OVERVIEW OF MIPS FOR THE 2020 PERFORMANCE PERIOD

January 22, 2020
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Topics

• Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and the Quality Payment Program (QPP) Overview

• 2020 Merit-based Incentive Payment System (MIPS) Overview
  - Eligibility Criteria
  - Reporting Options
  - Performance Category Requirements
  - Performance Thresholds and Payment Adjustments

• Help and Support

• Question & Answer Session
MACRA AND QPP
Overview
MACRA stands for the Medicare Access and CHIP Reauthorization Act of 2015, which is bipartisan legislation signed into law on April 16, 2015.

What Do I Need to Know About MACRA?

- **MACRA:**
  - Repealed the Sustainable Growth Rate formula
  - Changed the way that Medicare pays clinicians and establishes a new framework to reward clinicians for value over volume
  - Required CMS by law to implement an incentive program which is referred to as the Quality Payment Program
MACRA
Medicare Payment Prior to MACRA

Previously a Fee-for-Service (FFS) payment system, where clinicians received payment based on **volume** of services, not **value**.

**What was the Sustainable Growth Rate (SGR) Formula?**

- Each year, Congress passed temporary “doc fixes” to avert cuts to Medicare payments
- No “fix” in 2015 would have resulted in a **21% cut** in Medicare payments to clinicians

**How Does MACRA Help?**

- MACRA replaces the SGR with a more predictable payment program, known as the Quality Payment Program, that incentives value over volume
MACRA requires CMS by law to implement an incentive program, referred to as the Quality Payment Program (QPP), that provides two participation tracks:

**MIPS**

- Merit-based Incentive Payment System

If you are a MIPS eligible clinician, you will be subject to a performance-based payment adjustment through MIPS.

**Advanced APMs**

- Advanced Alternative Payment Models

If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for sufficiently participating in an innovative payment model.
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 gpp.cms.gov
MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Overview
Combined legacy programs into a single, improved program.

- Physician Quality Reporting System (PQRS)
- Value-Based Payment Modifier (VM)
- Medicare EHR Incentive Program (EHR) for Eligible Professionals
Merit-based Incentive Payment System (MIPS)

Quick Overview

MIPS Performance Categories in 2020

- 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
Key Terms to Know...

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

• NPI – National Provider Identifier
  - 10-digit numeric identifier for individual clinicians

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

<table>
<thead>
<tr>
<th>Performance Period</th>
<th>Also referred to as...</th>
<th>Corresponding Payment Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>2017 “Transition” Year</td>
<td>2019</td>
</tr>
<tr>
<td>2018</td>
<td>“Year 2”</td>
<td>2020</td>
</tr>
<tr>
<td>2019</td>
<td>“Year 3”</td>
<td>2021</td>
</tr>
<tr>
<td>2020</td>
<td>“Year 4”</td>
<td>2022</td>
</tr>
</tbody>
</table>
Merit-based Incentive Payment System (MIPS)

General Timeline

- **Performance period**
  - Opens January 1, 2020
  - Closes December 31, 2020
  - Clinicians care for patients and record data during the year

- **Submit**
  - Data submission opens January 4, 2021
  - Deadline for submitting data is March 31, 2021
  - Clinicians are encouraged to submit data early

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

- **Adjustment**
  - MIPS payment adjustments are prospectively applied to each claim beginning January 1, 2022
MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Eligibility and Criteria
How Does CMS Determine if I Am Included in MIPS for the 2020 Performance Period?

- We start by identifying if you’re a **MIPS eligible clinician type**

- We then look to see if you **exceed** all three elements of the **low-volume threshold** criteria during a specific determination period

- If you meet these elements, you’re **required to participate** in MIPS
Are There Any Basic Exemptions?

If you are...

- Newly-enrolled in Medicare
- Below the low-volume threshold
- Significantly participating in Advanced APMs

...then you are excluded from MIPS
What is a MIPS Eligible Clinician?

- MIPS eligible clinicians are both physicians and non-physician clinicians who are eligible to participate in MIPS
- CMS, through rulemaking, defines the clinician types that are considered MIPS eligible clinicians for a specific performance year

So What?

