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Quality Payment Program 2019: Mapping a Route to Success

MA Association of Patient Account Management – December 14th, 2018

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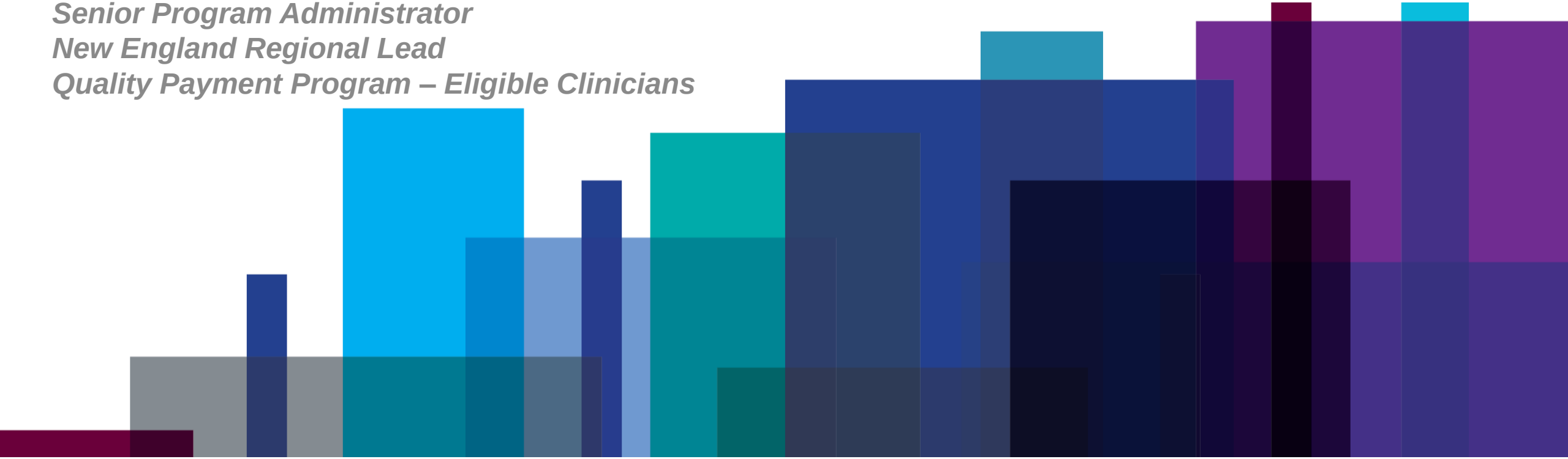
Quality Payment Program – Eligible Clinicians



