

# MIPS Tips

What You Need to Know About the  
Merit-Based Incentive Payment System (MIPS)



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# Part 1

Overview, Participation & Reporting, Performance & Scoring

# Disclaimer

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- The materials and documents presented are not intended to supersede any policies, procedures, or templates that vRad or your facility has approved and implemented, unless specifically noted.
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# Part 1

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- What is MACRA and MIPS
- Two Tracks for the Quality Payment Program
- Advanced Alternative Payment Models
- Merit-Based Incentive Payment System (MIPS)
- Participation and Reporting Methods
- MIPS Performance Categories & Scoring Weight
- Quick Overview of the Cost and Advancing Care Information Categories

A doctor in a white lab coat is seated at a grey table, holding a white rectangular sign with both hands. The sign contains text about MACRA. A blue stethoscope is lying on the table in front of the sign. The background is a plain, light grey wall.

# WHAT IS MACRA?

THE MOST SIGNIFICANT  
MEDICARE POLICY CHANGE  
IN RECENT HISTORY

# MACRA: Moving from Quantity to Quality Payments

Fee-for-service (FFS) payment system pays clinicians for volume of services, not value. The Sustainable Growth Rate (SGR) was established in 1997 to control Medicare payment costs.

**IF**



**Overall  
physician  
costs**

**>**



**Target  
Medicare  
expenditures**



**Physician payments  
cut across the board**



Each year, Congress has passed temporary **“doc fixes”** to avert cuts. Without the fix in 2015 there would have been a **21% cut** in Medicare payments to clinicians.

# What is MACRA?

## The Medicare Access and CHIP Reauthorization Act (MACRA)

- April 16, 2015 - Signed into law
- April 27, 2016 - CMS released a 962-page proposed rule to implement MACRA
- October 14, 2016 – CMS released the final rule to implement the Quality Payment Program (2,398 pg.)
- January 1, 2017 – first reporting year begins (transition year)

## What does MACRA do?

- Repeals the Sustainable Growth Rate (SGR)
- Changes the way that Medicare rewards clinicians: ***value over volume through the new Quality Payment Program:***
  - Merit-Based Incentive Payment System (MIPS) - Combines four quality programs
  - Bonus payments for participating in eligible alternative payment models (APMs)

## The Quality Payment Program has two tracks to choose from:

The Merit-based  
Incentive  
Payment System  
(MIPS)

or

Advanced  
Alternative  
Payment Models  
(APMs)

# Participation in the Quality Payment Program

It is your choice to participate, and if you do, how to participate.  
The QPP will impact your Medicare payments!

**The Quality Payment Program rewards high-value, patient centered care.**

**Clinicians can choose how they want to participate in the Quality Payment Program based on their:**

- Practice size
- Specialty
- Location
- Patient population
- Services provided





# Two Tracks for the Quality Payment Program



## Advanced APM path:

*If you receive 25% of Medicare payments or see 20% of your Medicare patients through an Advanced APM in 2017, then you earn a 5% incentive payment in 2019.*

## MIPS

*If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS.*

# Advanced APM Criteria

**Criterion 1:** At least 50% of the clinicians in each APM entity must use certified EHR technology to document & communicate clinical care info.

**Criterion 2:** Base payment on quality measures that are comparable to those used in the MIPS quality performance category.

- Ties payment to quality measures that are evidence-based, reliable, and valid.
- At least one of these measures must be an outcome measure if an appropriate outcome measure is available on the MIPS measure list

**Criterion 3:** Must meet two standards:

- Financial Risk Standard: must bear risk for monetary losses
- Nominal Amount Standard: the risk must meet a certain magnitude.

## These current APMs will qualify for Advanced APMs in 2017:

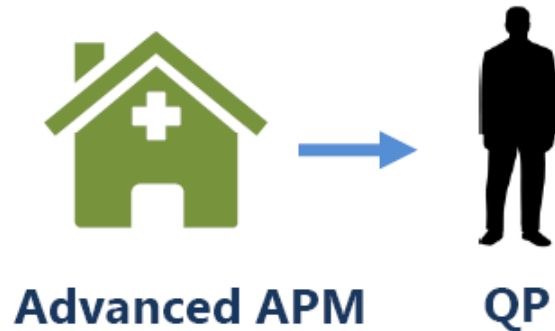
- Shared Savings Program (Tracks 2 and 3)
- Next Generation ACO Model
- Comprehensive ESRD Care (CEC)
- Comprehensive Primary Care Plus (CPC+)
- Oncology Care Model (OCM) (two-sided risk arrangement)



CMS set a high bar for what counts as an Advanced APM.

CMS estimates only a small percentage of providers would receive APM bonuses in 2019...as few as 5%.

# How to become a Qualifying APM Participant (QP)



You must have a **certain %** of your patients or payments through an **Advanced APM**.

QPs will:

**Be excluded from MIPS**

**Receive a 5% lump sum bonus**

Bonus applies in 2019-2024; then QPs receive higher fee schedule updates starting in 2026



# Legacy Programs Phase Out

MIPS Combines Legacy Programs into a single reporting program with FOUR categories



2016

■ Last PQRS Performance Period

2018

■ Last PQRS Payment Adjustment

2017

■ First MIPS Performance Period

2019

■ First MIPS Payment Adjustment

# Merit-Based Incentive Payment System (MIPS)

- Streamlines 3 current independent programs to work as one and to ease clinical burden.
- Adds a fourth category to promote ongoing improvement and innovation to clinical activities important to a practice or group.
- Moves Medicare Part B clinicians to a performance-based payment system.
- Provides clinicians with flexibility to choose the activities and measures that are most meaningful to their practice

## Performance Categories

 <b>Quality</b>	 <b>Improvement Activities</b>	 <b>Advancing Care Information</b>	 <b>Cost</b>
Replaces PQRS.	New category.	Replaces the Medicare EHR Incentive Program also known as Meaningful Use.	Replaces the Value-Based Modifier.

# Who is In the QPP and MIPS?

**A clinician with a unique billing TIN and NPI combination is part of the Quality Payment Program (QPP) if they bill Medicare Part B and bill more than the low-volume threshold:**

- Billing more than \$30,000 a year and providing care for more than 100 Medicare patients a year.
- **MIPS eligible clinicians (EC) for Years 1 and 2 (2017 & 2018):**
  - Physicians (MD/DO and DMD/DDS)
  - Physician assistants
  - Nurse Practitioners
  - Clinical nurse specialists
  - Certified registered nurse anesthetists
- **CY 2019+ MIPS performance years eligibility broadens to:**
  - Physical or occupational therapists
  - Speech language pathologists
  - Audiologists
  - Nurse midwives
  - Clinical social workers
  - Clinical psychologists
  - Dietitians/nutritional professionals



**NOTE: Eligible Clinician (EC)** replaces Eligible Provider (EP) that was used in PQRS program

# CY 2017 Exemptions from MIPS

- **Clinicians in their first year of Medicare Part B participation**
  - Newly enrolled in Medicare for the first time during the performance period (never submitted claims under Medicare).
  - Will not be treated as a MIPS EC until the subsequent year and that year's performance period.
- **Low-Volume Threshold:**
  - Clinicians or groups are excluded from MIPS if during the performance year they have:
    - Medicare billing charges less than or equal to \$30,000
    - OR
    - Provides care for 100 or fewer Part B-enrolled Medicare beneficiaries.

*(See next slide for clarification from CMS)*

- **Clinicians participating in an Advanced APM entity**





# Eligibility Scenario



To be eligible for the Quality Payment Program, a clinician must bill more than \$30,000 **AND** see more than 100 Medicare beneficiaries.

Quick Tip:  
“And” is the key  
to eligibility

In the example provided in this incident where a clinician billed \$29,000 and saw 101 patients, this clinician would be **EXEMPT** from the program because the clinician did not bill more than \$30,000.



+



=

**EXEMPT**  
From the Quality  
Payment Program

“Or” is the key  
to be exempt



# Definition of Non-Patient Facing MIPS Eligible Clinicians

## Definition

- MIPS eligible clinician that bills 100 or fewer patient-facing encounters during the *determination period*
- A group is non-patient facing if > 75% of NPIs billing under the group's TIN during a performance period are labeled as non-patient facing
- Patient-facing encounters include Medicare telehealth services (see Appendix P in the AMA's *CPT® 2017 Professional* edition for a list of telehealth CPT codes)
- CMS will publish a list of patient-facing encounters on the CMS Web site located at [QualityPaymentProgram.cms.gov](https://www.cms.gov/QualityPaymentProgram)
- CMS will let MIPS eligible clinicians know in advance of a performance period whether or not they qualify as a non-patient facing MIPS eligible clinician
- There are more flexible reporting requirements for non-patient facing clinicians



# Non-Patient Facing 24-month Determination Period

## Identifying non-patient facing MIPS clinicians for 2019 MIPS payment adjustment:

- Based on 12 months of data starting from September 1, 2015 to August 31, 2016.
- To account for identification of additional individual MIPS EC and groups, a second period from September 1, 2017 to August 31, 2017 will be analyzed.

## Following years:

- **Initial 12-month period:**
  - Last 4 months (September-December) of a calendar year 2 years prior to the performance period followed by
  - First 8 months (January – August) of the next calendar year
- **Second 12-month period:**
  - Used to identify previously unidentified EC not found in first period <sup>1</sup>.
  - Last 4 months of a calendar year 1 year prior to the performance period followed by
  - First 8 months of the performance period in the next calendar year

<sup>1</sup>. The non-patient facing status of any individual MIPS eligible clinician or group identified as non-patient facing during the first eligibility determination analysis will not be changed based on the second eligibility determination analysis.

# Non-Patient Facing MIPS Eligible Clinicians



## Quality Category

- CMS did not finalize the requirement of cross-cutting measures in the quality category
- There is no difference in requirements for patient facing and non-patient facing clinicians in the quality performance category (page 412 Final Rule)



## CPIA Category

- Total points for category = 40 points
- Patient-facing clinicians
  - Medium weighted activity = 10 points
  - High weighted activity = 20 points
- Non-patient facing clinicians
  - Medium weighted activity = 20 points
  - High weighted activity = 40 points

## Re-weighting MIPS performance categories:

Many non-patient facing MIPS eligible clinicians will not have sufficient measures and activities applicable and available to report under all performance categories under MIPS.

# MIPS Participation

## Individual



Report under an NPI number and TIN

## Group



A group, as defined by taxpayer identification number (TIN) would be assessed as a group practice across all four MIPS performance categories

## APM Entity Group



A collection of entities participating in an Alternative Payment Model

# Definition of MIPS Group Practice

## **MIPS Group Practice Defined by the final rule:**

- A single Tax Identification Number (TIN)
- ECs who have reassigned their billing rights to the TIN
- Two or more eligible clinicians as identified by individual NPIs
- Must include at least one MIPS eligible clinician

## **MIPS Group Reporting**

- Groups that elect to report as a group will be assessed as a group across all four MIPS performance categories
- The group, as a whole, is assessed to determine if the group (TIN) exceeds the low-volume threshold
- All individual NPIs in the group must report, even individuals that meet the low-volume threshold



# Registration for Group Reporting



## Groups required to register reporting via:

- CMS Web Interface
- Groups electing to report the Consumer Assessment of Healthcare Providers & Systems (CAHPS) for MIPS survey for the quality performance category
- Deadline to register is June 30, 2017
- May register anytime before June 30<sup>th</sup> but this date is your last opportunity to change the group reporting status!



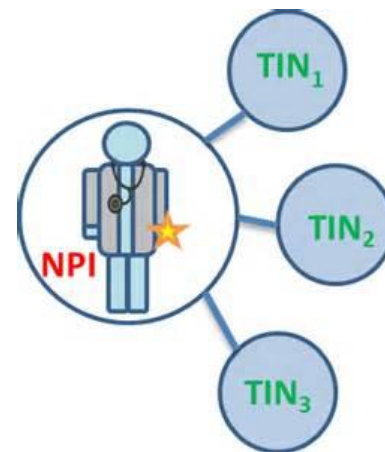
## CMS is considering establishment of a voluntary registration for

- Groups reporting via a qualified registry, QCDR, or EHR
- Would indicate which submission mechanism will be used for reporting data
- If technically feasible, this would allow CMS to identify the data submission mechanism a group intends to use and notify groups of the applicable requirements they would need to meet for the performance year.

