UPDATES FROM CMS

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CMS Strategic Goals

- **Empower patients and doctors to make decision about their health care**
- **Usher in a new era of state flexibility and local leadership**
- **Support innovative approaches to improve quality, accessibility, and affordability**
- **Improve the CMS customer experience**

Moving to Action

- Reducing Burden
- Meaningful Measurement
- Quality Payment Program
- Interoperability

PATIENTS
OVER PAPERWORK

Our top priority at CMS is putting patients first

CMS is committed to reducing unnecessary burden, increasing efficiencies, and improving the beneficiary experience.

PATIENTS OVER PAPERWORK

Some of CMS' Burden Reduction Initiatives include:

1. Documentation Requirements Simplification (DRS) Initiative
2. Electronic Health Record (EHR) Projects
3. Quality Measurement
4. Quality and Safety Oversight Requirements

PATIENTS OVER PAPERWORK

Documentation Requirements Simplification Accomplishments

- **Clarified:**
  - Signature requirements
    - Claims can’t be denied if support staff forget to sign part of the record
  - When MACs should check for Proof of Delivery
    - Will not be requested for every item
  - IRF medical review policy
    - Claims shouldn’t be denied just because a certain number of therapy hours weren’t met

PATIENTS
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CPI Sub-regulatory EHR Accomplishments

1. Provider-to-Payer Document Exchange
    - Revised the Electronic Submission of Medical Documentation (esMD) system to **accept structured medical records (CCDA)**
2. Provider-to-Provider Document Exchange
    - **Published** an Electronic Medical Documentation Interoperability (**EMDI) Implementation Guide**

PATIENTS
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Clinical Decision Support (CDS) Projects

1. Published **eClinical Templates & Clinical Data Elements**
2. Published Appropriate Use Criteria (AUC) for Advanced Imaging
3. CMS is exploring working with **HL7** and other payers to develop libraries of prior authorization and coverage rules that could be accessed by providers right at the point of service

PATIENTS
OVER PAPERWORK

CCSQ Sub-Regulatory EHR and Quality Payment Program (QPP) Accomplishments

1. Clarified guidance that clinicians may use **scribes** for EHR documentation so long as the clinician validates and signs off on the documentation.
2. Developed an **API** for data submission under QPP that can be used for reporting to MIPS for clinicians using registries or QCDRs
3. Developed a very user friendly **website for QPP** for obtaining information and submitting data.

PATIENTS
OVER PAPERWORK

CCSQ Sub-Reg Quality and Safety Oversight
Burden Reduction Accomplishments

1. Directed **surveyors of LTC Facilities to focus on education** rather than penalties related to implementation of Requirements of Participation (RoPs) for 18 months**.**
2. **Simplified the submission requirements** for providers writing **CoP Plans of Correction**. Providers can now just submit their plans as a Word attachment**.**
3. Reduced penalty amounts for non-compliance with CMS CoPs by moving to a **per-instance Civil Monetary Penalties (CMPs)** instead of **per-day CMPs.**
4. Allowed hospice providers to use **contract nurses in areas with a nursing shortage.**

MEANINGFUL MEASURES

Meaningful Measurement Objectives

Meaningful Measures focus everyone's efforts on the same quality areas and lend specificity, which can help:

- *Address high impact measure areas that safeguard public health*
- *Patient-centered and meaningful to patients*
- *Outcome-based where possible*
- *Relevant for and meaningful to providers*
- *Minimize level of burden for providers*
  - *Remove measures where performance is already very high and that are low value*
- *Significant opportunity for improvement*
- *Address measure needs for population based payment through alternative payment models*
- *Align across programs and/or with other payers (Medicaid, commercial payers)*

Meaningful Measures Framework

Meaningful Measure Areas Achieve:

- ✓ *High quality healthcare*
- ✓ *Meaningful outcomes for patients*

Criteria meaningful for patients and actionable for providers

Draws on measure work by:

- Health Care Payment Learning and Action Network
- National Quality Forum – *High Impact Outcomes*
- National Academies of Medicine – *IOM Vital Signs Core Metrics*

Includes perspectives from experts and external stakeholders:

- Core Quality Measures Collaborative
- Agency for Healthcare Research and Quality
- Many other external stakeholders

Quality Measures

Meaningful Measures

Promote Effective Communication & Coordination of Care
Meaningful Measure Areas:
- Medication Management
- Admissions and Readmissions to Hospitals
- Transfer of Health Information and Interoperability

Strengthen Person & Family Engagement as Partners in their Care
Meaningful Measure Areas:
- Care is Personalized and Aligned with Patient's Goals
- End of Life Care according to Preferences
- Patient's Experience of Care
- Patient Functional Status

Make Care Safer by Reducing Harm Caused in the Delivery of Care
Meaningful Measure Areas:
- Healthcare-Associated Infections
- Preventable Healthcare Harm

Promote Effective Prevention & Treatment of Chronic Disease
Meaningful Measure Areas:
- Preventive Care
- Management of Chronic Conditions
- Prevention, Treatment, and Management of Mental Health
- Prevention and Treatment of Opioid and Substance Use Disorders
- Risk Adjusted Mortality

Work with Communities to Promote Best Practices of Healthy Living
Meaningful Measure Areas:
- Equity of Care
- Community Engagement

Make Care Affordable
Meaningful Measure Areas:
- Appropriate Use of Healthcare
- Patient-focused Episode of Care
- Risk Adjusted Total Cost of Care