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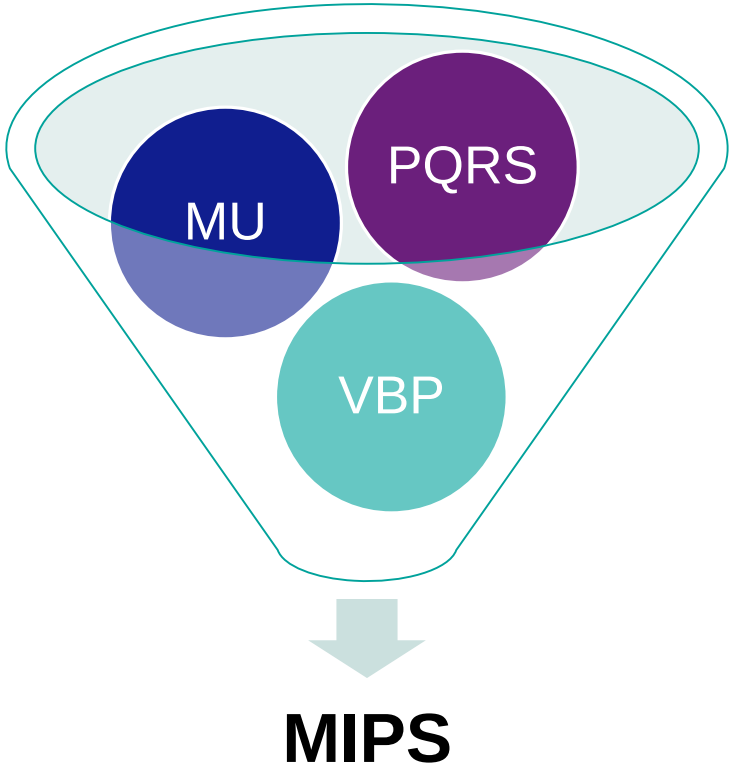
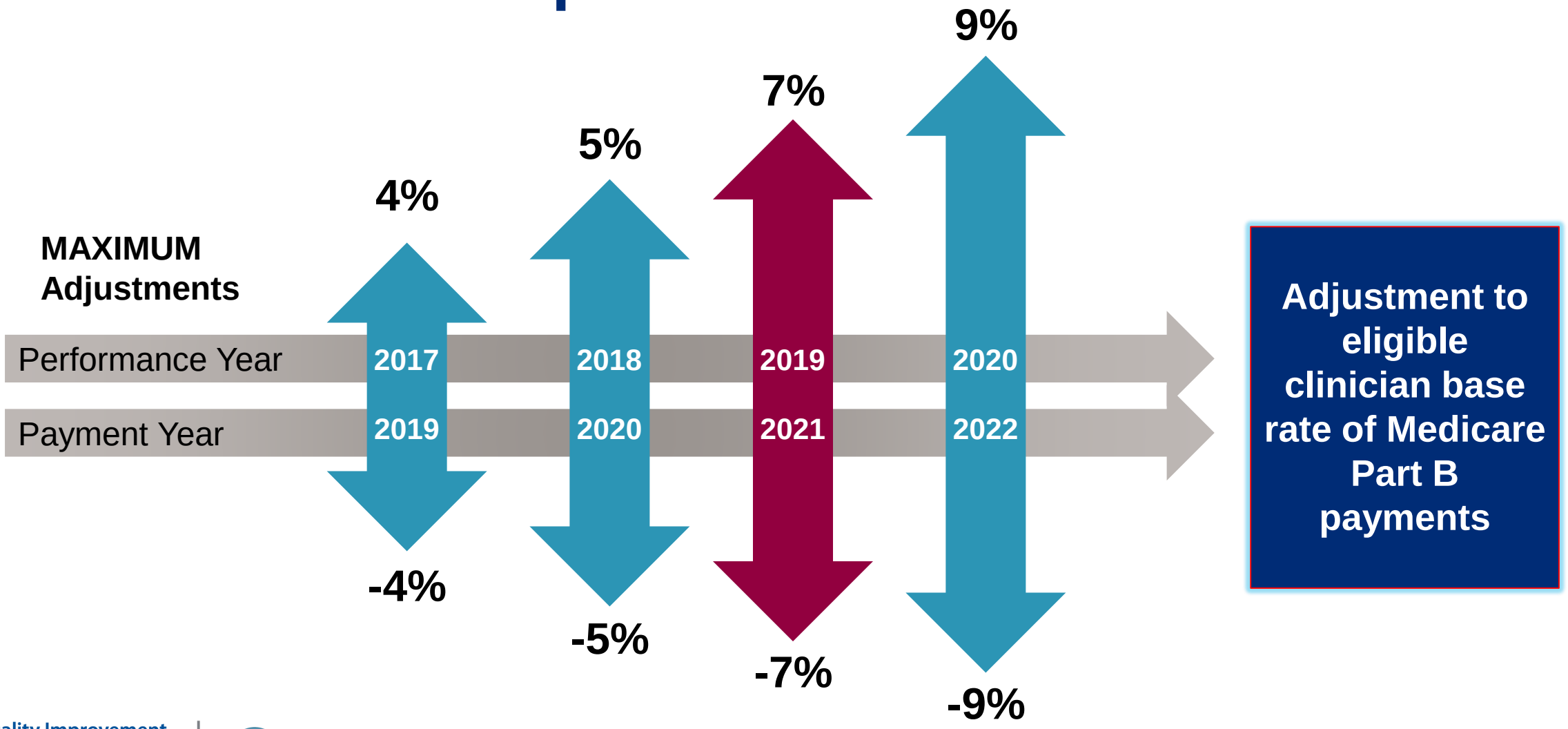
Agenda