- Being identified as a MIPS eligible clinician type is the first step in determining whether you’re required to participate in MIPS
- Clinicians who are not considered MIPS eligible clinicians are excluded from MIPS
No changes to the MIPS eligible clinician types in the 2020 performance period; they are the same as in the 2019 performance period:

- Physicians
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
- Clinical Psychologists
- Physical Therapists
- Occupational Therapists
- Speech Pathologists
- Audiologists
- Registered Dieticians or Nutrition Professionals
- Groups of such clinicians
What is the Low-Volume Threshold?

- The low-volume threshold is the second step in determining whether you are included in MIPS for a specific performance period.

- It helps CMS determine if you, as a MIPS eligible clinician, bill a sufficient amount of allowed charges under the Medicare Physician Fee Schedule (PFS), provide care for enough Medicare beneficiaries, and furnish an adequate amount of services to be included in MIPS.
**Merit-based Incentive Payment System (MIPS)**

**Low-Volume Threshold**

*No changes* to low-volume threshold criteria in the 2020 performance period.

The low-volume threshold includes MIPS eligible clinicians who:

- Bill more than $90,000 a year in allowed charges for covered professional services under the Medicare Physician Fee Schedule (PFS) *AND*
- Furnish covered professional services to more than 200 Medicare beneficiaries *AND*
- Provide more than 200 covered professional services under the PFS.

To be included in MIPS, a clinician **must exceed all three** criteria.

- **Note:** For MIPS APMs participants, the low-volume threshold determination will continue to be calculated at the APM Entity level.
What Are the Determination Periods for the 2020 Performance Period?

We look at your Medicare claims from two 12-month segments aligned to the fiscal year:

• October 1, 2018 – September 30, 2019 (historical period)
  
  - Determines your initial eligibility in MIPS
  - If you’re excluded during this initial run, you will maintain this status for the entire performance period

• October 1, 2019 – September 30, 2020 (performance period)
How Does the Low-Volume Threshold Apply to Groups?

- CMS will simultaneously conduct a similar look during a given determination period to see if your group contains at least one MIPS eligible clinician type and collectively exceeds the low-volume threshold.

So What?

- If your group has at least one MIPS eligible clinician and exceeds all three criterion, your group is eligible to participate in MIPS.
  - Please note that participating as a group is an option.
  - If you are excluded from MIPS as an individual but eligible to participate as a part of a group, you are not required to do so.

- If your group does not exceed all three criterion, your group is excluded from MIPS and does not need to submit any performance data.
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** *(No changes in the 2020 performance period)*
   - If you are a MIPS eligible clinician and meet or exceed at least one of the low-volume threshold criteria, you may opt-in to MIPS
   - If you opt-in, you’ll be subject to the MIPS rules, special status, and MIPS payment adjustment
## Opt-in

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

<table>
<thead>
<tr>
<th>Dollars</th>
<th>Beneficiaries</th>
<th>Professional Services (New-proposed)</th>
<th>Eligible for Opt-in?</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤ 90K</td>
<td>≤ 200</td>
<td>≤ 200</td>
<td>No – excluded</td>
</tr>
<tr>
<td>≤ 90K</td>
<td>≤ 200</td>
<td>&gt; 200</td>
<td>Yes (may also voluntarily report or not participate)</td>
</tr>
<tr>
<td>&gt; 90K</td>
<td>≤ 200</td>
<td>≤ 200</td>
<td>Yes (may also voluntarily report or not participate)</td>
</tr>
<tr>
<td>&gt; 90K</td>
<td>≤ 200</td>
<td>&gt; 200</td>
<td>Yes (may also voluntarily report or not participate)</td>
</tr>
<tr>
<td>≤ 90K</td>
<td>&gt; 200</td>
<td>&gt; 200</td>
<td>Yes (may also voluntarily report or not participate)</td>
</tr>
<tr>
<td>&gt; 90K</td>
<td>&gt; 200</td>
<td>&gt; 200</td>
<td>No – required to participate</td>
</tr>
</tbody>
</table>
Is There Somewhere I Can Go to Check My MIPS Status?

- You can check your participation status using the QPP Participation Status Tool on qpp.cms.gov

- We also encourage you to review the 2020 MIPS Quick Start Guide for additional information
What Happens if I Am Associated With Multiple Practices in the QPP Participation Status Tool?

