Introduction to the Quality Payment Program & MIPS

Patricia Gagliano, MD
Vice President, Health Care Quality Improvement
Presented to MSSNY Council
November 2, 2017
# Quality Payment Program

<table>
<thead>
<tr>
<th>Improve beneficiary outcomes</th>
<th>Reduce burden on clinicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase adoption of Advanced APMs</td>
<td>Maximize participation</td>
</tr>
<tr>
<td>Improve data and information sharing</td>
<td>Ensure operational excellence in program implementation</td>
</tr>
</tbody>
</table>

Deliver IT systems capabilities that meet the needs of users

**Quick Tip:** For additional information on the Quality Payment Program, please visit [app.cms.gov](http://app.cms.gov)
The Quality Payment Program

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.*
Merit-based Incentive Payment System (MIPS)

Combines legacy programs into a single, improved program

- Physician Quality Reporting System (PQRS)
- Value-Based Payment Modifier (VM)
- Medicare EHR Incentive Program (EHR) for Eligible Professionals (Meaningful Use or MU)

Example of the Legacy Program Phase Out for PQRS

<table>
<thead>
<tr>
<th>Last Performance Period</th>
<th>PQRS Payment End</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>2018</td>
</tr>
</tbody>
</table>
Eligible Clinicians:

Clinicians or Groups billing more than $30,000 a year in Medicare Part B allowed charges 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?

Clinicians who are:

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

2. 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

3. Significantly participating in Advanced APMs
   - Receive 25% of their Medicare payments
   - 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?

Performance year

submit

Feedback available

adjustment

2017 Performance Year

- Performance period opens January 1, 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?

Performance Categories

- Quality (PQRS): 60%
- Cost: 0%
- Advancing Care Information (MU): 25%
- Improvement Activities (New): 15%

Possible Total Score: 100 MIPS Points
MIPS Performance Category: Quality

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

- 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
MIPS Performance Category: Advancing Care Information (ACI)

- 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
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

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 TRANSFORMEDHEALTH.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 with connecting, contact SURSASSISTANCE.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: www.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.
- 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 APM. 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

Participate in an Advanced Alternative Payment Model

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

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

MIPS

Test
- Submit Nothing

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

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.

Not participating in the Quality Payment Program for the Transition Year will result in a negative 4% 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
- 1 Improvement Activity
- OR
- 4 or 5* Required Advancing Care Information Measures

*Depending on CEHRT edition
MIPS: Partial Participation for 2017

- 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.

JAN 1 → Oct 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.
Individual vs. Group Reporting

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

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

## Individual

- Qualified Clinical Data Registry (QCDR)
- Qualified Registry
- EHR
- Claims

## Group

- QCDR
- Qualified Registry
- EHR
- Administrative Claims
- CMS Web Interface
- CAHPS for MIPS Survey

## Quality

### Improvement Activities

- QCDR
- Qualified Registry
- EHR
- Attestation

### Advancing Care Information

- QCDR
- Qualified Registry
- EHR
- Attestation

*Must be reported via a CMS approved survey vendor together with another submission method for all other Quality measures.*
## Submission Methods: Helpful Information

<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 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.</td>
</tr>
<tr>
<td>Claims</td>
<td>Clinicians select measures and begin reporting through the routine billing processes.</td>
</tr>
</tbody>
</table>
IPRO’s Technical Assistance—Free-of-Charge

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
<table>
<thead>
<tr>
<th>IPRO Initiative</th>
<th>Quality Payment Program (QPP) Performance Category</th>
<th>QPP Performance Category Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cardiovascular Health</strong></td>
<td>Quality ID 236: Controlling high blood pressure</td>
<td>Percentage of patients 18-85 years of age who had a diagnosis of HTN and whose blood pressure was adequately controlled (&lt;140/90mmHg) during the measurement period</td>
</tr>
<tr>
<td></td>
<td>Quality ID 373: Hypertension: Improvement in blood pressure</td>
<td>Percentage of patients aged 18-85 years of age with a diagnosis of hypertension whose blood pressure improved during the measurement period.</td>
</tr>
<tr>
<td></td>
<td>Quality ID 317: Preventive care and screening: Screening for high blood pressure and follow-up documented</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>Quality ID 226: Preventive care and screening: Tobacco use: Screening and cessation intervention</td>
<td>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</td>
</tr>
<tr>
<td><strong>Diabetes Self-Management Education</strong></td>
<td>Quality ID 001: Diabetes: HbA1c Poor Control</td>
<td>Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c &gt; 9.0% during the measurement period</td>
</tr>
<tr>
<td></td>
<td>Improvement Activities: IA_BE_3: Engagement with QIN-QIO to implement self-management training programs</td>
<td>Engagement with a Quality Innovation Network-Quality Improvement Organization, which may include participation in self-management training programs such as diabetes.</td>
</tr>
<tr>
<td></td>
<td>Improvement Activities: IA_EPA_4: Additional improvements in access as a result of QIN-QIO technical assistance</td>
<td>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).</td>
</tr>
<tr>
<td><strong>Adult Immunizations</strong></td>
<td>Quality ID 110: Preventive care and screening: Influenza immunization</td>
<td>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</td>
</tr>
<tr>
<td></td>
<td>Quality ID 111: Pneumococcal vaccination status for older adults</td>
<td>Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.</td>
</tr>
<tr>
<td><strong>Antibiotic Stewardship</strong></td>
<td>Improvement Activities: IA_PSPA_15: Implementation of antibiotic stewardship program</td>
<td>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.</td>
</tr>
</tbody>
</table>
IPRO QPP CONTACT INFORMATION

Patricia Gagliano, MD  
Vice President, Health Care Quality Improvement  
pgagliano@ipro.org  
516-209-5281

Susan Hollander, MPH, CPHQ  
Senior Director  
shollander@ipro.org  
516-209-52541

Rebecca Van Vorst, MSPH  
Assistant Director  
rvanvorst@ipro.org  
518-320-3508