- MIPS Program Overview
- Eligibility and Participation
- Performance Categories
  - Quality
  - Promoting Interoperability
  - Improvement Activities
  - Cost
- General Updates
  - Virtual Groups
  - Data Submission
- Alternative Payment Models
- Questions and Open Discussion
- Resources

Merit-based Incentive Payment System (MIPS)



MIPS Financial Impact



Eligibility and Participation

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Eligibility – Clinician Types

- Physicians (MD, DO)
- Physician Assistants
- Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Clinical Nurse Specialists
- Physical Therapists
- Occupational Therapists
- Speech-Language Pathologists
- Audiologists
- Clinical Psychologists
- Registered Dieticians/Nutrition Professionals

Eligibility – Low-volume Threshold

Annual claims

- Submit at least $90,000 in Medicare Part B claims for covered professional services from the Physician Fee Schedule

Unique patients

- Treat at least 200 Medicare beneficiaries annually

Covered professional services

- Submit more than 200 covered professional services under the Physician Fee Schedule

MIPS Participation

Required Participation

- EC meets all three low-volume threshold criteria
- Must submit performance data to CMS to receive a performance score
- Will receive a positive or negative payment adjustment based on performance

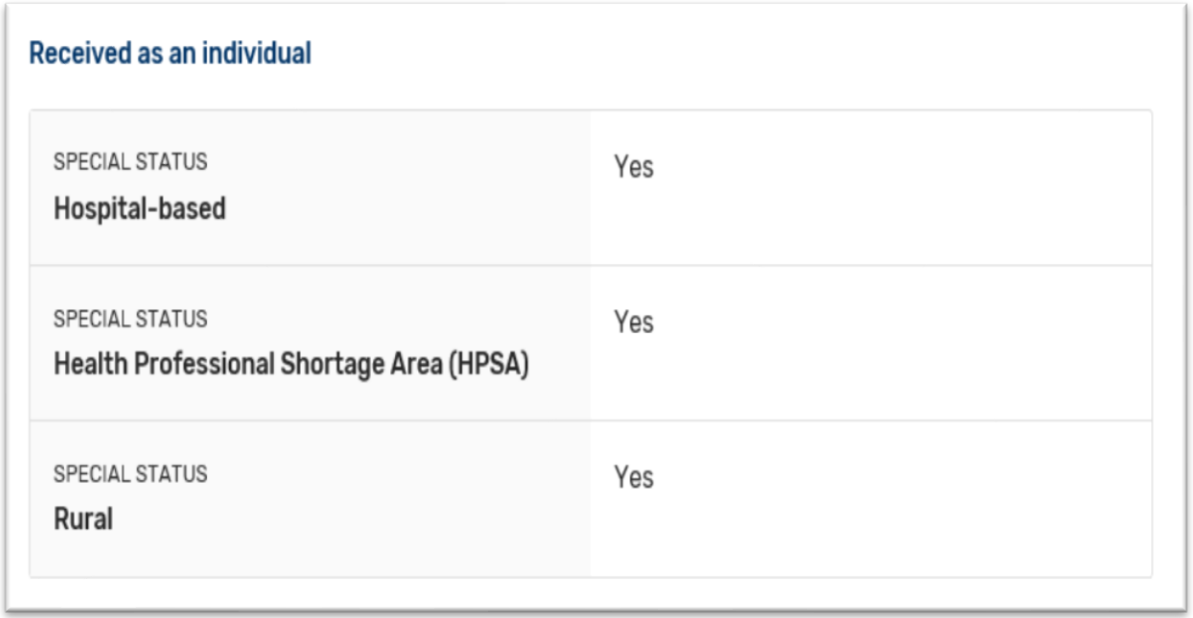
Opt-in Participation

- EC meets one or two low-volume threshold criteria
- Will submit performance data to CMS to receive a performance score
- Will receive a positive or negative payment adjustment based on performance

