to MIPS
- We want to hear from you
- If you're interested in helping us identify the best opt-in approaches for clinicians or groups, we encourage you to send your contact information to: [CMSQPPFeedback@Ketchum.com](mailto:CMSQPPFeedback@Ketchum.com)

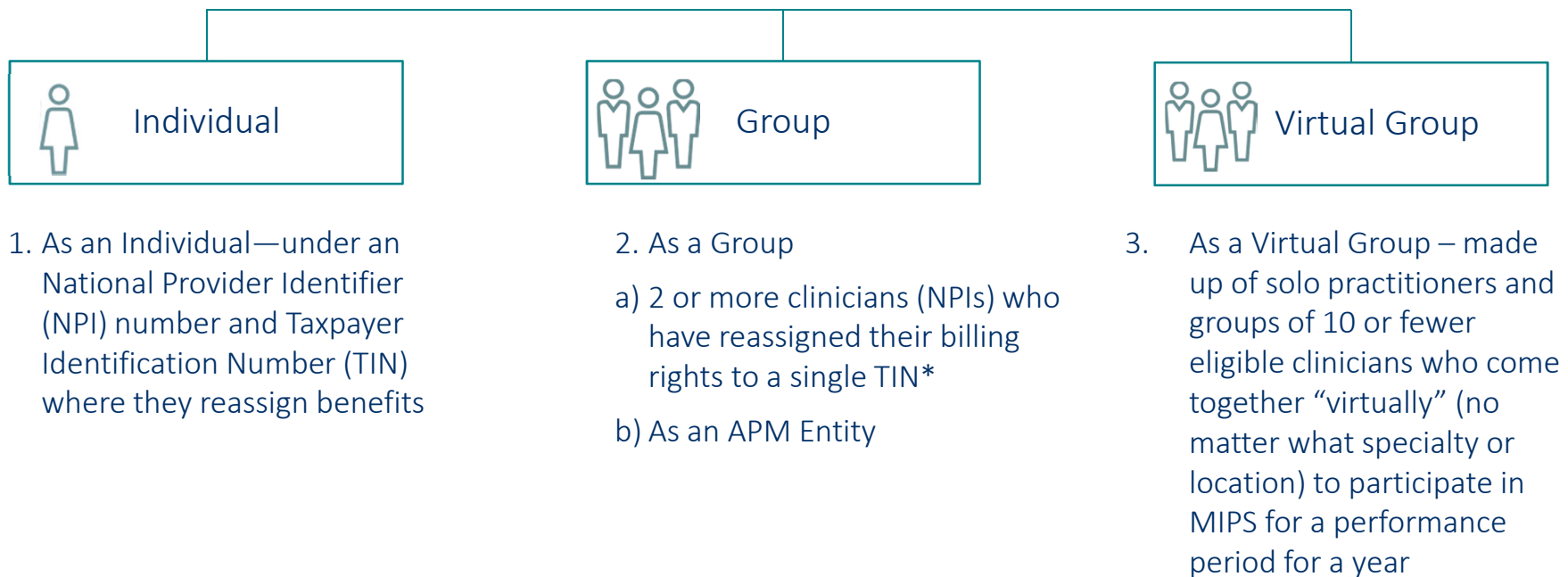
# MIPS Year 3 (2019) Final

## Reporting Options



*What are my reporting options if I am required to participate in MIPS?*

**Same** reporting options as Year 2. Clinicians can report as an/part of a:







# MIPS Year 3 (2019) Final

## Collection, Submission, and Submitter Types - Example



### Data Submission for MIPS Eligible Clinicians Reporting as Individuals





Performance Category	Submission Type	Submitter Type	Collection Type
 Quality	<ul style="list-style-type: none"> <li>• Direct</li> <li>• Log-in and Upload</li> <li>• Medicare Part B Claims (small practices only)</li> </ul>	<ul style="list-style-type: none"> <li>• Individual</li> <li>• Third Party Intermediary</li> </ul>	<ul style="list-style-type: none"> <li>• eCQMs</li> <li>• MIPS CQMs</li> <li>• QCDR Measures</li> <li>• Medicare Part B Claims Measures (small practices only)</li> </ul>
 Cost	<ul style="list-style-type: none"> <li>• No data submission required</li> </ul>	<ul style="list-style-type: none"> <li>• Individual</li> </ul>	-
 Improvement Activities	<ul style="list-style-type: none"> <li>• Direct</li> <li>• Log-in and Upload</li> <li>• Log-in and Attest</li> </ul>	<ul style="list-style-type: none"> <li>• Individual</li> <li>• Third Party Intermediary</li> </ul>	-
 Promoting Interoperability	<ul style="list-style-type: none"> <li>• Direct</li> <li>• Log-in and Upload</li> <li>• Log-in and Attest</li> </ul>	<ul style="list-style-type: none"> <li>• Individual</li> <li>• Third Party Intermediary</li> </ul>	-

