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Introduction to the Quality Payment Program & MIPS

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Quality Payment Program

- Improve beneficiary outcomes
- Reduce burden on clinicians
- Increase adoption of Advanced APMs
- Maximize participation
- Improve data and information sharing
- Ensure operational excellence in program implementation
- Deliver IT systems capabilities that meet the needs of users

Quick Tip: For additional information on the Quality Payment Program, please visit qpp.cms.gov

CMS

The Quality Payment Program

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Clinicians have two tracks from which to choose:

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.

OR

Advanced APMs

Advanced Alternative 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.

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Merit-based Incentive Payment System (MIPS)

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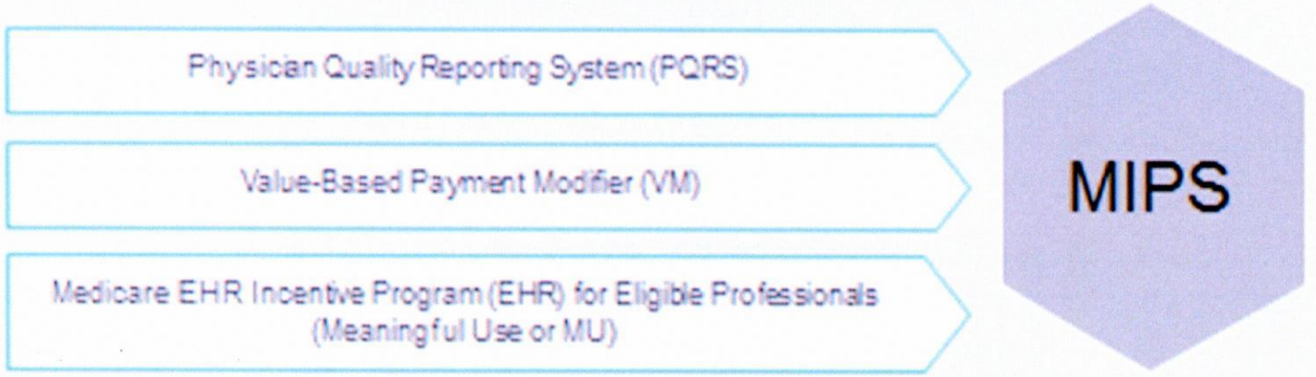
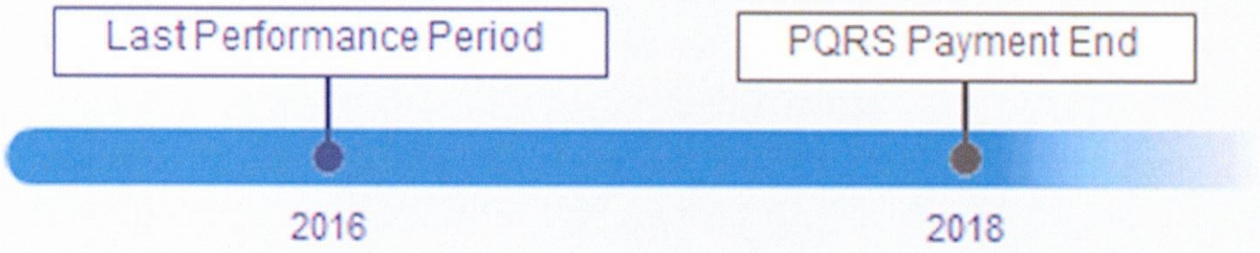
Combines legacy programs into a single, improved program



Example of the Legacy Program Phase Out for PQRS



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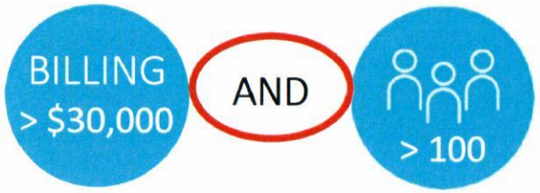
Eligible Clinicians:

Clinicians or Groups billing more than $30,000 a year in Medicare Part B <u>allowed charges</u> **AND** providing care for more than 100 Medicare patients a year.



These clinicians include:

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

Who is Exempt from MIPS?

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Clinicians who are:

Newly-enrolled in Medicare

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

OR

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

OR

Significantly participating in Advanced APMs

- Receive 25% of their Medicare payments

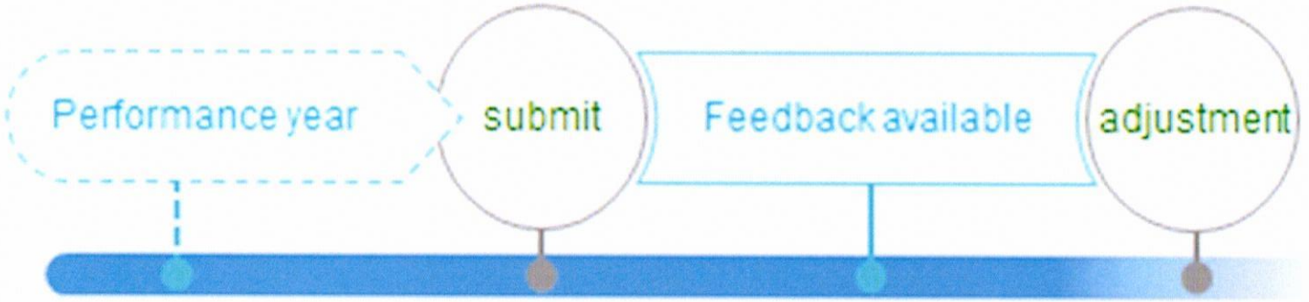
OR

- See 20% of their Medicare patients through an Advanced APM

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.

When Does MIPS Officially Begin?



2017
Performance Year

- Performance period opens January 1, 2017.
- 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 the 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 begin January 1, 2019.

What is the Merit-based Incentive Payment System?

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Performance Categories

Quality (PQRS)

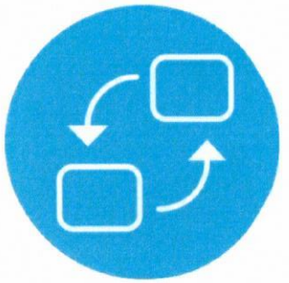
60%

Cost

0%

Advancing Care Information (MU)

25%



Improvement Activities (New)

15%

Possible Total Score: 100 MIPS Points

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MIPS Performance Category: Quality

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- **60%** of Final Score in 2017
- 270+ measures available
  - You **select 6** individual measures
    - 1 must be an **Outcome** measure

      OR
    - **High-priority** measure
      - Defined as outcome measures, appropriate use measure, patient experience, patient safety, efficiency measures, or care coordination.
  - You may also select specialty-specific set of measures

Replaces PQRS and Quality portion of the Value Modifier

Provides for an easier transition for those who have reporting experience due to familiarity

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MIPS Performance Category: Cost

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- No reporting requirement; **0%** 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.

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

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MIPS Performance Category: Advancing Care Information (ACI)

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- 25% of Final Score in 2017
- Promotes patient engagement and the electronic exchange of information using certified EHR technology
- Ends and replaces the Medicare EHR Incentive Program (also known as Medicare Meaningful Use)
- Greater flexibility in choosing measures
- In 2017, there are *2 measure sets for reporting to choose from based on EHR* edition:

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

CMS

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:

1. Expanded Practice Access	2. Population Management	3. Care Coordination
4. Beneficiary Engagement	5. Patient Safety and Practice Assessment	6. Participation in an APM
7. Achieving Health Equity	8. Integrating Behavioral and Mental Health	9. Emergency Preparedness and Response

Technical Assistance for Clinicians

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CMS has free resources and organizations to provide help to clinicians who are participating in the Quality Payment Program:

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 TCPI@CMMIInnovationHealth.com for extra assistance.

Locate the PTN(s) and SAN(s) in your state

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@NORC.ORG

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.

Locate the QIN-QIO that serves your state

Quality Innovation Network (QIN) Directory

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.

To learn more, view the Technical Assistance Resource Guide:
https://qpp.cms.gov/resources/education

Pick Your Pace for Participation for the Transition Year

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Participate in an Advanced Alternative Payment Model

- Some practices may choose to participate in an Advanced Alternative Payment Model in 2017

MIPS

Test

Submit Something

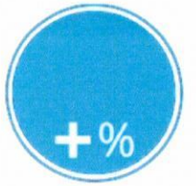
- Submit **some** data after January 1, 2017
- Neutral payment adjustment

Partial Year

Submit a Partial Year

- Report for 90-day period after January 1, 2017
- Neutral or positive payment adjustment

Full Year



Submit a Full Year

- Fully participate starting January 1, 2017
- Positive payment adjustment

Note: Clinicians do not need to tell CMS which option they intend to pursue.

<u>Not</u> participating in the Quality Payment Program for the Transition Year will result in a negative 4% payment adjustment.

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MIPS: Choosing to Test for 2017

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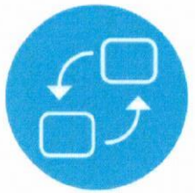
Submit Something