# ECs Who Bill Under Multiple TINS

**Individual eligible clinicians who are part of several groups and thus, associated with multiple TINs, participate in MIPS for each group (TIN) association.**

- Each unique TIN/NPI combination is considered a different MIPS eligible clinician
- MIPS eligible clinicians will need to meet the MIPS requirements for each TIN they are associated with unless they are excluded from the MIPS requirements based on one of the three exclusions
- MIPS performance will be assessed separately for each TIN under which an individual bills
- CMS will apply the MIPS adjustment at the TIN/NPI level



*Final Rule, pages 201 and 202*



# Reporting Periods and Frequencies

2017



## Reporting Period

January 1, 2017 through December 31, 2017

Can choose to report any 90 days up to the full year

- Minimum reporting period is **a continuous 90-day**
- 90-day period must end by December 31 (start no later than October 2)
- Reporting based on 12-month performance period (excluded from the 90-day minimum option):
  - CMS Web Interface
  - CAHPS for MIPS survey
  - The all-cause hospital readmission measure reporting by Claims Administration

## Reporting Frequency for Quality Measures

Quality measures include specification instructions of how often a measure must be reported, such as

- Within the flu season
- Once per year
- Each patient encounter

# MIPS Participation in 2017 Performance Year

## Pick Your Pace

**No participation:** If no data is submitted, you receive a negative 4% payment adjustment in 2019.

**Test the Quality Payment Program:** Submit some data after January 1, 2017 to avoid a negative payment adjustment (neutral adjustment)

- 1 Quality Measure or
- 1 Clinical Practice Improvement Activity or
- Base Advancing Care Information Measures

**Submit a Partial Year (continuous 90-day period):**

- Performance period can start between January 1, 2017 and October 2, 2017
- This option may qualify you for a neutral or small positive payment adjustment.
- 90 days of reporting six (6) Quality Measures, use of technology, and improvement activities

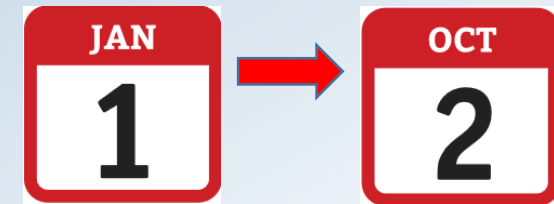
**Submit a Full Year:** Full participate for the entire calendar year and qualify for a modest positive payment.



**Whenever you choose to start, you'll need to:**

- Start by October 2<sup>nd</sup>
- Send in your performance data by March 31, 2018

**Start between:**



**Send data by:**



# Bonus Payments & Reporting Periods

**Key Takeaway:** Positive adjustments are based on the performance data on the performance information submitted, not the amount of information or length of time submitted.

- MIPS payment adjustment is based on:
  - Data submitted
  - Quality of your results
- Best way to get the max adjustment is to participate for a full year.
- BUT if you report for 90 days, you could still earn the max adjustment.
- A full year report will prepare you most for the future of the program.

**Performance Year 2018:** will require full year reporting



## 90-Day Period Flexibility

The 90-day period can differ across performance categories:

### EXAMPLE:

- CPIA category: report activity from June 1 to August 30, 2017
- Quality category: report measures from August 15, 2017 – November 1

*Final Rule, page 309*

# Submission Mechanisms

**ECs must use the same submission mechanism per performance category.**

- Can use one submission mechanism for sending quality measures and another for sending improvement activities data (CPIA)
- Cannot use two submission mechanisms for a single performance category (e.g. two via claims and 4 via registry)
- After the transition year (2017), only one method will be allowed.
- Claims-based measures: CMS intends to reduce the number of claims-based measures in the future as more measures are available through health IT mechanisms such as registries, QCDRs, and EHR vendors

**2017 Transition Year**



# How to Report: Submission Methods

Performance Category	Individual Reporting	Group Practice Reporting
Quality	<b>Claims</b>	QCDR
	QCDR Qualified registry EHR	Qualified registry EHR CMS Web Interface (groups of 25 or more) CMS-approved survey vendor for CAHPS for MIPS <sup>1</sup> . Administrative claims <sup>2</sup> . (No submission required)
CPIA Improvement Activities	Attestation QCDR Qualified registry EHR	Attestation QCDR Qualified registry EHR CMS Web Interface (groups of 25 or more)
Cost	Administrative claims (no submission required)	Administrative claims (no submission required)
Advancing Care Information	Attestation QCDR Qualified registry EHR	Attestation QCDR Qualified registry EHR CMS Web Interface (groups of 25 or more)

<sup>1</sup> Must be reported in conjunction with another data submission mechanism

<sup>2</sup> For all-cause hospital readmission measure

*Final Rule, Page 347-348*

# Definitions: Claims vs Claims Administration

## **“Claims” submission mechanism**

- Requires MIPS eligible clinicians to append certain billing codes to denominator eligible claims to indicate to CMS the required quality action or exclusion occurred.
- Data submitted on all claims with dates of service during the performance period that must be processed no later than 60 days following the close of the performance period
- Claim codes are identified in the Measure Specification documents
  - CPT I codes (the denominator or eligible services listed in the measure specifications)
  - CPT II codes (the numerator or the codes used to report the outcome of the action as indicated by the measure)
  - PQRS Modifiers (exclusions)

## **“Administrative claims” submission mechanism**

- All-cause hospital readmission measures for both the quality and cost performance categories of the final rule (Section II.E.5.b. for the quality and Section II.E.5.e. for the cost category)
- Requires no separate data submission to CMS
- Calculations based on data available from MIPS eligible clinicians’ billings on Medicare Part B claims

*Final Rule, page 331*

# Administrative claims: All-cause Hospital Readmission Measures

**Measure 458: All-cause hospital readmission:** The 30-day all-cause hospital readmission measure is a risk-standardized readmission rate for beneficiaries age 65 or older who were hospitalized at a short-stay acute care hospital and experienced an unplanned readmission for any cause to an acute care hospital within 30 days of discharge.

- This measure will only be scored for MIPS eligible clinicians and groups who have beneficiaries attributed to them and that meet the minimum case size requirements.
- This measure will be calculated only for groups of 16 or more eligible clinicians
- Requires no data submission



# Claims-Based Submission Method

## Appendix D: CMS-1500 Claim PQRS Example

Below is an example of an individual NPI reporting on a single CMS-1500 claim. See <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf> for more information and complete billing requirements.

**21. Review applicable PQRS measures related to ANY diagnosis (Dx) listed in Item 21. Up to 12 Dx may be entered.**

**Identifies claim line-item.**

**ICD Indicator identifies the ICD code set being reported (e.g., [0] ICD-10-CM diagnosis)**

**Enter the diagnosis code reference number as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis.**

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.	22. RESUBMISSION CODE	ORIGINAL REF. NO.											
A.	B.	C.	D.	E.	F.	G.	H.	I.	J.														
											23. PRIOR AUTHORIZATION NUMBER												
M80.069A	I20.0	I10																					
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #					
MM	DD	YY	MM	DD	YY																		
07	05	16	07	05	16							99213	A	47.00			NPI	0123456789					
07	05	16	07	05	16							4005F	A	0.01			NPI						
07	05	16	07	05	16							1090F	A	0.01			NPI						
07	05	16	07	05	16							G8598	B				NPI						
07	05	16	07	05	16							G8752	C				NPI						
07	05	16	07	05	16							G8754	C	0.01			NPI						
25. FEDERAL TAX ID. NUMBER										SSN EIN	26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov. claims, see back)		28. TOTAL CHARGE		29. BILLING PERIOD						
XX-XXXXXX										X	XXXX		X YES <input type="checkbox"/> NO <input type="checkbox"/>		\$								
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER ID. #			
SIGNED										DATE										a. NPI		b. XXXXXXXXXX	

**24D. Procedures, Services, or supplies - CPT/HCPCS and Modifier(s) as needed**

**QDC codes must be submitted with a line-item charge of \$0.01**

**33a. The NPI of the billing provider is entered here. Solo practitioners enter the individual NPI; if a group is billing, enter the NPI of the group.**

**For group billing, the rendering NPI number of the individual eligible professional who performed the service will be used from each line item in the PQRS calculations.**

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org) PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)



# QCDR vs Qualified Registry

## Qualified Clinical Data Registry (QCDR) reporting mechanism

- A QCDR will complete the collection and submission of quality measures data on behalf of individual eligible clinicians (ECs) and group practices
- To be considered a QCDR for purposes of MIPS, an entity must self-nominate and successfully complete a qualification process
- A QCDR is different from a qualified registry in that it is not limited to the list of measures in Table A of the final rule. They can include non-QPP measures that have been approved by CMS.
- Variance on cost, what QPP measures are supported, what non-QPP measures have been approved by CMS, and reporting options
- Reporting options may include continuous performance feedback reports, dashboards, peer comparisons, MOC reporting
- American College of Radiology National Radiology Data Registry (NRDR) fees in 2016: \$199 per ACR member and \$499 per non-member

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2016QCDRPosting.pdf>

## Qualified Registry Reporting

- A qualified registry is an entity that collects clinical data from an EP or MIPS group practice and submits it to CMS on behalf of the participants
- Variance on cost, what measures are supported, and reporting options

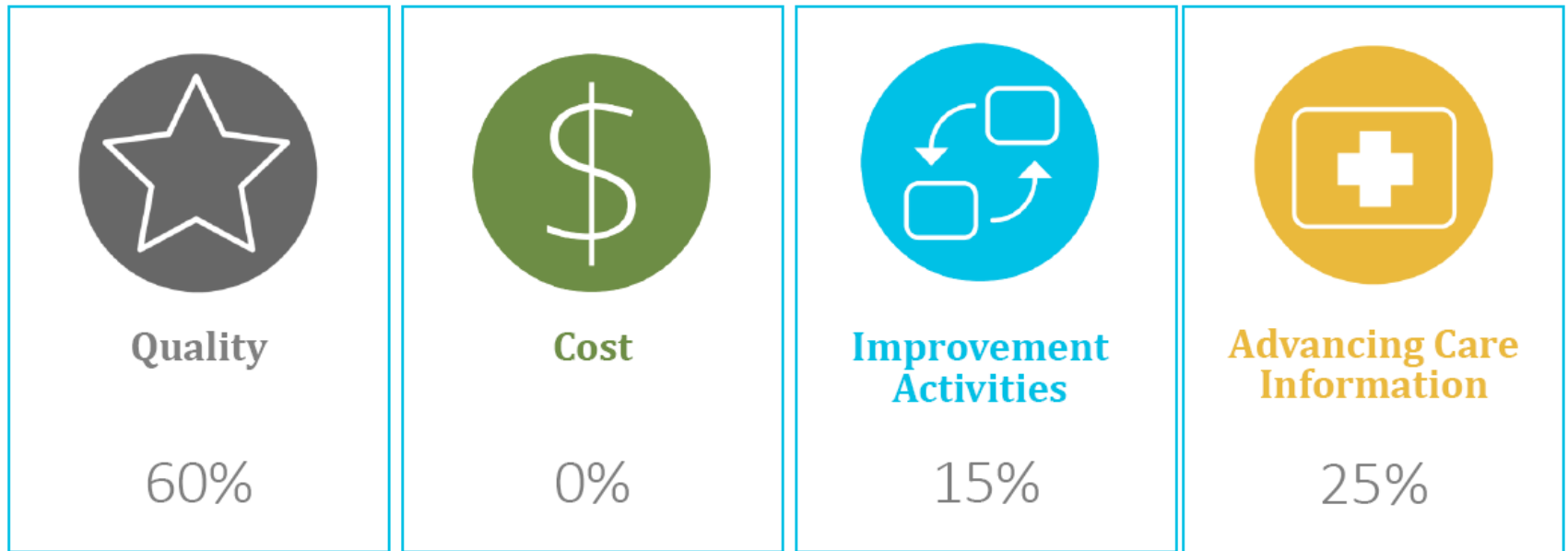
<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2016QualifiedRegistries.pdf>

## Claims vs. Registry-Based Reporting

### Registry and QCDR reporting can be more beneficial than claim-based reporting:

- Less oversight and time than reporting via claims
- Providers are not required to include CPT II codes or G codes on claims
- Validation or review of the data before submitted, allowing to add key clinical information at any time
- Feedback reports to improve process & performance
- Higher reporting success rate than claims





