2017 MIPS PLAYBOOK

MAKING SENSE OF MACRA

Includes:

Six steps to understanding the MIPS track

Two checklists that help you plan a course of action

Step-by-step approach to navigating the CMS website

AMERICAN ACADEMY OF FAMILY PHYSICIANS

TABLE OF CONTENTS

INTRODUCTION

The Medicare Access and CHIP Reauthorization Act (MACRA) was signed into law in April 2015. The legislation established the Quality Payment Program (QPP), which is the umbrella term for the two new tracks for Medicare payment: Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (AAPMs).

How to use this playbook

Most clinicians will initially participate in the MIPS track of QPP. The American Academy of Family Physician's (AAFP's) 2017 MIPS Playbook: Making Sense of MACRA helps you navigate this track. The information in this playbook helps you understand the reporting requirements of the MIPS track, and provides you checklists and actionable steps to prepare for successful performance in the QPP.

The two checklists in the playbook can help you plan your course of action in MIPS. The first checklist is most useful to those in small, solo, or independent practices. The second checklist directs physicians in employed or large group settings. We provide specific steps to focus practice improvement and reporting efforts. We recommend reviewing the appropriate checklist on the following pages as you follow the steps in the playbook.

*This playbook is for the 2017 MIPS performance period and does not include the proposed changes for the 2018 MIPS performance period.

This Enduring Material activity, 2017 MIPS Playbook: Making Sense of MACRA, has been reviewed and is acceptable for up to 5.00 Prescribed credit(s) by the American Academy of Family Physicians. Term of approval begins 08/16/2017. Term of approval is for 1 year(s) from this date. Physicians should claim only the credit commensurate with the extent of their participation in the activity. The AAFP is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. The American Academy of Family Physicians designates this Enduring Material activity for a maximum of 5.00 AMA PRA Category 1 credit(s)™. Physicians should only claim credit commensurate with the extent of their participation in the activity. CME activities approved for AAFP credit are recognized by the AOA as equivalent to AOA Category 2 credit.

It is the policy of the AAFP that all individuals in a position to control content disclose any relationships with commercial interests upon nomination/invitation of participation. Disclosure documents are reviewed for potential conflicts of interest and, if identified, conflicts are resolved prior to confirmation of participation. Only those participants who had no conflict of interest or who agreed to an identified resolution process prior to their participation were involved in this CME activity.

All individuals in a position to control content for this activity have indicated they have no relevant financial relationships to disclose.

CHECKLIST
FOR SMALL/INDEPENDENT PHYSICIANS

- ◯ Verify your MIPS-eligibility status by entering your national provider identifier (NPI) number using the **CMS Look-Up Tool**

- ◯ Determine if you are reporting as an individual or as a group (must report all categories as a group if selecting the group option)

- ◯ Review reporting method options and select at least one (only one reporting method per MIPS category)
  - Qualified Registry _____
  - Qualified Clinical Data Registry (QCDR) _____
  - Electronic Health Record (EHR) _____
  - Claims
  - Attestation (for ACI and improvement activities categories only)
  - CAHPS

- ◯ Pick Your Pace for performance period 2017 (test, partial, full)

- ◯ Determine your six required quality measures (at least one must be an outcome measure)
  - Outcome quality measure 1 _____
  - Quality measure 2 _____
  - Quality measure 3 _____
  - Quality measure 4 _____
  - Quality measure 5 _____
  - Quality measure 6 _____
  - Optional additional high-priority or outcome measure _____
  - Optional additional high-priority or outcome measure _____

- ◯ Incorporate data collection for each quality measure into your workflows

- ◯ Review and select improvement activities (skip if PCMH)
  - Improvement activity 1 _____
  - Improvement activity 2 _____
  - Improvement activity 3 _____
  - Improvement activity 4 _____

Note: If there are less than 15 clinicians in group, you only need to select one high-weighted activity or two medium-weighted activities.

CHECKLIST FOR SMALL/ INDEPENDENT PHYSICIANS (continued)

- ◯ Assess if you are going to report under the ACI category by determining if you will have certified electronic health record technology (CEHRT) during the performance period (only clinicians using CEHRT are eligible for points in the ACI category)
- ◯ Review base score measures in the ACI category
- ◯ Complete security risk analysis
- ◯ Determine if you are going to report additional ACI performance score measures
- ◯ Determine if there are any improvement activities you are performing using your CEHRT that can be reported to earn bonus ACI points
- ◯ Incorporate data collection for ACI measures into your workflows
- ◯ Aggregate your quality and ACI data

CHECKLIST
FOR GROUP/LARGE PRACTICES

- ◯ Verify your MIPS-eligibility status by entering your national provider identifier (NPI) number using the **CMS Look-Up Tool**

- ◯ Determine if you are reporting as individuals or as a group (must report all categories as a group if selecting the group option)

- ◯ Review reporting method options and select at least one (only one reporting method per MIPS category)
  - Qualified Registry _____
  - Qualified Clinical Data Registry (QCDR) _____
  - Electronic Health Record (EHR) _____
  - Claims
  - Attestation (for ACI and improvement activities only)
  - CMS Web Interface (For groups of 25 or more. Must register by June 30, 2017.)
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS)

- ◯ Verify if and how your group is participating in Pick Your Pace for performance period 2017 (test, partial, full)

- ◯ Determine the six quality measures your group has selected to report
  (at least one must be an outcome measure)
  - Outcome quality measure 1 _____
  - Quality measure 2 _____
  - Quality measure 3 _____
  - Quality measure 4 _____
  - Quality measure 5 _____
  - Quality measure 6 _____
  - Optional additional high-priority or outcome measure _____
  - Optional additional high-priority or outcome measure _____

- ◯ Verify how your group is incorporating data collection for each quality measure into workflows

CHECKLIST
FOR GROUP/LARGE PRACTICES (continued)

- ◯ Identify your group's selected improvement activities
  (Skip this step if the practice is a patient-centered medical home [PCMH] — if one group under a TIN has PCMH recognition, then all clinicians in the group under the TIN can claim credit in the improvement activities category)
  - Improvement activity 1 _____
  - Improvement activity 2 _____
  - Improvement activity 3 _____
  - Improvement activity 4 _____

  Note: If there are less than 15 clinicians in your group, you only need to select one high-weighted activity or two medium-weighted activities.

- ◯ Assess if your group is reporting under the ACI category by determining if you will have certified electronic health record technology (CEHRT) during the performance period (only clinicians using CEHRT are eligible for points in the ACI category)

- ◯ Review base score measures in the ACI category and ensure your group has completed the security risk analysis

- ◯ Determine if your group is reporting additional performance score measures in the ACI category

- ◯ Determine if there are any improvement activities your group is performing using CEHRT that can be reported to earn bonus ACI points

- ◯ Verify how your group is incorporating data collection for ACI measures into workflows

MACRA OVERVIEW

The MACRA legislation accomplishes three general objectives:

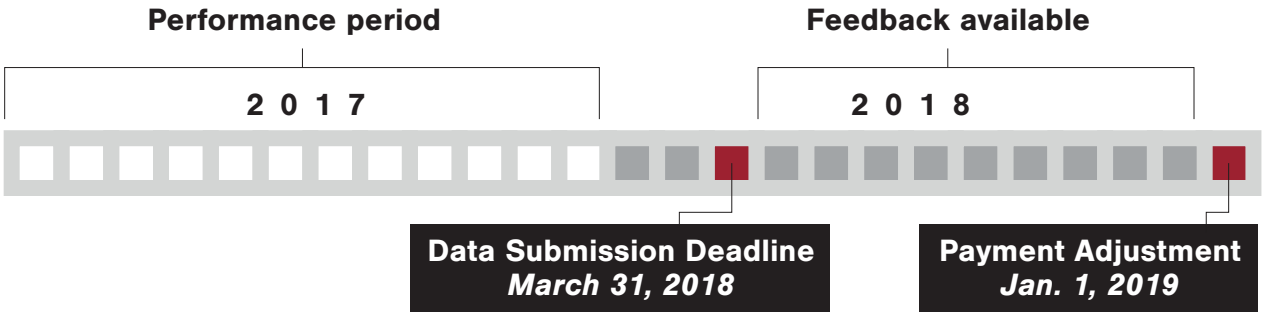
REPEALS the flawed sustainable growth rate (SGR)

EXTENDS the Children's Health Insurance Program (CHIP)

SHIFTS Medicare toward value-based payment models

The MACRA legislation calls for an annual baseline Medicare physician fee schedule update of 0.5% until 2019. From 2020 to 2025, updates will remain neutral (0%). From 2026 and onward, physicians reporting under the Merit-based Incentive Payment (MIPS) track will receive an annual 0.25% update. Qualified participants in an Advanced Alternative Payment Model (AAPM) will receive a 0.75% update. Performance in MIPS for any given year will affect payment two years after the performance period.

KEY DATES FOR THE 2017 PERFORMANCE PERIOD



ELIGIBILITY

The Centers for Medicare and Medicaid Services (CMS) has published a **CMS Look-Up Tool** for clinicians to verify their MIPS-eligibility status by entering their National Provider Identifier (NPI) number.

Eligible clinicians (ECs) for 2017 include: medical doctors, doctors of osteopathy, nurse practitioners, physician assistants, clinical nurse specialists, and certified registered nurse anesthetists.

Certain clinicians will not be subject to MIPS. These include:

- Clinicians in their first year of Medicare participation.
- Clinicians who fall below the low-volume threshold. To fall below the low-volume threshold, a clinician must have provided care to less than or equal to 100 Medicare Part B beneficiaries, or received $30,000 or less in Medicare Part B payments.
- Qualifying participants of in an AAPM.

MACRA OVERVIEW (continued)

Category weights and reporting requirements for 2017

Eligible clinicians (ECs) or groups will receive a final score based on performance in four MIPS categories: quality, cost, advancing care information (ACI), and improvement activities. The cost category is weighted at 0% for the 2017 transition year.

MIPS CATEGORY REPORTING REQUIREMENTS

Highlights for 2017

Quality

- Must report six measures
- One measure must be an outcome measure
- If reporting as a group, all participants must report the same measures

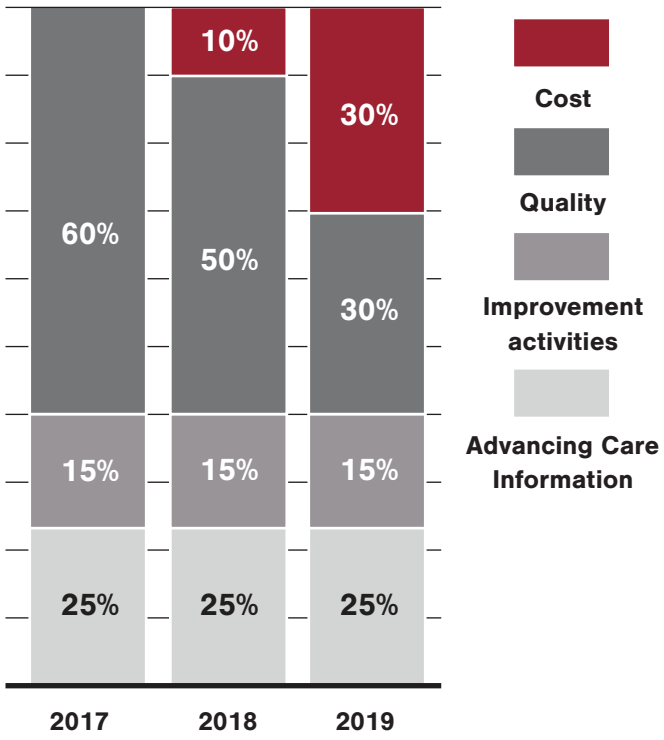
Cost

- Category weight is 0% for 2017
- Scheduled to increase to 30% in 2019 (percentages subject to change)

Improvement Activities

- Roughly based on medical home functions
- Physicians with a patient-centered medical home (PCMH) certification or recognition automatically receive full credit for the category
- Preferential scoring is given to practices with 15 or fewer clinicians

