The New CMS
Quality Payment Program:
What You Need to Know for 2017

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CMS = The Centers for Medicare & Medicaid Services
Disclosure

I have nothing to report, nor are there any real or perceived conflicts of interest, implied or expressed, in the following presentation.

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Agenda

• Introduce HSAG
• MACRA defined
• Understand the impact of NOT participating
• Overview of the MIPS categories, data submission methods, and scoring methodology
• Learn where to find program resources and stay informed
• Questions
HSAG: Your Partner in Healthcare Quality

- HSAG is the Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for Arizona, California, Florida, Ohio, and the U.S. Virgin Islands.
- Committed to improving healthcare quality for more than 35 years.
- QIN-QIOs in every state/territory are united in a network under the Centers for Medicare & Medicaid Services (CMS).
- The Medicare QIO Program is the largest federal program dedicated to improving healthcare quality at the community level.
HSAG is the Medicare QIN-QIO for Arizona, California, Florida, Ohio, and the U.S. Virgin Islands.

Nearly 25 percent of the nation’s Medicare beneficiaries
What Is MACRA?


* Children’s Health Insurance Program
What Does MACRA Do?

• **Repeals** the Sustainable Growth Rate (SGR) Formula.
• **Changes the way that Medicare pays clinicians** and establishes a new framework to reward clinicians for value over volume.
• **Streamlines** multiple quality reporting programs into one new system: MIPS.
• **Provides** bonus payments for participation in eligible Alternative Payment Models (APMs).
Clinicians have two tracks from which to choose:

**MIPS**

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

**Advanced APMs**

*If you decide to participate in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.*
Discussion Structure

• Part 1: What do I need to know about MIPS?
• Part 2: How do I prepare for and participate in MIPS?
Part 1: MIPS Basics
What Do I Need To Know?
A visualization of how legacy programs streamline into the MIPS performance categories

Example of legacy program phase out for PQRS

Source: The Centers for Medicare & Medicaid Services

PQRS = Physician Quality Reporting System
VM = Value-Based Payment Modifier
EHR= Electronic Health Record
What is the MIPS?

Performance Categories:

- Quality
- Cost
- Improvement Activities
- Advancing Care Information

- Comprised of four performance categories
- Provides MIPS-eligible clinician types included in the 2017 Transition Year with the flexibility to choose the activities and measures that are most meaningful to their practice.

Source: The Centers for Medicare & Medicaid Services
What Are the Performance Category Weights?

- Weights assigned to each category is based on a 1 to 100 point scale.

**Transition Year Weights**

- **Quality**: 60%
- **Cost**: 0%
- **Improvement Activities**: 15%
- **Advancing Care Information**: 25%

Note: These are defaults weights; the weights can be adjusted in certain circumstances.
When Does MIPS Officially Begin?

2017 Performance Year
- Performance period opens January 1, 2017.
- Performance period closes December 31, 2017.
- Clinicians care for patients and record data during the year.

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

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

January 1, 2019 Payment Adjustment
- MIPS payment adjustments are prospectively applied to each claim beginning on January 1, 2019.

Source: The Centers for Medicare & Medicaid Services
MIPS Participation
What Do I Need to Know?
Participation Basics

Must be a **MIPS-eligible clinician type** billing more than $30,000 a year in Medicare Part B allowed charges **AND** providing care for more than 100 Medicare patients a year.

**MIPS-eligible clinician types include:**

- Physicians
- Physician Assistants
- Nurse Practitioner
- Clinical Nurse Specialist
- Certified Registered Nurse Anesthetists

Source: The Centers for Medicare & Medicaid Services
The definition of Physicians:

- Doctors of Medicine
- Doctors of Osteopathy
- Doctors of Dental Surgery
- Doctors of Dental Medicine
- Doctors of Podiatric Medicine
- Doctors of Optometry
- Doctors of Chiropractic Medicine

Note: The following types of Clinicians may become eligible in 2019: Audiologist, Clinical Social Workers, Clinical Psychologist, Dietitians, Nurse Midwives, Nutritional Professionals, Occupational Therapist, Physical Therapist and Speech Pathologist.
Who Is Exempt From MIPS?

Clinicians who are:

- Newly-enrolled in Medicare
  - Enrolled in Medicare for the first time during the performance period (exempt until following performance year)

- Below the low-volume threshold
  - Medicare Part B allowed charges less than or equal to $30,000 a year
  - See 100 or fewer Medicare Part B patients a year

- Significantly participating in Advanced APMs
  - Receive 25% of Medicare payments
  - See 20% of Medicare patients through an Advanced APM

Source: The Centers for Medicare & Medicaid Services
If You Are Exempt...

• You may choose to voluntarily submit quality data to CMS to prepare for future participation, but you will not qualify for a payment adjustment based on your 2017 performance.

• This will help you hit the ground running when you are eligible for payment adjustments in future years.

Source: The Centers for Medicare & Medicaid Services
Participation Basics: Individual vs. Group Reporting

**Options**

1. **Individual** — under a NPI number and TIN where they reassign benefits

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

* If clinicians participate as a group, they are assessed as a group across all four MIPS performance categories.

NPI = National Provider Identifier
TIN = Tax Identification Number
Dr. “A” is an M.D.:
- A MIPS-eligible clinician type
- Billed $100,000 in Medicare Part B allowed charges
- Saw 110 patients

“So what?” Dr. A should actively participate in MIPS during the Transition Year to avoid a **4% reduction** in Medicare Part B payments in 2019 and possibly earn a positive payment adjustment.

