



2020 Participation in the Quality Payment Program (QPP)

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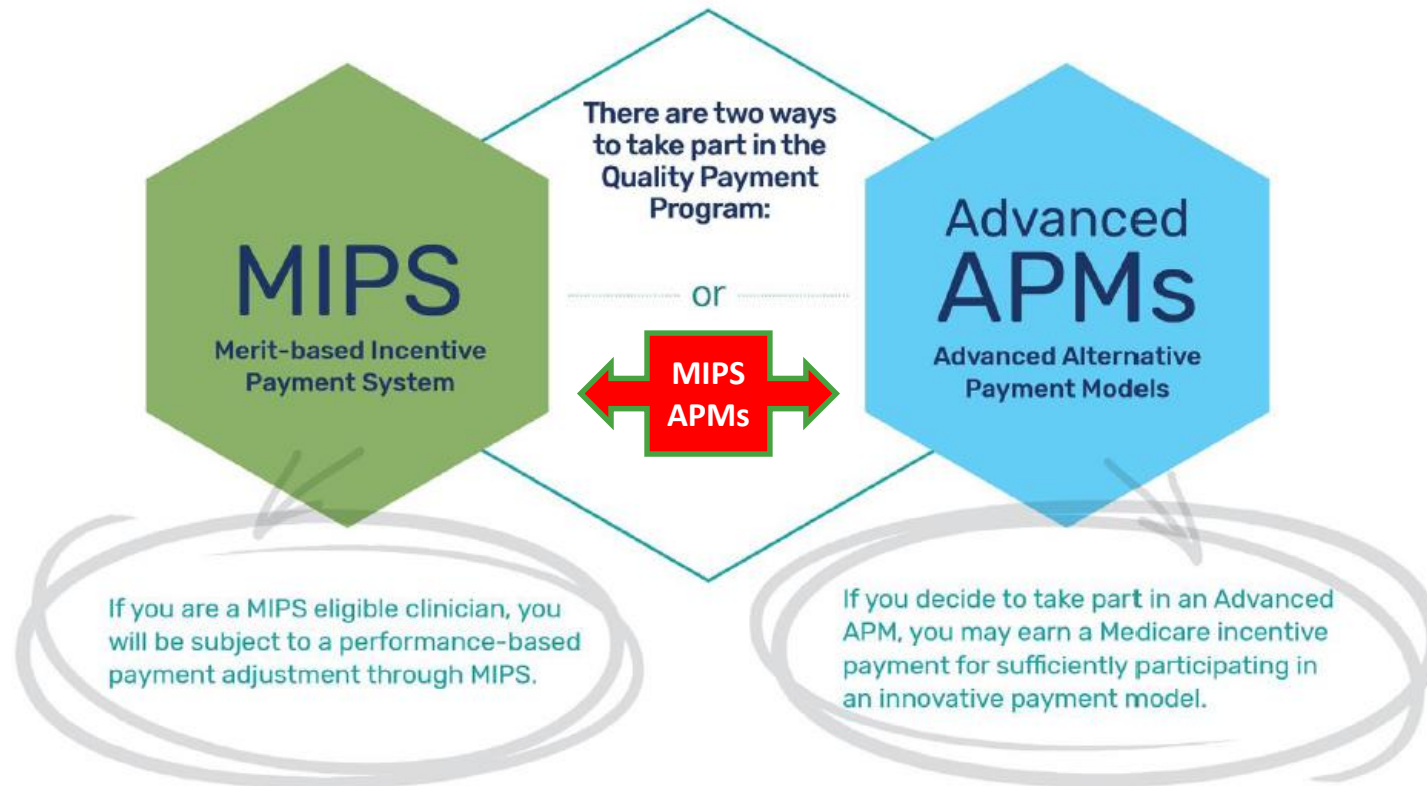


Agenda

- ▲ Quality Payment Program Basics
- ▲ Tracks of Participation
- ▲ The MIPS Final Score
- ▲ MIPS Timeline
- ▲ MVPs: MIPS Value Pathways
- ▲ Eligibility Criteria and Reporting Options
- ▲ MIPS Performance Categories
- ▲ Performance Thresholds & Payment Adjustments
- ▲ APMs: Alternative Payment Models
- ▲ Free Program Assistance

The Quality Payment Program – MIPS and Advanced APMs

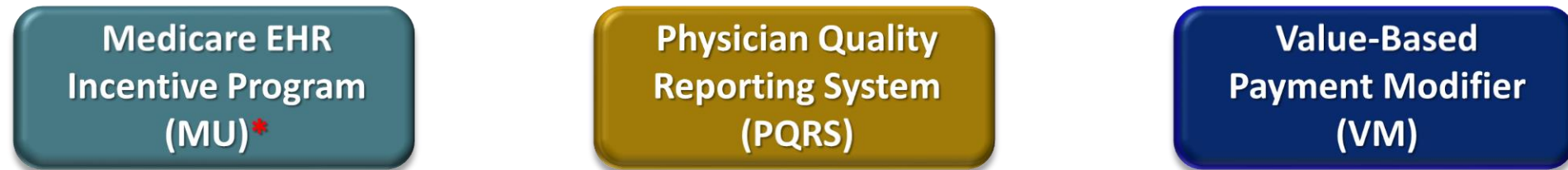
- ▲ The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) required CMS by law to implement an incentive program, referred to as the Quality Payment Program (QPP), which provides two participation tracks:



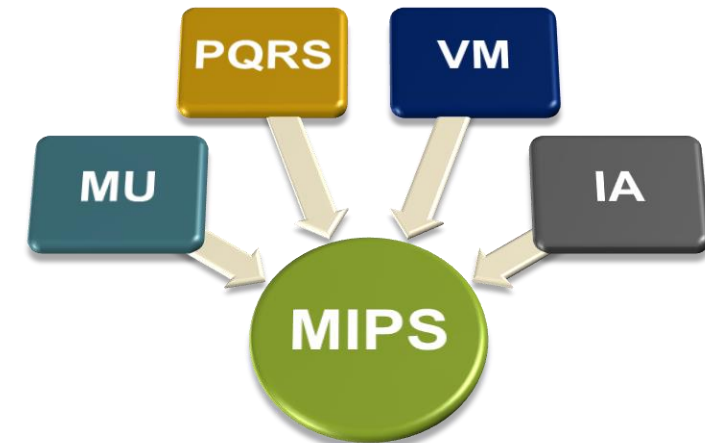
- ▲ Repealed the Sustainable Growth Rate (SGR) formula
- ▲ Changed the way Medicare pays clinicians and establishes a new framework to reward clinicians for value over volume (finally transitioning away from FFS payments)

What is MIPS?