# Transition Year Performance Category Weights for MIPS



## MIPS Composite Performance Score (CPS)




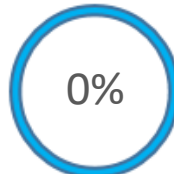
- Based on a 1 to 100 point scale
- The default weights are adjusted in certain circumstances
  - Example:* the Advancing Care Information category for radiologists reweights to the Quality category (so that Quality reweights as 85% of the CPS)
- CPS will determine payment adjustments
- Payment adjustments (not an incentive): neutral, positive or negative

# Categories for Radiology

Category	What do you need to do?	2017 Category Weight
 <p><b>Quality</b></p> <p><i>Replaces the Physician Quality Reporting System (PQRS).</i></p>	<p><b>Most participants:</b> Report up to 6 quality measures, including an outcome measure, for a minimum of 90 days.</p> <p><b>Groups using the web interface:</b> Report 15 quality measures for a full year.</p> <p><b>Groups in APMs qualifying for special scoring under MIPS, such as Shared Savings Track 1 or the Oncology Care Model:</b> Report quality measures through your APM. You do not need to do anything additional for MIPS quality.</p>	
 <p><b>Improvement Activities</b></p> <p><i>New category.</i></p>	<p><b>Most participants:</b> Attest that you completed up to 4 improvement activities for a minimum of 90 days.</p> <p><b>Groups with fewer than 15 participants, or eligible clinicians in a rural or health professional shortage area, or that are considered non-patient facing:</b> Attest that you completed up to 2 activities for a minimum of 90 days.</p> <p><b>Participants in certified patient-centered medical homes, comparable specialty practices, or an APM designated as a Medical Home Model:</b> You will automatically earn full credit. Groups in APMs qualifying for special scoring under MIPS, such as Shared Savings Program Track 1 or Oncology Care Model: You will automatically receive points based on the requirements of participating in the APM. For all current APMs under the APM scoring standard, this assigned score will be full credit. For all future APMs under the APM scoring standard, the assigned score will be at least half credit.</p> <p><b>Participants in any other APM:</b> You will automatically earn half credit and may report additional activities to increase your score.</p>	

Source: CMS QPP Fact Sheet

# Categories Difficult for Radiologists to Report

Category	What do you need to do?	2017 Category Weight
 <p><b>Advancing Care Information</b></p> <p><i>Replaces the Medicare EHR Incentive Program also known as Meaningful Use.</i></p>	<p>Fulfill the required measures for a minimum of 90 days:</p> <ul style="list-style-type: none"> <li>Security Risk Analysis</li> <li>e-Prescribing</li> <li>Provide Patient Access</li> <li>Send Summary of Care</li> <li>Request/Accept Summary of Care</li> </ul> <p>Choose to submit up to 9 measures for a minimum of 90 days for additional credit.</p> <p>OR</p> <p>You may not need to submit Advancing Care Information if these measures do not apply to you.</p>	 <p>25%</p>
 <p><b>Cost</b></p> <p><i>Replaces Value-Based Modifier.</i></p>	<p>No data submission required. Calculated from adjudicated claims.</p>	<p>Scoring starting in 2018</p>  <p>0%</p>

Source: CMS QPP Fact Sheet

# MIPS Payment Adjustments for Transition Year

**Final Scoring will be covered in Part 2:** Based on a 1 to 100 point scale

Final Score	Payment Adjustment
<b>≥70 points</b>	<ul style="list-style-type: none"><li>• Positive adjustment</li><li>• Eligible for exceptional performance bonus—minimum of additional 0.5%</li></ul>
<b>4-69 points</b>	<ul style="list-style-type: none"><li>• Positive adjustment</li><li>• Not eligible for exceptional performance bonus</li></ul>
<b>3 points</b>	<ul style="list-style-type: none"><li>• Neutral payment adjustment</li></ul>
<b>0 points</b>	<ul style="list-style-type: none"><li>• Negative payment adjustment of -4%</li><li>• 0 points = does not participate</li></ul>

Source: [Quality Payment Program Final Rule MLN Connects® Call](#) - 11/15/16

- This adjustment percentage grows to a potential of 9% in 2022 and beyond.
- During the first six payment years of the program (2019-2024), MACRA allows for up to \$500 million each year in additional positive adjustments for exceptional performance.

# Cost Performance Category

## Cost (replaces the Physician Value-Based Modifier Program)



- No reporting requirement
- 0% of final score in 2017
- Clinicians assessed on Medicare claims data at the TIN/NPI level
- CMS will still provide feedback on how you performed in this category in 2017, but it will not affect your 2019 payments
- Uses the measures previously used in the VM program or reported in the Quality and Resource Use Report (QRUR)
- All ten (10) measures included in the Cost Category were included in the 2014 QRUR
- Many non-patient facing MIPS ECs will not have sufficient measures available to report
- CMS intends to work with on alternative cost measures for non-patient facing ECs in future years

# Measures included in the Cost Category



Method Type/ Measure #	Episode Name and Description
A/1	<b>Mastectomy</b> Mastectomy is triggered by claims with any of the interventions assigned as mastectomy trigger codes [can triggered by either an ICD procedure code, or CPT codes in any setting (e.g. hospital, surgical center)]
A/5	<b>Aortic/Mitral Valve Surgery</b> Open heart valve surgery (Valve) episode is triggered by a patient claim with any of Valve trigger codes
A/8	<b>Coronary Artery Bypass Graft (CABG)</b> Coronary Artery Bypass Grafting (CABG) episode is triggered by an inpatient hospital claim with any of CABG trigger codes for coronary bypass. CABG generally is limited to facilities with a Cardiac Care Unit (CCU); hence there are no episodes or comparisons in other settings
A/24	<b>Hip/Femur Fracture or Dislocation Treatment, Inpatient (IP)-Based</b> Fracture/dislocation of hip/femur ( <u>HipFxFx</u> ) episode is triggered by claims with any of the interventions assigned as <u>HipFxFx</u> trigger codes. <u>HipFxFx</u> can be triggered by either an ICD procedure code or CPT codes in any setting
B/1	<b>Cholecystectomy and Common Duct Exploration</b> Episodes are triggered by the presence of a trigger CPT/HCPCS code on a claim when the code is the highest cost service for a patient on a given day. Medical condition episodes are triggered by IP stays with specified MS-DRGs

# Measures included in the Cost Category



Method Type/ Measure #	Episode Name and Description
B/2	<b>Colonoscopy and Biopsy</b> Episodes are triggered by the presence of a trigger CPT/HCPCS code on a claim when the code is the highest cost service for a patient on a given day. Medical condition episodes are triggered by IP stays with specified MS-DRGs
B/3	<b>Transurethral Resection of the Prostate (TURP) for Benign Prostatic Hyperplasia</b> For procedural episodes, treatment services are defined as the services attributable to the MIPS eligible clinician or group managing the patient's care for the episode's health condition
B/5	<b>Lens and Cataract Procedures</b> Procedural episodes are triggered by the presence of a trigger CPT/HCPCS code on a claim when the code is the highest cost service for a patient on a given day
B/6	<b>Hip Replacement or Repair</b> Procedural episodes are triggered by the presence of a trigger CPT/HCPCS code on a claim when the code is the highest cost service for a patient on a given day
B/7	<b>Knee Arthroplasty (Replacement)</b> Procedural episodes are triggered by the presence of a trigger CPT/HCPCS code on a claim when the code is the highest cost service for a patient on a given day



# Advancing Care Information Category (ACI) in 2017

## Final Policy to Reweight ACI Category to Zero



- CMS will automatically reweight the advancing care information performance category to zero for clinicians with lack of face-to-face patient interaction, hospital-based MIPS eligible clinicians, NPs, PAs, CRNAs and CNSs
- The 25% ACI score is reweighted to the Quality Performance Category ( $60\% + 25\% = 85\%$  for Quality)
- Hospital-based MIPS EC: [Final Rule, page 907]
  - Defined as a MIPS eligible clinician who furnishes 75 percent or more of his or her covered professional services in sites of service identified by the Place of Service (POS) codes:
    - Inpatient hospital (POS 21)
    - On campus outpatient hospital (POS 22)
    - Emergency room (POS 23)
  - Based on claims with dates of service between September 1 of the calendar year 2 years preceding the performance period through August 31 of the calendar year preceding the performance period
- **Future considerations for non-patient facing physicians**

# Advancing Care Information Category (ACI)

## CY 2017

- 25% of the final score
- Clinicians must use 2014 or 2015 certified EHR technology or a combination of the two to report
- ECs who only have technology certified to the 2014 Edition would not be able to report certain measures specified for the advancing care information performance category that correlate to a Stage 3 measure for which there was no Stage 2 equivalent
- In CY 2018, CMS will require use of the 2015 Edition
- **Submission methods** remain the same
- **Minimum 90-day reporting** in 2017 and 2018 (to support CEHRT upgrade)



# Advancing Care Information Category (ACI) in 2017

- In 2017, there are 2 *measure sets for reporting based on EHR* edition
- Five (5) required measures in base score with 8 optional performance measures to earn higher score
- Total possible 155 points; only 100 required for maximum
- **Table 10** *Advancing Care Information Performance Category Scoring Methodology for 2017 Advancing Care Information Transition --Objectives and Measures* (page 849)
- CMS will reweight the category to zero and assign the 25% to the other performance categories to offset difference in the MIPS final score if objectives and measures are not applicable to a clinician
- Significant hardship clinicians can apply to have their score weighted to zero by March 31, 2018.
- CMS will specify the form and manner that reweighting applications are submitted outside the rulemaking process. Additional information on the submission process will be available after the rule is published. (Final Rule, pg 919)



# Advancing Care Information Category (ACI)

2 measure sets for reporting based on EHR edition



## For those using EHR Certified to the 2015 Edition:

### *Option 1*

Advancing  
Care  
Information  
Objectives and  
Measures

### *Option 2*

Combination  
of the two  
measure sets

## For those using 2014 Certified EHR Technology:

### *Option 1*

2017  
Advancing  
Care  
Information  
Transition  
Objectives and  
Measures

### *Option 2*

Combination  
of the two  
measure sets

Source: [Quality Payment Program Final Rule MLN Connects® Call](#) - 11/15/16

# Resources

Quality Payment Program website – <https://QPP.CMS.GOV>

**Final Rule:** *Medicare Program; Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models*; Centers for Medicare & Medicaid Services, 42 CFR Parts 414 and 495

<https://www.federalregister.gov/documents/2016/05/09/2016-10032/medicare-program-merit-based-incentive-payment-system-mips-and-alternative-payment-model-apm>

**Executive Summary;** Department of Health and Human Services; Centers for Medicare & Medicaid Services; 42 CFR Parts 414 and 495 [CMS-5517-FC] RIN 0938-AS69; <https://qpp.cms.gov/education>

**CMS.gov Webinars and Educational Programs:**

<https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events.html>

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-Events.html>

It is best to direct your questions to [QPP@cms.hhs.gov](mailto:QPP@cms.hhs.gov)

# Part 2

## Quality Measures and Improvement Activities Categories

# Disclaimer

- This presentation is designed to provide participants with reimbursement and coding related news, updates and guidance.
- The materials and documents presented are not intended to supersede any policies, procedures, or templates that vRad or your facility has approved and implemented, unless specifically noted.
- The information, while accurate, to the best of our knowledge, at the time of production, may not be current at the time of use.
- Information is provided as general guidance only and is not a recommendation for a specific situation. Viewers should consult official sources (CMS, ACR, AMA) or a qualified attorney for specific legal guidance.
- Information provided is based on Medicare Part B billing guidelines and may or may not pertain to Medicare Part A billing. Viewers should consult their Part A – Medicare Administrative Contractor website for hospital billing guidelines.

# Part 2





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- Quality Performance Category
- Clinical Practice Improvement Activities Performance Category
- Final Scoring: the Composite Performance Score (CPS)

Please note that the references to page numbers of the Final Rule in these presentations are based on the downloaded PDF format.