Remember: To be eligible

BILLING >$30,000  AND  >100

Source: The Centers for Medicare & Medicaid Services
Participation Example: Individual Level—Exempt from MIPS

Dr. “B” is a D.O:
• A MIPS-eligible clinician type
• Billed $100,000 in Medicare Part B allowed charges
• Saw 80 patients

“So what?” Dr. B. would be EXEMPT from MIPS due to seeing less than 100 patients.

Remember: To be eligible

BILLING
>$30,000

AND

>100

Source: The Centers for Medicare & Medicaid Services
Participation Basics: Group Level

Options

Individually (Assessed at the TIN/NPI level)

- Dr. “A”
  - Billed $100K
  - Saw 100 patients
  - Included in MIPS
  - Exempt from MIPS

- Dr. “B”
  - Billed $100K
  - Saw 80 patients

- Nurse Practitioner
  - Billed $50K
  - Saw 40 patients
  - Exempt from MIPS

Group (Assessed at the TIN level)

- As a Group (Dr. A, Dr. B, NP)
  - Billed $250K
  - Saw 230 patients
  - All included in MIPS

Remember: To participate

BILLING >$30,000 AND >100

Source: The Centers for Medicare & Medicaid Services
You Have Asked: “Does the $30,000 in Medicare Part B allowed charges AND 100 Medicare Part B patients also apply at the group level if my practice chooses group reporting?

Yes. For Transition Year 2017, the low-volume threshold for MIPS also applies at the group level.

“So what?” The low-volume threshold exclusion is based on both the individual (TIN/NPI) and group (TIN) status. For group-level reporting, a group (as a whole) is assessed to determine if it exceeds the low-volume threshold.
MIPS Eligibility
Do You Know Your Eligibility Status?
1. CMS verifies that you meet the definition of a MIPS-eligible clinician type. *Then…*

2. CMS reviews your historical Medicare Part B claims data from *9/1/15 to 8/31/16* to make the *initial* determination.  
   “So what?” If you are determined to be exempt during this review, you will remain exempt for the entire Transition Year.  
   *Later…*

3. CMS conducts a second determination on performance period Medicare Part B claims data from *9/1/16 to 8/31/17*.  
   “So what?”  
   • If you were included in the first determination, you may be reclassified as exempt for the Transition Year during the second determination.  
   • If you were initially exempt and later found to have claims/patients exceeding the low-volume threshold, you will remain exempt.
Getting Started:
Clinician Participation Letter Sample

Dear Medicare Clinician:

Thank you for your participation in Medicare and the services you provide to people with Medicare. You’re an integral part of the dedicated team of clinicians who serve more than 55 million people with Medicare. The clinician-patient relationship is central to our work at the Centers for Medicare & Medicaid Services and we continuously work to reduce the administrative burdens you may face when participating in Medicare programs. During this first year of transition to the Quality Payment Program, we have put together several program options, so you can choose the pace that best meets your practice needs. However, we know we can do more and are committed to diligently working with you over the next year to streamline the process as much as possible. Our goal is to further reduce burdensome requirements so that you can deliver the best possible care to patients. Our doors are open and we look forward to hearing your ideas and receiving your feedback so we can make additional improvements in year two of the Quality Payment Program.

Why am I getting this letter?
You have a practice identified by a taxpayer identification number (TIN) enrolled in Medicare. Starting in 2017, clinicians will participate in the new Quality Payment Program as a group or individually either through the Merit-based Incentive Payment System (MIPS) or participation in an Advanced Alternative Payment Model (APM). This letter lets you know if your group and the individuals in your group (if those individuals choose to report separately to the program) are exempt from MIPS because of the following:

- being a low-volume clinician (being below established program thresholds); or
- not being among the categories of clinicians included in the program in the first year.

In addition, you may be exempt from MIPS if you are:

- a new Medicare enrolled clinician; or
- if you are participating in certain Advanced Alternative Payment Models and your participation is sufficient to meet certain thresholds.

Attachment A provides low-volume and non-eligible provider type information in a list for each clinician and group.

MIPS replaces the Physician Quality Reporting System (PQRS), Value Modifier (VM) and the Medicare EHR Incentive Program for eligible clinicians who provide items and services under Medicare Part B. The Quality Payment Program will provide new tools and resources to help you give your patients the best possible, highest-value care. Even better, you could receive positive payment adjustments based on your participation, performance, and engaging in improvement activities. Clinicians who practice under multiple TINs will be notified at the TIN level of their eligibility, and may have different eligibilities for each TIN/practice.

This is the first year of this new program. Based on stakeholder feedback, we have made it much easier to participate in the program from the start. We reduced the number of proposed requirements and created a variety of timelines, so you can pick when you want to start and your pace of participation.

What do I need to do?
Review Attachment A. Determine whether you plan to participate as a group or if clinicians within your group will participate individually. If you participate in an Alternative Payment Model (APM), reach out to your model’s support inbox to learn more information about additional support that is available.

Let the clinicians assigned to your TIN know if they’re included in MIPS or exempt from MIPS if individual clinician participation is chosen as the method of participation.

- If included in MIPS, the clinicians:
  - Must participate to potentially earn an upward adjustment and avoid a negative adjustment to their Medicare Part B payments.
  - Can participate as an individual or as part of their group.
  - Can pick the pace of their participation for the first performance period. If they’re ready, they can collect performance data beginning with services that were furnished beginning on January 1, 2017. Clinicians can also choose to start anytime between January 1 and October 2, 2017.
  - Must submit any MIPS data to Medicare no later than March 31, 2018 to qualify for a positive or neutral payment adjustment, which will affect their 2019 Medicare Part B payments, and avoid up to a 4% negative payment adjustment in 2019.
**If the clinician is not included in MIPS, the clinician:**
- Won’t be subject to a positive or negative Medicare Part B payment adjustment in 2019 under MIPS.
- No further action is required unless your TIN decides to participate as a group and is above one of the low volume thresholds.
- May choose to voluntarily submit data individually to Medicare to learn, to obtain feedback on quality measures, and to prepare in the event MIPS is expanded in the future. Clinicians who submit data voluntarily will not be subject to a positive or negative payment adjustment.

