How to be Successful in the Quality Payment Program

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Presented by
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Objectives

- Participants will understand the four components of the Quality Payment Program
  1. Quality
  2. Advancing Care Information
  3. Clinical Practice Improvement Activities
  4. Cost
- Participants will understand who an eligible Provider is under the Quality Payment Program
- Participants will understand how to choose their Quality Measures
- Participants will know how to choose their improvement activities
CMS support of health care Delivery System Reform will result in better care, smarter spending, and healthier people.

**Key characteristics**
- Producer-centered
- Incentives for volume
- Unsustainable
- Fragmented Care

**Key characteristics**
- Patient-centered
- Incentives for outcomes
- Sustainable
- Coordinated care

**Systems and Policies**
- Fee-For-Service Payment Systems

**Systems and Policies**
- Value-based purchasing
- Accountable Care Organizations
- Episode-based payments
- Medical Homes
- Quality/cost transparency
The Quality Payment Program

- **MACRA** = Quality Payment Program for Medicare reimbursement to more than 600,000 Eligible Clinicians
- Serving 55 million Americans on Medicare
- A major step moving health care to pay for quality rather than volume
- Will continue to evolve over time
Polling Question #1

► How many clinicians including mid-levels do you have in your office?
The Program

The Quality Payment Program policy will:
- Reform Medicare Part B payments for more than 600,000 clinicians
- Improve care across the entire health care delivery system

Clinicians have two tracks to choose from:

**MIPS**

The Merit-based Incentive Payment System (MIPS)

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

**Advanced APMs**

Advanced Alternate Payment Models (APMs)

*If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.*
What is MIPS?

Combines legacy programs into single, improved reporting program

- PQRS
- VM
- EHR

Legacy Program Phase Out

- Last Performance Period: 2016
- PQRS Payment End: 2018
MIPS or an Advanced APM Program Cycle

- Performance Year: 2017
- Data Submission: March 31, 2018
- Feedback Available
- Adjustment: January 1, 2019
MIPS Payment Adjustments

2017  2018  2019  2020  2021  2022

± 4%  ± 5%  ± 7%  ± 9%

OR

Participate in the Advanced APM path:
If you receive 25% of Medicare payments or see 20% of your Medicare patients through an Advanced APM in 2017, then you earn a 5% incentive payment in 2019.
## 2019 (First Year) Penalty Risks Compared

<table>
<thead>
<tr>
<th>Prior Law</th>
<th>2019 adjustments</th>
<th>MIPS factors</th>
<th>2019 scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>PQRs</td>
<td>-2%</td>
<td>Quality measurement</td>
<td>60% of score</td>
</tr>
<tr>
<td>MU</td>
<td>-5%</td>
<td>Advancing Care Info.</td>
<td>25% of score</td>
</tr>
<tr>
<td>VBM</td>
<td>-4% or more*</td>
<td>Resource use</td>
<td>0% of score</td>
</tr>
<tr>
<td>Total penalty risk</td>
<td>-11% or more*</td>
<td>Improvement Activities</td>
<td>15% of score</td>
</tr>
<tr>
<td>Bonus potential (VBM only)</td>
<td>Unknown (budget neutral)*</td>
<td>Total penalty risk</td>
<td>Max of -4%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bonus potential</td>
<td>Max of 4%, plus potential 10% for high performers</td>
</tr>
</tbody>
</table>
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
  - OR
  - See 100 or fewer Medicare Part B patients a year

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

Dr. “A.” is:
• An eligible clinician
• Billed $100,000 in Medicare Part B charges
• Saw 110 patients

Therefore, Dr. A. would be ELIGIBLE for MIPS.

Remember: To be eligible
BILLING > $30,000 AND > 100
MIPS Four Performance Categories

Quality
Replaces the Physician Quality Reporting System (PQRS).

Improvement Activities
New category.

Advancing Care Information
Replaces the Medicare EHR Incentive Program also known as Meaningful Use.

Cost
Replaces Value-Based Modifier.
Pick Your Pace in MIPS For 2017

- Don’t participate – receive a (-4%) payment adjustment
- Submit one quality measure or one improvement activity – avoids the negative adjustment
- Submit 90 days of data – you may earn a neutral or small positive payment adjustment
- Submit a full year of data – you may earn a moderate positive payment adjustment
MIPS: Choosing to Test for 2017

- Submit minimum amount of 2017 data to Medicare
- Avoid a downward adjustment
- Gain familiarity with the program

Minimum Amount of Data

1. Quality Measure
   OR
   1. Improvement Activity
   OR
   4 or 5* Required Advancing Care Information Measures
MIPS: Partial Participation for 2017

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

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

Need to send performance data by March 31, 2018
MIPS: Full Participation for 2017

- 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
No Cost Category for 2017
MIPS Component Weights (When Fully Transitioned)
Polling Question #2

Did you participate in PQRS in 2016?