MIPS CATEGORY WEIGHTS



Advancing Care Information

- Based on Meaningful Use
- Must report base measures or the category score will be zero

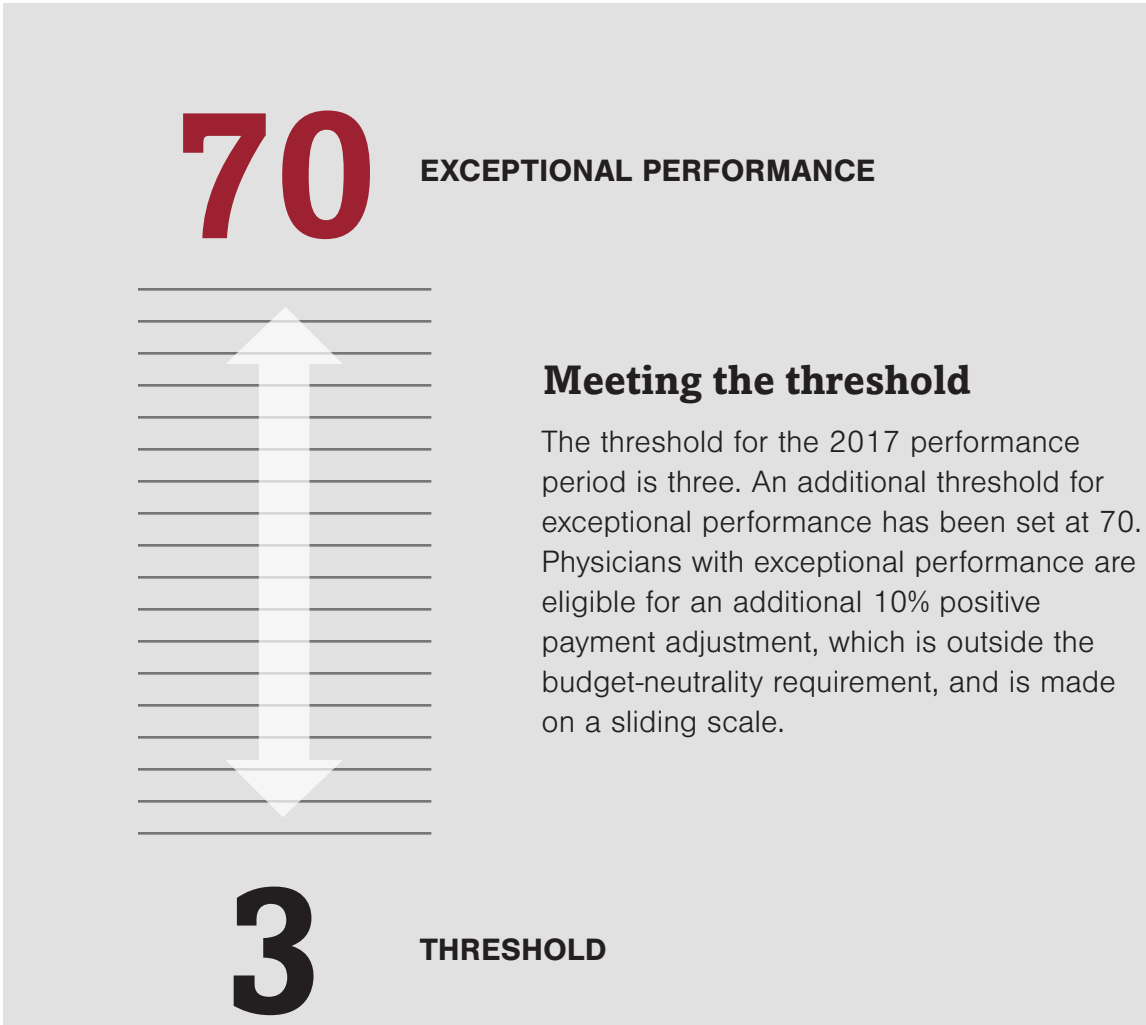
MACRA OVERVIEW (continued)

MIPS payment adjustments

The clinician's or group's final score will be compared to a performance threshold and compared to all MIPS clinicians (not just those in your specialty).

Scores above the threshold will receive sliding scale positive payment adjustments, and those below the threshold will receive sliding scale negative payment adjustments.

Payment adjustments are made on a claim-by-claim basis to Medicare Part B claims. MIPS payment adjustments are delivered in a budget-neutral fashion, so overall positive payment adjustments equal overall negative payment adjustments for all participants.



Meeting the threshold

The threshold for the 2017 performance period is three. An additional threshold for exceptional performance has been set at 70. Physicians with exceptional performance are eligible for an additional 10% positive payment adjustment, which is outside the budget-neutrality requirement, and is made on a sliding scale.

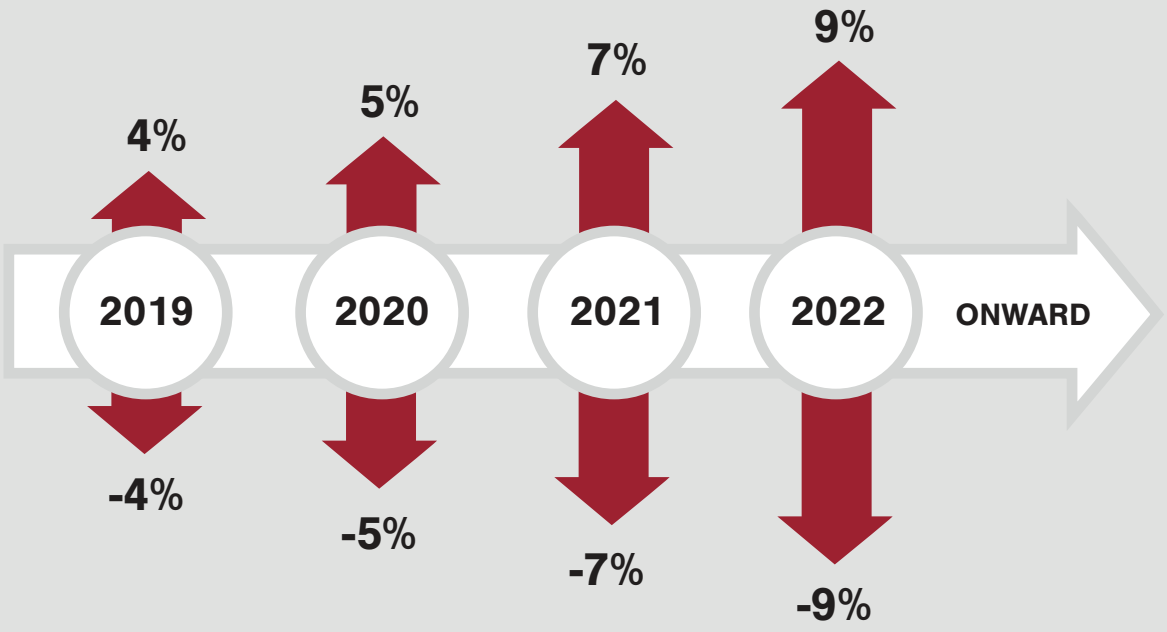
MACRA OVERVIEW (continued)

MIPS payment adjustments (continued)

Payment adjustments are not cumulative, meaning they reset to zero every year. All MIPS clinicians are compared to each other, not just specialty to specialty. Physicians who fall in the lowest quartile of MIPS scoring will automatically be adjusted to the maximum negative payment adjustment for that year.

For example, if the threshold is 100, clinicians receiving a final score of 25 or below will receive the maximum negative payment adjustment. An additional positive payment adjustment may be applied to ensure budget neutrality.

POSITIVE AND NEGATIVE PAYMENT ADJUSTMENTS



Exceptional performers are eligible (on a sliding scale) for an additional 10% positive payment adjustment. To ensure budget-neutrality, CMS may multiply the positive payment adjustments by three.

MACRA OVERVIEW (continued)

Group vs. individual reporting

Eligible clinicians can report at either the individual or group level. A group can be as little as two ECs billing in the same practice under the same tax identification number (TIN). Groups are scored at the group TIN level, but the final score is applied at the individual national provider identifier (NPI) level.

If an EC changes practices after the performance period, his/her score from the previous practice will be applied to the new practice.

When reporting as a group, all categories must be reported as a group (i.e., the quality category cannot be reported as an individual and ACI as a group).

MACRA OVERVIEW (continued)

Group vs. individual reporting (continued)

All ECs within the group must report on the same measures. This can be especially challenging for multi-specialty groups. The size of your practice may play a role in your decision to report as an individual or as a group.

The table explains the advantages and disadvantages of that decision.

INDIVIDUAL VS. GROUP REPORTING	INDIVIDUAL	GROUP
ADVANTAGES	• Can select own quality measures	• Ability to report all NPIs within practice at once
DISADVANTAGES	• Requires reporting for every NPI within the practice	• Includes all ECs within the practice, regardless of low-volume threshold status • Less flexibility in selecting measures • Difficulty reporting with multispecialty clinics
POINTS TO CONSIDER	• Reporting capabilities • All MIPS categories must be reported as an individual	• Management may decide your reporting level (individual vs. group) and mechanism (EHR, Qualified Registry, etc.) • How your MIPS final score will affect your salary/ contract negotiation • All MIPS categories must be reported as a group

Exemption due to low Medicare volume may be affected by individual and group reporting decisions. If your practice has chosen to report as a group, all ECs within the TIN will be included. This includes clinicians who fell below the low-volume threshold as individuals. You can review your individual and group low-volume status **online**.

MACRA OVERVIEW (continued)

Reporting mechanisms

There are several reporting mechanisms (also called methods) available to report measures. Mechanisms available vary by performance category and reporting level.

INDIVIDUAL VS. GROUP REPORTING MECHANISMS

MIPS CATEGORY	INDIVIDUAL	GROUP
QUALITY	• Qualified Clinical Data Registry (QCDR) • Qualified Registry • Electronic Health Record (EHR) • Claims	• Qualified Clinical Data Registry (QCDR) • Qualified Registry • EHR • CMS Web Interface (groups of 25+) • Use of Consumer Assessment of Healthcare Providers and Systems for MIPS Survey as a quality measure
COST	• No reporting required	• No reporting required
IMPROVEMENT ACTIVITIES	• Attestation • QCDR • Qualified Registry • EHR	• Attestation • QCDR • Qualified Registry • EHR
ADVANCING CARE INFORMATION	• Attestation • QCDR • EHR	• Attestation • QCDR • Qualified Registry • EHR • CMS Web Interface (groups of 25+)

MACRA OVERVIEW (continued)

MIPS APMs

To account for and address reporting overlap for clinicians participating in alternative payment models (APMs), CMS developed MIPS APMs. MIPS APMs will have preferential MIPS scoring, referred to as the APM Scoring Standard. There are two ways a clinician would be eligible for the APM Scoring Standard:

- Participating in an APM that does not meet the AAPM standards
- Not reaching qualified participant (QP) status within an AAPM

To view a list of MIPS APMs, visit the **CMS QPP website**.

While clinicians are assessed on the same four performance categories as other MIPS ECs, category weights under the APM Scoring Standard differ from reporting under MIPS.

APM SCORING STANDARD

MIPS CATEGORY	APM SCORING STANDARD SUMMARY
QUALITY	Measures reported directly through APM
COST	Not assessed
IMPROVEMENT ACTIVITIES	Automatic 100% credit (subject to annual review of model)
ADVANCING CARE INFORMATION	All TINs within APM must report (same requirements as MIPS ECs)

STEP 1: PICK YOUR PACE

In order to give physicians time to fully prepare for the QPP, CMS deemed 2017 a transition year to "Pick Your Pace." To avoid a negative payment adjustment in 2019, physicians reporting under MIPS must select from one of three Pick Your Pace options.

TEST: Submit data for one quality measure, OR one improvement activity, OR the four required ACI measures and avoid a negative payment adjustment.

PARTIAL PARTICIPATION: Submit at least 90 days of data for more than one quality measure, OR more than one improvement activity, OR more than the four required ACI measures and avoid a negative payment adjustment. Partial participation allows ECs to possibly receive a small positive payment adjustment.