# Categories for Radiology

Category	What do you need to do?	2017 Category Weight
 <p><b>Quality</b></p> <p><i>Replaces the Physician Quality Reporting System (PQRS).</i></p>	<p><b>Most participants:</b> Report up to 6 quality measures, including an outcome measure, for a minimum of 90 days.</p> <p><b>Groups using the web interface:</b> Report 15 quality measures for a full year.</p> <p><b>Groups in APMs qualifying for special scoring under MIPS, such as Shared Savings Track 1 or the Oncology Care Model:</b> Report quality measures through your APM. You do not need to do anything additional for MIPS quality.</p>	
 <p><b>Improvement Activities</b></p> <p><i>New category.</i></p>	<p><b>Most participants:</b> Attest that you completed up to 4 improvement activities for a minimum of 90 days.</p> <p><b>Groups with fewer than 15 participants, or eligible clinicians in a rural or health professional shortage area, or that are considered non-patient facing:</b> Attest that you completed up to 2 activities for a minimum of 90 days.</p> <p><b>Participants in certified patient-centered medical homes, comparable specialty practices, or an APM designated as a Medical Home Model:</b> You will automatically earn full credit. Groups in APMs qualifying for special scoring under MIPS, such as Shared Savings Program Track 1 or Oncology Care Model: You will automatically receive points based on the requirements of participating in the APM. For all current APMs under the APM scoring standard, this assigned score will be full credit. For all future APMs under the APM scoring standard, the assigned score will be at least half credit.</p> <p><b>Participants in any other APM:</b> You will automatically earn half credit and may report additional activities to increase your score.</p>	

Source: CMS QPP Fact Sheet

# Category Weights

## Weight for each Performance Category for Future Payment Years

**TABLE 29: Final Weights by Performance Category**

Performance Category	2019 MIPS Payment Year	2020 MIPS Payment Year	2021 MIPS Payment Year and beyond
Quality	60%	50%	30%
Cost	0%	10%	30%
Improvement Activities	15%	15%	15%
Advancing Care Information*	25%	25%	25%

\*The weight for advancing care information could decrease (not below 15 percent) if the Secretary estimates that the proportion of physicians who are meaningful EHR users is 75 percent or greater. The remaining weight would then be reallocated to one or more of the other performance categories.

Final Rule, Page 1212



# Quality Performance Category

# Comparing PQRS to the Quality Performance Category

	PQRS	2017 QUALITY PERFORMANCE CATEGORY
<b>Reporting Criteria</b>	<p>Report at least 9 measures across 3 NQS domains</p> <p>Report 1 cross-cutting measure if at least 1 patient face-to-face encounter</p>	<ul style="list-style-type: none"> <li>- Report at least 6 measures (NQS domains not required)</li> <li>- No cross-cutting measure requirements in 2017</li> <li>- Report 1 Outcome measure, or 1 High Priority measure, if an Outcome measure is not available</li> </ul>
<b>Patient Threshold</b>	Report each measure on at least 50% of applicable Medicare patients	<p>2017: 50% of applicable patients *</p> <p>2018: 60% of applicable patients **</p>
<b>Measures Group Reporting</b>	Optimizing Patient Exposure to Ionizing Radiation (Measures 359-364)- reported using a 20 Patient Sample Method via a registry.	MIPS eliminates Measures Group reporting. The OPEIR measures are listed as individual measures which can be reported via registry.
<b>Scoring</b>	Report all required measures to avoid payment adjustment	<p>Report all required measures.</p> <ul style="list-style-type: none"> <li>- Credit received for those measures that meet the data completeness threshold.</li> <li>- Eligible clinicians performance will influence their score.</li> </ul>
<b>Consumer Assessment of Healthcare Providers &amp; Systems (CAHPS)</b>	Groups with $\geq 100$ EPs participating via GPRO were required to administer the CAHPS for PQRS survey	CAHPS no longer required for groups of 100 or more. Clinicians can receive bonus points for electing CAHPS

\* 50% of all patients, regardless of payer, for EHR, registry, or QCDR reporting (Medicare B patients for Claims reporting)

\*\* CMS plans to incorporate higher thresholds in future years to ensure a more accurate assessment of a MIPS eligible clinician's performance on the quality measures and to avoid any selection bias.

# MIPS Quality Performance Category

Replaces PQRS and the Quality portion of the Value Modifier program

60%

60% of final score

Select 6 of about 300 quality measures (minimum of 90 days to be eligible for maximum payment adjustment); 1 must be:

- Outcome measure OR
- High-priority measure—defined as outcome measure, appropriate use measure, patient experience, patient safety, efficiency measures, or care coordination

Different requirements for groups reporting CMS Web Interface or those in MIPS APMs



May also select specialty-specific set of measures

Source: [Quality Payment Program Final Rule MLN Connects® Call](#) - 11/15/16

**Reminder:** Positive adjustments are based on the performance data on the quality measures submitted, not the amount of information or length of time submitted.

85%

CMS will automatically reweight the Advancing Care Information performance category to zero for radiologists who lack face-to-face patient encounters. The 25% ACI score will be reweighted to the Quality performance category.

# Summary of Quality Data Submission Criteria for CY 2017

## MIPS Reporting for Radiologists

Performance Period	Measure Type	Submission Mechanism	Submission Criteria	Data Completeness
A minimum of one continuous 90-day period during CY2017	Individual MIPS eligible clinicians	Part B Claims	Report at least six measures	50% of MIPS eligible <b>Medicare Part B patients</b> for the performance period
			Include one outcome measure <sup>1</sup> .	
			If an outcome measure is not available report a high priority measure	
			If less than six measures apply, then report on each applicable measure.	
			Select measures from either the list of all MIPS Measures (Table A) or a set of specialty-specific measures (Table E)	
A minimum of one continuous 90-day period during CY2017	Individual MIPS eligible clinicians or Groups	QCDR Registry EHR	Report at least six measures	50% of MIPS eligible patients <b>across all payers</b> <sup>2</sup> for the performance period
			Include one outcome measure	
			If an outcome measure is not available report a high priority measure	
			If less than six measures apply, then report on each applicable measure.	
			Select measures from either the list of all MIPS Measures (Table A) or a set of specialty-specific measures (Table E)	


1. Five (5) measures plus one (1) outcome measure

2. CMS finalized including all-payer data for the QCDR, qualified registry, and EHR submission mechanisms. CMS admits they do not currently have optimal capability to validate data completeness for all-payer data. Validation of all-payer data will therefore continue to be reviewed based on the data submission mechanism used. (Final Rule, page 466)

# Quality Performance Category

- ✓ Each measure submitted or reported will count for 3-10 possible points (60 maximum)
- ✓ 2 bonus points for each outcome measure and 1 bonus point for each other high priority measure that is reported in addition to the 1 high priority measure that is already required.
- ✓ ECs will only receive bonus points if they submit a high priority measure with a performance rate that is greater than zero, measure meets the case minimum and data completeness requirements.
- ✓ Finalized the cap for high priority measures from 5 percent to 10 percent of the denominator (total possible points the MIPS eligible clinician could receive in the quality performance category) of the quality performance category for the first 2 years. [10% of 60 points = 6 maximum bonus points]
- ✓ A high priority measure is defined as
  - Outcome measure
  - Appropriate use measure
  - Patient safety measure
  - Efficiency measure
  - Patient experience measure
  - Care coordination measure

**Finding Outcome Measures in Table A:** Measures labeled as Outcome or Intermediate Outcome measures qualify. There are seventy-one (71) outcome measures.



Indicator	NQF/ Quality #	CMS E-Measure ID	National Quality Strategy Domain	Data submission Method	Measure Type	Measure Title
* § !	0059/001	122 V5	Effective Clinical Care	Claims, Web Interface, Registry, EHR	Intermediate Outcome	Diabetes: Hemoglobin A1c (>9%): Percentage of patients with diabetes who had A1c during the measurement period.  Comments: One comment on inclusion of this measure.

# Selecting Measures Appropriate for Your Practice

- **TABLE A: Finalized Individual Quality Measures Available for MIPS Reporting in 2017** (Final Rule, Appendix, page 2085)
- Quality Payment Program website at this link: <https://qpp.cms.gov/measures/quality>
- The **2016 PQRS Measures Specifications Supporting Documents** can be found at the following link:  
<https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/pqrs/measurescodes.html>
- **Table D:** New Measures for 2017 (page 2222)
- **Table E:** Specialty Measure sets (Radiology page 2308)
- **Table F:** Deleted Measures (Page 2332)
- **Table G:** Changed Measures (page 2347)

Note: the information contained in Tables D and G of the Appendix have been incorporated into Table A.



# Selecting Measures Appropriate for Your Practice

**TABLE A:**  
**Finalized Individual Quality Measures Available for MIPS Reporting in 2017**

## Indicator column:

Plus symbol (+) - New finalized measures

Asterisk (\*) - Existing measures with finalized substantive changes are noted with an asterisk (\*)

Section Sign (§) - core measures as agreed upon by Core Quality Measure Collaborative (CQMC)

Exclamation point (!) - high priority measures

Double exclamation point (!!)- high priority measures that are appropriate use measures

Legend	
●	Selected Features
Chloride data, collected since 1990	
⬆	Less than 250 mg/l, increasing chloride values
⬆	250 to 1,000 mg/l, increasing chloride values
⬆	Greater than 1,000 mg/l, increasing chloride values
○	Less than 250 mg/l, stable chloride values
⬆	250 to 1,000 mg/l, stable chloride values
□	Greater than 1,000 mg/l, stable chloride values
⬆	Less than 250 mg/l, decreasing chloride values
⬆	250 to 1,000 mg/l, decreasing chloride values
⬆	Greater than 1,000 mg/l, decreasing chloride values
⊖	Limited CL data

# Measure 145: Radiology: Fluoroscopy Exposure Dose or Time

Indicator	NQF/ Quality #	CMS E-Measure ID	National Quality Strategy Domain	Data submission Method	Measure Type	Measure Title and Description <sup>†</sup>	Primary Measure Steward
!!	N/A/145	N/A	Patient Safety	Claims, Registry	Process	<p><b>Radiology: Exposure Dose or Time Reported for Procedures Using Fluoroscopy:</b> Final reports for procedures using fluoroscopy that document radiation exposure indices, or exposure time and number of fluorographic images (if radiation exposure indices are not available).</p> <p><b>Comment:</b> One commenter identified a discrepancy regarding the proposed data submission methods for this measure in the proposed rule.</p> <p><b>Response:</b> CMS has corrected this discrepancy throughout the appendix of the final rule with comments and appreciates the commenter for their thorough review.</p> <p><b>Final Decision:</b> CMS is finalizing Q #145 for the 2017 Performance Period. This measure is reportable via claims and registry data submission methods.</p>	American College of Radiology

!! Appropriate Use; Patient Safety = High Priority Measure  
Submission Method: Claims based or Registry

# Radiology Specialty Set

## Table 20a. Diagnostic Radiology Specialty Set (14 measures)

- Appendix of the Final rule, Page 2308
- No Outcome Measures
- Multiple high priority
- Eight (8) measures designated for claims-based submission method
- Fourteen (14) measures designated for registry submission method
- Discrepancy in reporting submission method for Measure 145
  - Table A indicates both Claims and Registry submission methods
  - Table E: Diagnostic Radiology Set indicates 'registry' only
  - Both submission methods listed on the QPP website
  - Both submission methods listed in the 2016 Specification document and Measure 145 is not listed in Table G, Changed Measures

## 20b. Interventional Radiology Specialty Set (4 measures)

- Appendix of the Final rule, Page 2310
- Three (3) Outcome Measures
- All four measures designated for registry submission method



# Diagnostic Radiology Specialty Set

MIPS ID Number	NQF/ PQRS	CMS E-Measure ID	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description*	Measure Steward
<b>20. Radiology</b>							
20a. Diagnostic Radiology							
!!	N/A/ 145	N/A	Registry	Process	Patient Safety	Radiology: Exposure Dose or Time Reported for Procedures Using Fluoroscopy  Final reports for procedures using fluoroscopy that document radiation exposure indices, or exposure time and number of fluorographic images (if radiation exposure indices are not available)	American College of Radiology
!	0508 / 146	N/A	Claims, Registry	Process	Efficiency and Cost Reduction	Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening  Percentage of final reports for screening mammograms that are classified as "probably benign"	American College of Radiology
!	N/A/ 147	N/A	Claims, Registry	Process	Communicat ion and Care Coordinatio n	Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy  Percentage of final reports for all patients, regardless of age, undergoing bone scintigraphy that include physician documentation of correlation with existing relevant imaging studies (e.g., x-ray, MRI, CT, etc.) that were performed	Society of Nuclear Medicine and Molecular Imaging
	0507 / 195	N/A	Claims, Registry	Process	Effective Clinical Care	Radiology: Stenosis Measurement in Carotid Imaging Reports	American College of Radiology