- Yes
- No
- N/A
Most participants: Report up to 6 quality measures, including an outcome measure, for a minimum of 90 days.

Groups using the web interface: Report 15 quality measures for a full year.

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

300 measures available
Selected Specialty Measure Set Categories

- Allergy/Immunology
- Anesthesiology
- Cardiology
- Dermatology
- Diagnostic Radiology
- Electrophysiology Cardiac Specialist
- Emergency Medicine
- Gastroenterology
- General Oncology
- General Practice/Family Medicine
- General Surgery
- Hospitalists
- Internal Medicine
- Interventional Radiology

- Mental/Behavioral Health
- Neurology
- Obstetrics/Gynecology
- Ophthalmology
- Orthopedic Surgery
- Otolaryngology
- Pathology
- Pediatrics
- Physical Medicine
- Plastic Surgery
- Preventive Medicine
- Radiation Oncology
- Rheumatology
- Thoracic Surgery
- Urology
- Vascular Surgery
MIPS Scoring for Quality
(60% 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
- Readmission measure is included for group reporting with groups with at least 16 clinicians and sufficient cases

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

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

Bonus points are available
Measures for Primary Care

WWW.QPP.CMS.GOV

1. What PQRS measures have you reported in the past?
2. Do you have any quality measures you are working on with other payers?
3. What is the top 5 diagnosis of patients seen in your office?
4. Who is responsible for quality in your office?
5. What method do you plan on using to report your measures?
Measures for Specialty Care

1. What PQRS measures have you reported in the past?
2. Do you have any quality measures you are working on with other payers?
3. What is the top 5 diagnosis of patients seen in your office?
4. Who is responsible for quality in your office?
5. What method do you plan on using to report your measures?
6. Is there a measure set for your specialty?

WWW.QPP.CMS.GOV
Improvement Activities

► Must perform selected activities for 90 consecutive days
► Must attest each activity performed for 90-day period by selecting “Yes” during reporting
► May report activities through:
  – Qualified Registry
  – Electronic Health Record (EHR)
  – Qualified Clinical Data Registry (QCDR)
  – CMS Web Interface (for groups of 25 clinicians or more)
MIPS Performance Category: Improvement Activities

- No clinician or group has to attest to more than 4 activities
- **Special consideration for:**
  - Practices with 15 or fewer clinicians
  - Rural or geographic HPSA
  - Non-patient facing
  - APM
  - Certified Medical Home

- **Keep in mind:** This is a new category
Goals of Improvement Activities

- Highlight improved beneficiary health outcomes, patient engagement and safety based on evidence.
- Reduce health disparities
- Contribute to improvement in patient care practices or improvement in performance on quality measures and cost performance categories.

New Measures will be added each year and posted no later than November 1 for 2017 for reporting in 2018.
MIPS Performance Category: Improvement Activities

- Attest to participation in activities that improve clinical practice
  - Examples: Shared decision making, patient safety, coordinating care, increasing access

- **Clinicians choose** from 90+ activities under 9 subcategories:

|-----------------------------|--------------------------|---------------------|
Select from 93 Possible IAs

- Additional improvements in access as a result of QIN/QIO TA
- Annual registration in the Prescription Drug Monitoring Program
- Chronic care and preventative care management for empaneled patients
- Completion of training and receipt of approved waiver for provision opioid medication-assisted treatments
- Depression screening
- Diabetes screening
- Engagement with QIN-QIO to implement self-management training programs
- Implementation of antibiotic stewardship program
- Integration of patient coaching practices between visits
- Measurement and improvement at the practice and panel level
- Participation in AAFP MOC Part IV
- Population empanelment
- TCPI participation
- Unhealthy alcohol use
- Tobacco use
- Use of telehealth services that expand practice access

*Free assistance from QIN/QIO
Cost – Not Included in 2017

Cost Measures from VM

1. Medicare Spending Per Beneficiary (MSPB)
2. Total Per-Capita Cost for All Attributed Beneficiaries

*VM – Value Modifier or Value Based Payment Modifier data available On Quality Resource Use Report (QRUR)
Quality Performance: Assessment Tools Available Now

- PQRS Feedback report
- Health Plan HEDIS Report
- QRUR Report – Quality Resource Use Report
Where do I access the QRUR?