FULL PARTICIPATION: Submit at least 90 days of data for all required quality measures, AND all required improvement activities, AND more than the required ACI measures to avoid a negative payment adjustment. Full participation allows ECs to possibly receive a moderate positive payment adjustment.

STEP 1: PICK YOUR PACE (continued)

PICK YOUR PACE KEY POINTS

- Report at least one measure or improvement activity to avoid a negative 4% payment adjustment in 2019.
- Full participation requires at least 90 days of reporting (a full year is not required).
- The more measures or improvement activities reported can increase your final score and potentially lead to a higher positive payment adjustment in 2019.

Physicians with minimal or no quality reporting program experience may find the **test** option the easiest way to begin participation in the QPP.

Testing allows for an easier transition as it lets physicians become familiar with capturing data without having to report the full requirements.

Partial participation offers physicians with experience in quality reporting programs an opportunity to use their prior experience to satisfy the MIPS requirements. All measures previously included in the Physician Quality Reporting System (PQRS) program are included in MIPS. In addition, the measures in the ACI category mirror measures available under the Medicare EHR Incentive Program (Meaningful Use). Physicians should look for overlap between the MIPS requirements and work already in place.

Physicians who are comfortable with quality reporting and looking to maximize their score may find **full participation** to be an appropriate option. While full participation requires at least 90 days of data, it does not require reporting the same 90 days across all categories.

The above represents recommendations by the AAFP. Physicians should choose the reporting level that is most comfortable to them. Physicians are not bound to a reporting level based on their previous quality reporting program experience.

Failure to report any data in 2017 will result in a negative 4% payment adjustment to Medicare Part B claims in 2019.

STEP 2: SELECT A REPORTING METHOD

Physicians should select the reporting method that works best for their individual or group situation. The reporting methods previously available in the Physician Quality Reporting System (PQRS) program are still available in the MIPS track.

REPORTING METHOD	ADVANTAGES	DISADVANTAGES	POINTS TO CONSIDER
 **Claims**	• No cost • CMS calculates performance • EHR is not required • Only report on Medicare Part B patients	• Mistakes are common and errors cannot be corrected • Difficult to monitor performance • Not available for group reporting • Must report with each claim	• Suitable if the number of Medicare patients is very small • Practice management/ billing systems may have built-in support for claims reporting • Cannot submit activities for ACI or improvement activities • May not be available in future years • Administrative burden may be high
 **Electronic Health Record (EHR)**	• EHR extracts and submits data to CMS • Normally no fees if data is submitted without vendor assistance • May offer easier reporting method for groups • Bonus points available for electronic end-to-end reporting	• May have cost associated with data submission if done through a vendor • Data must be captured according to EHR vendor specifications • Must report on at least 50% of patients eligible for measure, regardless of payer	• Inquire about automation of feedback reports • Ensure strong technical assistance is available • Documentation errors may yield incorrect performance rates • Built-in feedback reports may be limited, depending on vendor
 **Qualified Registry**	• Versatile data entry options (manual data entry, billing files, EHR files, or a combination) • May upload data throughout performance period or one-time after close of year • Registry submits information to CMS on behalf of clinicians • Bonus points available for electronic end-to-end reporting	• Costs associated with set-up and reporting • Must report on at least 50% of patients eligible for measure, regardless of payer • Electronic data upload requires some IT skills	• Inquire about feedback report availability • Ensure strong technical support is available • Determine if registry can connect directly with EHR • Reporting a measures group is no longer an available option • EHR not required, but helpful

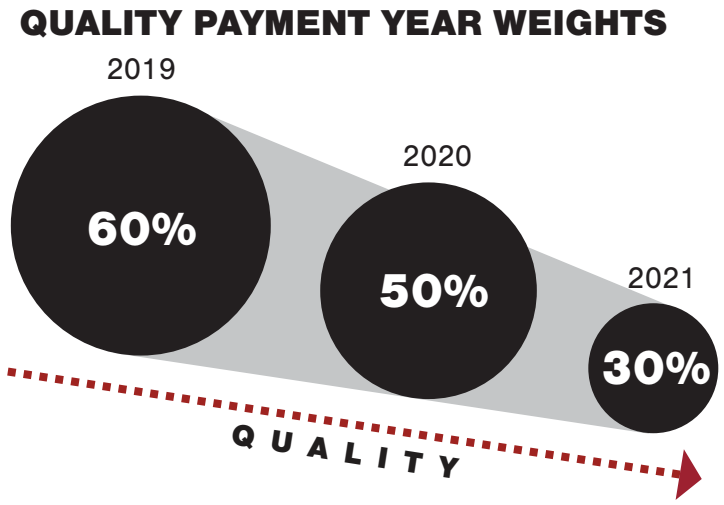
Continued on next page.

STEP 2: SELECT A REPORTING METHOD (continued)

REPORTING METHOD	ADVANTAGES	DISADVANTAGES	POINTS TO CONSIDER
 **Qualified Clinical Data Registry (QDCR)**	• Data extracted from EHR and submitted to QCDR on a regular basis • Bonus points available for electronic end-to-end reporting • Use of QCDRs can earn points under both quality and improvement activities categories of MIPS	• Costs associated with setup and reporting • May be labor intensive to implement • Limited number of QCDRs available on market • Must report on at least 50% of patients eligible for measure, regardless of payer	• Inquire about automation of feedback reports • Ensure strong technical assistance is available • Ensure it can dovetail with population health efforts
 **CMS Web Interface**	• May offer easier reporting option for large groups • Uses a subset of the same measures as the Medicare Shared Savings Program (MSSP) • Bonus points available for electronic end-to-end reporting	• Available to groups of 25 or more ECs only • Must register to use this method • Must report on all measures that are part of the Web Interface • Performance based only on a sample of 248 Medicare beneficiaries	• Performance compared to accountable care organizations (ACOs), which may have higher than average performance rates • Not available for improvement activities reporting • All or nearly all measures are electronic Clinical Quality Measures (eCQMs), so they are built-in to most EHRs
 **Attestation**	• No cost • Offers familiarity for physicians with Meaningful Use experience	• Attestation portal has not been released • Will need to extract data from EHR to report ACI measures	• Only available for ACI and improvement activities categories

QUALITY OVERVIEW

For many physicians, quality is the most familiar MIPS category. Many features come from the previous PQRS program. The quality category is the most heavily weighted as the QPP begins, but the weight decreases over time.



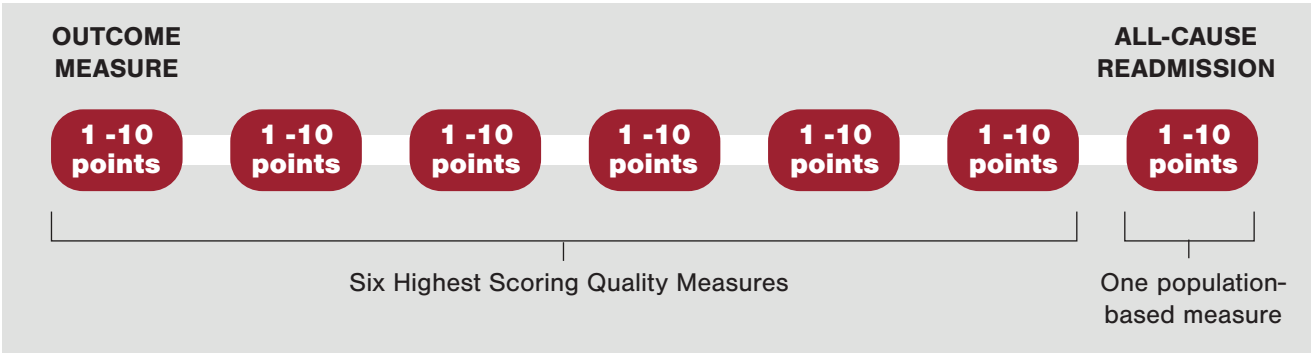
Measure scoring

Clinicians are required to report at least six quality measures (out of a possible 271), including one outcome measure (the CMS Web Interface is an exception). Physicians may report more than six measures, but CMS will only use the six with the highest performance to calculate the quality score.

CMS will calculate the all-cause hospital readmission measure for groups of 16 or more clinicians with a minimum measure case size of 200. Groups reporting through the CMS Web Interface will report on all of the 14 Web Interface measures (only 11 will be scored in 2017).

Individuals and groups should search the **AAFP MIPS Measures Tool** and determine which measures could potentially give them the highest score.

QUALITY SCORING SYSTEM



QUALITY OVERVIEW (continued)

The following represents the points available in the quality category by group size, or in the case of the CMS Web Interface, by reporting option.

Groups of 15 or fewer clinicians
Points available (without bonus) = 60 (6 measures x 10 points each)

Submit through CMS Web Interface
Points available (without bonus) = 120 (11 measures x 10 points, plus all-cause hosptial readmissions)

Groups of 16 or more clinicians
Points available (without bonus) = 70 (6 measures x 10 points, plus all-cause hosptial readmissions)

Each quality measure reported can earn a performance score if it:

- Meets a case minimum of 20 unique patients (200 for all-cause hospital readmission)
- Has a benchmark to be compared against (benchmark = historical level of performance on a measure typically from data two years prior that had at least 20 clinicians/entities reporting and earning a score on the measure)
- Meets data completeness criteria (50% of all patients who are eligible for the measure must be reported, regardless of payer; unless reporting through CMS Web Interface, CAHPS, or claims)

In 2017, if a measure is reported that has no benchmark or does not meet data completeness criteria, it will not be scored on performance, but physicians will earn three points just for reporting the measure.

In general, each measure can earn up to 10 points. Performance on a measure is compared to a benchmark, which has a two-year look back. Benchmarks are then broken down into performance deciles where a physician can earn a range of points. Individuals and groups should search the **AAFP MIPS Measures Tool**, and strategize as to which measures could potentially give them the highest score.

Two types of bonus points are available in the quality category. Each type is capped at 10% of the total possible points. For most clinicians (those not reporting using the CMS Web Interface), this means each set of bonus points will be capped at 10% of the 60-70 points available in the quality category (i.e., 6-7 points).

Physicians can earn two extra points for each extra outcome and patient experience measure reported, one point for each high-priority measure reported, and one point for each measure reported electronically end-to-end.

QUALITY OVERVIEW (continued)

To determine which measures fall into these categories, visit the **CMS QPP website** and look under > MIPS > Explore Measures > Quality Measures.

Other high-priority measures are defined as:

- Appropriate use
- Patient safety
- Efficiency
- Care coordination

Physicians can also earn one bonus point for measures reported using end-to-end electronic reporting. End-to-end electronic reporting means the MIPS-eligible clinician:

Uses certified electronic health record technology (CEHRT) to record the measure's demographic and clinical data elements

Exports and transmits measure data electronically to a third party, or a third-party intermediary (e.g., QCDR)

Third-party intermediary uses automated software to aggregate data, calculate measures, and submit electronically to CMS

CMS will use the six highest measures to calculate your quality measure score. The hypothetical example illustrates how a quality score would be calculated.

Measure Score		Bonus Score		Preliminary Quality Score		Total Points Possible		Quality Category Weight		Quality Score
50	+	0	=	50	÷	60	×	60%	=	50

The quality category accounts for 60% of the final score. If you are in a group of 16 or more, CMS will calculate the all-cause hospital readmission measure and the total possible points would be 70.

STEP 3: SELECT QUALITY MEASURES

Once you've selected your Pick Your Pace option and determined a reporting method, it's time to review and select quality measures. Review **quality measures** that best fit your practice.

Clinicians are required to report at least six quality measures, including one outcome measure (the CMS Web Interface option is an exception). Clinicians may report more than six measures, and the Centers for Medicare and Medicaid Services (CMS) will only use the six with the highest performance to calculate the quality score.

To maximize your MIPS score, you should consider several factors about selecting quality measures. These include benchmarks, ability to receive a score, and the potential for bonus points.