# 20a. Diagnostic Radiology Specialty Set

## 20a. Diagnostic Radiology Specialty Set (14 measures)

Symbol	Measure	Submission Method	Measure Type	Measure Title and Description
!!	145	Claims, Registry	Process	Fluoroscopy Exposure Time Reported
!	146	Claims, Registry	Process	Mammo: Inappropriate use of Probably Benign
!	147	Claims, Registry	Process	Nuclear Medicine: Correlation with Existing Imaging for All Patients Undergoing Bone Scintigraphy
	195	Claims, Registry	Process	Stenosis Measurement in Carotid Imaging
!	225	Claims, Registry	Structure	Reminder System for Screening Mammograms
!*	359	Registry	Process	Optimizing Patient Exposure to Ionizing Radiation
!!*	360	Registry	Process	Optimizing Patient Exposure to Ionizing Radiation
!*	361	Registry	Structure	Optimizing Patient Exposure to Ionizing Radiation
!*	362	Registry	Structure	Optimizing Patient Exposure to Ionizing Radiation
!*	363	Registry	Structure	Optimizing Patient Exposure to Ionizing Radiation
!!*	364	Registry	Process	Optimizing Patient Exposure to Ionizing Radiation
	405	Claims, Registry	Process	Appropriate Follow-up Imaging for Incidental Abdominal Lesions
!!	406	Claims, Registry	Process	Appropriate Follow-Up Imaging for Incidental Thyroid Nodules
	436	Claims, Registry	Process	Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques

### Symbol Legend

*	Finalized substantive changes (Data Submission method changing from Measures Group to Registry)
!	High Priority Measure
!!	High Priority Measure that are Appropriate Use Measures

## 20b. Interventional Radiology Specialty Set

Symbol	Measure	Submission Method	Measure Type	Measure Title and Description
!	259	Registry	Outcome	Rate of Endovascular Aneurysm Repair (EVAR) of Small or Moderate Non-Ruptured Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged to Home by Post-Operative Day #2)
!	265	Registry	Process	Biopsy Follow-Up: biopsy results have been reviewed and communicated to the primary care/referring physician and patient
!	344	Registry	Outcome	Rate of Carotid Artery Stenting (CAS) for Asymptomatic Patients, Without Major Complications (Discharged to Home by Post-Operative Day #2)
!	345	Registry	Outcome	Rate of Postoperative Stroke or Death in Asymptomatic Patients Undergoing Carotid Artery Stenting

Symbol Legend	
!	High Priority Measure

# Reporting More Measures than Required

**There is no penalty or harm in submitting more measures than required:**

- Can benefit the clinician
- CMS will score all measures and use only those that have the highest performance
- Could result in a MIPS eligible clinician receiving a higher score

## Submitting via Multiple Submission Mechanisms:

- Would be a rare situation where a EC would submit data for the quality performance category through a registry and claims
- CMS would score all the options (such as scoring the quality performance category with data from a registry, and also scoring the quality performance category with data from claims)
- CMS would use the highest performance category score for the MIPS eligible clinician final score
- Will not however, combine the submission mechanisms to calculate an aggregated performance category score (e.g. reporting two measures via claims and 4 measures via registry)

**Performance Influences Final Score and Payment Adjustments**



# Quality Measures Specifications Supporting Documents

## Measure #145: Radiology: Exposure Time Reported for Procedures Using Fluoroscopy – National Quality Strategy Domain: Patient Safety

### 2016 PQRS OPTIONS FOR INDIVIDUAL MEASURES: CLAIMS, REGISTRY

#### DESCRIPTION:

Final reports for procedures using fluoroscopy that document radiation exposure indices, or exposure time and number of fluorographic images (if radiation exposure indices are not available)

#### INSTRUCTIONS:

This measure is to be reported **each time** fluoroscopy is performed in a hospital or outpatient setting during the reporting period. There is no diagnosis associated with this measure. It is anticipated that clinicians providing the services for procedures using fluoroscopy will submit this measure.

**NOTE:** Fluoroscopy exposure time and number of images must be relayed via the order management System or in the HL7 transmission so that the information is pulled into our final reports.

vRad's OMS system requires submission of this information. HL7 clients should confirm that vRad is receiving and that the information is feeding into the final report.



# Measure 145 Specification Supporting Document

## **Measure Reporting via Claims:**

CPT or HCPCS codes are used to identify patients who are included in the measure's denominator. Quality data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT or HCPCS codes, and the appropriate quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

## **Measure Reporting via Registry:**

CPT or HCPCS codes are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.



Fluoroscopy provides us with "x-ray movies" to visualize internal organs while they are in motion.

# Measure 145 Specification Supporting Document

The denominator identifies the patient population for the applicable measure's quality action (numerator).

## **DENOMINATOR:**

All final reports for procedures using fluoroscopy

***DENOMINATOR NOTE:*** The final report of the fluoroscopy procedure or fluoroscopy guided procedure includes the final radiology report, definitive operative report, or other definitive procedure report that is communicated to the referring physician, primary care physician, follow-up care team, and/or maintained in the medical record of the performing physician outside the EHR or other medical record of the facility in which the procedure is performed.

## **Denominator Criteria (Eligible Cases):**

**Patient encounter during the reporting period (CPT or HCPCS):** 0075T, 0202T, 0234T, 0235T, 0236T, 0237T, 0238T, 0338T, 0339T, 22510, 22511, 22513, 22514, 22526, 25606, 25651, 26608, 26650, 26676, 26706, 26727, 27235, 27244, 27245, 27509, 27756, 27759, 28406, 28436, 28456, 28476, 34841, 34842, 34843, 34844, 34845, 34846, 34847, 34848, 36147, 36221, 36222, 36223, 36224, 36225, 36226, 36251, 36252, 36253, 36254, 36598, 37182, 37183, 37184, 37187, 37188, 37211, 37212, 37213, 37214, 37215, 37216, 37217, 37218, 37220, 37221, 37224, 37225, 37226, 37227, 37228, 37229, 37230, 37231, 37236, 37238, 37241, 37242, 37243, 37244, 43260, 43261, 43262, 43263, 43264, 43265, 43274, 43275, 43276, 43277, 43278, 43752, 47537, 49440, 49441, 49442, 49446, 49450, 49451, 49452, 49460, 49465, 50382, 50384, 50385, 50386, 50387, 50389, 50590, 52303, 61623, 61630, 61635, 61640, 61645, 61650, 62263, 62264, 62280, 62281, 62282, 62302, 62304, 62305, 64610, 70010, 70015, 70170, 70332, 70370, 70371,

# Measure 145 Specification Supporting Document

## **NUMERATOR:**

Final reports for procedures using fluoroscopy that include radiation exposure indices, or exposure time and number of fluorographic images (if radiation exposure indices are not available)

### **Definition:**

**Radiation exposure indices** - For the purposes of this measure, radiation exposure indices should, if possible, include at least one of the following:

1. Skin dose mapping
2. Peak skin dose (PSD)
3. Reference air kerma ( $K_{a,r}$ )
4. Kerma-area product (PKA)

If the fluoroscopic equipment does not automatically provide any of the above radiation exposure indices, exposure time and the number of fluorographic images taken during the procedure may be used.

### **Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Radiation Exposure indices, or Exposure Time and Number of Fluorographic Images (if radiation exposure indices are not available) Documented in Final Procedure Report**

***Performance Met: G9500:***

Radiation exposure indices, exposure time or number of fluorographic images in final report for procedures using fluoroscopy, documented

**OR**

**Radiation Exposure indices, or Exposure Time and Number of Fluorographic Images (if radiation exposure indices are not available) not Documented in Final Procedure Report, Reason not Given**

***Performance Not Met: G9501:***

Radiation exposure indices, exposure time or number of fluorographic images not documented in final report for procedure using fluoroscopy, reason not given

# Measure 145 Specification Supporting Document

## **RATIONALE:**

Increasing physician awareness of patient exposure to radiation is an important step towards reducing the potentially harmful effects of radiation as a result of imaging studies. One study by Darling et al found a significant correlation between documentation of fluoroscopy time by the radiologist in the dictated radiology report and reduced overall fluoroscopy time. Additional studies demonstrate that providing physicians with feedback regarding their fluoroscopy time leads to a reduction in average fluoroscopy times.

## **CLINICAL RECOMMENDATION STATEMENTS:**

All available radiation dose data should be recorded in the patient's medical record. If cumulative air kerma or air kerma-area-product data are not available, the fluoroscopic exposure time and the number of acquired images (radiography, cine, or digital subtraction angiography) should be recorded in the patient's medical record. (ACR, 2013)

For the present, and for the purpose of this guideline, adequate recording of dose metrics is defined as documentation in the patient record of at least one of the following for all interventional procedures requiring fluoroscopy (in descending order of desirability): skin dose mapping, PSD, Ka,r, PKA, and fluoroscopic time/number of fluorographic images. Note, however, that this is adequate recording; this document recommends recording of all available dose metrics. (SIR, 2012)

[ACR] should now encourage practices to record actual fluoroscopy time for all fluoroscopic procedures. The fluoroscopy time for various procedures (eg, upper gastrointestinal, pediatric voiding cystourethrography, diagnostic angiography) should then be compared with benchmark figures...More complete patient radiation dose data should be recorded for all high-dose interventional procedures, such as embolizations, transjugular intrahepatic portosystemic shunts, and arterial angioplasty or stent placement anywhere in the abdomen and pelvis. (Amis et al., ACR, 2007)

Measure & record patient radiation dose:

- Record fluoroscopy time
- Record available measures - DAP (dose area product), cumulative dose, skin dose (NCI, 2005)

# PROPOSED RULE: Quality Performance Compared to Baseline Performance Period

## An all or nothing approach in PQRS

- An EC would have had each measure reported scored by comparing their performance to a baseline performance period.
- Baseline period is 2 years prior to performance year (2015 performance will be the baseline for the 2017 report year).
- Benchmark must have a minimum of 20 ECs who reported meeting the minimum criteria.
- ECs with a zero performance rates are not included in the benchmark count.
- Baseline period measure performance broken into deciles.

Physicians will be competing for points and available dollars



# Final Rule: Quality Scoring in 2017

## 2017 Performance Threshold = 3 point floor

- CMS modified their proposed policy in which they would only score the measures that meet certain standards (such as required case minimum).
- For the transition year, CMS will automatically provide 3 points for quality measures that are submitted, regardless of whether they lack a benchmark or do not meet the case minimum or data completeness requirements.
- Finalizing the decile scoring method for assigning points, but for the transition year, CMS is also adding a 3-point floor for all submitted measures. This means that MIPS eligible clinicians will receive between 3 and 10 points per reported measure:
  - Allows partial credit because the MIPS eligible clinician can still achieve points even if the MIPS eligible clinician does not submit all the required measures.
  - Graded on the curve or performance compared to peers (achievement).

**For example:** a MIPS eligible clinician has six applicable measures yet only submits two measures:

- the two submitted measures will be scored and will receive three to ten achievement points for each measure based on the MIPS eligible clinician's performance compared to measure benchmarks
- the MIPS eligible clinician will receive a 0 for every required measure that is not submitted.



# Final Rule: 2017 Quality Scoring

**Table 17** summarizes the Quality scoring rules and identifies two classes of measures for scoring purposes. The name classification is subject to change in future years. (Final Rule, pages 1093-1094)

**TABLE 17: Quality Performance Category: Scoring Measures Based on Performance for Performance Period 2017**

Measure Type	Description	Scoring Rules
Class 1 – Measure can be scored based on performance	Measures that were submitted or calculated that met the following criteria: 1) The measure has a benchmark <sup>29</sup> ; 2) Has at least 20 cases; and 3) Meets the data completeness standard (generally 50 percent.)	<ul style="list-style-type: none"><li>• Receive 3 to 10 points based on performance compared to the benchmark.</li></ul>
Class 2 – Measure cannot be scored based on performance and is instead assigned a 3-point score.	Measures that were submitted, but fail to meet one of the class 1 criteria. Measures either 1) Do not have a benchmark, 2) Do not have at least 20 cases, or 3) Measure does not meet data completeness criteria.	<ul style="list-style-type: none"><li>• Receive 3 points</li><li>• Note: This Class 2 measure policy does not apply to CMS Web Interface measures and administrative claims-based measures.</li></ul>

<sup>29</sup> Benchmarks needed 20 reporters with at least 20 cases meet data completeness and performance greater than 0 percent.