- If you’re in multiple practices you are required to participate in MIPS for each associated practice (TIN/NPI) where you exceed the low volume threshold.

- You will receive a payment adjustment based on the TIN/NPIs where the low volume threshold was exceeded.

- Any associated practices (TIN/NPIs) where you did not exceed the low volume threshold (or was otherwise excluded from MIPS) would not receive a payment adjustment.
MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Reporting Options
What Are My Reporting Options if I Am Required to Participate in MIPS?

MIPS eligible clinicians can report as an/as part of a:

1. **Individual**: under an National Provider Identifier (NPI) number and Taxpayer Identification Number (TIN) where they reassign benefits

2. **Group**:
   a) Two (2) or more clinicians (NPIs) who have reassigned their billing rights to a single TIN
   b) As an APM Entity

3. **Virtual Group**: made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together “virtually” (no matter what specialty or location) to participate in MIPS for a performance period
**Key Terms to Know...**

- **Collection type** – a set of quality measures with comparable specifications and data completeness criteria including, as applicable, including, but not limited to: electronic clinical quality measures (eCQMs); MIPS Clinical Quality Measures\(^*\) (MIPS CQMs); Qualified Clinical Data Registry (QCDR) measures; Medicare Part B claims measures; CMS Web Interface measures; the CAHPS for MIPS survey; and administrative claims measures.

- **Submitter type** – the MIPS eligible clinician, group, virtual group, or third party intermediary acting on behalf of a MIPS eligible clinician, group, or virtual group, as applicable, that submits data on measures and activities.

- **Submission type** – the mechanism by which a submitter type submits data to CMS, including: direct, sign-in and upload, sign-in and attest, Medicare Part B claims, and the CMS Web Interface.
  - The Medicare Part B claims submission type is for clinicians or groups in small practices only to continue providing reporting flexibility.

\(^*\)The term MIPS CQMs replaces what was formerly referred to as “registry measures” since clinicians that don’t use a registry may submit data on these measures.
## Merit-based Incentive Payment System (MIPS)

Collection, Submission, and Submitter Types - Example

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

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Submission Type</th>
<th>Submitter Type</th>
<th>Collection Type</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality</strong></td>
<td>• Direct</td>
<td>• Individual</td>
<td>• eCQMs</td>
</tr>
<tr>
<td></td>
<td>• Sign-in and Upload</td>
<td>• Individual</td>
<td>• MIPS CQMs</td>
</tr>
<tr>
<td></td>
<td>• Medicare Part B Claims (small practices only)</td>
<td>• Third Party Intermediary</td>
<td>• QCDR Measures</td>
</tr>
<tr>
<td></td>
<td>• Individual</td>
<td>• Individual</td>
<td>• Medicare Part B Claims Measures (small practices only)</td>
</tr>
<tr>
<td><strong>Cost</strong></td>
<td>• No data submission required</td>
<td>• Individual</td>
<td>-</td>
</tr>
<tr>
<td><strong>Improvement Activities</strong></td>
<td>• Direct</td>
<td>• Individual</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>• Sign-in and Upload</td>
<td>• Third Party Intermediary</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>• Sign-in and Attest</td>
<td>• Individual</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>• Individual</td>
<td>• Third Party Intermediary</td>
<td>-</td>
</tr>
<tr>
<td><strong>Promoting Interoperability</strong></td>
<td>• Direct</td>
<td>• Individual</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>• Sign-in and Upload</td>
<td>• Third Party Intermediary</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>• Sign-in and Attest</td>
<td>• Individual</td>
<td>-</td>
</tr>
</tbody>
</table>
### Merit-based Incentive Payment System (MIPS)
Collection, Submission, and Submitter Types - Example