Voluntary Participation

- EC is ineligible due to low-volume threshold
- Able to submit performance data to CMS to receive a performance score
- Will not receive a positive or negative payment adjustment based on performance

Special Status Determination



- **Hospital-based** – furnish more than 75% of covered professional services at POS 21, 22, 23

- **ASC-based** – furnish more than 75% of covered professional services at POS 24
- **Non-patient Facing** – bill for less than 100 patient facing encounters during determination period
- **Small Practice** – ≤15 eligible clinicians
- **HPSA** – practice designation under the Public Health Service Act
- **Rural** – practice zip code designation by the Health Resources and Services Administration

Special Status FAQs

What if I am excluded as an individual but part of a group?

- ECs that are individually excluded are not required to submit data to CMS
  - If that EC is part of group that chooses to report as a group, all NPIs within the group must be included in all data reports, so that EC would be included in the group's data submission

Do hospital-based groups submit Promoting Interoperability data?

- In order for a hospital-based group to be excluded from submitting Promoting Interoperability data, 100% of the group's ECs must be hospital-based ECs
- Non-patient facing or ASC-based groups must be comprised of at least 75% non-patient facing or ASC-based ECs to receive exclusion

Determination Periods

Determination Period #1

October 1st, 2017

September 30th, 2018

*With 30-day claims run out

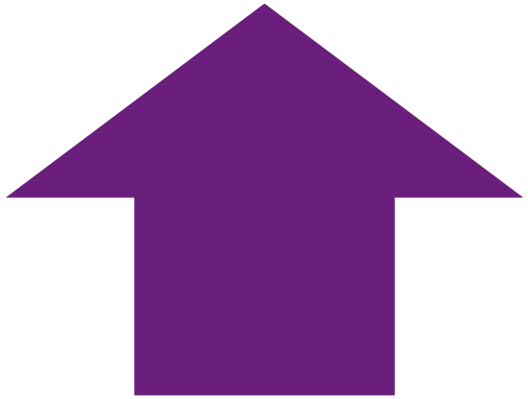
Determination Period #2

October 1st, 2018

September 30th, 2019

MIPS Performance Threshold

Earn at least **30 MIPS points** to earn a positive payment adjustment



Earn **75 MIPS points** or more to be eligible for the exceptional performer bonus

MIPS Performance Categories

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Quality Performance Category

Report on six or more quality measures

Include at least one outcome or high priority measure

Bonus points available for end-to-end reporting, additional outcome/high priority measures

Full calendar year reporting period (January 1 – December 31, 2019)

Must meet data completeness requirements

45% of MIPS score*

Quality Performance Category – Small Practices

Claims-based

ECs in small practices (<15 ECs) may still submit quality measure data via claims-based reporting (as an individual or group)

Bonus Points

ECs in small practices will earn 6 bonus points that will be applied to the quality performance category numerator

Facility-based Measures Eligibility

Clinicians that furnish at least 75% of their covered professional service in Place of Service (POS) 21 (inpatient hospital), 22 (on-campus outpatient hospital) or 23 (emergency department)

- Must have at least one service billed as POS 21 or 23
- There must be a Hospital VBP Program Total Performance Score present (facility at which the clinician or group provided services to the most Medicare beneficiaries during the year claims are drawn)

Quality Measures – Opportunities for Success

Care plan

Quality ID 047 – high priority

Closing the Referral Loop: Receipt of Specialist Report

Quality ID 347 – high priority

Documentation of Current Medications in the Medical Record

Quality ID 130 – high priority

Falls: Risk Assessment

Quality ID 154 – high priority

Use of High-Risk Medications in the Elderly

Quality ID 238 – high priority

Diabetes: Hemoglobin A1c Poor Control (>9)