# Quality Measures: Data Completeness

## Scoring Approach of Non-Web Interface Measures

Data completeness, with/without case minimum criteria met /benchmark	Possible scores per measure
No measures reported	0
Partial data (below data completeness criteria requirement) without case minimum criteria met, regardless of whether the measure is at 0% performance rate or not	3
Partial data (below data completeness criteria requirement) without a benchmark*, regardless of whether the measure is at 0% performance rate or not	3
Complete data (data completeness criteria met) without case minimum criteria met, regardless of whether the measure is at 0% performance rate or not	3
Complete data (data completeness criteria met) without a benchmark, regardless of whether the measure is at 0% performance rate or not	3
Complete data (data completeness criteria met) with case minimum criteria met, the measure has a benchmark, and the measure is at 0% performance rate	3
Complete data (data completeness criteria met) with case minimum criteria met, the measure has a benchmark, and the performance rate is <b>greater than 0%</b> performance rate**	3–10

\* Benchmarks need 20 reporters with at least 20 cases meeting data completeness and performance greater than 0 percent.

\*\* Given the global 3-point floor for low performance, a measure that would have received 1 or 2 points will now receive 3 points.



# Establishing Performance Benchmarks

- Each benchmark must have a minimum of 20 individual clinicians or groups who reported the measure meeting the data completeness requirement and minimum case size criteria and performance greater than zero.
- CMS will publish the numerical baseline period benchmarks prior to the start of the performance period (or as soon as possible thereafter).
- For quality measures for which there is no comparable data from the baseline period, CMS will use information from the performance period to create measure benchmarks.
  - For 2017, finalizing a 3-point floor for new measures and measures without a benchmark.
- Separate benchmarks are used for the following submission mechanisms:
  - EHR
  - QCDR
  - Qualified registry
  - Claims submission
  - CMS Web Interface
  - CMS-approved survey vendor for CAHPS for MIPS
  - Administrative claims

Final Rule, page 1066

# MIPS Scoring for Quality Performance Category

60% of Final Score in Transition Year (2017) – 85% for Radiologists unable to report ACI

The diagram illustrates the calculation of the Total Quality Performance Category Score. On the left, a grey circle contains the text "Total Quality Performance Category Score". To its right is an equals sign. Further right is a fraction. The numerator of the fraction is the sum of two terms: "Points earned on required 6 quality measures" and "Any bonus points", separated by a plus sign. The denominator of the fraction is "Maximum number of points\*".

$$\text{Total Quality Performance Category Score} = \frac{\left[ \text{Points earned on required 6 quality measures} \right] + \left[ \text{Any bonus points} \right]}{\text{Maximum number of points*}}$$

Source: [Quality Payment Program Final Rule MLN Connects® Call](#) - 11/15/16

Maximum score cannot exceed 100% (cap the total possible points at 60)

Bonus points cannot exceed 10% of the denominator (maximum of 6 pts)

# Final Rule: MIPS Quality Scoring in 2017

## Example 1: Individual practitioner submits 6 measures via claims as follows:

- 2 measures (one of which is an outcome measure) with high performance:  
Earns a score of 10 out of 10 on both of these measures [2 measures x 10 points = 20 pts]  
No bonus points for the meeting the required outcome measure
- 1 measure that lacks minimum case size [3 pts]
- 1 measure that lacks a benchmark [3 pts]
- 1 measure that does not meet the data completeness requirement [3pts]
- 1 measure with low performance [3pts]

**20+12 = 32 points out of the 60 possible points**

**32 pts divided by 60 max points = 0.53 points for the Quality Performance Category**

**For the final composite score the 0.53 points is weighted by 60% (or 85% if exempt from ACI category)**

53.3 points x 60% (or 85% in exempt from ACI) x 100 = final score added to the practitioner's MIPS final composite score

0.53 x 60% x 100 = 31.8 points toward the final composite score, OR

0.53 x 85% x 100 = 45 points toward the final composite score

# Final Rule: MIPS Quality Scoring in 2017

## Example 2: Individual practitioner submits 4 measures

(This practitioner had no other denominators or measures applicable to his billing).

**CMS will validate data submitted through claims and registries for those who have less than six measures and/or did not submit an outcome/high priority measure. If CMS determines this practitioner only had opportunity to report 4 measures, the scoring is adjusted as follows:**

- 1 measure (outcome measure) with performance scoring of 9 out of 10 [9 points]
- 1 measure (high priority) with performance score of 4.1 [4.1 pts + 1 bonus pt = 5.1 pts]
- 1 measure that lacks a benchmark [3 pts]
- 1 measure (high priority) does not meet data completeness requirement [3pts (no bonus pt.)]
- 2 measures unable to report [0 pts]

$9 + 5.1 + 3 + 3 = 20.1$  points + 0 bonus points out of the ~~60~~ **40 possible points**

**20.1 pts divided by ~~60~~ 40 max points = 0.50 pts** [This eligible clinician was unable to report on 6 measures as his qualifying patient population did not support 6 applicable measures. So the total possible points is adjusted to 40 (4 measures x 10 pts)]

### Final Composite Score (CPS) –

The 0.50 points is weighted by the category weight of 60% or 85% x 100

$0.50 \times 60\% \times 100 = 30$  pts toward final CPS

$0.50 \times 85\% \times 100 = 42.5$  pts toward final CPS

During the live recording of this presentation, an error in the calculation was noted. The total possible points in this scenario should be 40 (not 60 on the slide from the live presentation.)

40 would be the maximum points in this example after the CMS validation process noted above.



# MIPS Improvement Activities

# MIPS Improvement Activities Performance Category

## New Performance Category based on EC's own performance

- There are eight (8) subcategories for improvement activities (related to the goal of the activity):
  - Achieving health equity
  - Integrated behavioral and mental health
  - Beneficiary engagement
  - Care coordination
  - Emergency response and preparedness
  - Expanded practice access (access to care)
  - Patient safety and practice assessment
  - Population management
- For an activity to count toward individual-level reporting, a clinician must participate or engage in the selected activities for at least 90 days
- For an activity to count toward group-level reporting, at least one clinician under the group's taxpayer identification number (TIN) must participate in the activity for at least 90 days
- Clinicians choose the activities that best fit their practice

# Data Submission for Improvement Activities

## Simple attestation submitted directly to CMS

- **Individual EC or Group:** reports with a Yes or No response on whether the selected activities were performed for at least 90 continuous days
- **Third party submission:** Attestation submitted on your behalf by your health information technology (IT) vendor, qualified clinical data registry (QCDR), or qualified registry
- **Web Interface:** Groups of 25 or more eligible clinicians have the additional option to report via the CMS Web Interface

## Deadline for Data Submission:

March 31, 2018



# 93 Activities Listed in the Final Rule Inventory

**Table H: Finalized Improvement Activities Inventory** (Appendix, page 2382)

Subcategory	Activity	Weighting	Eligible for Advancing Care Information Bonus (Designated with asterisk * if eligible)
Expanded Practice Access	<p>Provide 24/7 access to MIPS eligible clinicians, groups, or care teams for advice about urgent and emergent care (e.g., eligible clinician and care team access to medical record, cross-coverage with access to medical record, or protocol-driven nurse line with access to medical record) that could include one or more of the following:</p> <p>Expanded hours in evenings and weekends with access to the patient medical record (e.g., coordinate with small practices to provide alternate hour office visits and urgent care);</p> <p>Use of alternatives to increase access to care team by MIPS eligible clinicians and groups, such as e-visits, phone visits, group visits, home visits and alternate locations (e.g., senior centers and assisted living centers); and/or</p> <p>Provision of same-day or next-day access to a consistent MIPS eligible clinician, group or care team when needed for urgent care or transition management.</p>	High	*
Expanded Practice Access	Use of telehealth services and analysis of data for quality improvement, such as participation in remote specialty care consults, or teleaudiology pilots that assess ability to still deliver quality care to patients.	Medium	



# Activity Options for Radiology – Not a Complete List

Select activities based on your practice!

Subcategory	Activity	Weighting	Eligible for Advancing Care Information Bonus (Designated with asterisk * if eligible)
Care Coordination	Timely communication of test results defined as timely identification of abnormal test results with timely follow-up.	Medium	
Patient Safety and Practice Assessment	Participation in Maintenance of Certification Part IV for improving professional practice including participation in a local, regional or national outcomes registry or quality assessment program. Performance of activities across practice to regularly assess performance in practice, by reviewing outcomes addressing identified areas for improvement and evaluating the results.	Medium	
Patient Safety and Practice Assessment	For eligible professionals not participating in Maintenance of Certification (MOC) Part IV, new engagement for MOC Part IV, such as IHI Training/Forum Event; National Academy of Medicine, AHRQ Team STEPPS®.	Medium	
Patient Safety and Practice Assessment	Use decision support and standardized treatment protocols to manage workflow in the team to meet patient needs.	Medium	*

# Improvement Activities

Achieve a total of 40 points for 15% of Final Score in Transition Year

Total points = 40

## Activity Weights

- Medium = 10 points
- High = 20 points

## Alternate Activity Weights\*

- Medium = 20 points
- High = 40 points

\*For clinicians in small, rural, and underserved practices or with non-patient facing clinicians or groups

Full credit for clinicians in a patient-centered medical home, Medical Home Model, or similar specialty practice

Source: [Quality Payment Program Final Rule MLN Connects® Call](#) - 11/15/16

# Scoring Methodology for Improvement Activities

## Example 1:

Activity	Subcategory	Total Possible Points	Relative Weight (based on whether a small, rural, geographic HPSA or non-patient facing MIPS eligible clinician)	Total Score
For Midsize Practice (not rural, HPSA or non-patient facing)				
Activity 1 (Medium Weighted)	Population Management	10	1	30/40 points
Activity 2 (High Weighted)	Expanded Practice Access	20	1	
Total	30			

## Example 2:

	Activity	Subcategory	Total Possible Points	Relative Weight (based on whether a small, rural, geographic HPSA or non-patient facing MIPS eligible clinician)	Total Score
<b>For Small, Rural, HPSA Practice or Non-Patient Facing Clinician</b>					
Clinician #1	Activity 1 (Medium Weighted)	Population Management	10	2	20 points
	Activity 2 (Medium Weighted)	Integrated Behavioral and Mental Health	10	2	20 points
	Total				40/40 points
Clinician #2	Activity 1 (High Weighted)	Patient Safety and Practice Assessment	20	2	40 points
	Total				40/40 points

Final Rule

Pages 1199 - 1200

# Scoring Improvement Activities

From previous slide:

**Example 1:** 30 out of 40 points =  $0.75 \times 100 = 75$

**Example 2:** 40 out of 40 points =  $1.0 \times 100 = 100$

The diagram illustrates the formula for calculating the Improvement Activities Performance Category Score. On the left, a blue circle contains the text "Improvement Activities Performance Category Score". This is followed by an equals sign. To the right of the equals sign is a large blue bracket. Inside the bracket, the text "Total number of points scored for completed activities" is positioned above a horizontal line, and "Total maximum number of points (40)" is positioned below the line. To the right of the bracket is a blue multiplication sign followed by the number 100.

$$\text{Improvement Activities Performance Category Score} = \left[ \frac{\text{Total number of points scored for completed activities}}{\text{Total maximum number of points (40)}} \right] \times 100$$

Source: [Quality Payment Program Final Rule MLN Connects® Call](#) - 11/15/16

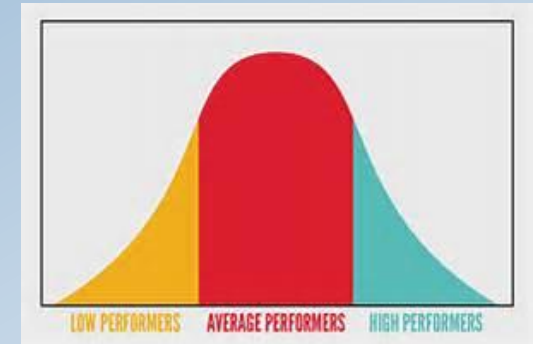


## MIPS Composite Performance Score (CPS)

# MIPS Payment Adjustment Factors

## Grading on a Curve

- MACRA requires CMS to specify a MIPS adjustment factor (referred to as a MIPS payment adjustment factor) for each EC for a year.
- The adjustment factor is determined by comparing the final annual score of the EC to the performance threshold established for such year.
- Applying adjustment factors results in differential payments:
  - A final score at the performance threshold receives a zero (neutral payment adjustment)
  - A final score above the performance threshold receives a positive MIPS adjustment factor on a linear sliding scale
  - A final score below the performance threshold receive a negative MIPS adjustment factor on a linear sliding scale
- Positive MIPS adjustment factors may be increased or decreased by a scaling factor (not to exceed 3.0) to ensure the **budget neutrality** requirement is met.