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

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Submission Type</th>
<th>Submitter Type</th>
<th>Collection Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>• Direct</td>
<td>• Group</td>
<td>• eCQMs</td>
</tr>
<tr>
<td></td>
<td>• Sign-in and Upload</td>
<td>• Third Party Intermediary</td>
<td>• MIPS CQMs</td>
</tr>
<tr>
<td></td>
<td>• CMS Web Interface <em>(groups of 25 or more eligible clinicians)</em></td>
<td>• CMS Approved Survey Vendors</td>
<td>• QCDR Measures</td>
</tr>
<tr>
<td></td>
<td>• Medicare Part B Claims <em>(small practices only)</em></td>
<td></td>
<td>• CMS Web Interface Measures</td>
</tr>
<tr>
<td>Cost</td>
<td>• No data submission required</td>
<td>• Group</td>
<td>-</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>• Direct</td>
<td>• Group</td>
<td>-</td>
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<td></td>
<td>• Sign-in and Upload</td>
<td>• Third Party Intermediary</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>• Sign-in and Attest</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Promoting Interoperability</td>
<td>• Direct</td>
<td>• Group</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>• Sign-in and Upload</td>
<td>• Third Party Intermediary</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>• Sign-in and Attest</td>
<td></td>
<td>-</td>
</tr>
</tbody>
</table>
What is a Performance Period Under MIPS?

- A **performance period** is the length of time that you or your group are required to report data for a specific MIPS performance category.

- In order to receive the highest possible MIPS final score, you should report data for the minimum performance period under each performance category.

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Performance Periods for 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>12-months</td>
</tr>
<tr>
<td>Cost</td>
<td>12-months</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>90-days</td>
</tr>
<tr>
<td>Promoting Interoperability</td>
<td>90-days</td>
</tr>
</tbody>
</table>

**Note:** Most improvement activities have a continuous 90-day performance period, but several improvement activities require completion of modules where there is a year-long or alternate performance period. The performance period for improvement activities is 90 days unless otherwise stated in the activity description and in the MIPS Data Validation Criteria.
What is a Performance Category Weight?

• A “weight” is the overall value assigned to each performance category

Did You Know?

• The performance category weights have gradually increased over the last three performance years

• For the 2022 performance year, when the program is fully implemented, both Quality and Cost will be weighted at 30%
MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Quality Performance Category Requirements
Merit-based Incentive Payment System (MIPS)

Quality Performance Category

Quality Basics for 2020

• 45% of your MIPS Final Score
• Total of 218 quality measures
• You select 6 individual measures
  - 1 must be an outcome measure OR a high-priority measure (if an outcome is not available)
    • High-priority measures fall within these categories: Outcome, Patient Experience, Patient Safety, Efficiency, Appropriate Use, Care Coordination, and Opioid-Related
  - If less than 6 measures apply, you should report on each applicable measure
  - You may also select a specialty-specific set of measures
Merit-based Incentive Payment System (MIPS)

Quality Performance Category

Quality Basics for 2020

Bonus points:

• Outcome or patient experience: 2 points
  - After the first required outcome measure is submitted

• Other high-priority measures: 1 point
  - After the first required measure is submitted

• Each measure submitted using electronic end-to-end reporting: 1 point

• Small practice bonus: 6 points
Quality Basics for 2020

Data completeness

• We check to see if you or your group have submitted data on a minimum percentage of your patients that meet a quality measure’s denominator criteria

• In 2020, the thresholds are:
  - 70% for data submitted on QCDR measures, CQMs, and eCQMS (all-payer data)
  - 70% for data submitted on Medicare Part B claims measures (Part B data)

• Measures that do not meet the data completeness criteria earn 0 points
  - Small practices receive 3 points for measures that do not meet data completeness

Review the 2020 Quality Performance Category Quick Start Guide for more information on reporting requirements and measures.
Quality Performance Category Measures

The 2020 Final Rule:
- Removed low-bar, standard of care, and process measures
- Focused on outcome and other high priority measures
- Added new specialty sets
  - Speech Language Pathology
  - Audiology
  - Clinical Social Work
  - Chiropractic Medicine
  - Pulmonology
  - Nutrition/Dietician
  - Endocrinology

Did You Know?
For more information on Quality measures, you can review:
- 2020 MIPS Quality Measures List
- 2020 QCDR Measure Specifications
- 2020 Clinical Quality Measure Specifications and Supporting Documents
- 2020 CMS Web Interface Measures Specifications and Supporting Documents
- 2020 Medicare Part B Measure Specifications and Supporting Documents
MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Cost Performance Category Requirements
**Merit-based Incentive Payment System (MIPS)**