**If the clinician is a participant in an Advanced APM, the clinician:**
- Should determine and confirm participation in the Advanced APM (visit [http://go.cms.gov/APMlist](http://go.cms.gov/APMlist) to see an up to date list of Advanced APMs).
- Should continue to fulfill the participation requirements of the Advanced APM. The Quality Payment Program does NOT change how any particular Advanced APM rewards value or operates, and Advanced APMs have their own quality reporting and participation requirements.
- Should know that there are special benefits for those who meet threshold levels of participation in an Advanced APM for a year. These benefits include exemption from the MIPS reporting and payment adjustments, and a 5% lump sum APM incentive payment. If CMS determines the clinician is a Qualifying APM Participant (QPP) in any one of three determinations conducted throughout a performance year, a clinician can become a QPP by participating in an Advanced APM and reaching the thresholds for sufficient Medicare Part B payments or Medicare patients through the Advanced APM.
- Should know that eligible clinicians participating in Advanced APMs who do not meet the threshold to be QPPs may qualify as a Partial Qualifying APM Participant (Partial QPP) if they meet certain minimum thresholds of Medicare Part B payments or Medicare patients through the Advanced APM. Partial QPPs can elect to report to MIPS and be subject to MIPS payment adjustments, or not to report to MIPS, and be excluded from MIPS payment adjustments.
- Should know that MIPS eligible clinicians participating in Advanced APMs who do not meet the threshold to be QPPs or Partial QPPs will be subject to MIPS. However, they may receive special MIPS scoring considerations.
- Should consider the impact under the Quality Payment Program if the clinician wants to exit the Advanced APM during the year, as exiting early could nullify these benefits.

If your TIN would like to report MIPS data as a group, the group will get one MIPS final score based on the group's performance. You should plan your participation and let the eligible clinicians assigned to your TIN know what they need to do for your group to successfully participate in MIPS. If you participate as a group, you will be assessed as a group across all MIPS performance categories.

**Get help & more information**
Attachment B has further guidance, including helpful questions and answers about the Quality Payment Program. If you need more help, you can also:

- Visit qpp.cms.gov for helpful resources or
- Contact the Quality Payment Program at QPP@cms.hhs.gov or 1-866-288-8292 (Monday-Friday 8AM-8PM ET) to find local help in your community. TTY users can call 1-877-715-6222.
Attachment A: What is this?
• Explains who is included in MIPS and should actively participate.
  • Identifies included vs. exempt status.
• List the NPIs associated with the TIN.
• Provides contact information for the QPP for direct support.
Getting Started:
MIPS Participation Look-Up Tool

2. Enter your NPI into the search field and click “Check NPI.”
Getting Started: MIPS Participation Look-Up Tool—Included

MIPS Participation Status

To check if you need to submit data to MIPS, enter your 10-digit National Provider Identifier (NPI) number.

If you’re exempt from MIPS with the first review, you won’t need to do anything else for MIPS this year. If you are included in MIPS, you may be exempt with the second review of eligibility determinations at the end of 2017. Learn more about MIPS eligibility.

NATIONAL PROVIDER IDENTIFIER (NPI)

Check Now

Participation Status

JANE A. SAMPLE MD must submit data to MIPS by March 2018. This clinician will need to report as an individual or with a group.

What Can I Do Now?

Source: The Centers for Medicare & Medicaid Services
### Clinician Details

**JANE A. SAMPLE MD**

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Doctor of Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associated TINs</td>
<td>1</td>
</tr>
<tr>
<td>Enrolled in Medicare Before January 1, 2017</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### Practice Details

**JANE A. SAMPLE MD**

**1234 CLINICIAN ROAD MIPS, FL 00000-0000**

- **For this clinician at this practice**
  - Non-Patient Facing: No
  - Hospital Based: No
  - Small Practice: Yes
  - Rural: No
  - Health Professional Shortage Area (HPSA): No

- **For this practice**
  - Non-Patient Facing: No
  - Hospital Based: No
  - Small Practice: Yes
  - Rural: No
  - Health Professional Shortage Area (HPSA): No

- **Special Status At This Practice**
  [View descriptions of each special status]

- **Included in MIPS**
  - This clinician has billed Medicare for more than $30,000 and has provided care for more than 100 patients at this practice.
Getting Started:
MIPS Participation Look-Up Tool—Exempt

MIPS Participation Status

To check if you need to submit data to MIPS, enter your 10-digit National Provider Identifier (NPI) number.

If you’re exempt from MIPS with the first review, you won’t need to do anything else for MIPS this year. If you are included in MIPS, you may be exempt with the second review of eligibility determinations at the end of 2017. Learn more about MIPS eligibility.

NATIONAL PROVIDER IDENTIFIER (NPI)

Check Now

Participation Status

Exempt from MIPS

JOE D. SAMPLE ARNP is not required to submit data to MIPS for 2017 for the practice(s) listed below.
Getting Started: MIPS Participation Look-Up Tool—Exempt (cont.)

Clinician Details

JOE D. SAMPLE ARNP
XXXXXXXXXXXX

Provider Type | Nurse Practitioner
Associated TINs | 1
Enrolled in Medicare Before January 1, 2017 | Yes

Special Status At This Practice

View descriptions of each special status

Practice Details

CLINICIANS GROUP, INC.
1234 CLINICIAN ROAD MIPS, FL 00000-0000

If the clinician reports as an individual

- Exempt from MIPS
  - This clinician has billed Medicare for $30,000 or less at this practice.
- Included in MIPS
  - This practice has billed Medicare for more than $30,000 and has provided care for more than 100 patients.