- ▲ The Merit-based Incentive Payment System
- ▲ Combines multiple legacy Medicare Part B programs into a single program

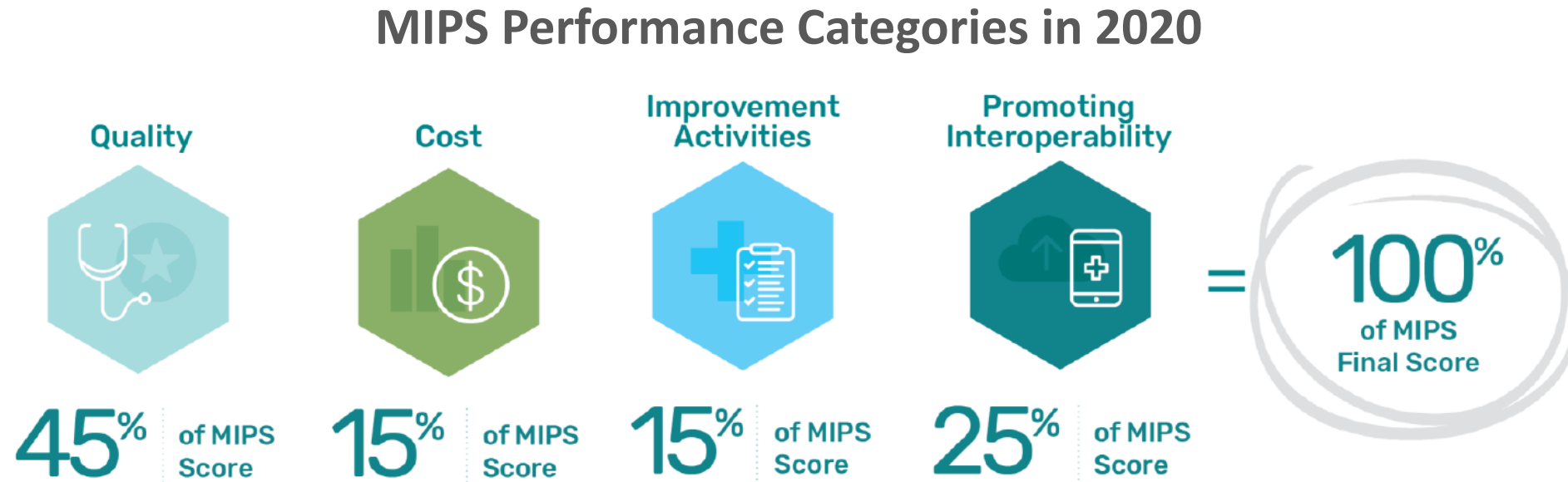


- ▲ (4) MIPS Performance Categories:
 - Quality (PQRS/Value Modifier-Quality Program)
 - Cost (Value Modifier-Cost Program)
 - Promoting Interoperability (PI) (Medicare MU)
 - Improvement Activities (IA)



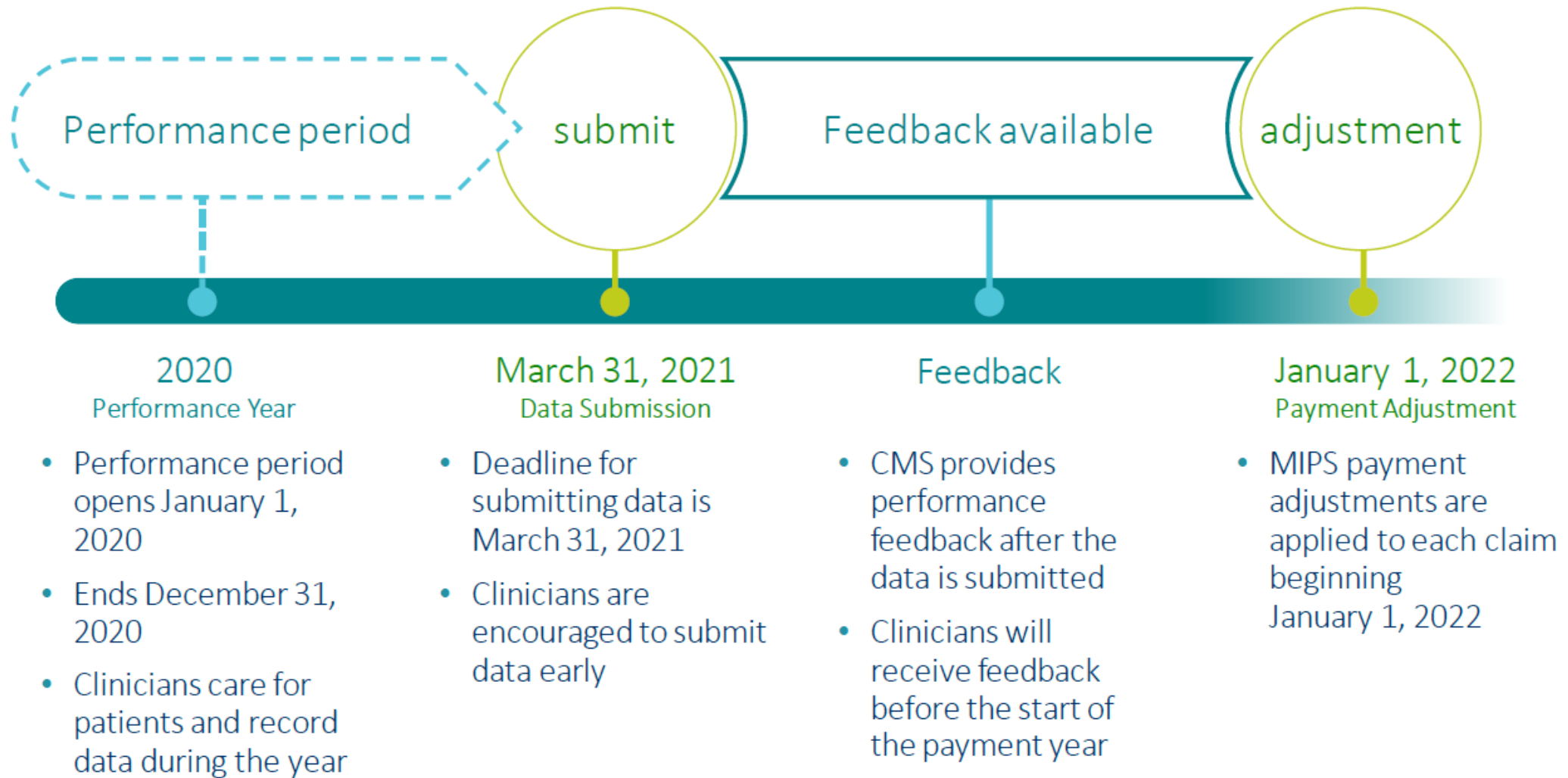
**QPP/MIPS does not alter or end the Medicaid EHR Incentive Program
(Now called the Medicaid Promoting Interoperability Program)*