# MIPS Year 3 (2019) Final

## Collection, Submission, and Submitter Types - Example



### Data Submission for MIPS Eligible Clinicians Reporting as Groups

Performance Category	Submission Type	Submitter Type	Collection Type
 Quality	<ul style="list-style-type: none"> <li>Direct</li> <li>Log-in and Upload</li> <li>CMS Web Interface (groups of 25 or more eligible clinicians)</li> <li>Medicare Part B Claims (small practices only)</li> </ul>	<ul style="list-style-type: none"> <li>Group</li> <li>Third Party Intermediary</li> </ul>	<ul style="list-style-type: none"> <li>eCQMs</li> <li>MIPS CQMs</li> <li>QCDR Measures</li> <li>CMS Web Interface Measures</li> <li>CMS Approved Survey Vendor Measure</li> <li>Administrative Claims Measures</li> <li>Medicare Part B Claims (small practices only)</li> </ul>
 Cost	<ul style="list-style-type: none"> <li>No data submission required</li> </ul>	<ul style="list-style-type: none"> <li>Group</li> </ul>	-
 Improvement Activities	<ul style="list-style-type: none"> <li>Direct</li> <li>Log-in and Upload</li> <li>Log-in and Attest</li> </ul>	<ul style="list-style-type: none"> <li>Group</li> <li>Third Party Intermediary</li> </ul>	-
 Promoting Interoperability	<ul style="list-style-type: none"> <li>Direct</li> <li>Log-in and Upload</li> <li>Log-in and Attest</li> </ul>	<ul style="list-style-type: none"> <li>Group</li> <li>Third Party Intermediary</li> </ul>	-

# MIPS Year 3 (2019) Final

## Performance Periods



Year 2 (2018) Final

Performance Category	Performance Period
 Quality	12-months
 Cost	12-months
 Improvement Activities	90-days
 Promoting Interoperability	90-days



Year 3 (2019) Final - *No Change*

Performance Category	Performance Period
 Quality	12-months
 Cost	12-months
 Improvement Activities	90-days
 Promoting Interoperability	90-days

# MIPS Year 3 (2019) Final



## Quality Performance Category



### Basics:

- **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



## *What else do I need to know?*

- For 2019, we are:
  - Removing 26 quality measures, including those that are process, duplicative, and/or topped-out
  - Adding 8 measures (4 Patient-Reported Outcome Measures), 6 of which are high-priority
  - **Total of 257** quality measures for 2019
- Same bonus points as Year 2, with the following changes:
  - Added the **small practice bonus** of **6 points** to the Quality performance category
  - Updated the definition of high-priority to include the opioid-related measures



# MIPS Year 3 (2019) Final

## Cost Performance Category



### Basics:

- 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

### *What else do I need to know?*

- Same case minimum 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
- Same measure attribution requirements as Year 2, with the following additions:
  - For procedural episodes: CMS will attribute episodes to the clinician that performs the procedure
  - For acute inpatient medical condition episodes: CMS will attribute episodes to each clinician who bills inpatient evaluation and management (E&M) claim lines during a trigger inpatient hospitalization under a TIN that renders at least 30 percent of the inpatient E&M claim lines in that hospitalization

# MIPS Year 3 (2019) Final



Facility-based Quality and Cost Performance Measures



## *What is it?*

- Facility-based scoring is an option for clinicians that meet certain criteria beginning with the 2019 performance period
  - CMS finalized this policy for the 2019 performance period in the 2018 Final Rule
  - Facility-based scoring allows for certain clinicians to have their Quality and Cost performance category scores based on the performance of the hospitals at which they work

# MIPS Year 3 (2019) Final



## Facility-based Quality and Cost Performance Measures



### Applicability: Individual

- MIPS eligible clinician furnishes 75% or more of their covered professional services in inpatient hospital (Place of Service code 21), on-campus outpatient hospital (POS 22), or an emergency room (POS 23), based on claims for a period prior to the performance period
- Clinician would be required to have at least a single service billed with POS code used for inpatient hospital or emergency room

### Applicability: Group

- Facility-based group would be one in which 75% or more of eligible clinicians billing under the group's TIN are eligible for facility-based measurement as individuals