If the clinician reports as a group

- Non-Patient Facing: No
- Hospital Based: No
- Small Practice: Yes
- Rural: No
- Health Professional Shortage Area (HPSA): No

For this practice

- Non-Patient Facing: No
- Hospital Based: No
- Small Practice: Yes
- Rural: No
- Health Professional Shortage Area (HPSA): No

Source: The Centers for Medicare & Medicaid Services
Eligibility for Clinicians: Specific Facilities

- Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC)
  - *Eligible clinicians billing under the RHC or FQHC payment methodologies are not subject to the MIPS payment adjustment.*

*However...*

- Eligible clinicians in a RHC or FQHC billing under the Physician Fee Schedule (PFS) are required to participate in MIPS and are subject to a payment adjustment.

Please note: MIPS-eligible clinician types who **do not exceed** the low-volume threshold will be **exempt** from MIPS.
Eligibility for Non-Patient Facing Clinicians

- Non-patient facing clinicians are eligible to participate in MIPS as long as they exceed the low-volume threshold, are not newly enrolled, and are not a Qualifying APM Participant (QP) or Partial QP that elects not to report data to MIPS.
- The non-patient facing MIPS-eligible clinician threshold for individual MIPS-eligible clinicians is \( \leq 100 \) patient facing encounters in a designated period.
- A group is non-patient facing if \( > 75 \) percent of NPIs billing under the group’s TIN during a performance period are labeled as non-patient facing.
- There are more flexible reporting requirements for non-patient facing clinicians.

Source: The Centers for Medicare & Medicaid Services
Non-Patient Facing Clinicians: Examples

- **Pathologists** who advise on appropriate testing and interpret/diagnose the changes caused by disease in tissues and body fluids
- **Radiologists** who primarily provide consultative support to a referring physician or provide image interpretation
- **Nuclear Medicine Physicians** who play an indirect role in patient care
- **Anesthesiologists** who are primarily providing supervision oversight to Certified Registered Nurse Anesthetists

Source: The Centers for Medicare & Medicaid Services
Participation for Clinicians in Specific Facilities

• Hospital-based
  – Clinicians are considered hospital-based if they provide **75 percent or more** of their services in an:
    • Inpatient hospital
    • On-campus outpatient hospital; or
    • Emergency room
  – Hospital-based clinicians **are subject to MIPS** if they exceed the low-volume threshold and should report the Quality and Improvement Activities performance categories.
    • Hospital-based MIPS-eligible clinician types qualify for an **automatic reweighting** of the **Advancing Care Information** performance category to zero. However, they can still choose to report if they would like, and, if data is submitted, CMS will score their performance and weight their Advancing Care Information performance accordingly.

Source: The Centers for Medicare & Medicaid Services
MIPS Reporting
What Do I Need to Know?
Pick Your Pace for Participation for the Transition Year

<table>
<thead>
<tr>
<th>Participate in an Advanced APM</th>
<th>Submit Something:</th>
<th>Submit a Partial Year:</th>
<th>Submit a Full Year:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some practices may choose to participate in an Advanced APM in 2017</td>
<td>Submit <strong>some</strong> data after January 1, 2017</td>
<td>Report for 90-day period after January 1, 2017</td>
<td>Fully participate starting January 2017</td>
</tr>
<tr>
<td>Test Pace</td>
<td>Neutral or small payment adjustment</td>
<td>Some positive payment adjustment</td>
<td>Modest positive payment adjustment</td>
</tr>
<tr>
<td>Partial Year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full Year</td>
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<td></td>
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</tbody>
</table>

Not participating in the QPP for the Transition Year will result in a negative 4 percent payment adjustment.

Source: The Centers for Medicare & Medicaid Services
MIPS: Choosing to Test for 2017

You have asked: What is a minimum amount of data?”

Submit Something

Submit a minimum of 2017 data to Medicare
Avoid a downward adjustment

1 Quality Measure

OR

1 Improvement Activity

OR

4 or 5* Required Advancing Care Information Measures

Source: The Centers for Medicare & Medicaid Services

* Depending on certified electronic health record technology (CEHRT) edition
MIPS: Partial Participation for 2017

• Submit 90 days of 2017 data to Medicare
• May earn a positive payment adjustment

“So what?” — If you are not ready on January 1, you can start anytime between January 1 and October 2

Need to send performance data by March 31, 2018

Source: The Centers for Medicare & Medicaid Services
MIPS: Full Participation for 2017

Submit a Full Year

- Submit a full year of 2017 data to Medicare
- May earn a positive payment adjustment
- Best way to earn largest payment adjustment is to submit data on all MIPS performance categories

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 Data Submission Methods

How Will I Send My Data to CMS?
Data Submission Methods: Visualization

<table>
<thead>
<tr>
<th>Quality</th>
<th>Individual</th>
<th>Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Qualified Clinical Data Registry (QCDR)</td>
<td>• QCDR (Qualified Clinical Data Registry)</td>
</tr>
<tr>
<td></td>
<td>• Qualified Registry</td>
<td>• Qualified Registry</td>
</tr>
<tr>
<td></td>
<td>• EHR</td>
<td>• EHR</td>
</tr>
<tr>
<td></td>
<td>• Claims</td>
<td>• Administrative Claims</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• CMS Web Interface (groups of 25 or more)</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>• Attestation</td>
<td>• Attestation</td>
</tr>
<tr>
<td></td>
<td>• QCDR</td>
<td>• QCDR</td>
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<tr>
<td></td>
<td>• Qualified Registry</td>
<td>• Qualified Registry</td>
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<tr>
<td></td>
<td>• EHR</td>
<td>• EHR</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>• Attestation</td>
<td>• Attestation</td>
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<td></td>
<td>• QCDR</td>
<td>• QCDR</td>
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<td></td>
<td>• EHR</td>
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Source: The Centers for Medicare & Medicaid Services
## Data Submission Methods: Mechanisms Explained