In order for MIPS quality measures to be scored on performance, they must meet three criteria: benchmarks, data completeness, and case minimums.

MIPS QUALITY MEASURE CRITERIA

- Have a benchmark
- Meet data completeness criteria
- Have 20-patient case minimum

Measures submitted that fail to meet one or more of the criteria will be assigned three points in 2017.

(Note: this policy does not apply to CMS Web Interface or to the all-cause readmission calculated measure.)

Benchmarks

Benchmarks are a historical level of performance on a measure against which a physician will be assessed. Benchmarks are taken from data two years prior to the performance period (i.e., 2015 data is used for performance period 2017). Each benchmark is broken down into performance deciles. The decile where your performance falls will determine how many points are awarded for the measure. Scores in the top decile are automatically awarded the full points.

Physicians should use benchmark data to determine how performance on specific measures will impact their MIPS quality score.

STEP 3: SELECT QUALITY MEASURES (continued)

Benchmarks (continued)

As an example, 2017 benchmarks for registry reporting would place a clinician in the following decile if:

- Performance for Pneumonia Vaccination Status for Older Adults is 64%
- Performance for Tobacco Screening and Cessation Intervention is 90%

Though your actual rate for pneumonia vaccination is lower, you would receive more points for this measure (7-7.9 points) than for the tobacco screening measure (5-5.9 points), because your pneumonia vaccination performance rate falls into a higher decile.

MEASURE NAME	Decile 3 (3-3.9 pts)	Decile 4 (4-4.9 pts)	Decile 5 (5-5.9 pts)	Decile 6 (6-6.9 pts)	Decile 7 (7-7.9 pts)	Decile 8 (8-8.9 pts)	Decile 9 (9-9.9 pts)	Decile 10 (10 pts)
Pneumonia Vaccination Status for Older Adults (Quality ID 111)	12.24-24.02	24.03-36.34	36.35-48.51	48.52-58.95	58.96-68.05	68.06-77.77	77.78-90.19	> 90.20
Tobacco Use: Screening and Cessation Intervention (Quality ID 226)	76.67-85.553	85.4-89.87	89.88-92.85	92.86-95.15	95.15-97.21	97.22-99.10	99.11-99.99	100

STEP 3: SELECT QUALITY MEASURES (continued)

Data completeness criteria

For the 2017 transition year of MIPS, the data completeness criteria varies by the reporting mechanism used for the quality category.

DATA COMPLETENESS CRITERIA BY REPORTING MECHANISM

Qualified Clinical Data Registry (QCDR)

Qualified Registry

Electronic Health Record (EHR)

Qualified Survey Vendor (for CAHPS only)

Report on 50% of ALL patients eligible for the measure, regardless of payer, when reporting through QCDR, qualified registry, or EHR.

Sample identified by CMS.

CMS Web Interface

Report on all the measures in the measure set listed when reporting through the CMS Web Interface. Use the first 248 ranked Medicare beneficiaries in the order they appear.

Claims

Report on 50% of Medicare Part B patients eligible for the measure, when reporting through claims.

Once you've determined your reporting method, review your workflows to ensure you are capturing the appropriate patients for each measure.

STEP 3: SELECT QUALITY MEASURES (continued)

Data completeness criteria (continued)

Measures within the quality category must all be reported using the same reporting method. One exception is the optional reporting of Consumer Assessment of Healthcare Providers and Systems (CAHPS). CAHPS counts as one quality measure. If reporting CAHPS, it's permissible to use one other reporting mechanism to report the remaining measures.

Case minimum

In order to be scored on performance, a clinician must have a minimum of 20 cases (or patients) for the measure. Therefore, when selecting measures, consider whether the measure applies to a large enough portion of your patient panel.

NOTE: The case minimum is different than the 20-patient requirement when reporting PQRS measures groups. Under PQRS measures groups, clinicians were only required to report on 20 patients. The case minimum for MIPS means the measure must be applicable to at least 20 patients. However, you need to report on all denominator-eligible patients. For the 2017 performance period, measures reported that do not meet the case minimum requirements will not be scored on performance, and will receive a maximum of three points.

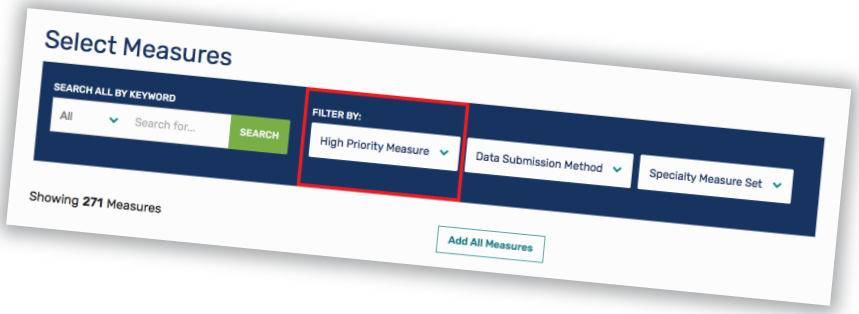
Bonus points

You can earn bonus points for reporting extra outcome, patient experience, or other high-priority measure defined by CMS. Bonus points are also available for measures that are submitted using end-to-end electronic reporting. Like other measures, for a measure to earn bonus points, it must meet data completeness criteria and case minimum requirements.

Physicians can earn two bonus points for additional outcome or patient experience measures, and one bonus point for reporting certain high-priority measures. High-priority measures are defined as outcome, appropriate use, patient safety, efficiency, patient experience, or care coordination measures.

High-priority measures

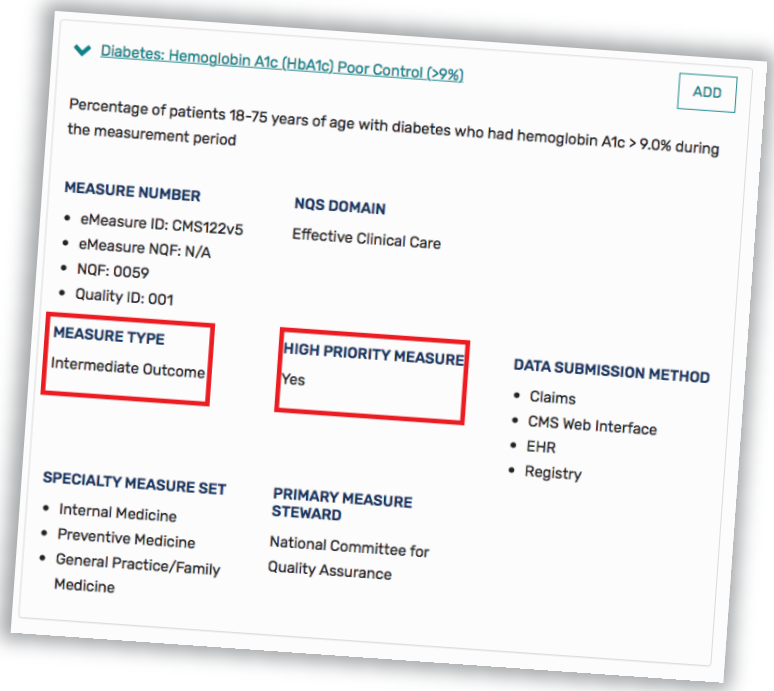
High-priority measures can be identified on the QPP website's **quality measures page**. Filter by "High Priority Measure."



STEP 3: SELECT QUALITY MEASURES (continued)

High-priority measures (continued)

Review information about the measure and details, such as data submission method, specialty measure set, and measure ID numbers.



Bonus points for each option are capped at 10% of your total score. For most family physicians, this means bonus points will be capped at six to seven points for high-priority measures and an additional six to seven points for end-to-end electronic reporting.

QUALITY CATEGORY KEY POINTS

- For full participation, physicians must report six measures, including one outcome measure.
- A higher performance rate does not always equate to a higher decile score.
- In order to be scored on performance, the measure must have a benchmark, meet case minimum, and data completeness criteria.

To help you navigate the **CMS QPP website**, the AAFP outlined three scenarios based upon physicians' level of experience with quality reporting. These contain screen shots of the quality section of the QPP website and precise steps, guiding the user through the process of selecting quality measures.

The three scenarios are:

1. **Limited or No Previous Quality Reporting Experience**
2. **Previous Quality Reporting Experience**
3. **Maximize MIPS Score Using Previous Quality Reporting Experience**

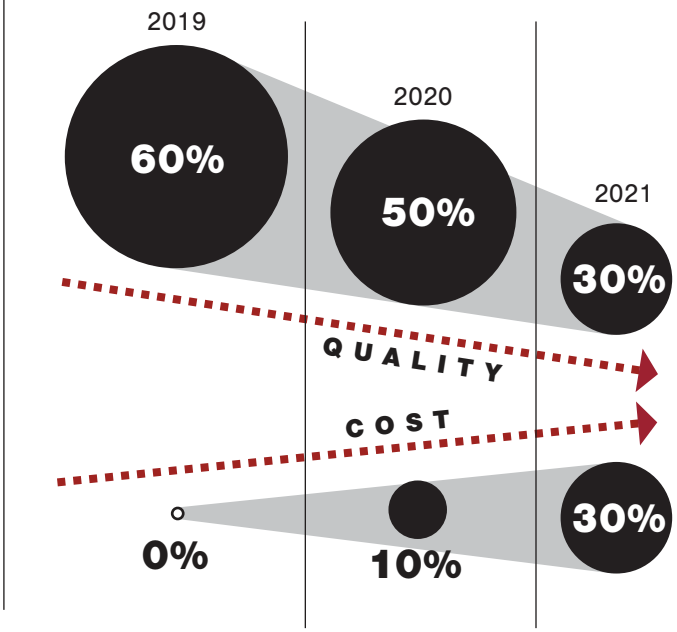
These scenarios are available in Appendix A.

COST OVERVIEW

The cost category accounts for 0% of the final score in the 2017 performance period. However, clinicians will receive feedback on their performance. The weight of the cost category will increase as the weight of the quality category decreases.

The cost category does not require any data submission, as CMS will use claims data to calculate clinicians' performance.

QUALITY AND COST PAYMENT YEAR WEIGHTS



COST CATEGORY MEASURES (for 2018 and beyond)

Total per Capita Costs

Medicare Spending per Beneficiary (MSPB)

Ten episode-based measures

The Total per Capita Costs and MSPB measures were included in the Value-Modifier calculation. Physicians have been provided with feedback on the episode-based measures through the supplemental Quality and Resource Use Report (sQRUR).

COST OVERVIEW (continued)

Cost category measures

MEASURE	EXPLANATION	ATTRIBUTION
Total per Capita Costs	• Assesses all Medicare Part A and B costs for each attributed beneficiary • Clinicians must have at least 20 unique beneficiaries attributed to them to be scored on this measure	**Two-step process:** • Beneficiaries are attributed to a TIN if beneficiary received more primary care services from primary care physicians, nurse practitioners, physician assistants, or clinical nurse specialists within that TIN than from clinicians in any other TIN • If a beneficiary is not attributed to a TIN using the first step, the beneficiary will be attributed to a TIN if they received more primary care services from specialist physicians within a TIN than from clinicians in any other TIN
Medicare Spending per Beneficiary	• Assesses Medicare Part A and B costs incurred during an episode • Episode includes the dates falling between three days prior to an Inpatient Prospective Payment System (IPPS) hospital admission (also called an index admission) and 30 days post-hospital discharge • Evaluates the observed cost of episodes compared to expected costs	• Episodes will be attributed to the clinician who provided the plurality of Medicare Part B services to a beneficiary during an index admission • Clinicians who do not see patients in the hospital will not be attributed to any episodes and not scored on the measure • Clinicians must be attributed to at least 35 cases to be scored on this measure
Episode-based measure	• Ten measures in 2017 (most are triggered by an inpatient stay or CPT code) • Many measures will not apply to clinicians who only practice in an ambulatory setting • Must be assigned at least 20 cases to be scored on these measures • One measure that may apply to family physicians is colonoscopy and biopsy	• Each measure has a different attribution methodology, depending on the type of measure

Cost measures are risk adjusted to account for differences in patient characteristics, such as multiple chronic conditions, that may affect a clinician's performance on the measure. Cost measure benchmarks are established using data from the performance period and not a historical two-year look-back period, which is used in the quality performance category. A measure will be benchmarked if it has 20 groups or individual clinicians who can be attributed to the case minimum for the measure. A measure without a benchmark will not be scored or included in the cost category score.