Quality ID 001 – outcome, high priority

Promoting Interoperability Performance Category

Report on five required measures

Two bonus measures – opioid prescribing-related

Security Risk Analysis is required and does not earn points

At least 90-day, continuous reporting period

2015 certified EHR technology is required

25% of MIPS score*

Promoting Interoperability Measures

Objective	Measure	Max Points	Exclusion – Reweighting
Electronic Prescribing	ePrescribing	10	Yes – Points evenly distributed to the Health Information Exchange measures
	Query of Prescription Drug Monitoring Program	5 (bonus)	N/A
	Verify Opioid Treatment Agreement	5 (bonus)	N/A
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	20	Yes – Reweighting information not available based on current rule making
	Support Electronic Referral Loops by Receiving and Incorporating Health Information	20	Yes – Reweighted to Support Electronic Referral Loops by Sending Health Information
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	40	No
Public Health and Clinical Data Exchange	<u>Choose two of the following:</u> Immunization Registry Reporting Electronic Case Reporting Public Health Registry Reporting Clinical Data Registry Reporting Syndromic Surveillance Reporting	10	Yes – Reweighted to Provide Patients Electronic Access to Their Health Information

Promoting Interoperability Performance Category

Special Status Considerations

- Automatic Promoting Interoperability category reweighting for ECs that are considered to be:
  - Hospital-based
  - Non-patient facing
  - Ambulatory-surgery center-based

If ECs are part of group, group may still need to submit PI data

Eligible Clinician Types

- Automatic Promoting Interoperability category reweighting for the following EC types:

❑ Physician Assistants

❑ Nurse Practitioners

❑ Certified Register Nurse Anesthetists

❑ Clinical Nurse Specialists

❑ Physical Therapists

❑ Occupational Therapists

❑ Speech-Language Pathologists

❑ Clinical Psychologists

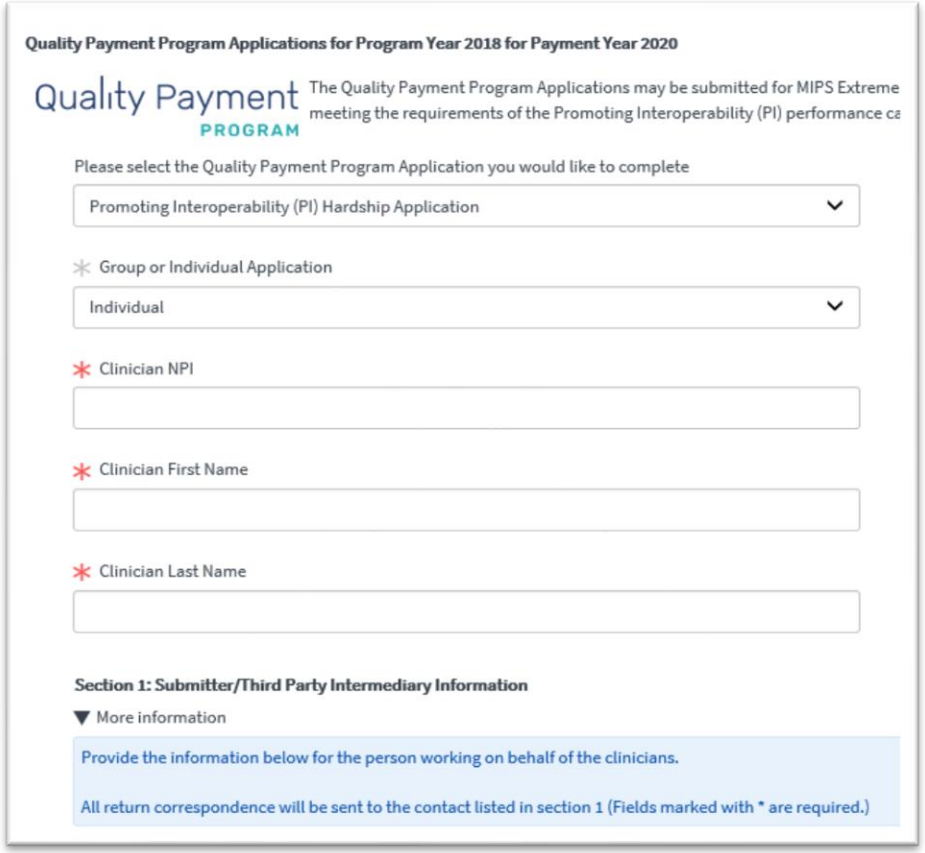
❑ Audiologists

❑ Registered Dieticians/Nutritional Professionals

Promoting Interoperability Hardship Exception

- Eligible clinicians and groups can submit an application citing:
  - Part of a small practice
  - Decertified EHR technology
  - Insufficient Internet connectivity
  - Extreme and uncontrollable circumstances
  - Lack of control over the availability of CEHRT
- Applications due by **December 31st, 2019**

➢ Reweighs Promoting Interoperability category to 0% and Quality to 70%



Improvement Activity Performance Category

Report on one to four Improvement Activities based on practice size and weight

Activities are weighted medium (10 points) or high (20 points)

Patient-Centered Medical Home (PCMH) recognition earns full credit

At least 90-day, continuous reporting period

Promoting Interoperability CEHRT bonus no longer available

15% of MIPS score

Improvement Activity Performance Category

Special Status Considerations

- ECs with one of the following special status designations are required to submit one to two Improvement Activities to achieve full credit:
  - Small practice EC
  - Rural
  - HPSA
  - Non-patient facing

Supporting Documentation

- CMS reserves the right to audit any data submission for up to 10 years
- With Improvement Activities being an attestation only (Yes/No) submission there is a high likelihood for audit
- Be sure to prepare adequate supporting documentation to tell the story of what has been done to implement and sustain the chosen activity

Improvement Activities Opportunities for Success

Advance care planning **IA_PM_12**	**Annual registration Prescription Drug Monitoring Program** **IA_PSPA_5**	**Engagement with QIN-QIO to implement self-management programs** **IA_BE_3**
Care transition document practice improvements **IA_CC_10**	**Collection of patient experience/satisfaction data on beneficiary engagement** **IA_BE_6**	**CDC's Guideline for Prescribing Opioids for Chronic Pain** **IA_PSPA_22**

Cost Performance Category

Medicare Spending Per Beneficiary (MSPB)

Total Per Capita Cost (TPCC)

Eight episode-based measures

Full calendar year reporting period (January 1 – December 31, 2019)

No data submission required, CMS will pull from claims

15% of MIPS score*

Cost Measures

Medicare Spending Per Beneficiary

Calculated based on **what Medicare pays** for services performed by an individual clinician/TIN during a Medicare Spending Per Beneficiary episode, which includes:

Period 3-days prior

During the episode

30-days post-hospital stay

Case minimum – 35 episodes

Total Per Capita Cost

Calculated from **all Medicare Part A and Part B claims** during the MIPS performance period based on patients attributed to a clinician/TIN

Note: *Patients will only be attributed to one clinician/TIN using the level of primary care services that were received and the clinician specialty that performed the services*

Case minimum – 20 episodes

Cost – Episode-based Measures

Measure Topic	Measure Type	Case Minimum
Elective Outpatient Percutaneous Coronary Intervention (PCI)	Procedural	10
Knee Arthroscopy	Procedural	10
Revascularization for Lower Extremity Chronic Critical Limb Ischemia	Procedural	10
Routine Cataract Removal with Intraocular Lens (IOL) Implantation	Procedural	10
Screening/Surveillance Colonoscopy	Procedural	10
Intracranial Hemorrhage or Cerebral Infarction	Acute inpatient medical condition	20
Simple Pneumonia with Hospitalization	Acute inpatient medical condition	20
ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)	Acute inpatient medical condition	20