<table>
<thead>
<tr>
<th>Submission Mechanism</th>
<th>How Does It Work?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Clinical Data Registry (QCDR)</td>
<td>A QCDR is a CMS-approved entity that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients. Each QCDR typically provides tailored instructions on data submission for eligible clinicians.</td>
</tr>
<tr>
<td>Qualified Registry</td>
<td>A Qualified Registry collects clinical data from an eligible clinician or group of eligible clinicians and submits it to CMS on their behalf.</td>
</tr>
<tr>
<td>Electronic Health Record (EHR)</td>
<td>Eligible clinicians submit data directly through the use of an EHR system that is considered certified EHR technology (CEHRT). Alternatively, clinicians may work with a qualified EHR data submission vendor (DSV) who submits on behalf of the clinician or group.</td>
</tr>
<tr>
<td>Attestation</td>
<td>Eligible clinicians prove (attest) that they have completed measures or activities.</td>
</tr>
<tr>
<td>CMS Web Interface</td>
<td>A secure internet-based data submission option for groups of 25 or more eligible clinicians reporting quality data to CMS. The CMS Web Interface is partially pre-populated with claims data from the group’s Medicare Part A and B beneficiaries who have been assigned to the group. The group then completes data for the pre-populated patients.</td>
</tr>
<tr>
<td>Administrative Claims</td>
<td><em>Only available for Quality reporting.</em> Administrative claims submissions require no separate data submissions to CMS. These measures do not allow for any selection of measures or require any action by groups. CMS calculates these measures based on data available from administrative claims.</td>
</tr>
<tr>
<td>CAHPS for MIPS Survey</td>
<td>CMS-approved survey vendor that collects and submits data about the experience of care at the practice on behalf of the group.</td>
</tr>
</tbody>
</table>
Data Submission Methods: Group Registration

Registration was required for MIPS-eligible clinician types participating as a group of 25 or more that wished to report via:

- Web Interface
- CAHPS for MIPS survey

Group registration closed on June 30, 2017.

Otherwise, clinicians did not need to register their group with CMS.

CAHPS = Consumer Assessment of Healthcare Providers and Systems

Source: The Centers for Medicare & Medicaid Services
MIPS Performance Categories
What Do I Need to Know?
MIPS Performance Category: Quality—Requirements for the Transition Year

• Requirements for the Transition Year:
  
  • **Test Means...**
    — Submitting a minimum amount of data for **one** measure for 2017

  • **Partial and Full Means...**
    — Submitting at least **six** quality measures, including at least one Outcome measure, for 90 days or a full year.

  • **Quality measures vary by submission mechanism.**

Note: Groups are encouraged to select the quality measures that are most appropriate for their practice and patient population.
Select 6 of about 271 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.

The all-cause hospital readmission measure will be scored for groups that have ≥ 16 clinicians and a sufficient number of cases (no requirement to submit).
MIPS Performance Category: Cost

- No reporting requirement; 0 percent of final score in 2017
- Clinicians assessed on Medicare claims data
- CMS will still provide feedback on how you performed in this category in 2017, but it will not affect your 2019 payments.

*Keep in mind:*

- Uses measures previously used in the Physician Value-Based Modifier program or reported in the Quality and Resource Use Report (QRUR)
- Only the scoring is different

Source: The Centers for Medicare & Medicaid Services
MIPS Performance Category: IA—Requirements for the Transition Year

• Requirements for the Transition Year:

  • **Test Means...**
    - Submitting 1 Improvement Activity
    - Activity can be high or medium weight

  • **Partial and Full Means...**
    - Choosing 1 of the following combinations:
      - 2 high-weighted activities
      - 1 high-weighted activity and 2 medium-weighted activities
      - At least 4 medium-weighted activities

Source: The Centers for Medicare & Medicaid Services
MIPS Performance Category: IA—Special Consideration

15 or fewer participants, non-patient-facing clinicians, or if you are in a rural or health professional shortage area: Attest that you completed up to 2 activities for a minimum of 90 days.

Participants in certified patient-centered medical homes, comparable specialty practices, or an APM designated as a Medical Home Model: You will automatically earn full credit.

Participants in certain APMs, such as Shared Savings Program Track 1 or the 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.

Source: The Centers for Medicare & Medicaid Services
MIPS Performance Category: ACI—Requirements for the Transition Year

- **Test Means...**
  - Submitting 4 or 5 base score measures
    - Depends on use of 2014 or 2015 Edition
    - Reporting all required measures in the base score to earn any credit in the **Advancing Care Information** performance category

- **Partial and Full Means...**
  - Submitting more than the base score in year 1

Source: The Centers for Medicare & Medicaid Services
MIPS Performance Category:  
ACI Base Measure Requirements

### Advancing Care Information Objectives and Measures:

Base Score Required Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Security Risk Analysis</td>
<td>yes</td>
</tr>
<tr>
<td>e-Prescribing</td>
<td>1 patient</td>
</tr>
<tr>
<td>Provide Patient Access</td>
<td>1 patient</td>
</tr>
<tr>
<td>Send a Summary of Care</td>
<td>1 patient</td>
</tr>
<tr>
<td>Request/Accept a Summary of Care</td>
<td>1 patient</td>
</tr>
</tbody>
</table>

#### 2017 Advancing Care Information Transition Objectives and Measures:

Base Score Required Measures

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Security Risk Analysis</td>
<td>yes</td>
</tr>
<tr>
<td>e-Prescribing</td>
<td>1 patient</td>
</tr>
<tr>
<td>Provide Patient Access</td>
<td>1 patient</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>1 patient</td>
</tr>
</tbody>
</table>