Make Care Safer by Reducing Harm Caused in the Delivery of Care

Patient Safety

Meaningful Measure Areas

- Healthcare-Associated Infections
- Preventable Healthcare Harm

Measures

- Central Line-Associated Bloodstream Infection (CLABSI) HACRP, LTCH QRP, Medicaid & CHIP, QIO
- Surgical Site Infections (SSI) IQR
- Methicillin-Resistant Staphylococcus Aureus (MRSA) Bacteremia Outcome Measure LTCH QRP, IRF QRP
- Catheter-Associated Urinary Tract Infection (CAUTI) IRF QRP, LTCH QRP, QIO
- Early Elective Delivery Medicaid & CHIP
- Percent of Patients or Residents with Pressure Ulcers that are New or Worsened IRF QRP, LTCH QRP, SNF QRP, HH QRP

Programs Using Illustrative Measures

Hospital-Acquired Condition Reduction Program (HACRP)
Long-Term Care Hospital Quality Reporting Program (LTCH QRP)
Medicaid and CHIP (Medicaid & CHIP)
Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)
Skilled Nursing Facility Quality Reporting Program (SNF QRP)
Hospital Inpatient Quality Reporting (IQR) Program
Home Health Quality Reporting Program (HH QRP)
Quality Improvement Organization (QIO)

Taking a Critical Look at Measures

Quality Measures

You Said: CMS quality programs have too many quality measures that are not meaningful to patients or providers. Reporting on these measures takes valuable time away from patient care.

We Heard You: Across our rules, CMS is adopting policies that balance the meaningfulness of quality measurement data with efforts to limit provider burden and improve the doctor-patient relationship. In 2017, CMS took initial steps to reduce the number of quality measures in our programs, and will continue to make progress on this initiative in 2018.

Hospital Outpatient Quality Reporting Program

- Remove six measures,
- Estimated burden reduction of 457,490 hours and $16.7 million

Ambulatory Surgical Center (ASC) Quality Reporting Program

- Finalized the removal of three measures.
- Estimated Burden Reduction of 1,314 hours and $48,066 for the 2019 payment determination.
- Delayed implementation of the Consumer Assessment of Healthcare Providers and Systems Outpatient and Ambulatory Surgery Survey (OAS CAHPS) under the ASCQR Program beginning with the 2018 data collection.

Taking a Critical Look at Measures

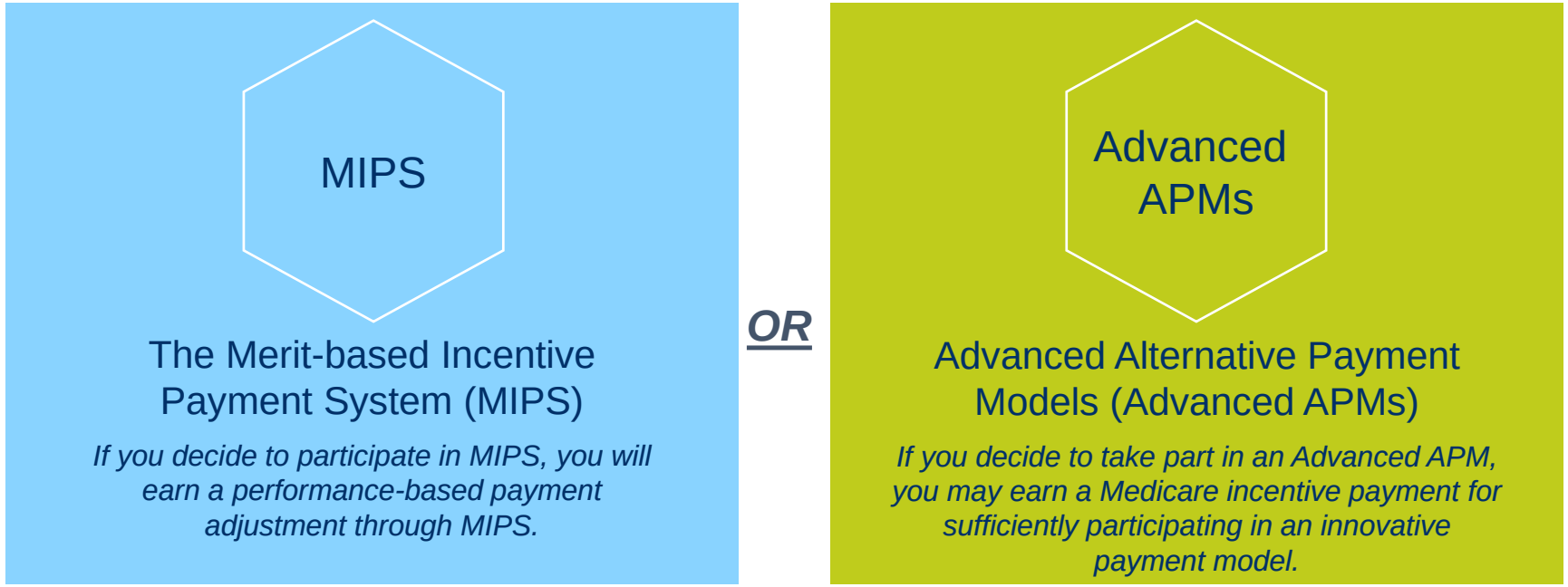
- **End Stage Renal Disease Quality Incentive Program**
  - Replaced two current vascular access measures with two vascular access measures that are more meaningful to providers and patients and are strongly associated with desired patient outcomes.
  - Updated the current transfusion measure to reflect the specifications that the National Quality Forum endorsed for that measure which was based on input from physicians, patients and other stakeholders.
- **Removal of OASIS Items**
  - In 2017, CMS finalized that effective January 1, 2019, it would remove 235 data elements from 33 items on the Outcome and Assessment Information Set (OASIS) assessment instrument.
  - Net burden reduction of $145,986,343 and HH clinician burden of 2,016,386 hours annually.