Cost Performance Category

**Cost Basics for 2020**

- **15%** of your MIPS Final Score

- **No** reporting requirement – data is pulled from administrative claims

- Measures include:
  - Medicare Spending Per Beneficiary Clinician (MSPB-C) measure
  - Total Per Capita Cost (TPCC) measure
  - 18 episode-based measures

- In order to be scored on a cost measure, you or your group must have enough attributed cases to meet or exceed the case minimum for that cost measure

Review the [2020 Cost Performance Category Quick Start Guide](#) for more information on reporting requirements and measures.
Cost Performance Category

Merit-based Incentive Payment System (MIPS)

**Cost Performance Category Measures**

There are 20 cost measures in total for the 2020 performance period:

<table>
<thead>
<tr>
<th>Cost Measures</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Spending Per Beneficiary Clinician (MSPB-C)</td>
<td>1</td>
</tr>
<tr>
<td>Total Per Capita Cost (TPCC)</td>
<td>1</td>
</tr>
<tr>
<td>Episode-based measures</td>
<td>18</td>
</tr>
</tbody>
</table>

The 2020 Final Rule added **10 new episode-based** measures to continue expanding access to the Cost performance category.
Cost Performance Category Measures

The 2020 Final Rule also revised the existing Medicare Spending Per Beneficiary Clinician (MSPB-C) and Total Per Capita Cost (TPCC)

- **MSPB-C:**
  - Refined attribution methodology for medical and surgical episode
  - Service exclusions for costs that are unlikely to be influenced by clinicians

- **TPCC:**
  - Refined attribution methodology for identifying primary care relationships
  - Specialty exclusions for clinicians who don’t provide primary care services
  - Refined risk adjustment to account for changes in patient health status during the year

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Improvement Activities
Performance Category Requirements
**Merit-based Incentive Payment System (MIPS)**

**Improveement Activities Performance Category**

*Improvement Activities Basics for 2020*

- **15%** of your MIPS Final Score
- Total of **105 Improvement Activities** for 2020
- Each activity contains a weight:
  - **Medium** – worth 10 points
  - **High** – worth 20 points
- Select an activity and **attest “yes”** to completing

**You must **earn 40 points** to receive the full Improvement Activities category score**

- Small practices, non-patient facing clinicians, and/or clinicians located in rural or health professional shortage areas (HPSAs) receive double-weighting and report on no more than 2 activities to receive the highest score

Review the [2020 Improvement Activities Performance Category Quick Start Guide](#) for more information on reporting requirements and measures.
Improvement Activities Performance Category Measures

The 2020 Final Rule:

- Added 2 new Improvement Activities
- Modified 7 existing Improvement Activities
- Removed 15 existing Improvement Activities

Review the 2020 Improvement Activities Inventory and 2020 MIPS Data Validation Criteria for more information.
MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Promoting Interoperability
Performance Category
Requirements
Promoting Interoperability Basics for 2020

- 25% of your MIPS Final Score
- Must use **2015 Edition Certified EHR Technology (CEHRT)**
- Performance-based scoring at the individual measure level
- Groups and virtual groups qualify for automatic reweighting of this performance category when more than 75% of the clinicians in the group or virtual group are hospital-based.

- **Four** Objectives:
  - e-Prescribing
  - Health Information Exchange
  - Provider to Patient Exchange
  - Public Health and Clinical Data Exchange

Review the [2020 Promoting Interoperability Performance Category Quick Start Guide](#) for more information on reporting requirements and measures.
## Merit-based Incentive Payment System (MIPS)

Promoting Interoperability Performance Category

### Promoting Interoperability Objectives and Measures

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Measures</th>
<th>Maximum Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>e-Prescribing</td>
<td>• e-Prescribing</td>
<td>• 10 points</td>
</tr>
<tr>
<td></td>
<td>• Query of Prescription Drug Monitoring Program (PDMP)</td>
<td>• 5 bonus points</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>• Support Electronic Referral Loops by Sending Health Information (formerly Send a Summary of Care)</td>
<td>• 20 points</td>
</tr>
<tr>
<td></td>
<td>• Support Electronic Referral Loops by Receiving and Incorporating Health Information</td>
<td>• 20 points</td>
</tr>
<tr>
<td>Provider to Patient Exchange</td>
<td>• Provide Patients Electronic Access to their Health Information</td>
<td>• 40 points</td>
</tr>
</tbody>
</table>
| Public Health and Clinical Data Exchange | • Immunization Registry Reporting  
• Electronic Case Reporting  
• Public Health Registry Reporting  
• Clinical Data Registry Reporting  
• Syndromic Surveillance Reporting | • 10 points |
Promoting Interoperability Performance Category