COST OVERVIEW (continued)

Cost scoring

An EC's performance will be compared to the measure benchmark and assigned 1 to 10 points. The cost performance category score is the average of all scored cost measures. When reporting as a group, CMS will aggregate the scores of individual clinicians within the TIN.

For example, a TIN may have one clinician with 10 attributed cases and another with 12 attributed cases. If they are reporting as individuals, they would not be scored on the measure. However, if they were reporting as a group, they would receive a score since they reach the 20-case minimum threshold (10 cases + 12 cases = 22 cases).

COST CATEGORY KEY POINTS

- Cost accounts for 0% of the final score in the 2017 performance year, but increases as the weight in the quality category decreases.
- Beginning in 2018, clinicians will be assessed on their performance in Total per Capita Costs, Medicare Spending per Beneficiary (MSPB), and episode-based measures.
- Cost measures are risk adjusted to account for differences in patient characteristics, such as multiple chronic conditions that may affect a clinician's performance on the measure.

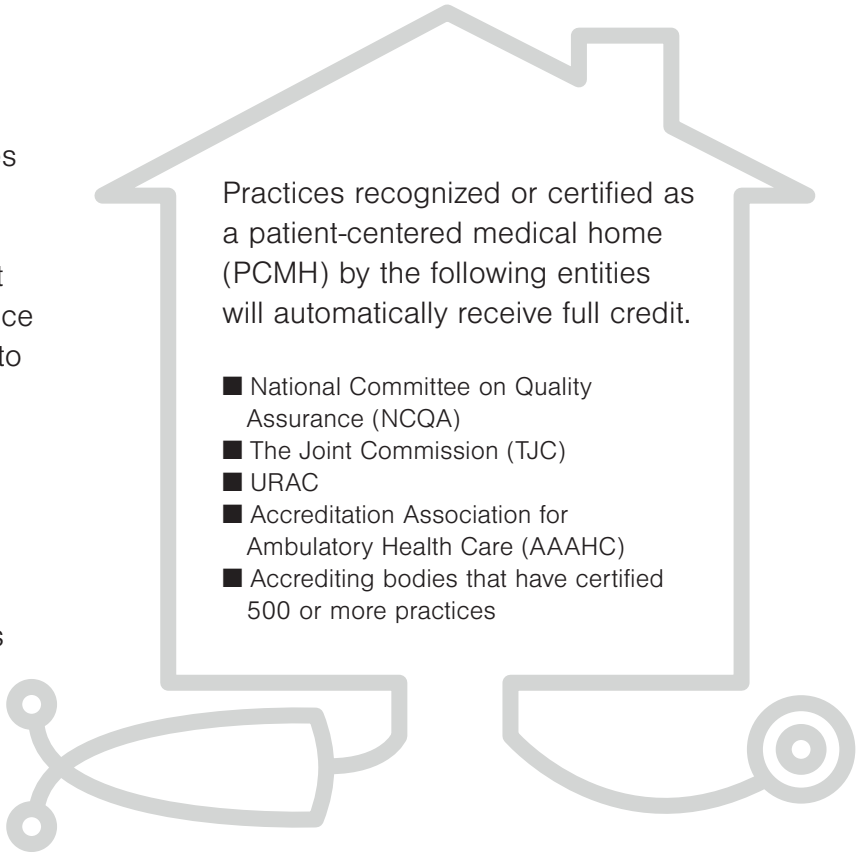
IMPROVEMENT ACTIVITIES OVERVIEW

The improvement activities category accounts for 15% of your MIPS final score in 2017. While the improvement activities category is new, the functions within it should be familiar to family physicians. Improvement activities improve clinical practice or care delivery, and are likely to result in improved health outcomes.

If one clinic under a TIN is recognized or certified as a PCMH, the entire TIN would automatically receive full points in the category.

Eligible clinicians not in a recognized PCMH can select from a list of 92 improvement activities. Each activity is weighted as either high (20 points) or medium (10 points). With a maximum score of 40 points in this category, most ECs will need to attest that they completed two high-weighted activities, four medium-weighted activities, or a combination to equal 40 points for a minimum of 90 consecutive days during the performance period.

There are 18 technology-based improvement activities that qualify for bonus points under the ACI category. Additional guidance will be issued by CMS about how data will need to be submitted for the improvement activities category.



Practices recognized or certified as a patient-centered medical home (PCMH) by the following entities will automatically receive full credit.

- National Committee on Quality Assurance (NCQA)
- The Joint Commission (TJC)
- URAC
- Accreditation Association for Ambulatory Health Care (AAAHC)
- Accrediting bodies that have certified 500 or more practices

Certain groups will receive double the points for each activity. They will only need to complete two medium-weighted activities or one high-weighted activity. These are:

Groups with 15 or fewer clinicians

Practices located in a rural, or health professional shortage area (HPSA)

Practices or ECs that are non-patient facing

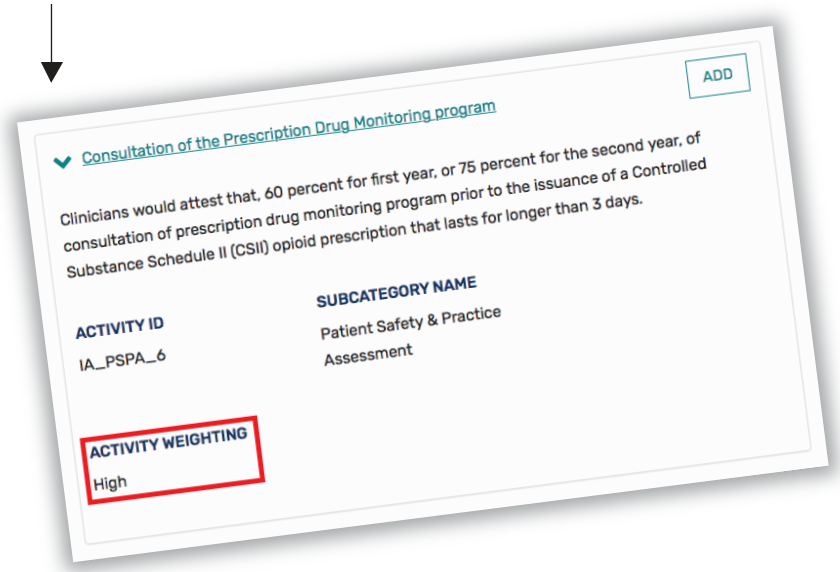
STEP 4: SELECT IMPROVEMENT ACTIVITIES MEASURES

The improvement activities category is designed to assess quality improvement and practice improvement efforts. There is flexibility in this category to choose activities that are most meaningful to your practice.

Prior to selecting improvement activities, physicians should review the list of 92 available activities on the **CMS QPP website**, where physicians can see a description of the activity and weight classification. Then, assess current workflows. Some activities are activities that many physicians already do as standard of care, such as checking the prescription drug monitoring program (PDMP) before prescribing an opioid.

Select improvement activities that you can attest you carried out in your clinic for 90 consecutive days during the performance period. CMS has published **validation criteria** that include suggestions for documentation for each activity.

For example, if choosing the improvement activity, "Use group visits for common chronic conditions" (IA_BE_19), physicians would need to show billing documentation for group visit services if an audit were to occur.



IMPROVEMENT ACTIVITIES CATEGORY KEY POINTS

- Practices certified as a PCMH will automatically receive full credit in this category.
- Carry out improvement activities for a consecutive 90 days.
- Maximize your score in ACI by earning bonus points (see ACI overview section) by choosing improvement activities that utilize CEHRT functionalities.

ADVANCING CARE INFORMATION OVERVIEW

The advancing care information (ACI) category is based on the Medicare EHR Incentive Program (also called Meaningful Use). It is weighted at 25% of the final score.

The ACI category differs from Meaningful Use in a few ways. In Meaningful Use, physicians could only satisfy the requirements by meeting thresholds. The ACI category does not have thresholds in 2017. Instead, clinicians will receive points based on their actual performance rate on measures. Additionally, clinicians can report as a group. Meaningful Use required reporting at the individual level. Those electing to report as a group will need to report all MIPS categories as a group.

The ACI category requires the use of certified electronic health record technology (CEHRT). Clinicians may use 2014 Edition CEHRT, 2015 Edition CEHRT, or a combination of both. Clinicians can use the **Certified Health IT Product List** to review if their EHR is certified. Clinicians who do not have CEHRT are still eligible to participate in MIPS, but will not receive any of the points in the ACI category.

Hardship exception

Physicians can apply for a hardship exception from the ACI category. Physicians will need to apply annually. If the exception is approved, the weight of the ACI category will be redistributed to the quality category. Hardships may be granted for those who demonstrate insufficient internet connectivity or extreme and uncontrollable circumstances.

Base score

To achieve a base score in ACI, clinicians must report on a set of required measures (referred to as base measures). The base score evaluates if a clinician performed the activity. Clinicians must report a numerator and denominator of at least one for each measure (and attest "Yes" to the Security Risk Analysis). Clinicians must report on ALL base measures to receive a base score. **Failure to report even one measure will result in a base score of zero and an ACI score of zero.**

SCORING

Scoring within the ACI category is broken into:

Base score	Performance score	Bonus points
50	Up to 50 additional points (Nine possible reporting measures are available worth 10 points per measure)	Up to 15 points

While there is the potential to score **more than 100 points**, CMS capped the total at **100**.

ADVANCING CARE INFORMATION OVERVIEW (continued)

Performance score

The performance score assesses a clinician's (or group's) performance on each measure and awards up to 10 points per measure. A clinician's performance rate is determined by the numerator and denominator submitted for each measure. Points are assigned based on performance according to the performance scoring table.

PERFORMANCE MEASURE SCORING
(points per measure)

1-10% = **1 point**	51-60% = **6 point**
11-20% = **2 points**	61-70% = **7 points**
21-30% = **3 points**	71-80% = **8 points**
31-40% = **4 points**	81-90% = **9 points**
41-50% = **5 points**	91-100% = **10 points**

Clinicians are scored based on their performance on a number of ACI measures. Certain measures are included in the base score, performance score, or both. The base and performance measures table indicates which category the measure is scored under.

BASE AND PERFORMANCE SCORE MEASURES

★ Three base measures (Provide Patient Access, Send a Summary of Care, Request/Accept Summary of Care) may be included in the performance score.

The performance score contributes up to 50 additional points to the ACI score. There is the potential to score more than 100 points, but CMS capped the total at 100.

*Measure is NOT required in 2017

MEASURE	BASE SCORE MEASURES (REQUIRED)	PERFORMANCE SCORE MEASURES (REQUIRED)
Security Risk Analysis	✓	
e-Prescribing	✓	
Provide Patient Access	★	★
Send a Summary of Care	★	★
Request/Accept Summary of Care*	★	★
Patient-specific Education		✓
View, Download, and Transmit		✓
Secure Messaging		✓
Patient-generated Health Data		✓
Clinical Information Reconciliation		✓
Immunization Registry Reporting		✓

ADVANCING CARE INFORMATION OVERVIEW (continued)

Bonus points

Clinicians can earn bonus points by attesting to additional registries (five points), or by attesting that they used CEHRT to complete certain improvement activities (10 points).

Clinicians can attest to active engagement with additional registries beyond the immunization registry, which is already considered a performance score measure.

REGISTRIES THAT QUALIFY FOR THE ACI BONUS

Syndromic Surveillance Reporting

Electronic Case Reporting

Public Health Reporting

Specialized Reporting

Since the immunization registry is an optional performance measure, it does not qualify for bonus points. Clinicians can earn the registry bonus points even if they do not attest to using an immunization registry. A maximum of five bonus points will be awarded, regardless of the number of additional registries a clinician attests to using.