Quality Payment
PROGRAM

Quality Payment Program

MIPS and Advanced APMs

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, that provides for two participation tracks:



Quality Payment Program

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

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

Merit-based Incentive Payment System (MIPS)

Quick Overview

MIPS Performance Categories for Year 2 (2018)

- Comprised of **four** performance categories in 2018.
- **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 2 (2018)

Who is Included?

***No change** in the types of clinicians eligible to participate in 2018*

MIPS eligible clinicians include:

Physicians

Physician Assistants

Nurse Practitioners

Clinical Nurse Specialists

Certified Registered Nurse Anesthetists

MIPS Year 2 (2018)

Performance Period

Change: *Increase to Performance Period*

Transition Year 1 (2017) Final

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

Year 2 (2018) Final

Performance Category	Minimum Performance Period
Quality	12-months
Cost	12-months
Improvement Activities	90-days
Advancing Care Information	90-days

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.

MIPS Year 2 (2018)

Virtual Groups

New: Virtual Groups

What is a virtual group?

- A virtual group 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 for a year.

- To be eligible to join or form a virtual group, you would need to be a:
  - **Solo practitioners** who exceed the low-volume threshold individually, and are not a newly Medicare-enrolled eligible clinician, a Qualifying APM Participant (QP), or a Partial QP choosing not to participate in MIPS.
  - **Group** that has 10 or fewer eligible clinicians and exceeds the low-volume threshold at the group level.

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).

MIPS Year 2 (2018)

Complex Patient Bonus

New: Complex Patient Bonus

- Up to **5 bonus points** available for treating complex patients based on medical complexity.
  - As measured by Hierarchical Condition Category (HCC) risk score and a score based on the percentage of dual eligible beneficiaries.
- MIPS eligible clinicians or groups must submit data on at least 1 performance category in an applicable performance period to earn the bonus.

MIPS Year 2 (2018)

Small Practice Bonus

New: Small Practice Bonus

- **5 bonus points** added to final score of any MIPS eligible clinician or group who is in a small practice (15 or fewer clinicians), so long as the MIPS eligible clinician or group submits data on at least 1 performance category in an applicable performance period.

- Burden Reduction Aim:
  - We recognize the challenges of small practices and will provide a 5 point bonus to help them successfully meet MIPS requirements.

MIPS Year 2 (2018)

MIPS: Performance Threshold & Payment Adjustment

Change: *Increase in Performance Threshold and Payment Adjustment*

Transition Year 1 (2017) Final

- 3 point threshold
- Exceptional performer set at 70 points
- Payment adjustment set at +/- 4%

Year 2 (2018) Final

- 15 point threshold
- Exceptional performer set at 70 points
- Payment adjustment set at +/- 5%

How can I achieve 15 points?

- Report all required Improvement Activities.
- Meet the Advancing Care Information base score and submit 1 Quality measure that meets data completeness.
- Meet the Advancing Care Information base score, by reporting the 5 base measures, and submit one medium-weighted Improvement Activity.
- Submit 6 Quality measures that meet data completeness criteria.

MIPS Year 2 (2018)

MIPS: Performance Threshold & Payment Adjustment

***Change:** Increase in Performance Threshold and Payment Adjustment*

Transition Year 1 (2017) Final

Final Score 2017	Payment Adjustment 2019
≥70 points	• Positive adjustment • Eligible for exceptional performance bonus—minimum of additional 0.5%
4-69 points	• Positive adjustment • Not eligible for exceptional performance bonus
3 points	• Neutral payment adjustment
0 points	• Negative payment adjustment of -4% • 0 points = does not participate

Year 2 (2018) Final

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

MIPS Year 2 (2018)

Advancing Care Information

Basics:

- **25%** of Final Score in 2018
- Comprised of Base, Performance, and Bonus score
- Promotes patient engagement and the electronic exchange of information using certified EHR technology
- Two measure sets available to choose from based on EHR edition.

CEHRT Requirements:

- Burden Reduction Aim: MIPS eligible clinicians may use either the 2014 or 2015 CEHRT or a combination in 2018.
- A **10% bonus** is available for using only 2015 Edition CEHRT.

Measures and Objectives:

- CMS finalizes exclusions for the E-Prescribing and Health Information Exchange Measures.

Scoring:

- No change to the base score requirements for the 2018 performance period/2020 payment year.
- For the performance score, MIPS eligible clinicians and groups will earn 10% for reporting to any one of the Public Health and Clinical Data Registry Reporting measures as part of the performance score.
- For the bonus score a 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% Advancing Care Information bonus for completion of at least 1 of the specified Improvement Activities using CEHRT.
- Total bonus score available is 25%

MIPS Year 2 (2018)

Advancing Care Information

Basics:

- **25%** of Final Score in 2018
- Comprised of Base, Performance, and Bonus score
- Promotes patient engagement and the electronic exchange of information using certified EHR technology
- Two measure sets available to choose from based on EHR edition.

Exceptions:

- Based on authority granted by the 21st Century Cures Act and MACRA , **CMS will reweight the Advancing Care Information performance category to 0 and reallocate the performance category weight of 25% to the Quality performance category** for the **following reasons:**

Automatic reweighting:

- Hospital-based MIPS eligible clinicians;
- Ambulatory Surgical Center (ASC)— based MIPS eligible clinicians, finalized retroactive to the transition year;
- Nurse practitioners, physician assistants, clinical nurse specialist, certified registered nurse anesthetists

Reweighting through an approved application:

- **New hardship exception for clinicians in small practices** (15 or fewer clinicians);
- New decertification exception for eligible clinicians whose EHR was decertified, retroactively effective to performance periods in 2017.
- Significant hardship exceptions—CMS will not apply a 5-year limit to these exceptions;

- **New deadline of December 31** of the performance year for the submission of hardship exception applications for 2017 and future years.
- Revised definition of hospital-based MIPS eligible clinician to include covered professional services furnished by MIPS eligible clinicians in an off-campus-outpatient hospital (POS 19).