Promoting Interoperability Performance Category Measures

The 2020 Final Rule:

- Revised the optional Query of Prescription Drug Monitoring Program (PDMP) measure to require a yes/no attestation, available for bonus points
- Removed the Verify Opioid Treatment Agreement measure

Review the 2020 MIPS Promoting Interoperability Measure Specifications for more information.
MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Performance Thresholds and Payment Adjustments
Merit-based Incentive Payment System (MIPS)

Performance Thresholds and Payment Adjustments

**Basics for 2020**

- **45 point** performance threshold
  - This is the *minimum* number of points needed to avoid a negative payment adjustment and earn a neutral payment adjustment

- Additional performance threshold for exceptional performance set at **85 points**

- We’ll compare your final score to the performance threshold (and exceptional performance threshold) to determine your payment adjustment

- Payment adjustment *could be* +/-9%

*To ensure budget neutrality, positive MIPS payment adjustment factors will 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.*
**Merit-based Incentive Payment System (MIPS)**

Performance Thresholds and Payment Adjustments

### 2020 Point Breakdown and Payment Adjustment

<table>
<thead>
<tr>
<th>Final Score 2020</th>
<th>Payment Adjustment 2022</th>
</tr>
</thead>
</table>
| ≥85 points       | • Positive adjustment greater than 0%  
                   • Eligible for additional payment for exceptional performance —minimum of additional 0.5%  |
| 45.01-84.99 points | • Positive adjustment greater than 0%  
                   • Not eligible for additional payment for exceptional performance |
| 45 points        | • Neutral payment adjustment |
| 11.26-44.99      | • Negative payment adjustment greater than -9% and less than 0% |
| 0 11.25 points   | • Negative payment adjustment of -9% |

**Did You Know?**

• The performance threshold has incrementally increased since 2017

• For the 2022 performance year, the performance threshold (the number in the green box) will be based on the mean or median of the final scores for all MIPS eligible clinicians
MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Help and Support
Merit-based Incentive Payment System (MIPS)

Key Resources

- Quality Payment Program website – qpp.cms.gov
- QPP Participation Status Look-up Tool
- MIPS Explore Measures Tool
- QPP Resource Library
- QPP Webinar Library
- QPP Help and Support Page
- QPP Listserv – available on the Quality Payment Program website
Merit-based Incentive Payment System (MIPS)

Getting Started Checklist

**Action Items to Consider:**

- Familiarize yourself with contents and tools on the Quality Payment Program website – [qpp.cms.gov](http://qpp.cms.gov)

- Check your participation status using the [QPP Participation Status Look-up Tool](http://qpp.cms.gov)

- If you’re included OR intend to opt-in to MIPS:
  - Determine whether you want to participate as an individual or as a part of a group
  - Identify the measures and activities on which you or your group will report
  - Begin capturing quality measure data – remember, you must collect data for 12 months for the Quality performance category (this is important if you’re planning to opt-in)

- Reach out to the various forms of **FREE** support (next slide)
  - Quality Payment Program Service Center
  - Quality Payment Program Technical Assistance
Technical Assistance
Available Resources

CMS has no cost resources and organizations on the ground to provide help to clinicians who are participating in the Quality Payment Program:

Small & Solo Practices
Small, Underserved, and Rural Support (SURS)
- Provides virtual outreach, guidance, and 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 assistance getting connected, contact QPPSURS@IMPAQINT.com.

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 QPP@cms.hhs.gov
  • Customers who are hearing impaired can dial 711 to be connected to a TRS Communications Assistant.
- 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.

Learn more about technical assistance: https://qpp.cms.gov/about/help-and-support#technical-assistance
Q&A
Q&A Session

To ask a question, please dial:

1-866-452-7887

If prompted, use passcode: 796 3535

Press *1 to be added to the question queue.

You may also submit questions via the chat box.

Speakers will answer as many questions as time allows.