Source: The Centers for Medicare & Medicaid Services

*CEHRT = Certified Electronic Health Record Technology
**MIPS Performance Category: ACI—Additional Measures**

### Advancing Care Information

**Objectives and Measures:**

**Performance Score**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Electronic Access</td>
<td>Provide Patient Access*</td>
</tr>
<tr>
<td>Patient Electronic Access</td>
<td>Patient-Specific Education</td>
</tr>
<tr>
<td>Coordination of Care through Patient Engagement</td>
<td>View, Download and Transmit (VDT)</td>
</tr>
<tr>
<td>Coordination of Care through Patient Engagement</td>
<td>Secure Messaging</td>
</tr>
<tr>
<td>Coordination of Care through Patient Engagement</td>
<td>Patient-Generated Health Data</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Send a Summary of Care*</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Request/Accept a Summary of Care*</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Clinical Information Reconciliation</td>
</tr>
<tr>
<td>Public Health and Clinical Data</td>
<td>Immunization Registry</td>
</tr>
<tr>
<td>Registry Reporting</td>
<td>Reporting</td>
</tr>
</tbody>
</table>

### 2017 Advancing Care Information Transition Objectives and Measures

**Performance Score Measures**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Electronic Access</td>
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<td>View, Download and Transmit (VDT)</td>
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<td>Patient-Specific Education</td>
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</tr>
<tr>
<td>Secure Messaging</td>
<td>Secure Messaging</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Health Information Exchange*</td>
</tr>
<tr>
<td>Medication Reconciliation</td>
<td>Medication Reconciliation</td>
</tr>
<tr>
<td>Public Health Reporting</td>
<td>Immunization Registry Reporting</td>
</tr>
</tbody>
</table>

*Performance Score:* Additional achievement on measures above the base score requirements

*Certified Electronic Health Record Technology*

Source: The Centers for Medicare & Medicaid Services

2015 CEHRT*

2014 CEHRT*
MIPS Performance Category: ACI: Flexibility

1. CMS will automatically reweight the ACI performance category to zero for MIPS clinicians who lack of Face-to-Face Patient Interaction, NP, PA, CRNAs, and CNS’
   - Reporting is optional although if clinicians choose to report, they will be scored.

2. A clinician can apply to have his performance category score weighted to zero and the 25% will be assigned to the Quality category for the following reasons:
   1. Insufficient internet connectivity
   2. Extreme and uncontrollable circumstances
   3. Lack of control over the availability of CEHRT

NP = nurse practitioner; PA = physician’s assistant; CRNAs = certified registered nurse anesthetists; CNS = certified nursing assistant

Source: The Centers for Medicare & Medicaid Services
Hospital-based MIPS clinicians qualify for an automatic reweighting of the ACI Performance Category.
- 75% or more of Medicare services performed in the inpatient, on-campus outpatient department, or emergency department
- CMS will reweight the category to zero and assign the 25% to the quality performance category.
- If data is submitted, CMS will score their performance and weight their ACI performance accordingly.
MIPS Scoring Methodology
What Do I Need to Know?
MIPS Scoring for Quality (60 Percent of Final Score in Transition Year)

Select 6 of the approximately 300 available quality measures (minimum of 90 days)
- Or a specialty set
- Or CMS Web Interface measures

Clinicians receive 3 to 10 points on each quality measure based on performance against benchmarks.

Failure to submit performance data for a measure = 0 points.

Quick Tip:
Easier for a clinician who participates longer to meet case volume criteria needed to receive more than 3 points.

Bonus points are available
- 2 points for submitting an additional outcome measure
- 1 point for submitting an additional high-priority measure
- 1 point for using CEHRT to submit measures electronically end-to-end

Source: The Centers for Medicare & Medicaid Services
MIPS Scoring for Cost
(0 Percent of Final Score in Transition Year)

No submission requirements

Clinicians assessed through claims data

Clinicians earn a maximum of 10 points per episode cost measure

Source: The Centers for Medicare & Medicaid Services
MIPS Scoring for IAs
(15 Percent 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, designated rural area, and Designated HPSA* practices; and non-patient facing MIPS-eligible clinicians or groups

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

*HPSA = Health Professional Shortage Area

Source: The Centers for Medicare & Medicaid Services
MIPS Performance Category: ACI
(25 Percent of Final Score in Transition Year)

- **Earn up to 155 percent maximum score**, which will be capped at 100 percent.

![Diagram]

- **Base Score**: 50%
- **Performance Score**: 90%
- **Bonus Score**: 15%

**Final Score**

Earn 100 or more percent and receive FULL 25 points of the total ACI Performance Category Final Score.

The overall ACI score would be made up of a base score, a performance score, and a bonus score for a maximum score of a 100 percentage points.