MIPS Year 2 (2018)

Cost

Basics:

- ***Change:*** **10% Counted toward Final Score in 2018**
- Medicare Spending per Beneficiary (MSPB) and total per capita cost measures are included in calculating Cost performance category score for the 2018 MIPS performance period.
- These measures were used in the Value Modifier and in the MIPS transition year

- *Change*: Cost performance category weight is **finalized at 10% for 2018.**
- 10 episode-based measures adopted for the 2017 MIPS performance period will not be used.
- We are developing new episode-based measures with significant clinician input and are providing feedback on these measures this fall through field testing.
- This will allow clinicians to see their cost measure scores before the measures are potentially included in the MIPS program.
- We will propose new cost measures in future rulemaking.

MIPS Year 2 (2018)

Cost

Basics:

- ***Change:* 10% Counted toward Final Score in 2018**
- Medicare Spending per Beneficiary (MSPB) and total per capita cost measures are included in calculating Cost performance category score for the 2018 MIPS performance period.
- These measures were used in the Value Modifier and in the MIPS transition year

Reporting/Scoring:

- Each individual MIPS eligible clinician's and group's cost performance will be calculated using administrative claims data if they meet the case minimum of attributed patients.
- Individual MIPS eligible clinicians and groups are not required to submit any additional information for the cost performance category.
- Performance is compared against performance of other MIPS eligible clinicians and groups during the performance period so benchmark is not based on a previous year.
- Performance category score is the average of the two measures: Medicare Spending per Beneficiary (MSPB) and total per capita cost measures.
- If only one measure can be scored, it will serve as the performance category score.

Alternative Payment Models (APMs)

Quick Overview

- APMs are approaches to paying for health care that incentivize quality and value.
- As defined by MACRA, APMs include CMS Innovation Center models (authorized under section 1115A, other than a Health Care Innovation Award), MSSP (Medicare Shared Savings Program), demonstrations under the Health Care Quality Demonstration Program, and demonstrations required by federal law.
- Advanced APMs are a subset of APMs. To be an Advanced APM, a model must meet the following three statutory requirements:
  - Requires participants to use **certified EHR technology**;
  - Provides payment for covered professional services based on **quality measures** comparable to those used in the MIPS quality performance category; and
  - Either: (1) is a **Medical Home Model expanded** under CMS Innovation Center authority OR (2) requires **participants to bear a more than nominal amount of financial risk**.
- In order to achieve status as a Qualifying APM Participant (QP) and qualify for the 5% APM incentive payment for a year, eligible clinicians must receive a certain percentage of payments for covered professional services or see a certain percentage of patients through an Advanced APM during the associated performance period.

Advanced APMs

Generally Applicable Nominal Amount Standard

Transition Year 1 (2017) Final

- Total potential risk under the APM must be equal to at least either:
  - 8% of the average estimated Parts A and B revenue of the participating APM Entities for the QP performance period in 2017 and 2018, OR
  - 3% of the expected expenditures an APM Entity is responsible for under the APM for all performance years.

Year 2 (2018) Final

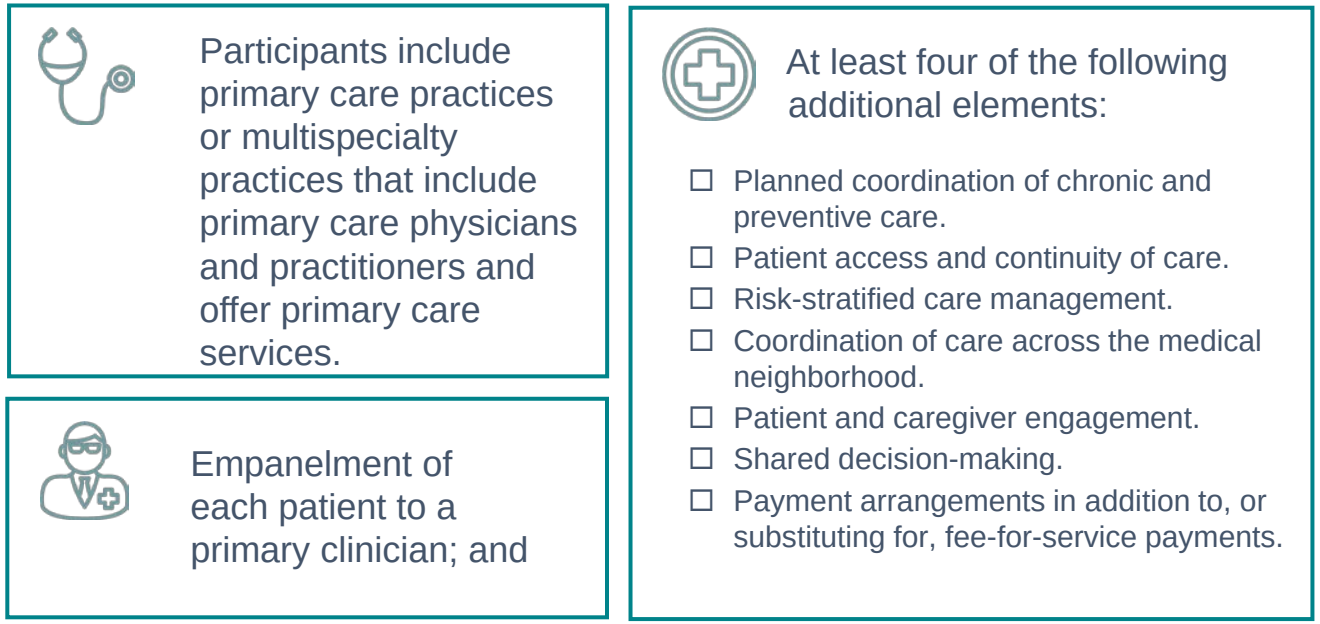
**The 8% revenue-based standard is extended for two additional years, through performance year 2020.