### Transition Year Performance Threshold of 3

The setting a floor of 3 on the threshold will “flatten the curve”.

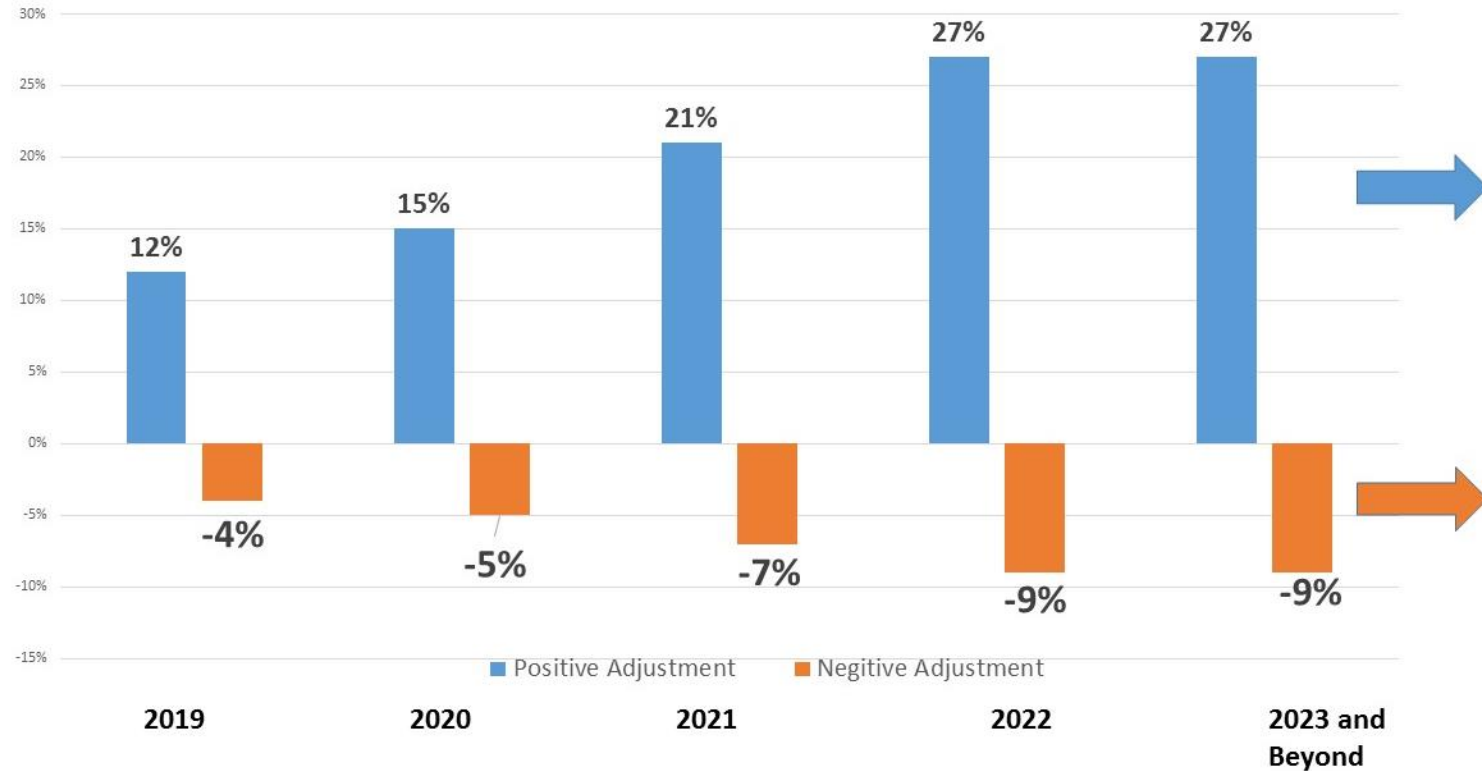
Fewer MIPS eligible clinicians would receive a negative MIPS payment adjustment.

This will lower the scaling factor required by budget neutrality, resulting in lower positive payment adjustments per-EC.

Transition year does provide more opportunities for clinicians to participate and become familiar with MIPS.

# MIPS Payment Adjustments

Scaling Factor (not to exceed 3.0)



# Exceptional Performance Bonus Payment

**Exceptional performers receive additional positive adjustment factor –up to \$500M available each year from 2019 to 2024**

**Exceptional Performance Factor:** CMS will establish an “additional performance threshold” that defines which eligible clinician will receive the exceptional performance payment.

An additional bonus (not to exceed 10%) will be applied to payments to eligible clinicians with exceptional performance where CPS is equal to or greater than an “additional performance threshold,” defined as the 25th percentile of possible values above the CPS performance threshold.

**The additional performance threshold for the 2019 MIPS payment year is 70 points.**





# Payment Adjustments for the Transition Year 2017

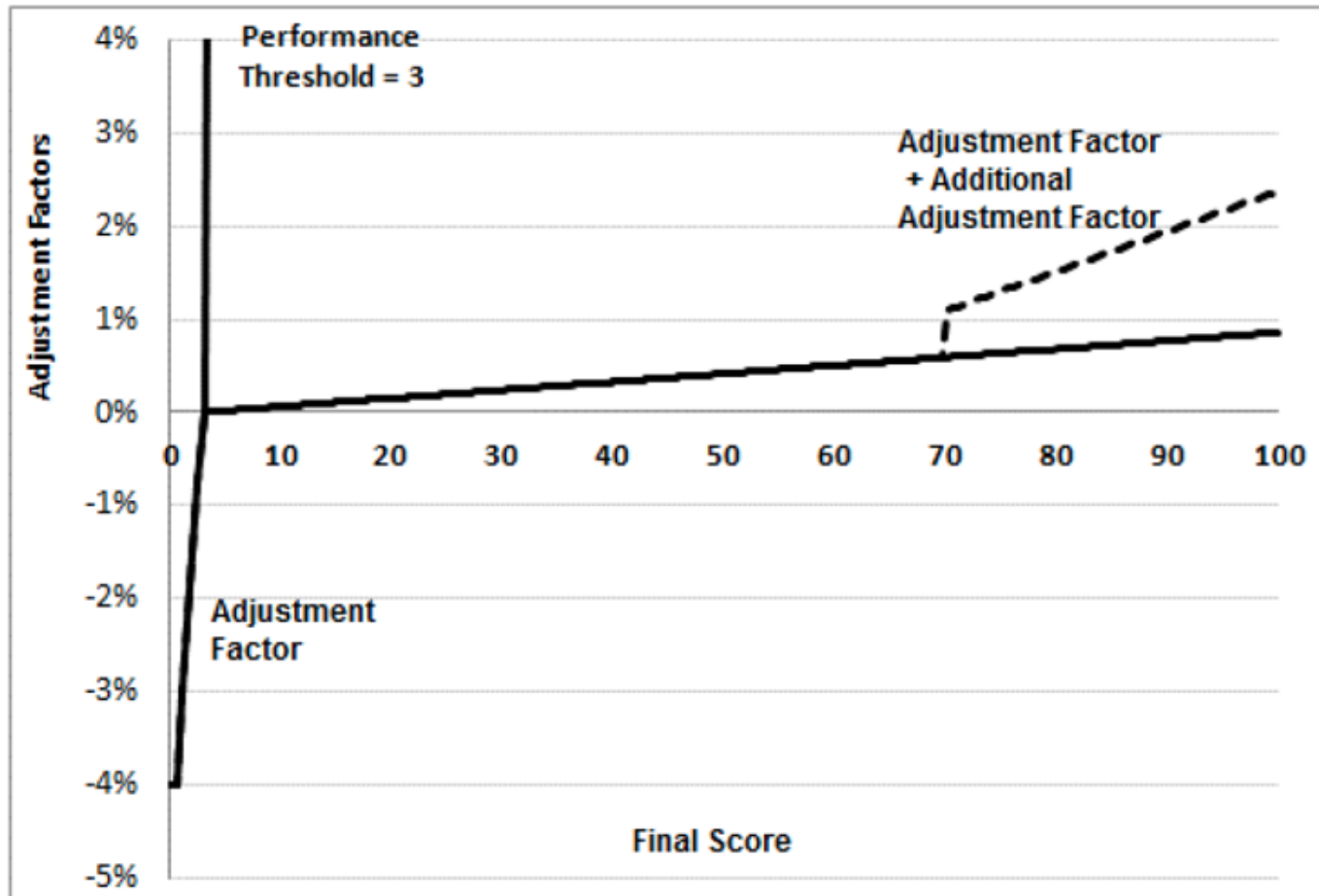
## Adjustment Applied to Payments in CY 2019

Final Score	Payment Adjustment
<b>≥70 points</b>	<ul style="list-style-type: none"><li>• Positive adjustment</li><li>• Eligible for exceptional performance bonus—minimum of additional 0.5%</li></ul>
<b>4-69 points</b>	<ul style="list-style-type: none"><li>• Positive adjustment</li><li>• Not eligible for exceptional performance bonus</li></ul>
<b>3 points</b>	<ul style="list-style-type: none"><li>• Neutral payment adjustment</li></ul>
<b>0 points</b>	<ul style="list-style-type: none"><li>• Negative payment adjustment of -4%</li><li>• 0 points = does not participate</li></ul>

Source: [Quality Payment Program Final Rule MLN Connects® Call](#) - 11/15/16

# MIPS Payment Adjustment Factors for 2019 Payment Year

**FIGURE A:** Illustrative Example of MIPS Payment Adjustment Factors Based on Final Scores and Final Performance Threshold and Additional Performance Threshold (Final Rule, page 1284)



# Calculating the Final MIPS Score

Final Score =

$$\left[ \begin{array}{l} \text{Clinician Quality} \\ \text{performance} \\ \text{category score} \times \\ \text{actual Quality} \\ \text{performance} \\ \text{category weight} \end{array} \right] + \left[ \begin{array}{l} \text{Clinician Cost} \\ \text{performance} \\ \text{category score} \times \\ \text{actual Cost} \\ \text{performance} \\ \text{category weight} \end{array} \right] + \left[ \begin{array}{l} \text{Clinician} \\ \text{Improvement} \\ \text{Activities} \\ \text{performance} \\ \text{category score} \times \\ \text{actual} \\ \text{Improvement} \\ \text{Activities} \\ \text{performance} \\ \text{category weight} \end{array} \right] + \left[ \begin{array}{l} \text{Clinician} \\ \text{Advancing Care} \\ \text{Information} \\ \text{performance} \\ \text{category score} \times \\ \text{actual Advancing} \\ \text{Care Information} \\ \text{performance} \\ \text{category weight} \end{array} \right] \times 100$$

Source: [Quality Payment Program Final Rule MLN Connects® Call](#) - 11/15/16

# Final Scoring Scenarios

## Radiologist reporting as an individual:



### Scenario 1:

Submits 4 quality measures, out of six applicable measures (failing to report on two).

Does not submit anything for the Improvement Activity category.

Exempt from the Advancing Care Information category.

CMS allows a three-point floor per measure because the case minimum requirement was not met.

(3 points x 4 measures = 12 points)

Quality performance category is weighted at 85% for this non-patient facing radiologist  
(ACI 25% is reweighted to the Quality category 60%)

$(12 \text{ points} / \text{total possible points of } 60) \times 85\% = 0.17 \times 100 = 17 \text{ points}$

**FINAL COMPOSITE PERFORMANCE SCORE is 17 points**

# Final Scoring Scenarios

## Radiologist reporting as an individual:

### Scenario 2:

Submits 6 measures:

5 quality measures with high performance; One of the measures is an outcome measure.

1 with slightly above average performance.

Submits two medium weight activities in the IA category. (40/40 points)

Exempt from the Advancing Care Information category.