QRURs are available at the TIN level and accessed via the CMS Enterprise Portal (portal.cms.gov) by authorized individuals of solo or group practices.
How to Obtain Your Solo Provider’s Report Through Your EIDM

► A solo practitioner is defined as a TIN with only 1 EP, as identified by an NPI, that bill under the TIN.

► One person must first sign up for an EIDM account with the Individual Practitioner role.

► If you do not have an account, access: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/Guide-for-Completing-EIDM-Account-setup-for-Migrating-IACS-Users.pdf
A group is defined as a TIN with 2 or more eligible professionals (EPs), as identified by their National Provider Identifier (NPI), that bill under the TIN.

To access a group's QRUR, one person from the group must first sign up for an EIDM account with the Security Official role.

If you do not have an account or correct access, visit https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/Guide-for-Completing-EIDM-Account-setup-for-Migrating-IACS-Users.pdf
Your TIN’S 2017 Value Modifier

Average Quality, Average Cost = Neutral Adjustment (0.0%)

Your ACO’s performance was determined to be average on quality measures. As a participant in a Shared Savings Program ACO in 2015, your TIN’s cost composite is classified as Average Cost.

This means that the Value Modifier applied to payments for items and services under the Medicare Physician Fee Schedule for physicians billing under your TIN in 2017 will result in a neutral adjustment, meaning no adjustment (0.0%)

The scatter plot below shows how your TIN (“You” diamond) compares to a representative sample of other TINs on the Quality Composite scores used to calculate the 2017 Value Modifier.

Note: The scatter plot shows performance among a representative sample of all TINs with Quality and Cost.
Value Modifier for 2017

The Value Modifier calculated for your TIN is shown in the highlighted cell in Exhibit 1. The Value Modifier applied to payments for items and services under the Medicare Physician Fee Schedule for physicians billing under your TIN in 2017 will result in a neutral adjustment, meaning no adjustment (0.0%).

Exhibit 1. 2017 Value Modifier Payment Adjustments under Quality-Tiering (Shared Savings Program Participant TINs with Fewer Than 10 Eligible Professionals)

<table>
<thead>
<tr>
<th></th>
<th>Low Cost</th>
<th>Average Cost</th>
<th>High Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Quality</td>
<td>Does not apply</td>
<td>Does not apply</td>
<td>Does not apply</td>
</tr>
<tr>
<td>Average Cost</td>
<td>0.0%</td>
<td>0.0%</td>
<td>+1.0 x AF</td>
</tr>
<tr>
<td>High Cost</td>
<td>Does not apply</td>
<td>Does not apply</td>
<td>Does not apply</td>
</tr>
</tbody>
</table>

Exhibit 2. Your TIN’s Quality Composite Score

Low Quality  Average Quality  High Quality

Standard Deviations from the Peer Group Mean (Positive Scores Are Better)
Exhibit 2 - Your TIN’S Quality Tier

Quality Composite Score Classified into one of three tiers
- High
- Average
- Low
Your TIN’S Cost Tier: Average

The Cost Composite Score for participants of a Shared Savings Program ACO is provided in this report for informational purposes only and is based on the TIN’s cost performance, not the ACO’s cost performance.

Exhibit 4. Your TIN’s Cost Composite Score

<table>
<thead>
<tr>
<th>Low Cost</th>
<th>Average Cost</th>
<th>High Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤ -4.0</td>
<td>You 0.03</td>
<td>≥ 4.0</td>
</tr>
<tr>
<td>-3.5</td>
<td></td>
<td></td>
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<tr>
<td>-3.0</td>
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<tr>
<td>-2.5</td>
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<td>2.5</td>
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<td>3.0</td>
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<tr>
<td>3.5</td>
<td></td>
<td></td>
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<tr>
<td>≥ 4.0</td>
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Standard Deviations from the Peer Group Mean (Negative Scores Are Better)
Resources

► QRUR Help Desk by email at vhelpdesk@cms.hhs.gov or by phone at 888-734-6433 (select option 3) with questions or feedback about this report.

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 2018.
Polling Question #3

How are you planning on Participating in the Quality Payment Program this year?

- Full Year Submission
- Partial Year Submission
- Test Year
- Not Participating
- N/A
CMS QPP Website and PORTAL

https://QPP.cms.gov

Modernizing Medicare to provide better care and smarter spending for a healthier America.

What's the Quality Payment Program?
The Quality Payment Program improves Medicare by helping you focus on care quality and the one thing that matters most — making patients healthier. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate formula, which
Questions?

For Additional Assistance

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(>15 Clinicians)

QPPSURS@alliantquality.org
(<16 Clinicians)