- Total potential risk under the APM must be equal to at least either:
  - 8% of the average estimated Parts A and B revenue of the participating APM Entities for QP Performance Periods 2017, 2018, 2019, and 2020, OR
  - 3% of the expected expenditures an APM Entity is responsible for under the APM for all performance years.

Advanced APMs

Medical Home Model

A Medical Home Model is an APM that has the following features:



Medical Home Models are subject to different (more flexible) standards in order to meet the financial risk criterion to become an Advanced APM.

Advanced APMs

Medical Home Model: 50 Clinician Cap (50 eligible clinician limit)

Transition Year 1 (2017) Final

- For performance year 2018 and thereafter, the medical home standard applies only to APM Entities with fewer than 50 clinicians in their parent organization.

Year 2 (2018) Final

- 2017 Participants in Round 1 of the Comprehensive Primary Care Plus Model are exempted from the 50 clinician cap.

Advanced APMs

All-Payer Combination Option: Performance Year 2019 Timeline for Other Payer Advanced APM Determinations

Medicaid

January 2018	April 2018	September 2018	November 2018	December 2018
Submission form available for States	Deadline for State submissions	Submission form available for ECs CMS posts initial list of Medicaid APMs	Deadlines for EC submissions	CMS posts final list of Medicaid APMs

CMS Multi-Payer Models

January 2018	June 2018	September 2018	August 2019	December 2019
Submission form available for Other Payers	Deadline for Other Payer submissions	CMS posts list of Other Payer Advanced APMs for PY 2019	Submission form available for ECs	CMS updates list of Other Payer Advanced APMs for PY 2019 Deadline for EC submission

Advanced APMs

All-Payer Combination Option: Performance Year 2019 Timeline for Other Payer Advanced APM Determinations

Medicare Health Plans

April 2018
Submission form available for Medicare Health Plans

June 2018
Deadline for Medicare Health Plan submissions

September 2018
CMS posts list of Other Payer Advanced APMs for PY 2019

August 2019
Submission form available for ECs

December 2019
CMS updates list of Other Payer Advanced APMs for PY 2019

Deadline for EC submissions

Remaining Other Payer Payment Arrangements

January 2018 – December 2018

Other Payer Advanced APM determinations will not be made for performance year 2019. We intend to add this option in future years.

August 2019
Submission form available for ECs

December 2019
CMS updates list of Other Payer Advanced APMs for PY 2019

Deadline for EC submissions

Advanced APMs

- Comprehensive End Stage Renal Disease Care Model (Two-Sided Risk Arrangements)
- Oncology Care Model (Two-Sided Risk Arrangement)
- Shared Savings Program Track 3
- Comprehensive Primary Care Plus (CPC+)
- Medicare Accountable Care Organization (ACO) Track 1+ Model
- Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1 - CEHRT)
- Next Generation ACO Model
- Shared Savings Program Track 2
- Bundled Payments for Care Improvement Advanced Model (BPCI Advanced)*
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)

**BPCI Advanced is scheduled to begin in October 2018. BCPI Advanced participants will have an opportunity to achieve QP status, or be scored under the APM scoring standard for MIPS, starting in performance year 2019.*

CMS Innovation Center RFI

The CMS Innovation Center Request for Information (RFI) sought broad input related to a new direction for the CMS Innovation Center. In its new direction, CMMI seeks to promote **patient-centered care** and **test market-driven reforms** that: empower beneficiaries as consumers, provide price transparency, increase choices and competition to drive quality, and improve outcomes. The following slides provide a snapshot view of the volume of RFI comments, responding stakeholder types, and topics of greatest interest to respondents.

The administration plans to launch models in several focus areas:

- Expanded Opportunities for Participation in Advanced APMs
- Consumer-Directed Care and Market-Based Innovation Models
- Physician Specialty Models
  - Physician-Focused Payment Model Technical Advisory Committee (PTAC) Recommended Models
- Prescription Drug Models
- Medicare Advantage (MA) Innovation Models
- State-Based and Local Innovation, including Medicaid-focused Models
- Mental and Behavioral Health Models
- Program Integrity

Guiding Principles

- Choice and competition in the marketplace
- Provider choice and incentives
- Patient-centered care
- Benefit design and price transparency
- Transparent model design and evaluation
- Small scale testing

Technical Assistance

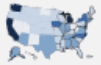
Available Resources

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.