Clinicians can also earn 10 bonus points using CEHRT to complete one of 18 improvement activities. A list of activities can be found on page 9 of this **CMS QPP fact sheet**. A maximum of 10 bonus points will be awarded, regardless of the number of improvement activities a clinician completes using CEHRT functionalities.

A graphic illustration detailing base, performance, and bonus score measures, as well as the calculation CMS uses to determine your ACI category score can be found in **Appendix B**.

ADVANCING CARE INFORMATION OVERVIEW (continued)

ACI scoring example

This example shows ACI scoring if a clinician reports the ACI base measures ONLY.

BASE AND PERFORMANCE SCORE MEASURE EXAMPLE

MEASURE	BASE SCORE
Security Risk Analysis	10
E-Prescribing	10
Send Summary of Care	10
Provide Patient Access	10
Request/Accept Summary of Care	10
TOTAL	50

MEASURE	PERFORMANCE SCORE
Send Summary of Care	8
Provide Patient Access	8
Request/Accept Summary of Care	5
TOTAL	21

Three of the base score measures are also considered performance score measures. By reporting on applicable patients, this EC receives base score and performance score points. The performance rate for the three overlapping base score measures was converted to points.

To calculate the ACI score, sum the base and performance scores and multiply by the category weight.

$$50 + 21 = 71 \Rightarrow 71 \times 0.25 = 17.75$$

Base score	Performance score		ACI category weight	ACI score

STEP 5: SELECT ADVANCING CARE INFORMATION MEASURES

To help decide what data needs to be collected during the performance period, clinicians should begin by determining their desired level of reporting for the ACI category. To avoid a score of zero in the ACI category, you must report all of the base score measures. Clinicians should decide if they are planning to submit only base score measures, base and performance score measures, and if they will submit additional information for bonus points.

ADVANCING CARE INFORMATION CATEGORY KEY POINTS

- Must report all base measures or you will receive a zero in the ACI category.
- If you do not have an EHR, you cannot participate and receive points in the ACI category, but you can participate in other MIPS categories.
- To simplify reporting, report performance on the three overlapping base measures that are also performance measures (Provide Patient Access, Send a Summary of Care, Request/ Accept Summary of Care).

Clinicians who have never attested to Meaningful Use should work with their EHR vendor to understand the documentation requirements for reporting measures. Assess which measures would be easiest to incorporate into workflows. Reporting the base measures may be an appropriate place to begin as this allows you to earn at least half of the ACI score, while also providing the potential for a performance score on overlapping measures.

Those who decide to report additional performance score measures should review any previous Meaningful Use activity when selecting ACI measures. Consider reporting the measures that are already incorporated into your workflows. If you choose to submit to earn bonus points, review the **list of improvement activities** and determine whether there are CEHRT functions available to perform any of the activities, particularly functions that are also required for the ACI category. It is important to note that reporting at any level has the potential to increase your performance score.

Once measures have been selected, re-examine the data capture processes with your EHR vendor and staff. This allows you to verify with your EHR vendor that the information is still being captured correctly and can be extracted for reporting purposes. Reinforce the data capture process with staff to ensure consistency and standardized workflows.

As the performance period progresses, monitor the performance on your selected measures. Explore whether your EHR vendor can run monthly or quarterly reports. Identify areas where performance is lower than expected and examine whether the workflow is still effective and being completed appropriately. Work with your team (particularly new staff) to look over documentation techniques.

An overview detailing how to access ACI measures on the QPP website is available in **Appendix C**.

STEP 6: BUILDING THE MIPS FINAL SCORE

The MIPS scoring system is on a scale from zero to 100. CMS has set the performance threshold at only three points for the 2017 performance period. Therefore, doing a minimal amount of reporting (i.e., the test option in Pick Your Pace) ensures you do not receive a negative payment adjustment in 2019.

	QUALITY	COST	ADVANCING CARE INFORMATION	IMPROVEMENT ACTIVITIES	MIPS FINAL SCORE
Weight	60%	0%	25%	15%	100%
Category Points	50	–	71	40	–
Calculation*	50/60 x 0.6	–	71/100 x 0.25	40/40 x 0.15	–
Category Score	50	–	17.75	15	82.75

FINAL MIPS SCORE

* Calculation: Total category points earned divided by total possible category points, multiplied by category weight

Based on hypothetical examples, this clinician has scored above the exceptional performance threshold.

If the clinician did not participate in the ACI category, they would still score 65 points, which would still qualify for a positive payment adjustment.

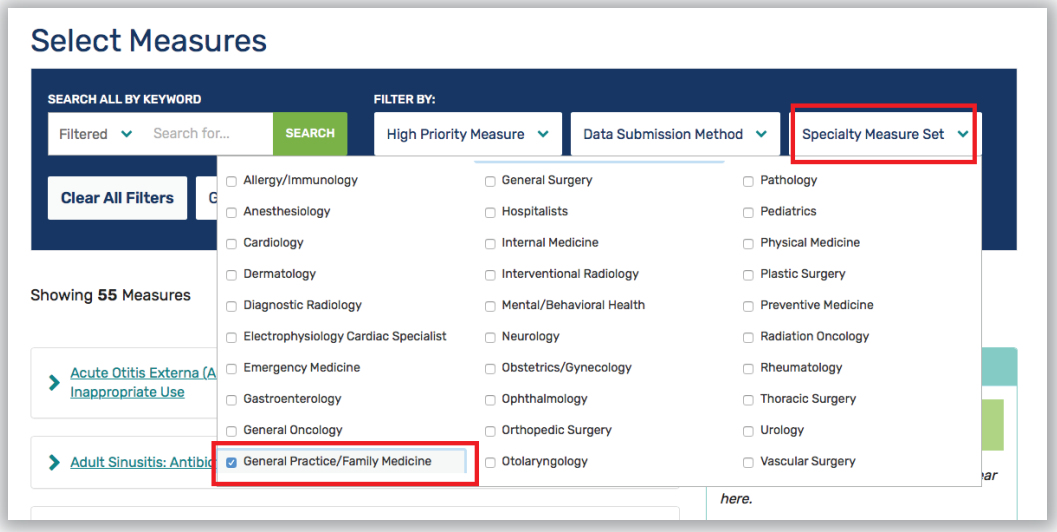
APPENDIX A: QUALITY MEASURES SCENARIOS

Example 1: Limited or No Previous Quality Reporting Experience

If physicians are not fully reporting in 2017, they can report as little as one measure for one patient. This allows ECs to avoid a negative 4% payment adjustment in 2019. The following steps guide physicians who have not reported quality data before about how to select and report a measure.

1. Review the list of top diagnoses in your practice. This information can typically be extracted from an EHR. Work with your EHR vendor or billing staff to run reports of the top diagnoses. If you do not have an EHR, visit with your clinical staff to begin reviewing your panel and identifying common diagnoses.

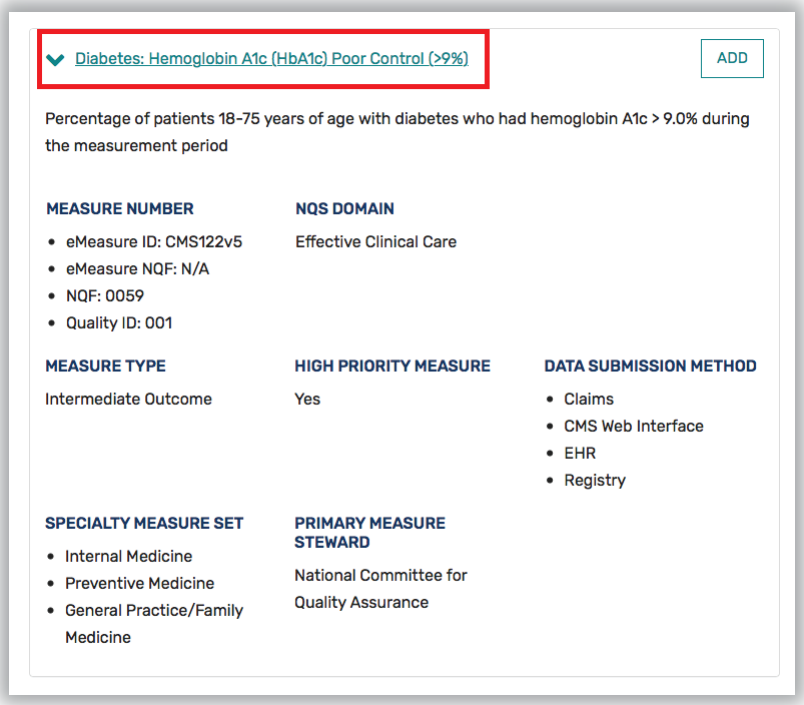
2. Once you have identified your top diagnoses, review the list of MIPS measures. These measures can be found on the **CMS QPP website**. To narrow the list to the Family Medicine Specialty Set, click the "Specialty Measure Set" drop down and select "General Practice/Family Medicine."



The Family Medicine Specialty Set contains 55 measures. Scroll through the list of measures and identify the measures that align with your top diagnoses. You can also narrow by "Data Submission Method" by clicking the drop-down menu and selecting your desired method. For information on reporting method, see the playbook's **Step 2: Select a Reporting Method**.

APPENDIX A: QUALITY MEASURES SCENARIOS (continued)

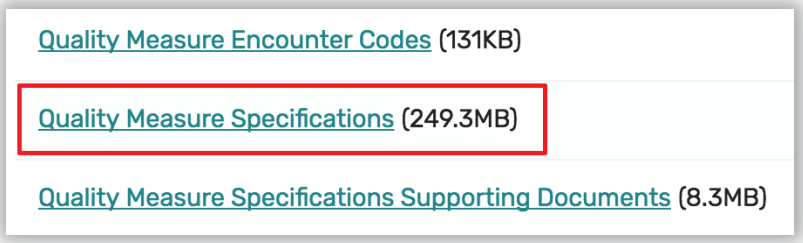
To view more information on each measure, click on the measure title and it will expand and include measure-specific information.



- Measure Description: provides a brief description of the measure's intent
- Measure Number: various measure identifiers–you will want to take note of the Quality ID.
- National Quality Strategy (NQS) domain: measure classification
- Measure Type: purpose of the measure (is it measuring whether an action occurred [process], how performance changed on a measure [outcome], etc.)
- High Priority Measure: measures prioritized because of impact on patients (includes outcome, appropriate use, patient safety, efficiency, patient experience, and care coordination measures)
- Data Submission Method: which reporting methods can be used to report the measure–some measures may not be able to be reported using certain reporting methods
- Specialty Measure Set: list of specialty sets that include this measure
- Primary Measure Steward: entity who developed and maintains the measure

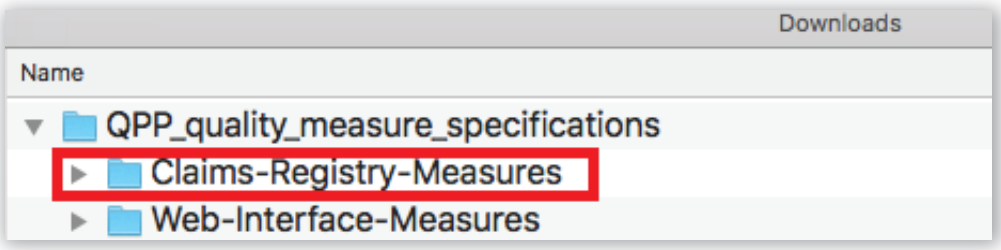
3 After you have selected your measure(s), you will want to review the measure specification(s).

- Measure specifications can be downloaded from the **CMS QPP website**. Scroll to the bottom of the page and select "Quality Measure Specifications." This is a large zip file that will download. It contains measure specifications for ALL quality measures. If you are reporting via EHR or QCDR, check with your vendor to determine how to best capture the data.