**Keep in mind**: You need to fulfill the Base score or you will get a zero in the ACI Performance Category.
### ACI Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Performance Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide Patient Access</td>
<td>Up to 10%</td>
</tr>
<tr>
<td>Patient-Specific Education</td>
<td>Up to 10%</td>
</tr>
<tr>
<td>View, Download, Transmit (VDT)</td>
<td>Up to 10%</td>
</tr>
<tr>
<td>Secure Messaging</td>
<td>Up to 10%</td>
</tr>
<tr>
<td>Patient-Generated Health Data</td>
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</tr>
<tr>
<td>Send a Summary of Care</td>
<td>Up to 10%</td>
</tr>
<tr>
<td>Request/Accept a Summary of Care</td>
<td>Up to 10%</td>
</tr>
<tr>
<td>Clinical Information Reconciliation</td>
<td>Up to 10%</td>
</tr>
<tr>
<td>Immunization Registry Reporting</td>
<td>0 or 10%</td>
</tr>
</tbody>
</table>

### ACI Transitional Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Performance Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide Patient Access</td>
<td>Up to 20%</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Up to 20%</td>
</tr>
<tr>
<td>View, Download, Transmit (VDT)</td>
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</tr>
<tr>
<td>Patient-Specific Education</td>
<td>Up to 10%</td>
</tr>
<tr>
<td>Secure Messaging</td>
<td>Up to 10%</td>
</tr>
<tr>
<td>Medication Reconciliation</td>
<td>Up to 10%</td>
</tr>
<tr>
<td>Immunization Registry Reporting</td>
<td>0 or 10%</td>
</tr>
</tbody>
</table>

### 2015 CEHRT*

<table>
<thead>
<tr>
<th>Measure</th>
<th>Performance Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide Patient Access</td>
<td>Up to 10%</td>
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<tr>
<td>View, Download, Transmit (VDT)</td>
<td>Up to 10%</td>
</tr>
<tr>
<td>Secure Messaging</td>
<td>Up to 10%</td>
</tr>
<tr>
<td>Patient-Generated Health Data</td>
<td>Up to 10%</td>
</tr>
<tr>
<td>Send a Summary of Care</td>
<td>Up to 10%</td>
</tr>
<tr>
<td>Request/Accept a Summary of Care</td>
<td>Up to 10%</td>
</tr>
<tr>
<td>Clinical Information Reconciliation</td>
<td>Up to 10%</td>
</tr>
<tr>
<td>Immunization Registry Reporting</td>
<td>0 or 10%</td>
</tr>
</tbody>
</table>

### 2014 CEHRT*

<table>
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<tr>
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<th>Performance Score</th>
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</thead>
<tbody>
<tr>
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<td>Up to 20%</td>
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<tr>
<td>Health Information Exchange</td>
<td>Up to 20%</td>
</tr>
<tr>
<td>View, Download, Transmit (VDT)</td>
<td>Up to 10%</td>
</tr>
<tr>
<td>Patient-Specific Education</td>
<td>Up to 10%</td>
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<tr>
<td>Secure Messaging</td>
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<tr>
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</tr>
<tr>
<td>Immunization Registry Reporting</td>
<td>0 or 10%</td>
</tr>
</tbody>
</table>

*CEHRT = Certified Electronic Health Record Technology

Source: The Centers for Medicare & Medicaid Services
MIPS Scoring for ACI
Additional Measures Scoring (cont.)

Performance Score (worth up to 90 percent)

- Report up to 9 ACI Measures
  - 2015 CEHRT*
- OR
- Report up to 7 2017 ACI Transition Measures
  - 2014 CEHRT*

Each measure is worth 10–20%. The percentage score is based on the performance rate for each measure:

<table>
<thead>
<tr>
<th>Performance Rate 1–10</th>
<th>1%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Rate 11–21</td>
<td>2%</td>
</tr>
<tr>
<td>Performance Rate 21–30</td>
<td>3%</td>
</tr>
<tr>
<td>Performance Rate 31–40</td>
<td>4%</td>
</tr>
<tr>
<td>Performance Rate 41–50</td>
<td>5%</td>
</tr>
<tr>
<td>Performance Rate 51–60</td>
<td>6%</td>
</tr>
<tr>
<td>Performance Rate 61–70</td>
<td>7%</td>
</tr>
<tr>
<td>Performance Rate 71–80</td>
<td>8%</td>
</tr>
<tr>
<td>Performance Rate 81–90</td>
<td>9%</td>
</tr>
<tr>
<td>Performance Rate 91–100</td>
<td>10%</td>
</tr>
</tbody>
</table>

*CEHRT = Certified Electronic Health Record Technology
MIPS Scoring for ACI
Bonus Score

For reporting on one or more of the following Public Health and Clinical Data Registry Reporting measures:
- Syndromic Surveillance Reporting (14 and 15)
- Specialized Registry Reporting (14)
- Electronic Case Reporting (15)
- Public Health Registry Reporting (15)
- Clinical Data Registry Reporting (15)

5% Bonus

For using CEHRT to report certain Improvement Activities:

10% Bonus

Source: The Centers for Medicare & Medicaid Services
## MIPS Performance Category: ACI
### Improvement Activities Eligible for ACI Bonus

<table>
<thead>
<tr>
<th>IA Performance Category Subcategory</th>
<th>Activity Name</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expanded Access Practice</td>
<td>Provide 24/7 access to eligible clinicians or groups who have real-time access to patient’s medical record</td>
<td>High</td>
</tr>
<tr>
<td>Population Management</td>
<td>Anticoagulant management improvements</td>
<td>High</td>
</tr>
<tr>
<td>Population Management</td>
<td>Glycemic management services</td>
<td>High</td>
</tr>
<tr>
<td>Population Management</td>
<td>Chronic care and preventive care management for empaneled patients</td>
<td>Medium</td>
</tr>
<tr>
<td>Population Management</td>
<td>Implementation of methodologies for improvements in longitudinal care management for high risk patients</td>
<td>Medium</td>
</tr>
<tr>
<td>Population Management</td>
<td>Implementation of episodic care management practice improvements</td>
<td>Medium</td>
</tr>
<tr>
<td>Population Management</td>
<td>Implementation of medication management practice improvements</td>
<td>Medium</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>Implementation of use of specialist reports back to referring clinician or group to close referral loop</td>
<td>Medium</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>Implementation of documentation improvements for practice/process improvements</td>
<td>Medium</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>Implementation of practices/processes for developing regular individual care plans</td>
<td>Medium</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>Practice improvements for bilateral exchange of patient information</td>
<td>Medium</td>
</tr>
<tr>
<td>Beneficiary Engagement</td>
<td>Use of certified EHR to capture patient reported outcomes</td>
<td>Medium</td>
</tr>
<tr>
<td>Beneficiary Engagement</td>
<td>Engagement of patients through implementation of improvements in patient portal</td>
<td>Medium</td>
</tr>
<tr>
<td>Beneficiary Engagement</td>
<td>Engagement of patients, family, and caregivers in developing a plan of care</td>
<td>Medium</td>
</tr>
<tr>
<td>Patient Safety and Practice Assessment</td>
<td>Use of decision support and standardized treatment protocols</td>
<td>Medium</td>
</tr>
<tr>
<td>Achieving Health Equity</td>
<td>Leveraging a QCDR to standardize processes for screening</td>
<td>Medium</td>
</tr>
<tr>
<td>Integrated Behavioral and Mental Health</td>
<td>Implementation of integrated primary care behavioral health (PCBH) model</td>
<td>High</td>
</tr>
<tr>
<td>Integrated Behavioral and Mental Health</td>
<td>EHR Enhancements for behavioral health (BH) data capture</td>
<td>Medium</td>
</tr>
</tbody>
</table>
Calculating the Final Score Under MIPS