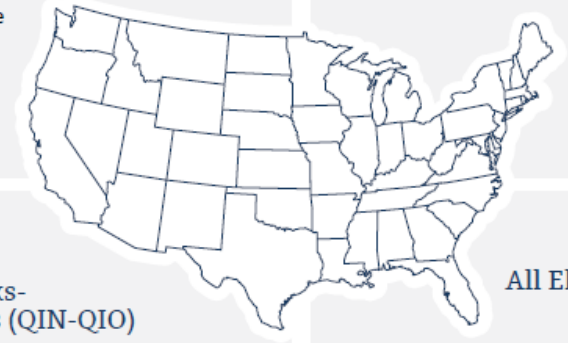


Locate the PTN(s) and SAN(s) In your state

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:

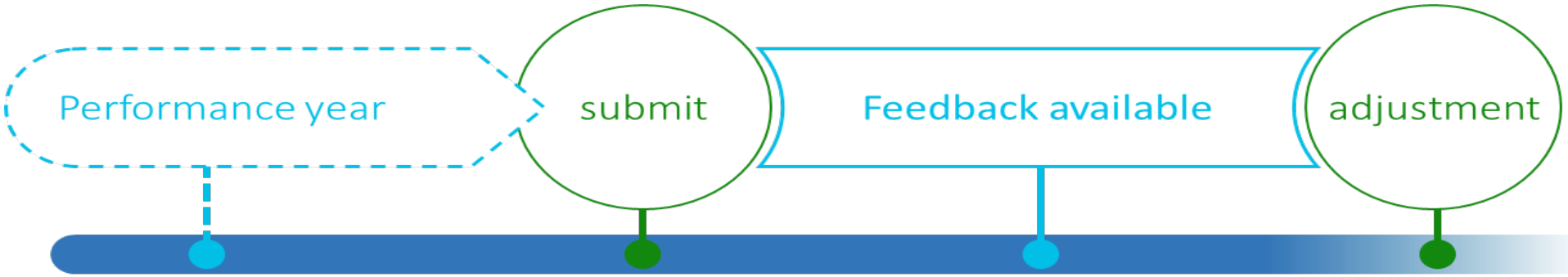
Quality Payment Program Website: qpp.cms.gov
Serves as a starting point for information on the Quality Payment Program.

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

Year 1 of the Quality Payment Program



2017
Performance Year

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- Closes December 31, 2017.
- Clinicians care for patients and record data during the year.

March 31, 2018
Data Submission

- Deadline for submitting data is March 31, 2018.
- Clinicians are encouraged to submit data early.

Feedback

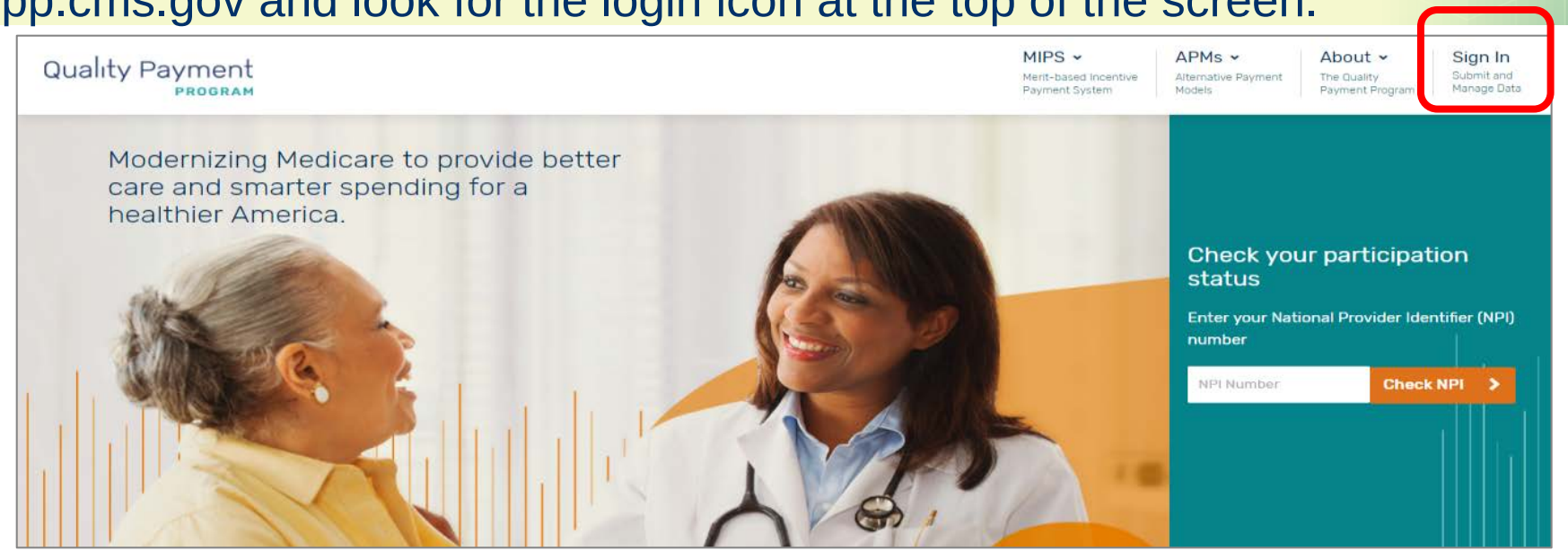
- CMS provides performance feedback after the data is submitted.
- Clinicians will receive feedback before the start of the payment year.

January 1, 2019
Payment Adjustment

- MIPS payment adjustments are prospectively applied to each claim begin January 1, 2019.