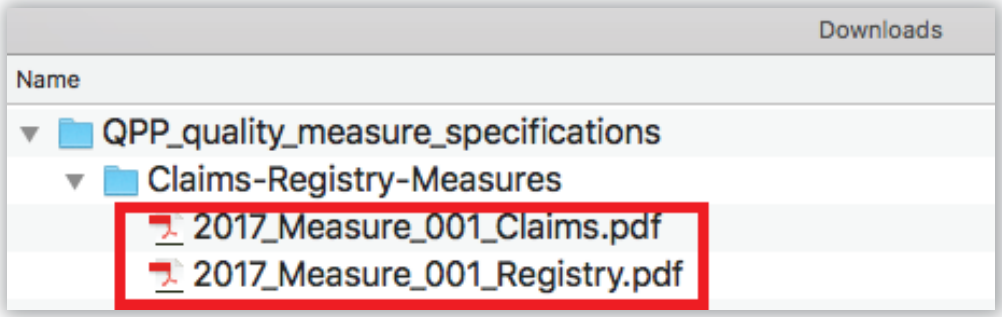


APPENDIX A: QUALITY MEASURES SCENARIOS (continued)

■ Within the file, there will be two folders. Open the folder titled, "Claims-Registry Measures."



■ Each measure will have two specification files–one for claims and one for registry reporting. They contain instructions for the measure based on the different reporting methods. Find the measure you would like to review by looking for the Quality ID (such as 001), and open the PDF that corresponds with your selected reporting method (claims or registry).



4. If you are reporting via registry, you will need to work with your registry to determine if they can connect directly to your EHR, or if you should use quality data codes to capture data. At the close of the reporting period, you will upload your information to the registry according to their requirements.

5. The measure specification contains instructions for reporting the measure denominator, and numerator, including quality data codes.

■ The measure specifications indicate how often the measure should be reported and who should report it. In 2017, measures can be reported as few as one time.

■ The denominator provides the criteria for who qualifies for the measure. It contains patient age, specific diagnosis, and encounter codes. Patients will be included in the denominator if they meet these criteria.

■ The numerator provides information on the outcome expected for the patients included in the measure. The quality data codes are also included. Quality data codes (QDCs) are CPT II or G-codes that are used for reporting purposes. Specific codes are added to the claims to indicate if the patient did or did not meet the expected outcome.

APPENDIX A: QUALITY MEASURES SCENARIOS (continued)

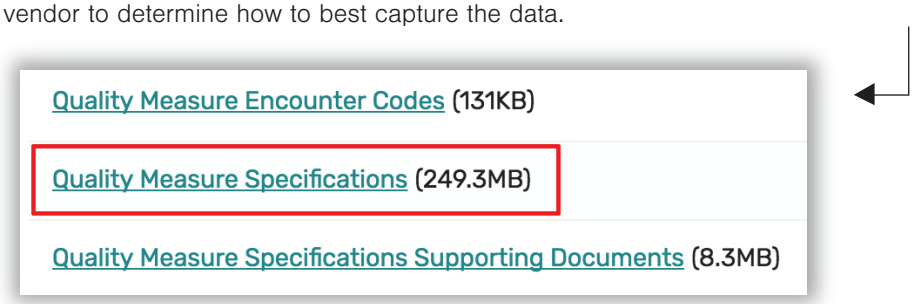
Example 2: Previous quality reporting experience

Physicians who have previously reported under PQRS or other quality initiatives will already have experience collecting data on quality measures. The following steps guide physicians on how to use their previous quality reporting experience to report under MIPS.

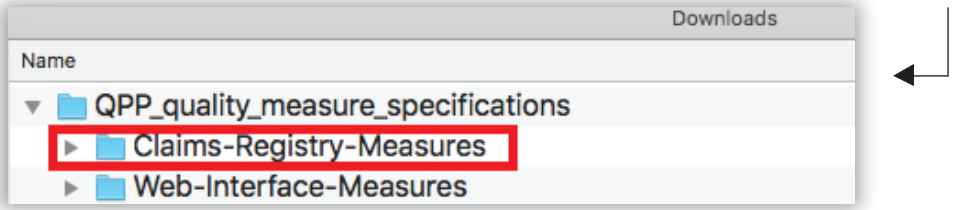
1. Review measures reported under PQRS or other quality initiatives. MIPS requires reporting on six measures (one of which must be an outcome measure). Since PQRS required reporting on nine measures, you have the option to reduce the number of measures you report or you can continue to report all nine. If you continue to report all nine, CMS will use the six with the highest performance to calculate your quality score. You can also select measures not previously reported. You are not limited to reporting the same measures reported under PQRS.

2. Go to the **CMS QPP website** and download the measure specifications for your selected measures.

■ Measure specifications can be downloaded from the **CMS QPP website**. Scroll to the bottom of the page and select "Quality Measure Specifications." This is a large zip file that will download. It contains measure specifications for ALL quality measures. If you are reporting via EHR or QCDR, check with your vendor to determine how to best capture the data.

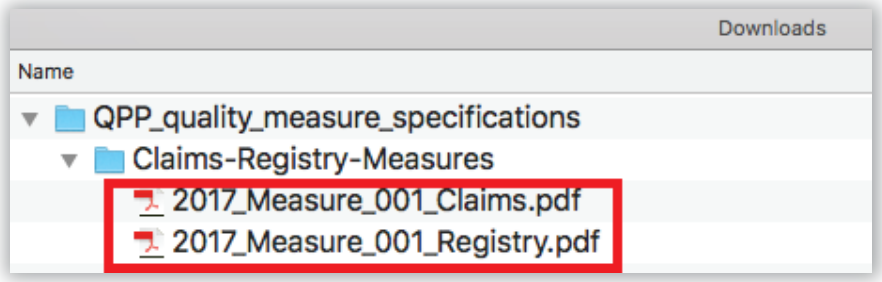


■ Within the file, there will be two folders. Open the folder titled, "Claims-Registry Measures."



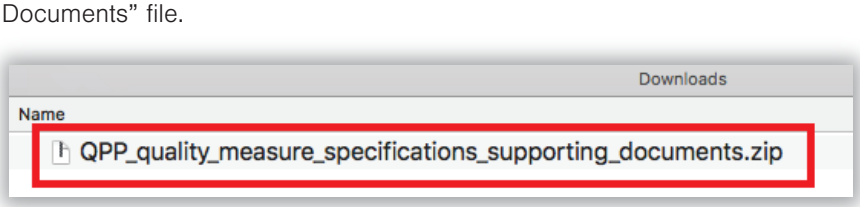
APPENDIX A: QUALITY MEASURES SCENARIOS (continued)

■ Each measure will have two specification files–one for claims and one for registry reporting. They contain instructions for the measure based on the different reporting methods. Find the measures you would like to review by looking for the Quality ID (such as 001) and open the PDFs that correspond with your selected reporting method (claims or registry).

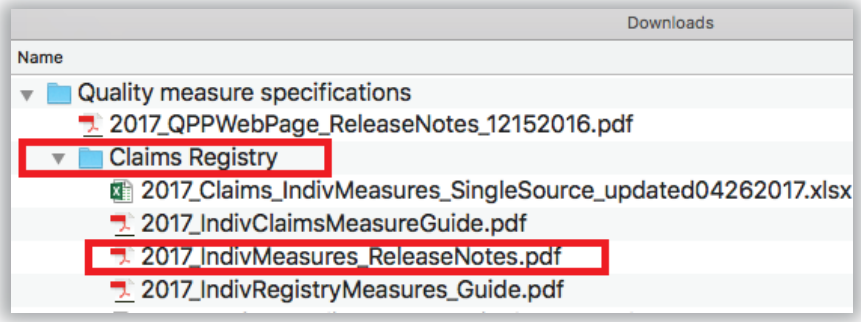


3. Once you've downloaded the measure specifications, review them. Ensure that your data collection processes are still accurate. Review any changes or updates with your staff.

■ CMS has also created "Release Notes" that highlight the changes to measures. These provide a high-level overview of updates made to the measures. Review the full measure specifications for your selected measures. The "Release Notes" can be found in the "Quality Measure Specifications Supporting Documents" file.



■ Open the "Claims Registry" folder and then the "2017_IndivMeasures_ReleaseNotes" PDF.



4. If you are reporting using a registry, at the close of the reporting period, work with your EHR vendor or registry to extract your data. Upload the data to the registry following their instructions.

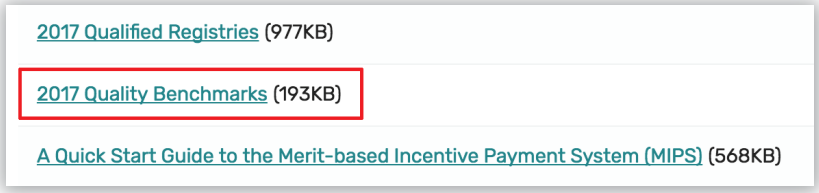
APPENDIX A: QUALITY MEASURES SCENARIOS (continued)

Example 3: Maximize your MIPS score using previous quality reporting experience

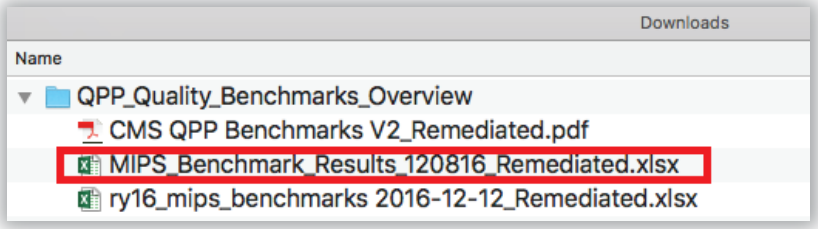
Physicians who have previously reported under the PQRS or other quality initiatives will already have experience collecting data on quality measures. The following instructions guide physicians on how to use PQRS performance information to maximize their MIPS scores.

1. Follow the steps from Example 2 to review the measure specifications for your selected measures.

2. To download measure benchmarks, visit the **CMS QPP website**. Scroll and select "2017 Quality Benchmarks." This is a large zip file that downloads. It contains measure specifications for ALL quality measures.



■ Within the folder, there will be three files. To review the benchmarks, open the excel file titled "MIPS_Benchmark_Results_120816_Remediated."



■ Once you've downloaded and opened the benchmarks spreadsheet, review the benchmarks that correspond with your selected measures and reporting method. Separate benchmarks are created for different submission mechanisms.

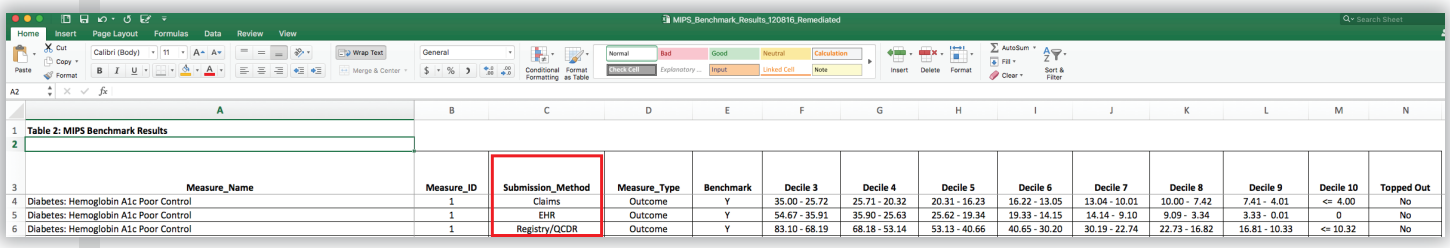


Table 2: MIPS Benchmark Results

Measure_Name	Measure_ID	Submission_Method	Measure_Type	Benchmark	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10	Topped Out
Diabetes: Hemoglobin A1c Poor Control	1	Claims	Outcome	Y	35.00 - 25.72	25.71 - 20.32	20.31 - 16.23	16.22 - 13.05	13.04 - 10.01	10.00 - 7.42	7.41 - 4.01	<= 4.00	No
Diabetes: Hemoglobin A1c Poor Control	1	EHR	Outcome	Y	54.67 - 35.91	35.90 - 25.63	25.62 - 19.34	19.33 - 14.15	14.14 - 9.10	9.09 - 3.34	3.33 - 0.01	0	No
Diabetes: Hemoglobin A1c Poor Control	1	Registry/QCDR	Outcome	Y	83.10 - 68.19	68.18 - 53.14	53.13 - 40.66	40.65 - 30.20	30.19 - 22.74	22.73 - 16.82	16.81 - 10.33	<= 10.32	No

APPENDIX A: QUALITY MEASURES SCENARIOS (continued)

■ If you are reporting the same measures you reported under PQRS, use your Quality and Resource Use Report (QRUR) to compare your historical performance to the QPP MIPS benchmarks (QRUR Exhibit 3 in the 2015 reports).