- 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

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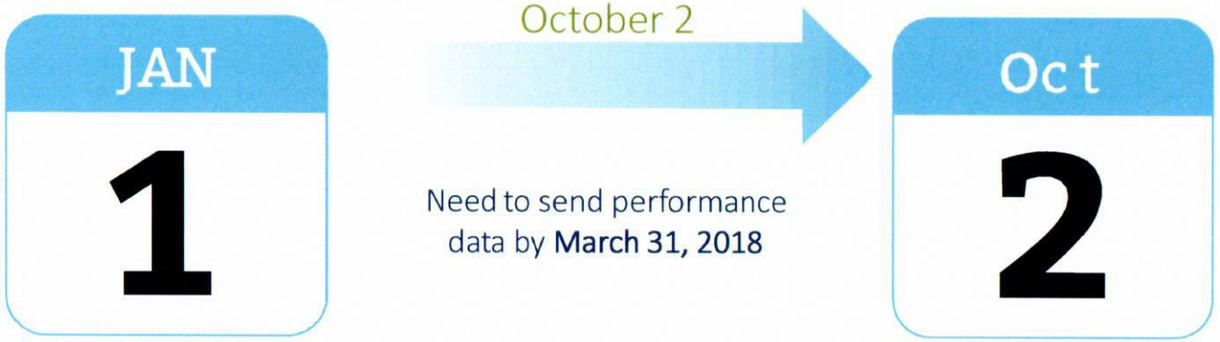
*Depending on CEHRT edition

MIPS: Partial Participation for 2017

Submit a Partial Year

- Submit **90 days** of 2017 data to Medicare
- May earn a neutral or 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

- 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.**

Individual vs. Group Reporting

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OPTIONS

1. **Individual**—under an National Provider Identifier (NPI) number and Taxpayer Identification Number (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

https://qpp.cms.gov/docs/QPP_Group_Participation_in_MIPS_2017.pdf

* If clinicians participate as a group, they are assessed as a group across all 4 MIPS performance categories

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Submission Methods

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	Individual	Group
Quality	• Qualified Clinical Data Registry (QCDR) • Qualified Registry • EHR • Claims	• QCDR • Qualified Registry • EHR • Administrative Claims • CMS Web Interface • CAHPS for MIPS Survey
Improvement Activities	• QCDR • Qualified Registry • EHR • Attestation	• QCDR • Qualified Registry • EHR • CMS Web Interface • Attestation
Advancing Care Information	• QCDR • Qualified Registry • EHR • Attestation	• QCDR • Qualified Registry • EHR • Attestation • CMS Web Interface

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*Must be reported via a CMS approved survey vendor together with another submission method for all other Quality measures.

Submission Methods: Helpful Information

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Submission Mechanism	How does it work?
Qualified Clinical Data Registry (QCDR)	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.
Qualified Registry	A Qualified Registry collects clinical data from an eligible clinician or group of eligible clinicians and submits it to CMS on their behalf.
Electronic Health Record (EHR)	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.
Attestation	Eligible clinicians prove (attest) that they have completed measures or activities.
CMS Web Interface	A secure internet-based application available to pre-registered groups of clinicians. CMS loads the Web Interface with the group's patients. The group then completes data for the pre-populated patients.
Claims	Clinicians select measures and begin reporting through the routine billing processes.

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IPRO's Technical Assistance—Free-of-Charge

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IPRO can assist you in:

- **Reviewing resources: https://ipro.org/for-providers/medicare-qpp**
- **Choosing measures in each Performance Category**
- **Reviewing specifications for each measure**
- **Ensuring that your EHR vendor can support the measures you have chosen (Registry and/or CEHRT)**
- **Periodically reviewing your measures to ensure you are on track for successful participation**
- **Identifying participation opportunities in IPRO initiatives for the Quality and Improvement Activities performance categories**

IPRO initiative	Quality Payment Program (QPP) Performance Category	QPP Performance Category Definition
Cardiovascular Health	Quality ID 236: Controlling high blood pressure	Percentage of patients 18-85 years of age who had a diagnosis of HTN and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period
	Quality ID 373: Hypertension: Improvement in blood pressure	Percentage of patients aged 18-85 years of age with a diagnosis of hypertension whose blood pressure improved during the measurement period.
	Quality ID 317: Preventive care and screening: Screening for high blood pressure and follow-up documented	Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated
	Quality ID 226: Preventive care and screening: Tobacco use: Screening and cessation intervention	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user
Diabetes Self-Management Education	Quality ID 001: Diabetes: HbA1c Poor Control	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period
	Improvement Activities: IA_BE_3: Engagement with QIN-QIO to implement self-management training programs	Engagement with a Quality Innovation Network-Quality Improvement Organization, which may include participation in self-management training programs such as diabetes.
	Improvement Activities: IA_EPA_4: Additional improvements in access as a result of QIN-QIO technical assistance	As a result of QIN-QIO technical assistance, performance of additional activities that improve access to services (e.g., investment of on-site diabetes educator).
Adult Immunizations	Quality ID 110: Preventive care and screening: Influenza immunization	Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization
	Quality ID 111: Pneumococcal vaccination status for older adults	Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.
Antibiotic Stewardship	Improvement Activities: IA_PSPA_15: Implementation of antibiotic stewardship program	Implementation of an antibiotic stewardship program that measures the appropriate use of antibiotics for several different conditions (URI Rx in children, diagnosis of pharyngitis, Bronchitis Rx in adults) according to clinical guidelines for diagnostics and therapeutics

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IPRO QPP CONTACT INFORMATION

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