Navigate to the Quality Payment Program

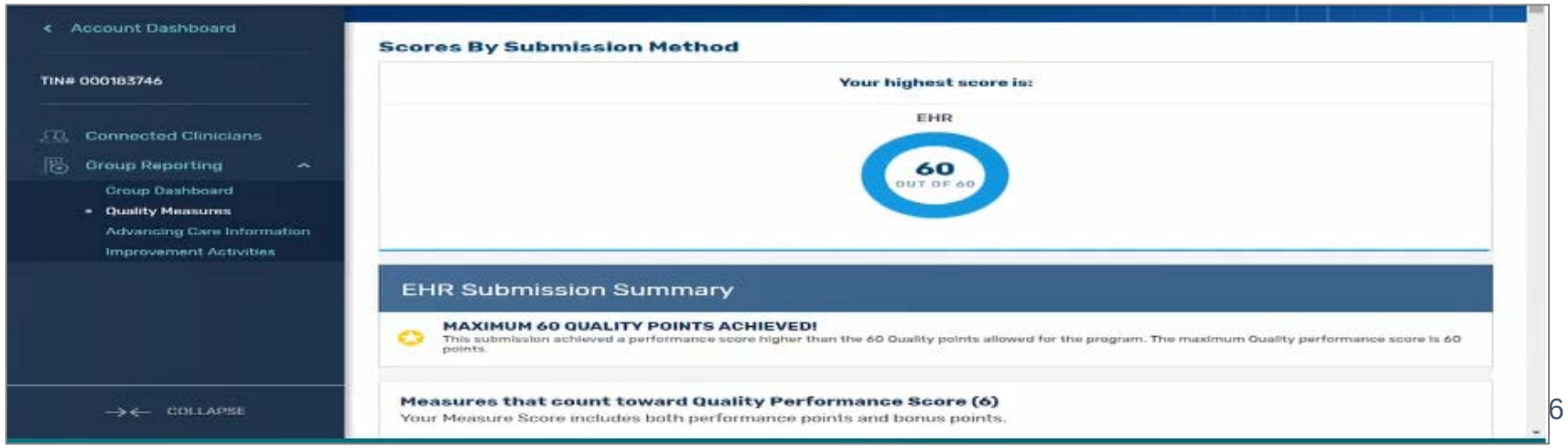
- Visit qpp.cms.gov and look for the login icon at the top of the screen.



- Clinicians who participate in the Quality Payment Program have one place to submit all of their data eliminating the need for multiple visits to multiple websites.

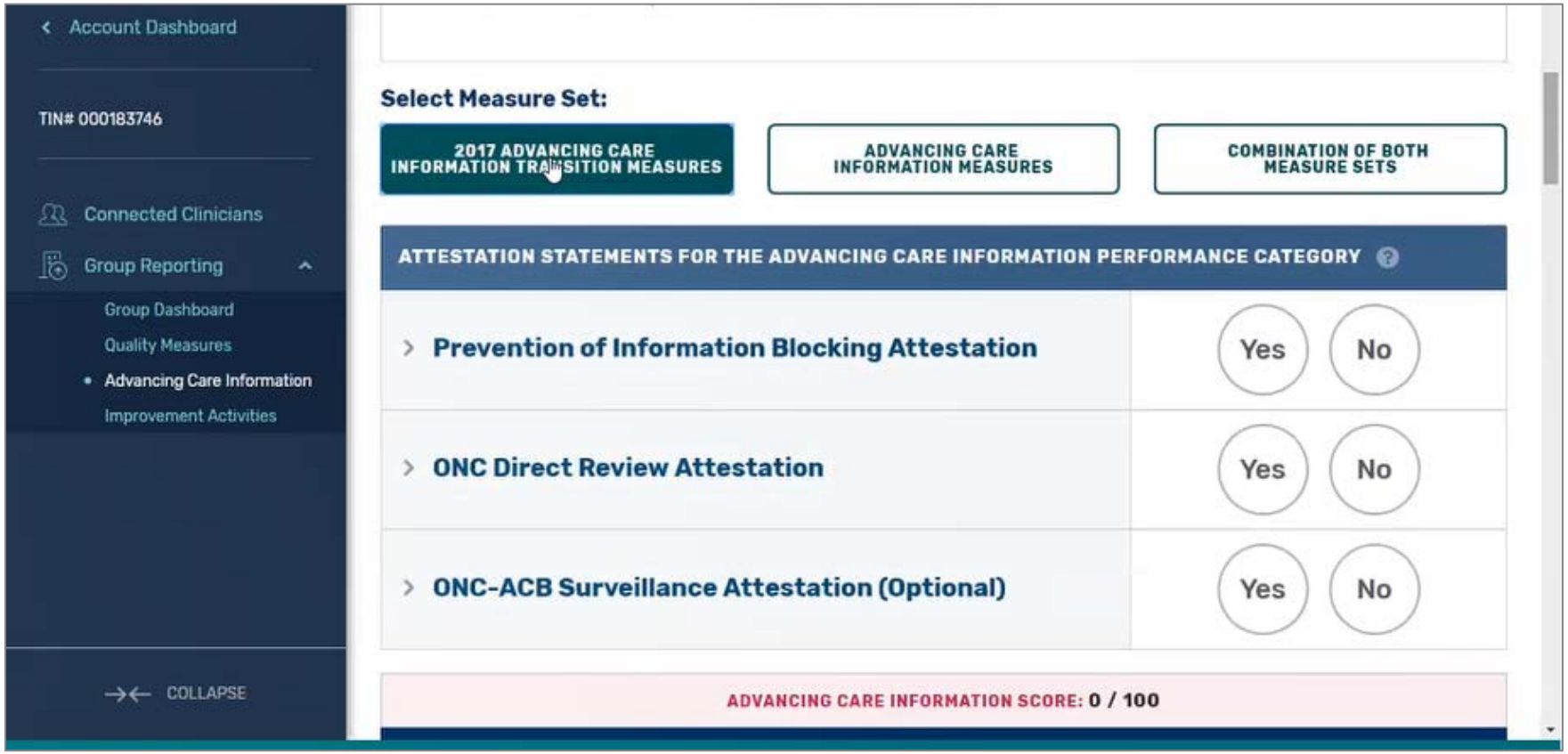
Reporting Data for the Quality Performance Category

Clinicians will see real-time initial scoring within the Merit-based Incentive Payment System (MIPS) performance categories based on their submissions.