# MIPS Year 3 (2019) Final



## Facility-based Quality and Cost Performance Measures



### Attribution

- Facility-based clinician would be attributed to hospital where they provide services to most patients
- Facility-based group would be attributed to hospital where most facility-based clinicians are attributed
- If unable to identify facility with the Hospital Value-based Purchasing (VBP) score to attribute clinician's performance, that clinician would not be eligible for facility-based measurement and would have to participate in MIPS via other methods

### Election

- Automatically apply facility-based measurement to MIPS eligible clinicians and groups who are eligible for facility-based measurement and who would benefit by having a higher combined Quality and Cost score
- No submission requirements for individual clinicians in facility-based measurement, but a group would need to submit data for the Improvement Activities or Promoting Interoperability performance categories in order to be measured as a facility-based group

# MIPS Year 3 (2019) Final



Facility-based Quality and Cost Performance Measures



## Measurement

- For facility-based measurement, the measure set for the fiscal year Hospital VBP Program that begins during the applicable MIPS performance period would be used for facility-based clinicians
- Example: For the 2019 MIPS performance period (Year 3), the measures used would be those for the 2020 Hospital VBP Program along with the associated benchmarks and performance periods

## Benchmarks

- Benchmarks for facility-based measurement are those that are adopted under the hospital VBP Program of the facility for the year specified

# MIPS Year 3 (2019) Final



Facility-based Quality and Cost Performance Measures



## Assigning MIPS Category Scores

- The Quality and Cost performance category scores (which are separate scores) for facility-based clinicians are based on how well the clinician's hospital performs in comparison to other hospitals in the Hospital VBP Program

## Scoring – Special Rules

- Some hospitals do not receive a Total Performance Score in a given year in the Hospital VBP Program, whether due to insufficient quality measure data, failure to meet requirements under the Hospital In-patient Quality Reporting (IQR) Program, or other reasons
- In these cases, we would be unable to calculate a facility-based score based on the hospital's performance, and facility-based clinicians would be required to participate in MIPS via another method



# MIPS Year 3 (2019) Final

## Improvement Activities Performance Category



### Basics:

- **15%** of Final Score in 2019
- Select Improvement Activities and attest “yes” to completing
- Activity weights remain the same:
  - Medium = 10 points
  - High = 20 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

### *What else do I need to know?*

- Total of 118 Improvement Activities for 2019
  - Added 6 new Improvement Activities
  - Modified 5 existing Improvement Activities
  - Removed 1 existing Improvement Activity
- CEHRT Bonus
  - Removed the bonus to align with the new Promoting Interoperability scoring requirements, which no longer consists of a bonus score component

# MIPS Year 3 (2019) Final



Promoting Interoperability Performance Category



## Basics:

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



## *What else do I need to know?*

- Eliminated the base, performance, and bonus scores
- New performance-based scoring at the individual measure level
- One set of Objectives and Measures based on 2015 Edition CEHRT
- Four Objectives:
  - e-Prescribing
  - Health Information Exchange
  - Provider to Patient Exchange
  - Public Health and Clinical Data Exchange
- Must report the required measures under each Objective or claim the exclusions, if applicable
- Added two new measures to the e-Prescribing Objective:
  - Query of Prescription Drug Monitoring Program (PDMP)
  - Verify Opioid Treatment Agreement

# MIPS Year 3 (2019) Final

Promoting Interoperability Performance Category



## Basics:

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



## *What else do I need to know?*

- For scoring:
  - Performance-based scoring at the individual measure level
  - Each measure will be scored on performance for that measure based on the submission of a numerator and denominator, or a “yes or no”
    - Must submit a numerator of at least one or a “yes” to fulfill the required measures
  - The scores for each of the individual measures will be added together to calculate a final score
  - If exclusions are claimed, the points will be allocated to other measures
- Reweighting:
  - Same requirements as Year 2, with the following additions:
    - Extended the automatic reweighting for the newly added clinician types

# MIPS Year 3 (2019) Final

## Performance Threshold and Payment Adjustments



Performance Period	Performance Threshold	Additional Payment Adjustment for Exceptional Performance Threshold	Payment Adjustment*
Year 1 (2017)	3 points	70 points	Up to +4%
Year 2 (2018)	15 points	70 points	Up to +5%
Year 3 (2019)	30 points	75 points	Up to +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.

# Technical Assistance

## Available Resources



CMS has free resources and organizations on the ground to provide help to clinicians who are participating 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.ISC@TruvenHealth.com](mailto:TCPI.ISC@TruvenHealth.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](mailto: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](http://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](mailto:QPP@cms.hhs.gov)



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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.

Learn more about technical assistance: <https://qpp.cms.gov/about/help-and-support#technical-assistance>