Measure Reference	Measure Name	Your TIN's Eligible Cases	Your TIN's Performance Rate	Benchmark	Benchmark – 1 Standard Deviation	Benchmark + 1 Standard Deviation	Standardized Score	Included in Domain Score?
1* (GPRO DM-2, CMS122v2)	Diabetes Mellitus (DM): Hemoglobin A1c Poor Control	84	5.95%	20.49%	1.85%	39.14%	0.78	Yes
39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older	241	100.00%	35.02%	4.82%	65.22%	2.15	Yes
48	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older	246	40.24%	75.01%	38.23%	100.00%	-0.95	Yes
111 (GPRO Prev-8, CMS127v2)	Preventive Care and Screening: Pneumococcal Vaccination for Older Adults	471	92.57%	45.42%	14.41%	76.42%	1.52	Yes
117 (CMS131v2)	Diabetes Mellitus (DM): Dilated Eye Exam	64	68.75%	87.50%	61.91%	100.00%	-0.73	Yes
119 (CMS134v2)	Diabetes Mellitus (DM): Medical Attention for Nephropathy	77	87.01%	80.93%	63.28%	98.57%	0.35	Yes
163 (CMS123v2)	Diabetes Mellitus (DM): Foot Exam	82	100.00%	65.65%	30.94%	100.00%	0.99	Yes

■ When reviewing the benchmark column, take note of the decile that corresponds with your historical performance rate (Your TIN's Performance Rate column). This can give you an indication of how you may score under MIPS. If your performance is high, but falls in a lower decile, you may want to consider reporting a different measure.

■ In this example, if the practice's performance remains stable (compared to their previous PQRS performance), they could earn between five and seven points, depending on their reporting method. Clinicians can review their individual performance by referencing the Supplemental Exhibits provided with their QRUR (Supplemental Exhibit 7 of the 2015 QRUR).

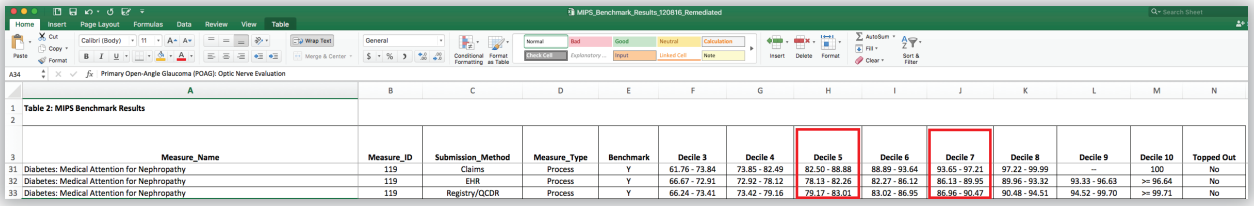


Table 2: MIPS Benchmark Results

Measure_Name	Measure_ID	Submission_Method	Measure_Type	Benchmark	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10	Topped Out
Diabetes: Medical Attention for Nephropathy	119	Claims	Process	Y	61.76 - 73.84	73.85 - 82.49	82.50 - 88.88	88.89 - 93.64	93.65 - 97.21	97.22 - 99.99	--	100	No
Diabetes: Medical Attention for Nephropathy	119	EHR	Process	Y	66.67 - 72.91	72.92 - 78.12	78.13 - 82.26	82.27 - 86.12	86.13 - 89.95	89.96 - 93.32	93.33 - 96.63	>= 96.64	No
Diabetes: Medical Attention for Nephropathy	119	Registry/QCDR	Process	Y	66.24 - 73.41	73.42 - 79.16	79.17 - 83.01	83.02 - 86.95	86.96 - 90.47	90.48 - 94.51	94.52 - 99.70	>= 99.71	No

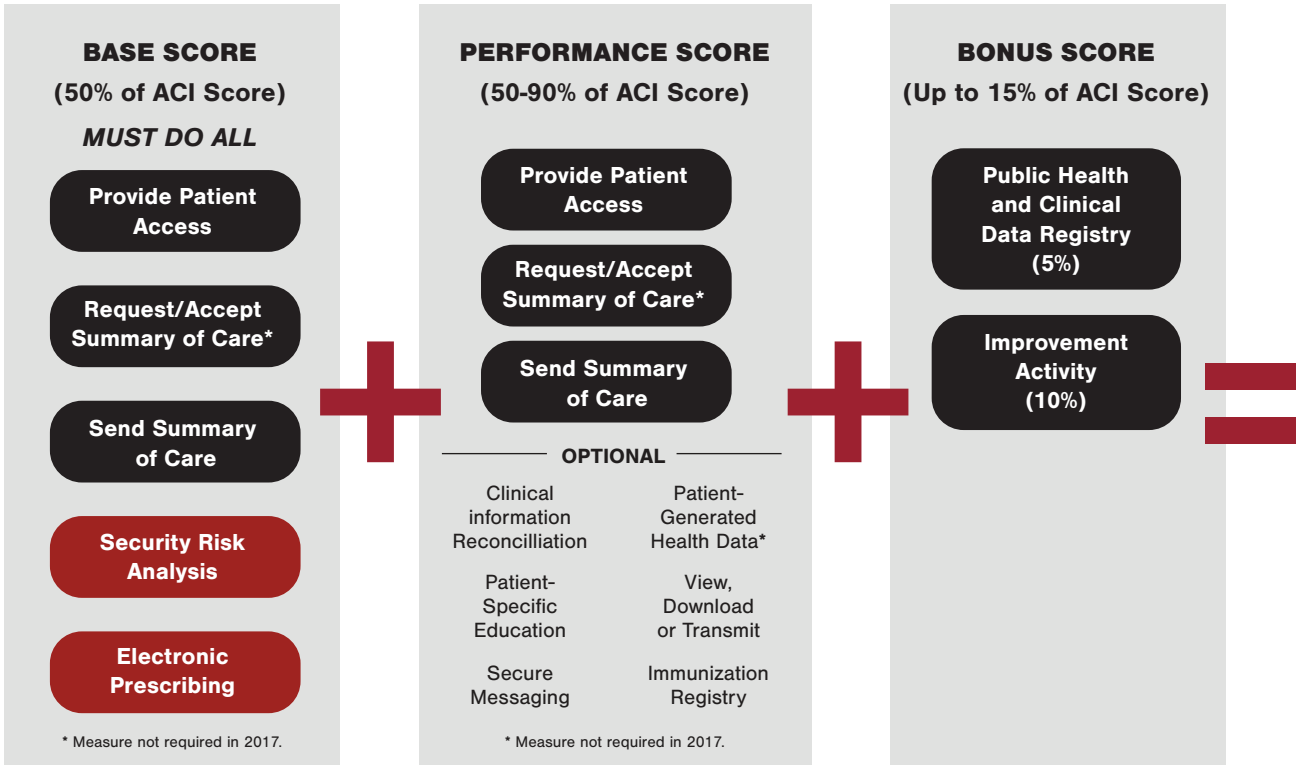
3. Throughout the performance period, work with your EHR vendor or registry to run monthly or quarterly reports. Use these reports to review your performance. Work with your team to make adjustments to improve lower performing measures.

4. Your score will be based on your performance if you:

   - ■ Report for a minimum of 90 days
   - ■ Select measures that have a benchmark
   - ■ Meet the data completeness criteria
   - ■ Meet the case minimum

Go back to Step 3: Select Quality Measures

APPENDIX B: HOW TO CALCULATE YOUR ADVANCING CARE INFORMATION CATEGORY SCORE



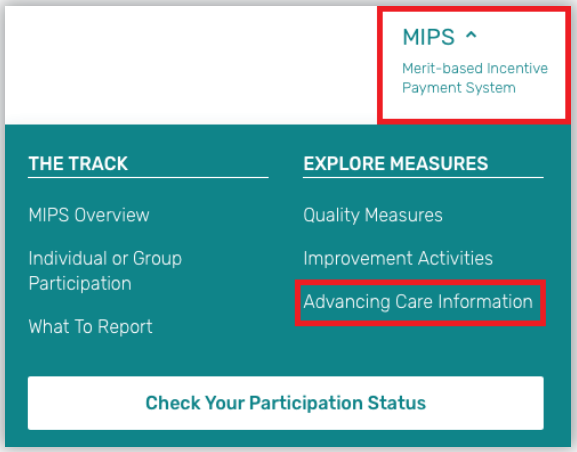
Go back to Advancing Care Information Overview

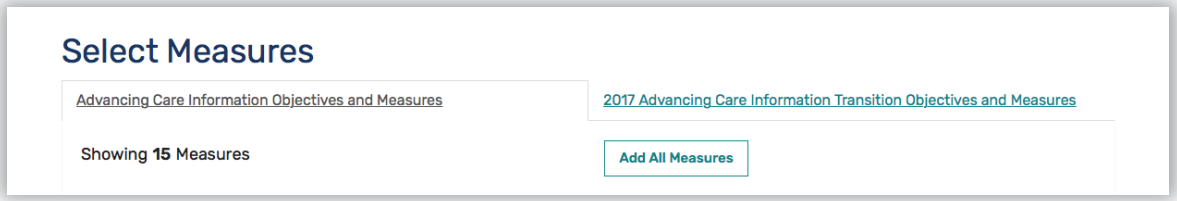
APPENDIX C: ACCESSING ADVANCING CARE INFORMATION MEASURES

Measures can be found on the **CMS QPP website**.

1. On the QPP website, select "Explore Measures" and then click the "Advancing Care Information" tab.

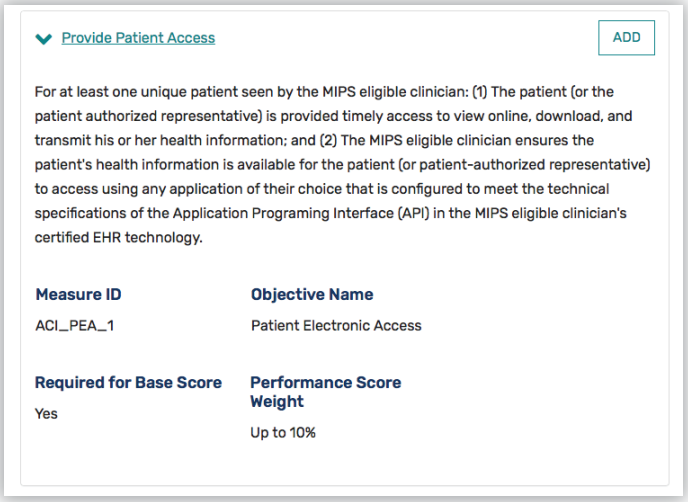
2. There will be two tabs to indicate the two sets of measures available. The tab labeled "2017 Advancing Care Information Transition Objectives and Measures" includes measures available in the 2017 performance period for users of 2014, 2015, or a combination of 2014 and 2015 Edition CEHRT.





3. Click the measure title to review the measure's requirements.

■ "Required for Base Score" indicates if the measure is a base score measure. "Performance Score Weight" indicates the measure is a performance score. If the measure is "Required for Base Score" AND has a "Performance Score Weight," the measure will be included in both the base score and the performance score.



Go back to Step 5: Select Advancing Care Information Measures

ACCESS THE POST-TEST FOR CME CREDIT AT:

www.aafp.org/macra-play-book-post-test