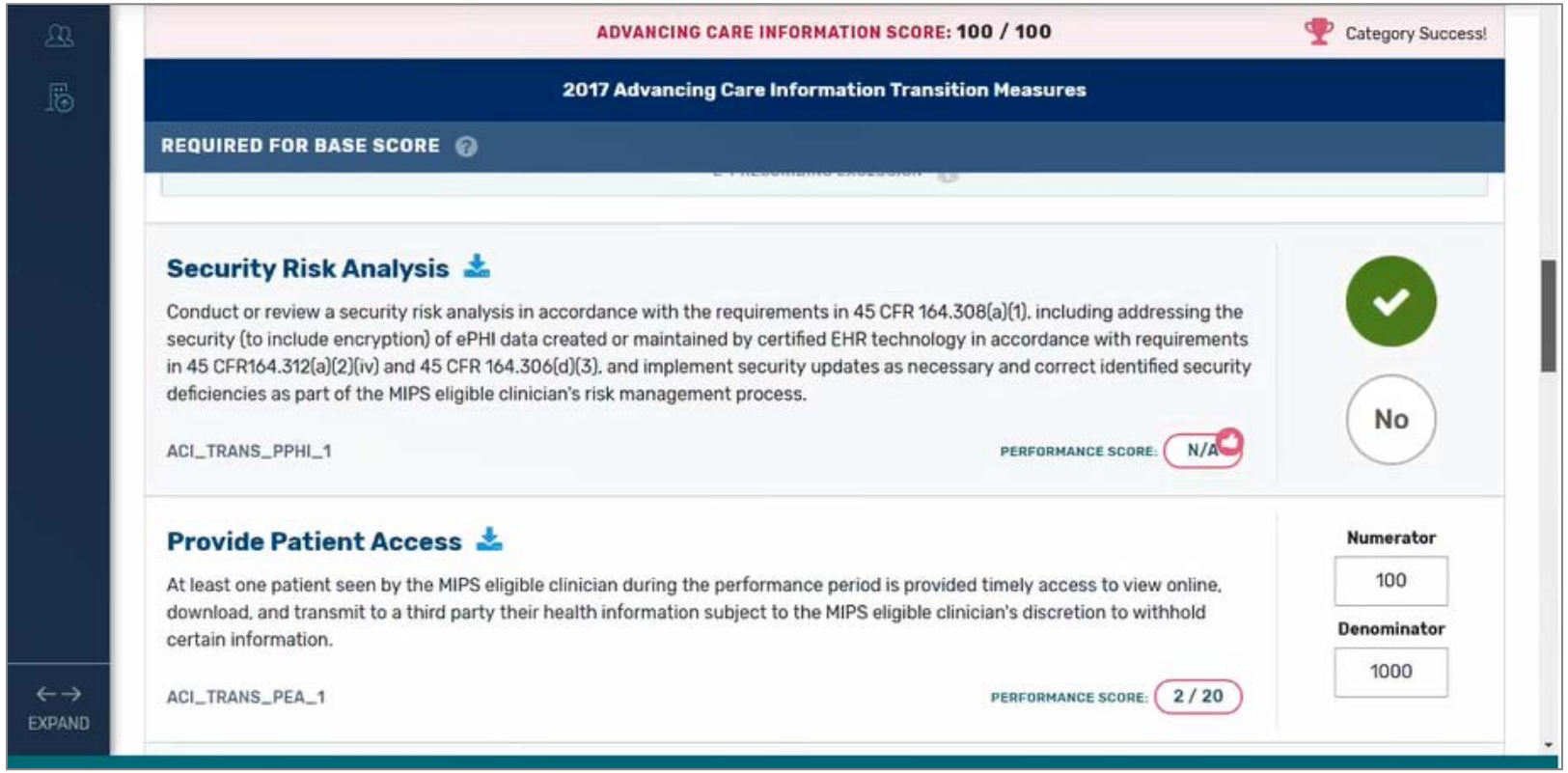
Reporting Data for the Advancing Care Information Performance Category

- You must attest to the first two statements in order to continue submitting data for the Advancing Care Information performance category.



Reporting Data for the Advancing Care Information Performance Category

- You will receive a real-time performance category score as you complete the Base, Performance, and Bonus score components of Advancing Care Information.



Year 3 Statutory Requirements

- **Quality weight to final score**:
  - 50% in 2020 payment year.
  - 30% in 2021 payment year and beyond.

- **Cost weight to final score:**
  - 10% in 2020 MIPS payment year.
  - 30% in 2021 MIPS payment year and beyond.
- **Performance Thresholds:**
  - Performance threshold set at 15 points; additional performance threshold stays at 70 points for exceptional performance in 2020 MIPS payment year
  - Performance threshold must be set at the mean/median by year 3 by extending the special rules from the initial 2 years to 5 years.
- **Advancing Care Information:**
  - Advancing Care Information category's requirements must become "more stringent" over time. We are continuing to explore new concepts and strategies for the Advancing Care Information category.

Interoperability

- We understand that it is very important that clinicians have access to all health information on their patients in order to be able to provide them with high quality care.
- CMS is committed to working with the Office of the National Coordinator (ONC) on implementation of the interoperability provisions of the 21st Century Cures Act in order to get to seamless but secure exchange of health information for providers and patients.
- CMS is looking closely at this issue and determining what we can do to address the problems with interoperability through our various levers.
- In the Meaningful Use program and the Quality Payment Program, we have focused our EHR measures on interoperability whereby 70% of those measures require the exchange of health information between providers or providers and patients
- CMS is also committed to working with the HHS OIG an ONC to address information blocking.

Questions, Comments and Solutions

Disclaimers

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