Category Weights Contributing to the MIPS Final Score



- ▲ The points earned in each performance category are added together to create the MIPS Final Score
- ▲ The MIPS Final Score is compared to the annually set MIPS performance threshold (45pts in 2020) to determine if the participant (aka Eligible Clinician or EC) or group receives a **positive, negative, or neutral payment adjustment**

2020 MIPS Timeline



MIPS Value Pathways (MVPs)...coming in 2021

▲ CMS received significant feedback in the first years of the program

- The current structure of MIPS and the reporting requirements are confusing
- There is too much choice and complexity when it comes to selecting and reporting measures and activities
- The measures and activities aren't always relevant to a clinician's specialty
- It's hard for patients to compare performance across clinicians

While there have been incremental changes/improvements to the program each year, additional long-term improvements are needed to align with CMS' goal to develop a meaningful program for every clinician, *regardless of practice size or specialty*.

The Answer: MIPS Value Pathways (MVPs)

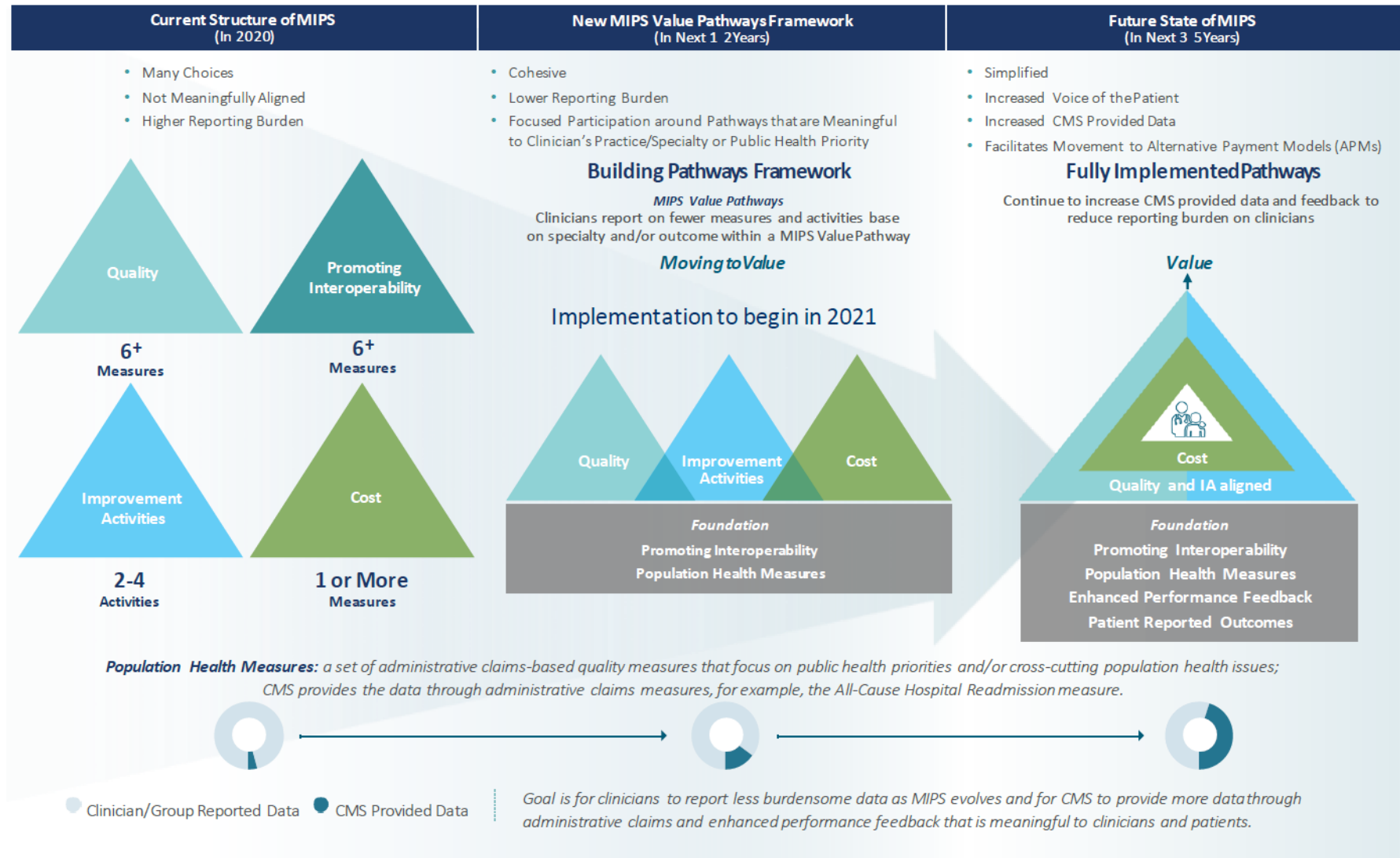
MIPS Value Pathways (MVPs)