Quality performance category weighted at 85% and Improvement activity category at 15%

### Quality performance category score:

5 measures x 10 points each + 1 measure x 6 points = 56 pts

56 points / total possible points of 60 = 0.93

### Improvement activities category score:

40 points/ total possible points of 40 = 1.0

### Composite score:

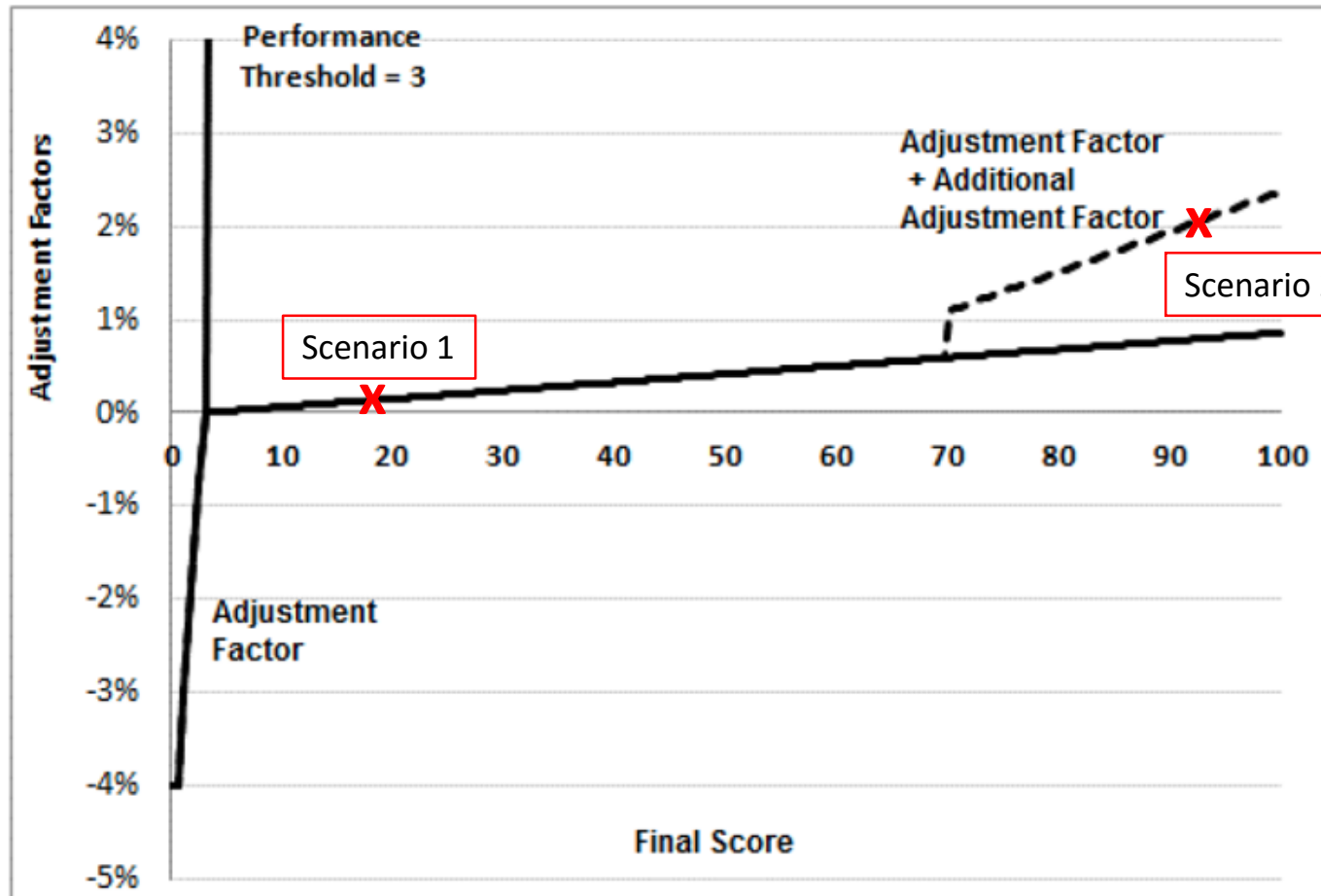
$(0.93 \times 85\%) + (1.0 \times 15\%) = .94 \times 100 = 94$  points

0.79 + 0.15 = .94 x 100 = 94

**FINAL COMPOSITE PERFORMANCE SCORE IS 94 points**

# MIPS Payment Adjustment Factors for 2019 Payment Year

**FIGURE A:** Illustrative Example of MIPS Payment Adjustment Factors Based on Final Scores and Final Performance Threshold and Additional Performance Threshold (Final Rule, page 1284)





# CMS Online Tool for QPP

# CMS Online Tool to Make Quality Payment Program Easier

## Application Program Interface (API)

- CMS has created this interactive site to help clinicians understand the program and successfully participate.
- This tool makes it easier for other organizations to retrieve and maintain the Quality Payment Program's measures
- Enable you to build applications for clinicians and their practices
- The API is available at: <https://QPP.cms.gov>





## Quality Measures

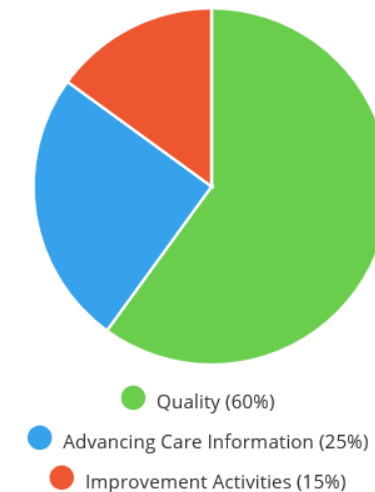
### Instructions

1. Review and select measures that best fit your practice.
2. Add up to six measures from the list below, including one outcome measure. You can use the search and filters to help find the measures that meet your needs or specialty.
3. If an outcome measure is not available that is applicable to your specialty or practice, choose another high priority measure.
4. Download a CSV file of the measures you have selected for your records.

**Groups in APMs qualifying for special scoring standards under MIPS, such as Shared Savings Program Track 1 or the Oncology Care Model:** Report quality measures through your APM. You do not need to do anything additional for the MIPS quality category.

**Note:** This tool is only for informational and estimation purposes. You can't use it to submit or attest to measures or activities.

### 2017 MIPS Performance



## Select Measures

# Filtering Your Search

Search All by Keyword:

All

▼

Search for...

SEARCH

Filter By:

High Priority Measure

▼

☐ Yes

☐ No

Data Submission Method

▼

Specialty Measure Set

▼

Showing 271 Measures

Add All Measures

Search All by Keyword:

All

▼

Search for...

SEARCH

Filter By:

High Priority Measure

▼

Data Submission Method

▼

☐ Administrative Claims

☐ Claims

☐ CSV

☐ CMS Web Interface

☐ EHR

☐ Registry

Specialty Measure Set

▼

Showing 271 Measures

> Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy - Avoidance of Inappropriate Use

> Acute Otitis Externa (AOE): Topical Therapy

> ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication

Selected Measures

0 Measures Added

Once you select measures they will appear here

ADD

# Viewing Diagnostic and Interventional Radiology Sets

Search All by Keyword:

Filter By:

Showing 271 Measures

- > [Acute Otitis Externa \(AOE\): Systemic A of Inappropriate Use](#)
- > [Acute Otitis Externa \(AOE\): Topical The](#)
- > [ADHD: Follow-Up Care for Children Pre Deficit/Hyperactivity Disorder \(ADHD\)](#)
- > [Adherence to Antipsychotic Medication Schizophrenia](#)

☐ Allergy/Immunology  
☐ Anesthesiology  
☐ Cardiology  
☐ Dermatology  
☐ Diagnostic Radiology  
☐ Electrophysiology Cardiac Specialist  
☐ Emergency Medicine  
☐ Gastroenterology  
☐ General Oncology  
☐ General Practice/Family Medicine  
☐ General Surgery  
☐ Hospitalists  
☐ Internal Medicine  
☐ Interventional Radiology  
☐ Mental/Behavioral Health  
☐ Neurology  
☐ Obstetrics/Gynecology  
☐ Ophthalmology  
☐ Orthopedic Surgery  
☐ Otolaryngology  
☐ Pathology  
☐ Pediatrics  
☐ Physical Medicine  
☐ Plastic Surgery  
☐ Preventive Medicine  
☐ Radiation Oncology  
☐ Rheumatology  
☐ Thoracic Surgery  
☐ Urology  
☐ Vascular Surgery

[Clear All Filters](#) Diagnostic Radiology ✕

Showing 14 Measures [Add All Measures](#)

> [Appropriate Follow-up Imaging for Incidental Abdominal Lesions](#) [ADD](#)

> [Appropriate Follow-up Imaging for Incidental Thyroid Nodules in Patients](#) [ADD](#)

**Selected Measures**

0 Measures Added

Once you select measures they will appear here

Select “Add All Measures” or “ADD” by Individual Measures. Click on Download.

[Clear All Filters](#) Diagnostic Radiology ✕

Showing 14 Measures [Add All Measures](#)

> [Appropriate Follow-up Imaging for Incidental Abdominal Lesions](#) [REMOVE](#)

> [Appropriate Follow-up Imaging for Incidental Thyroid Nodules in Patients](#) [REMOVE](#)

> [Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy](#) [REMOVE](#)

> [Optimizing Patient Exposure to Ionizing Radiation: Appropriateness: Follow-up CT Imaging for Incidentally Detected Pulmonary Nodules According to Recommended Guidelines](#) [REMOVE](#)

**Selected Measures**

14 Measures Added

[Download \(CSV\)](#) [Clear All](#)

Appropriate Follow-up Imaging for Incidental Abdominal Lesions ✕

Appropriate Follow-up Imaging for Incidental Thyroid Nodules in Patients ✕

Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy ✕

# Sample of a Download of Measure 145

MEASURE NAME	MEASURE DESCRIPTION	QUALITY ID	NQS DOMAIN	MEASURE TYPE	HIGH PRIORITY MEASURE	DATA SUBMISSION METHOD	SPECIALTY MEASURE SET	PRIMARY MEASURE STEWARD
Radiology: Exposure Dose or Time Reported for Procedures Using Fluoroscopy	Final reports for procedures using fluoroscopy that document radiation exposure indices, or exposure time and number of fluorographic images (if radiation exposure indices are not available)	145	Patient Safety	Process	Yes	Claims, Registry	Diagnostic Radiology	American College of Radiology

# Resources

Quality Payment Program website – <https://QPP.CMS.GOV>

**Final Rule:** Medicare Program; Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; Centers for Medicare & Medicaid Services, 42 CFR Parts 414 and 495

<https://www.federalregister.gov/documents/2016/05/09/2016-10032/medicare-program-merit-based-incentive-payment-system-mips-and-alternative-payment-model-apm>

**Executive Summary;** Department of Health and Human Services; Centers for Medicare & Medicaid Services; 42 CFR Parts 414 and 495 [CMS-5517-FC] RIN 0938-AS69;

<https://qpp.cms.gov/education>

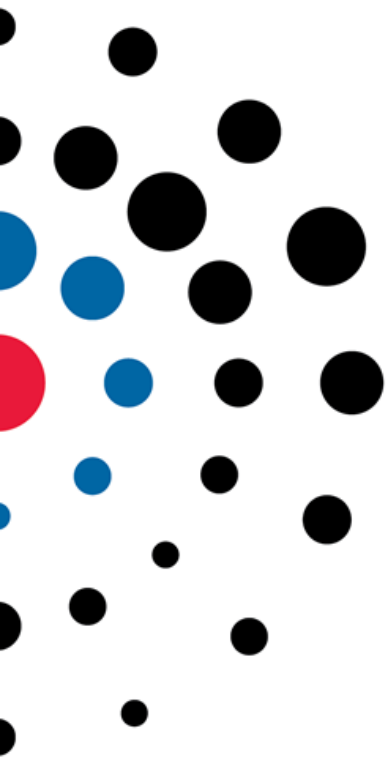
**CMS.gov Webinars and Educational Programs:**

<https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events.html>

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-Events.html>

*It is best to direct your questions to [QPP@cms.hhs.gov](mailto:QPP@cms.hhs.gov)*

**Quality Payment Program Service Center Phone: 1-866-288-8292**



Thank You



# Learn more!

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## Want to learn more about vRad teleradiology solutions?

Discover vRad's innovations in teleradiology, Virtual FTE radiologist staffing, radiology analytics, partnership models and more. [Contact us today](#).

### About vRad

vRad, a MEDNAX Company (NYSE: MD), is a global telemedicine company, the nation's leading radiology practice with 500+ U.S. board-certified and eligible physicians, and a leader in imaging analytics. vRad's clinical expertise and evidence-based insight help clients make better decisions for the health of their patients and their imaging services.