General MIPS Updates

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Virtual Groups

Election

- Virtual group election must occur prior to December 31, 2018 via email MIPS_VirtualGroups@cms.hhs.gov
- TIN/NPI-level written agreement must be in place

Eligibility Determination

- October 1, 2017-September 30, 2018, includes 30-day claims run out
- All NPIs within the TIN are counted
  - Participants may not have more than 10 NPIs in the TIN

Participation

- Virtual group performance is assessed as the aggregate across all performance categories
- Virtual group participants that are MIPS eligible will receive applicable payment adjustment

Complex Patient Bonus

5 point bonus available for the care for **complex patients** – based on hierarchical condition categories (HCC) and patient dual eligibility

HCC score derived from the second participation determination period

- **Oct. 1, 2018 through Sept. 30, 2019** (no claims runout period)

Data Submission

Collection Type	Submitter Type	Submission Type
eCQMs **MIPS CQMs (registry)** **QCDR measures** **Claims-based measures** **CMS Web Interface measures** **CAHPS for MIPS survey** **Administrative claims measures**	Submits data on measures and activities under MIPS: **MIPS eligible clinician** **Group** **Third party intermediary acting on behalf of a MIPS eligible clinician or group**	Mechanism by which a submitter type submits data to CMS, including: **Direct (via API)** **Log in and upload (Portal)** **Log in and attest (Portal)** **Medicare Part B claims** **CMS Web Interface**

Alternative Payment Models

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APM EHR Data Reporting

CEHRT Utilization

- Advanced APMs must ensure that at least 75% of their participants are utilizing a certified EHR technology in 2019

MSSP ACO-11

- Medicare Shared Savings participants will no longer report on ACO-11 (*Use of Certified EHR Technology*)

All-Payer Combination Option

- All-Payer Combination Option APM will allow clinicians to use a **combination** of Medicare participation in Advanced APMs and participation in Other Payer Advanced APMs to achieve qualifying participant status

Source	Claims Volume	Patient Volume
Medicare APM	25%	20%
Other Payers	25%	15%
TOTAL for QP Status	50%	35%

Quality Measures – CMS Web Interface

CMS Web Interface Measures		
Measure Name	**Measure ID**	**NQF #**
Falls: Screening for Future Falls	ACO-13	NQF# 0101
Preventive Care and Screening: Influenza Immunization	ACO-14	NQF# 0041
Preventive Care and Screening: Tobacco Use and Cessation Intervention	ACO-17	NQF# 0028
Preventive Care and Screening: Screening for Depression and Follow-up Plan	ACO-18	NQF# 0418
Colorectal Cancer Screening	ACO-19	NQF# 0034
Breast Cancer Screening	ACO-20	NQF# 3272
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	ACO-42	N/A
Depression Remission at 12-months	ACO-40	NQF# 0710
Diabetes Hemoglobin A1c Poor Control (>9%)	ACO-27	NQF# 0059
Hypertension: Controlling High Blood Pressure	ACO-28	NQF# 0018

Accountable Care Organizations – Proposed Rule

BASIC

- Begin as one-sided risk and move to similar risk as that of MSSP Track 1+
- First three years under one-sided risk, transition to two-sided risk for two years (5-year contract period)
- CEHRT attestation requirement

ENHANCED

- Similar risk found under MSSP Track 3
- Current ACO program participants would automatically follow this path
- Consideration for 5-year contract period
- CEHRT attestation requirement

Questions and Open Discussion

Contact Information

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Resources

- **New England QIN-QIO MACRA website: http://neqpp.org/**
  - **Ask A Question: http://neqpp.org/ask-question/**

- **CMS Quality Payment Program website: https://qpp.cms.gov/**
  - **QPP participation status lookup tool (https://qpp.cms.gov/participation-lookup)**
  - **CMS portal (https://qpp.cms.gov/login)**
  - **CMS QPP resource library (https://qpp.cms.gov/about/resource-library)**

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CMSMAD12018121629