- ▲ CMS is committed to the transformation of the Merit-based Incentive Payment System (MIPS) through the MIPS Value Pathways (MVPs), a new participation framework beginning in the 2021 performance year. This new framework will:
 - Remove barriers to Alternative Payment Model (APM) participation
 - Move away from siloed activities and towards an aligned set of measure options more relevant to a clinician's scope of practice that is meaningful to patient care
 - Promote value by focusing on Quality and Cost measures and Improvement Activities built on a foundation of population health measures calculated from administrative claims-based quality measures and Promoting Interoperability concepts
 - Further reduce reporting burden
 - Keep the patient at the center of our work
- ▲ After consideration of the comments submitted to the MVPs Request for Information, CMS finalized a modified proposal to define MVPs as a subset of measures and activities established through future rulemaking

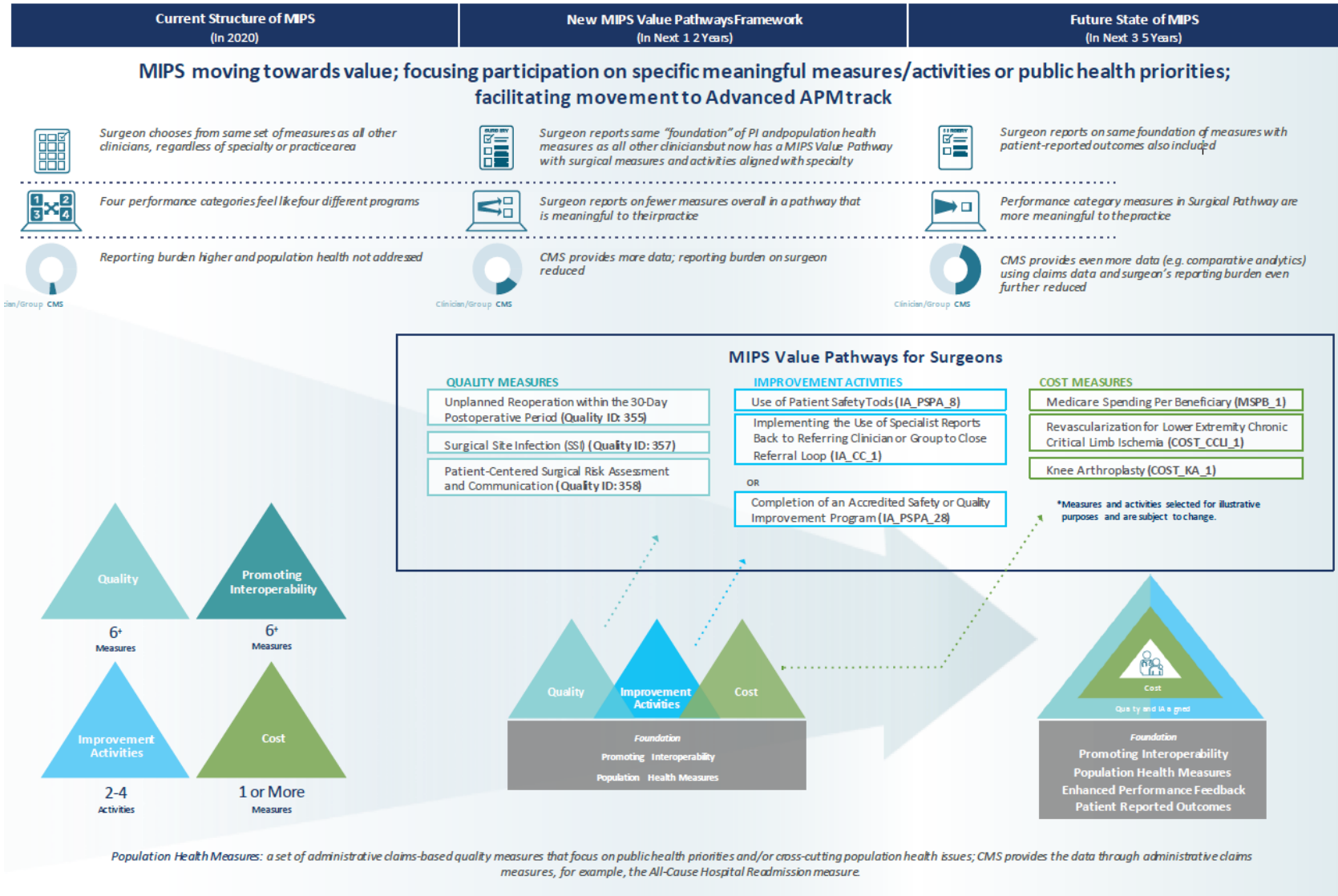
MIPS Value Pathways (MVPs)

- ▲ Through this new framework, CMS intends to:
 - Provide enhanced data and feedback to clinicians
 - Analyze existing Medicare information to provide clinicians and patients with more information to improve health outcomes
 - Reduce reporting burden by limiting the number of required specialty or condition specific measures
 - Note: All clinicians or groups reporting on a clinical area would be reporting the same measures sets
- ▲ CMS recognizes concerns about the implementation timeline of MVPs and will establish an incremental implementation that does not eliminate the current MIPS framework
- ▲ CMS is committed to working with stakeholders to develop this new framework, as well as develop additional ways to reduce burden in the MIPS program. They encourage the health care community to review the [MIPS Value Pathways video](#) and [illustrative diagrams](#). Participants can find more information available on the QPP website at: <https://qpp.cms.gov/mips/mips-value-pathways>