Final Score =

- Clinician Quality performance category score $\times$ actual Quality performance category weight
- Clinician Cost performance category score $\times$ actual Cost performance category weight
- Clinician Improvement Activities performance category score $\times$ actual Improvement Activities performance category weight
- Clinician ACI performance category score $\times$ actual ACI performance category weight

Source: The Centers for Medicare & Medicaid Services
### Final Score vs Payment Adjustment

<table>
<thead>
<tr>
<th>Final Score</th>
<th>Payment Adjustment</th>
</tr>
</thead>
</table>
| ≥70 points  | • Positive adjustment  
             | • Eligible for exceptional performance bonus—minimum of additional 0.5% |
| 4–69 points | • Positive adjustment  
             | • Not eligible for exceptional performance bonus |
| 3 points    | • Neutral payment adjustment |
| 0 points    | • Negative payment adjustment of -4%  
             | • 0 points = does not participate |

Source: The Centers for Medicare & Medicaid Services
Part 2: How to Prepare for and Participate in MIPS
Preparing and Participating in MIPS: A Checklist

- Determine your eligibility and understand the requirements.
- Choose whether you want to submit data as an individual or as a part of a group.
- Choose your submission method and verify its capabilities.
- Verify your EHR vendor or registry’s capabilities before your chosen reporting period.
- Prepare to participate by reviewing practice readiness, ability to report, and the Pick Your Pace options.
- Choose your measures. Visit qpp.cms.gov for valuable resources on measure selection and remember to review your current billing codes and Quality Resource Use Report to help identify measures that best suit your practice.
- Verify the information you need to report successfully.
- Care for your patients and record the data.
- Submit your data by March 31, 2018.

Source: The Centers for Medicare & Medicaid Services
How Do I Get Help?
Technical Assistance for Clinicians

CMS has free resources and organizations on the ground to provide help to clinicians who are eligible for the QPP:

**PRIMARY CARE & SPECIALIST PHYSICIANS**
Transforming Clinical Practice Initiative

- Supports more than 140,000 clinician practices through active, collaborative and peer-based learning networks over 4 years.
- Practice Transformation Networks (PTNs) and Support Alignment Networks (SANs) are located in all 50 states to provide comprehensive technical assistance, as well as tools, data, and resources to improve quality of care and reduce costs.
- The goal is to help practices transform over time and move toward Advanced Alternative Payment Models.
- Contact TCPIISC@TruvenHealth.com for extra assistance.

**SMALL & SOLO PRACTICES**
Small, Underserved, and Rural Support (SURS)

- Provides outreach, guidance, and direct technical assistance to clinicians in solo or small practices (15 or fewer), particularly those in rural and underserved areas, to promote successful health IT adoption, optimization, and delivery system reform activities.
  - Assistance will be tailored to the needs of the clinicians.
  - There are 11 SURS organizations providing assistance to small practices in all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands.
  - For more information or for assistance getting connected, contact QPPSURS@IMPAQINT.COM.

**LARGE PRACTICES**
Quality Innovation Networks-Quality Improvement Organizations (QIN-QIO)

- Supports clinicians in large practices (more than 15 clinicians) in meeting Merit-Based Incentive Payment System requirements through customized technical assistance.
- Includes one-on-one assistance when needed.
- There are 14 QIN-QIOs that serve all 50 states, the District of Columbia, Guam, Puerto Rico, and Virgin Islands.

**TECHNICAL SUPPORT**
All Eligible Clinicians Are Supported By:

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

- Quality Payment Program Service Center
  Assists with all Quality Payment Program questions.
  1-866-288-8292 TTY: 1-877-715-6222 QPP@cms.hhs.gov

- Center for Medicare & Medicaid Innovation (CMMI) Learning Systems
  Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs. More information about the Learning Systems is available through your model's support inbox.

Source: The Centers for Medicare & Medicaid Services
Request the appropriate technical assistance now!

- **QPP support for practices with 15 or less clinicians under TIN**, visit [https://goo.gl/MTGhua](https://goo.gl/MTGhua)

- **QPP support for practices with 16 or more clinicians under TIN**, visit [https://www.hsag.com/QPPEnroll](https://www.hsag.com/QPPEnroll)
Questions
Thank you!

Denise Hudson, NR-CMA
Health Informatics Specialist
This material was adapted by Health Services Advisory Group, the Medicare Quality Improvement Organization for Florida, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services, based on original content from CMS. The contents presented do not necessarily reflect CMS policy.
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