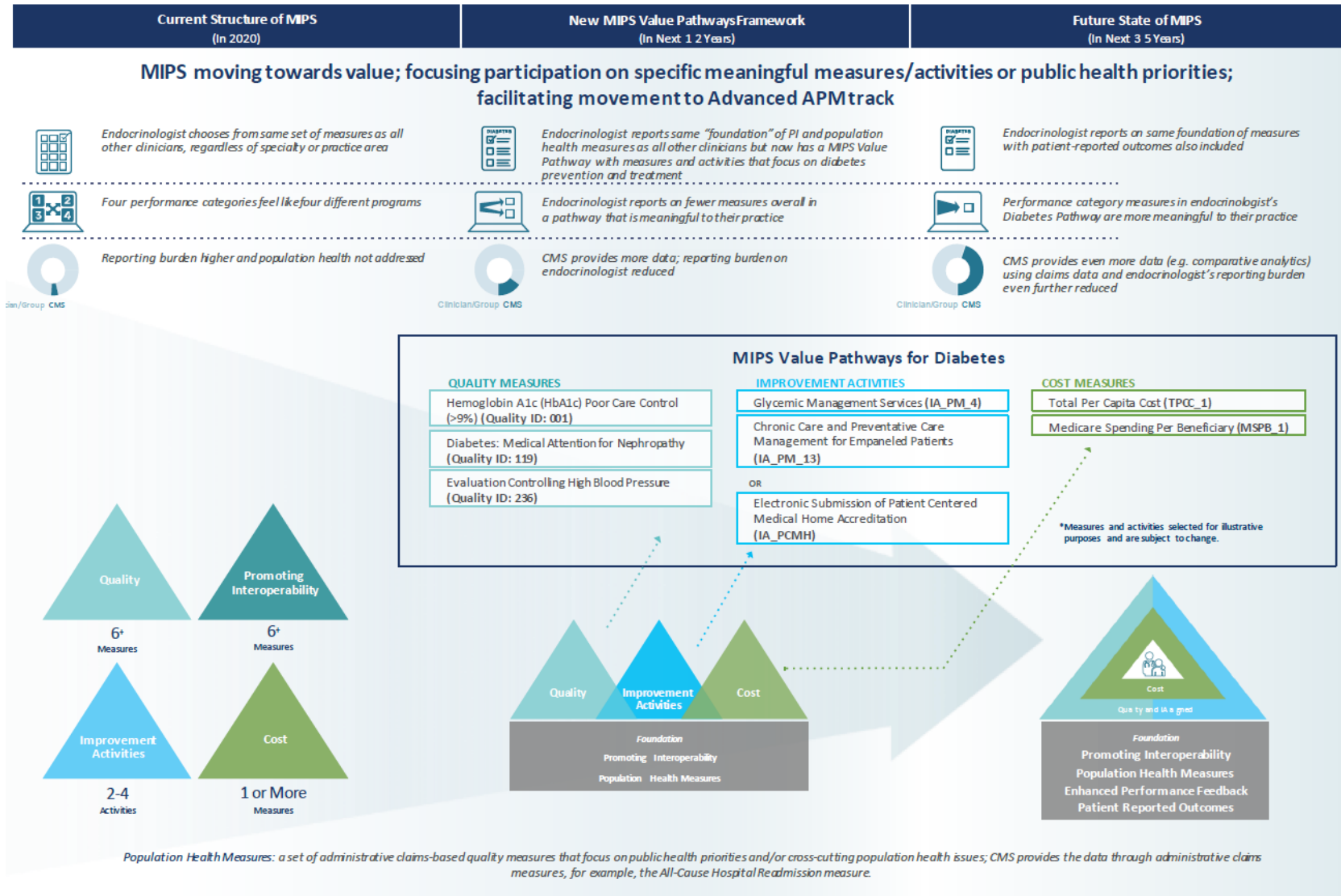
MIPS Value Pathways (MVPs)



MVPs Surgical Example



MVPs Diabetes Example





2020 Program Eligibility Criteria and Reporting Options

MIPS Year 4 (2020) – Who is Included?

▲ No changes to the MIPS Eligible Clinician (EC) types in the 2020 performance period; they are the same as in the 2019 performance period

▲ 2020 MIPS Eligible Clinicians:

- Physicians
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
- Clinical Psychologists
- Physical Therapists
- Occupational Therapists
- Audiologists
- Speech-language pathologists
- Registered Dietitians and other nutrition professionals
- Groups of such clinicians

MIPS Year 4 (2020) – Who is Included?

▲ As a reminder, the CMS definition of “Physician” includes:

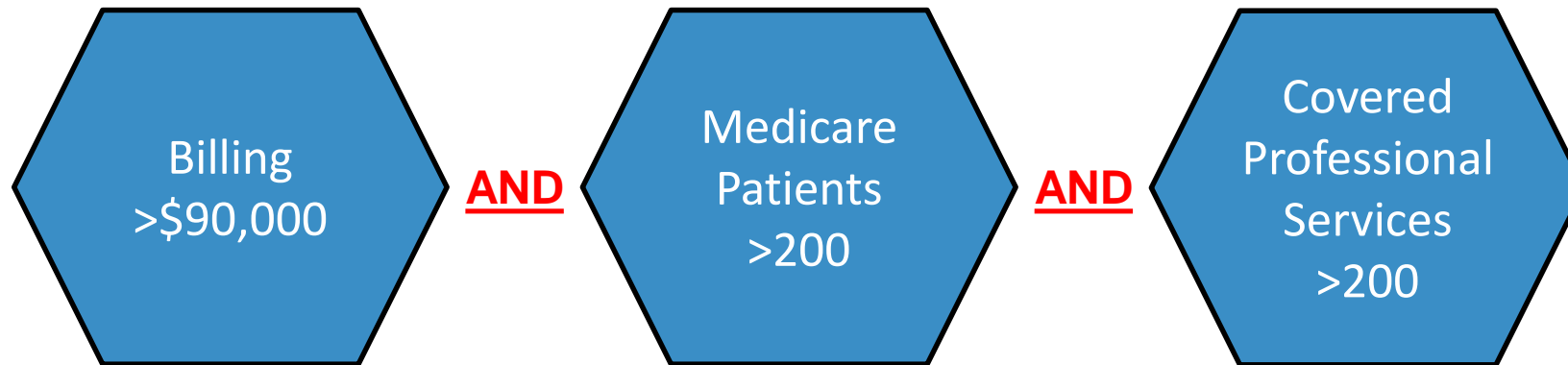
- Doctor of Medicine
- Doctor of Osteopathy
- Doctor of Dental Surgery
- Doctor of Dental Medicine
- Doctor of Podiatric Medicine
- Doctor of Optometry
- Doctor of Chiropractic Medicine (legally authorized to practice by a State in which s/he performs this function)

MIPS Year 4 (2020) – Who is Included?

▲ No Change to the Low-Volume Threshold for 2020:

1. Bill more than \$90,000 a year in allowed charges for covered professional services under the Medicare Physician Fee Schedule (PFS) and
2. Furnish covered professional services to more than 200 Medicare beneficiaries and
3. Provide more than 200 covered professional services under the PFS

▲ Check program eligibility at <https://qpp.cms.gov/participation-lookup>



▲ To be included in MIPS, a clinician (or group) must exceed all three criteria

- Note: For MIPS APM participants, the low-volume threshold determination is calculated at the APM Entity level (i.e. ACO level)

MIPS Year 4 (2020) – The “Opt-In” Option

▲ What happens if a clinician or group is excluded...but still wants to participate in MIPS?

➤ There are two options:

1. Voluntarily Participate

- Submit MIPS data to CMS and receive performance feedback
- No MIPS payment adjustment regardless of performance
- Some program data will still be publically available on the [Medicare Physician Compare](#) website

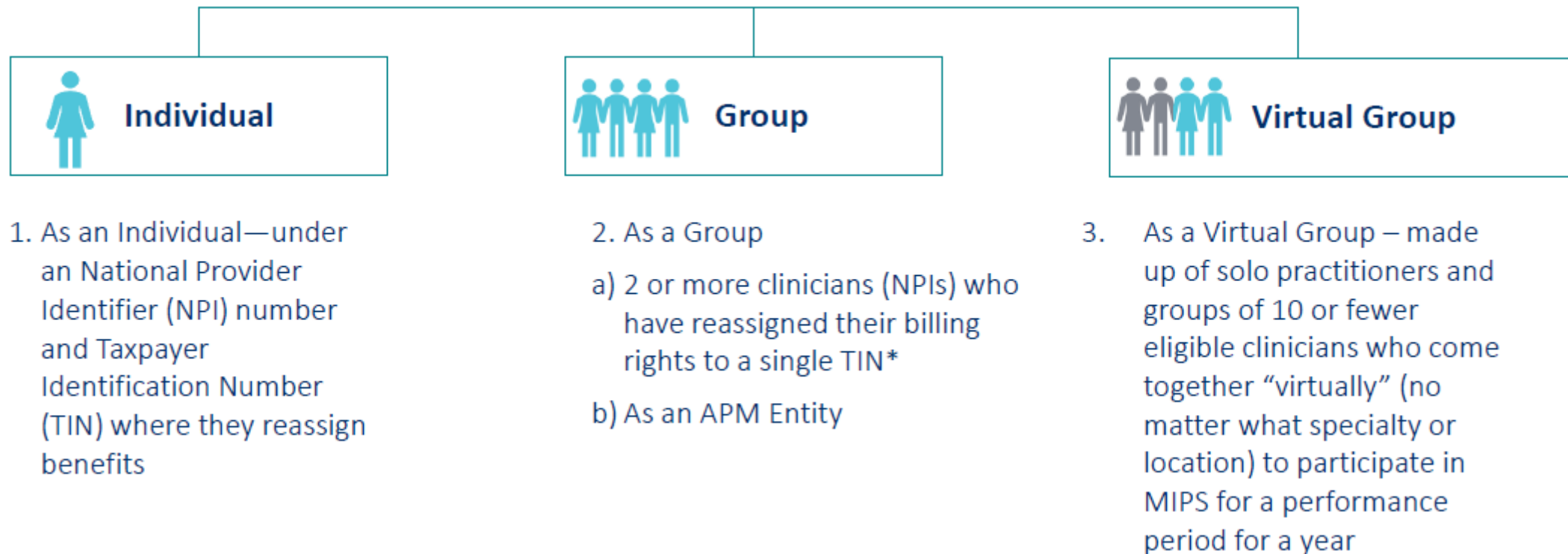
2. Opt-In

- If you are a MIPS eligible clinician type and meet or exceed at least (1) of the (3) low-volume threshold criteria, you may opt-in to MIPS participation
- If you opt-in, you'll be subject to MIPS program rules and subsequent MIPS payment adjustments (+/-/=)
- Once made, this annual decision is irrevocable for that single program year only
- For additional details on this option as well as the process for opting-in to MIPS, review the [Opt-In and Voluntary Reporting Election Toolkit](#)

MIPS Year 4 (2020) – Reporting Options


▲ What are my reporting options if I am required to participate in MIPS?

➤ No changes from prior performance year:



Group vs Individual Reporting?

- ▲ For many MIPS participants, it's best to submit both ways:

Scoring	
	<p>A group electing to submit data at the group level would have its performance assessed and scored across the TIN, which could include covered professional services furnished by individual NPIs within the TIN who are not required to participate in MIPS.</p> <p>A MIPS eligible clinician participating via a group will get the group's score. However, if the same MIPS eligible clinician also submits individual level data, CMS will use the higher of the two final scores for that clinician.</p>

- ▲ So with this in mind, the best overall strategy is:

- ALWAYS GROUP REPORT (*unless group score is below the minimum performance threshold*)
- Then, if an EC is eligible to report individually and his/her individual MIPS Final Score is *better* than the group average, ALSO report that clinician's *individual* data to CMS

With this strategy:

- Lower performer's scores in the group are raised by the higher group average, and
- Higher performers are not negatively affected by lower performers, as CMS will give these ECs their better individual scores instead of the lower group score



2020 Changes in the MIPS Performance Categories

2020 Performance Category High Level Changes

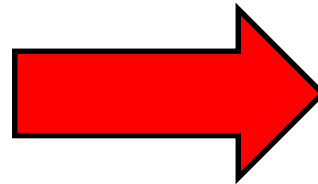
- ▲ **Quality:** Increase the data completeness threshold to 70%; continue to remove low-bar, standard of care process measures; address benchmarking for certain measures to avoid potentially incentivizing inappropriate treatment; focus on high-priority outcome measures; and add new specialty sets
- ▲ **Cost:** Add 10 new episode-based measures to continue expanding access to this performance category; revise the existing Medicare Spending Per Beneficiary Clinician (MSPB Clinician) and Total Per Capita Cost (TPCC) measures
- ▲ **Improvement Activities:** Increase the participation threshold for group reporting from a single clinician to 50% of the clinicians in the practice; update the Improvement Activity Inventory and establish criteria for removal in the future; and conclude the CMS Study on Factors Associated with Reporting Quality Measures
- ▲ **Promoting Interoperability:** Keep the Query of Prescription Drug Monitoring Program measure as an optional measure; remove the Verify Opioid Treatment Agreement measure; and reduce the threshold for a group to be considered hospital-based

MIPS Year 4 (2020) – Performance Periods

▲ No Change to MIPS Performance Periods

2019 Final

Performance Category	Performance Period
 Quality	12-months
 Cost	12-months
 Improvement Activities	90-days
 Promoting Interoperability	90-days



2020 Final

Performance Category	Performance Period
 Quality	12-months
 Cost	12-months
 Improvement Activities	90-days
 Promoting Interoperability	90-days

Quality Performance Category

Basics for 2020

- ▲ 45% of your MIPS Final Score
- ▲ Total of 218 quality measures
- ▲ Select and report on a minimum of 6 individual quality measures
 - 1 must be an outcome measure OR a high-priority measure (if an outcome is not available)
 - High-priority measures fall within these categories: Outcome, Patient Experience, Patient Safety, Efficiency, Appropriate Use, Care Coordination, and Opioid-Related
 - If fewer than 6 measures are clinically applicable, report on each applicable measure
 - If CMS agrees with you (see [Eligible Measures Applicability \(EMA\) Process](#)), category denominator will be appropriately lowered
 - May also select a specialty-specific set of measures
 - If selected measure set has fewer than 6 measures, denominator will be appropriately lowered

Quality Performance Category

Basics for 2020

▲ Bonus points are available

- 2 points for additional outcome or patient experience measures (after the first required outcome measure is submitted)
- 1 point for other high-priority measures (after the first required measure is submitted)
- 1 point for each measure submitted using electronic end-to-end reporting
- Small practice bonus of 6 points
- Bonus points capped at additional 10% of denominator

▲ Data completeness (aka “Cherry-Picking”)

- CMS checks to see if you or your group have submitted data on a minimum percentage of your patients that meet a reported quality measure’s denominator criteria
 - In 2020, the thresholds are:
 - 70% for data submitted on QCDR measures, CQMs, and eCQMS (all-payer claims)
 - 70% for data submitted on Medicare Part B claims measures (Part B claims only)
 - Measures that do not meet the data completeness criteria earn 0 points
 - Small practices (15 or fewer Medicare billing clinicians) receive 3 points for failing data completeness

Quality Performance Category

▲ Quality Performance Category Measures - 2020 Final Rule

- Removed low-bar, standard of care, and process measures
- Focused on outcome and other high priority measures
- Added new specialty measure sets
 - Speech Language Pathology
 - Audiology
 - Clinical Social Work
 - Chiropractic Medicine
 - Pulmonology
 - Nutrition/Dietician
 - Endocrinology

Quality Performance Category

▲ Modified benchmarks to avoid the potential for inappropriate treatment

- Established flat percentage benchmarks in limited cases where CMS determines that the measure's otherwise applicable benchmark could potentially incentivize treatment that could be inappropriate for patients
- The modified benchmarks will be applied to all collection types where the top decile for a historical benchmark is higher than 90% for the following measures:
 - **MIPS #1 [National Quality Forum (NQF) 0059]:**
 - Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)
 - **MIPS #236 [NQF 0018]:**
 - Controlling High Blood Pressure

Quality Performance Category Considerations

- ▲ **Use your patient population to guide measure selection**
 - Pick clinically relevant measures (if you can)
 - What's important to you and/or aligns with practice goals?
 - Specialty measure sets are rarely the best option
 - Registries can also create/use their own measures
 - Good option for Specialists with limited options in the “regular” set of measures
- ▲ **Low quality measure scores could be caused by:**
 - Vendor issues
 - Configuration issues (i.e. LOINC code not properly mapped)
 - Data entry issues
 - Actual “quality” issues
- ▲ **Data submission types matter under the Quality performance category**
 - Consider cost of submission type
 - More measure options via “Registry” than “EHR/eCQM”
 - Benchmarks
- ▲ **Topped Out Measures and “Capped at 7pts” Measures**

Quality Scores Vary by Submission Type

$$\text{Formula} = x + (q - a) / (b - a)$$

Your Performance Rate = 62

CLAIMS	EHR	REGISTRY
$5 + (62 - 46.94) / (62.62 - 46.94)$ $5 + (15.06) / (15.68)$ $5 + 0.960$	$8 + (62 - 52.14) / (63.12 - 52.14)$ $8 + (9.86) / (10.98)$ $8 + .897$	$6 + (62 - 57.07) / (64.78 - 57.07)$ $6 + (4.93) / (7.71)$ $6 + .639$
Total Points Awarded: 5.96	Total Points Awarded: 8.90	Total Points Awarded: 6.64

Measure Name	Measure ID	Submission Method	Decile_3	Decile_4	Decile_5	Decile_6	Decile_7	Decile_8	Decile_9	Decile_10
Preventive Care & Screening: Influenza Immunization	110	Claims	23.29 - 33.13	33.14 - 46.93	46.94 - 62.62	62.63 - 74.35	74.36 - 86.05	86.06 - 97.34	97.35 - 99.99	100.00
Preventive Care & Screening: Influenza Immunization	110	EHR	14.55 - 21.83	21.84 - 29.00	29.01 - 35.99	36.00 - 43.53	43.54 - 52.13	52.14 - 63.12	63.13 - 78.42	>= 78.43
Preventive Care & Screening: Influenza Immunization	110	Registry/QCDR	26.89 - 40.48	40.49 - 49.99	50.00 - 57.06	57.07 - 64.78	64.79 - 73.07	73.08 - 82.70	82.71 - 96.43	>= 96.44

x = decile column q = your performance rate a = low-end of decile column b = high-end of decile column

Avoid “Topped Out” Quality Measures (if you can)

- ▲ MANY measures are topped out but not yet capped at 7pts:

Measure_Name	Measure_ID	Submission_Method	Benchmark	Decile_3	Decile_4	Decile_5	Decile_6	Decile_7	Decile_8	Decile_9	Decile_10	TOPPED_OUT	SevenPointCap
Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	5	Registry/QCQR	Y	93.33 - 96.96	96.97 - 98.40	98.41 - 99.99	--	--	--	--	100	Yes	No
Coronary Artery Disease (CAD): Beta-Blocker Therapy - Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%)	7	Registry/QCQR	Y	96.17 - 98.11	98.12 - 99.76	99.77 - 99.99	--	--	--	--	100	Yes	No
Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	8	Registry/QCQR	Y	95.45 - 98.05	98.06 - 99.28	99.29 - 99.99	--	--	--	--	100	Yes	No
Diabetic Retinopathy: Communication with the Physician	19	Registry/QCQR	Y	70.29 - 84.41	84.42 - 92.72	92.73 - 98.56	98.57 - 99.99	--	--	--	100	Yes	No
Managing Ongoing Diabetes Care	47	Claims	Y	50.32 - 82.60	82.61 - 92.88	92.89 - 97.45	97.46 - 99.30	99.31 - 99.99	--	--	100	Yes	No

- ▲ Although not yet “topped out”, scoring options may still be limited:

Measure_Name	Measure_ID	Submission_Method	Benchmark	Decile_3	Decile_4	Decile_5	Decile_6	Decile_7	Decile_8	Decile_9	Decile_10	TOPPED_OUT	SevenPointCap
Cataract Surgery: Difference Between Planned and Final	389	Registry/QCQR	Y	77.17 - 90.90	90.91 - 96.96	96.97 - 99.21	99.22 - 99.99	--	--	--	100	No	No
Optimal Asthma Control	398	Registry/QCQR	Y	33.52 - 59.45	59.46 - 74.99	75.00 - 95.99	96.00 - 98.98	98.99 - 99.99	--	--	100	No	No

Cost Performance Category

Basics for 2020

- ▲ 15% of your MIPS Final Score
- ▲ No reporting requirement – data is pulled from administrative claims
- ▲ CMS measures participants on:
 - Medicare Spending Per Beneficiary (MSPB) measure
 - Total Per Capita Cost measure
 - 18 episode-based measures (10 of these are new in 2020)
- ▲ In order to be scored on a cost measure, an EC or group must have enough attributed cases to meet or exceed the case minimum for that cost measure
 - If any cost measures apply, they will constitute the total Cost category score
 - If no cost measures can be applied to the EC or group, the 15% category weight is reallocated to the Quality category (0% Cost / 60% Quality)

Cost Performance Category Changes



Overview:

- New episode-based measures and current global measures' attribution methodologies revised
- Different measure attribution for individuals and groups



Measures

2019 Final	2020 Final
<p>Measures:</p> <ul style="list-style-type: none">• Total Per Capita Cost (TPCC)• Medicare Spending Per Beneficiary (MSPB)• 8 episode-based measures <p>Case minimums:</p> <ul style="list-style-type: none">• 10 for procedural episodes• 20 for acute inpatient medical condition episodes	<p>Measures:</p> <ul style="list-style-type: none">• TPCC measure (Revised)• MSPB Clinician (MSPB-C) measure (Name and specification Revised)• 8 existing episode-based measures• 10 new episode-based measures <p>No changes to case minimums</p>

Cost Performance Category Changes



Overview:

- New episode-based measures and current global measures' attribution methodologies revised
- Different measure attribution for individuals and groups



Measure Attribution

2019 Final	2020 Final
<ul style="list-style-type: none">• All measures are attributed at the TIN/NPI level for both individuals and groups• Plurality of primary care services rendered by the clinician to determine attribution for the total per capita cost measure• Plurality of Part B services billed during the index admission to determine attribution for the MSPB measure	<ul style="list-style-type: none">• TPCC attribution will require a combination of 1) E&M services and 2) primary care service or a second E&M service from the same clinician group• TPCC attribution will exclude certain clinicians who primarily deliver certain non-primary care services or are in specialties that are unlikely to be responsible for primary care services.• MSPB clinician (MSPB-C) attribution changes will have a different methodology for surgical and medical patients• Measure attribution will be different for individuals and groups and will be defined in the applicable measure specifications.

Cost Performance Category Measures

▲ Medicare Spending per Beneficiary - Clinician (MSPB-C)

- Assesses the cost to Medicare for Parts A and B services provided to a beneficiary during an episode which comprises the period immediately prior to, during, and following a hospital stay, and compares the observed costs to expected costs
- Includes all Medicare Part A and Part B claims falling in the “episode window,” including claims with a start date between 3 days prior to a hospital admission (also known as the “index admission” for the episode) through 30 days after hospital discharge

▲ Total per Capita Costs for All Attributed Beneficiaries (TPCC)

- A payment-standardized, risk-adjusted, and specialty-adjusted cost measure focused on clinicians and clinician groups performing primary care services
- Specifically, the measure is an average of per capita costs across all attributed beneficiaries and includes all Medicare Parts A and B costs

2020 Episode-Based Cost Measures

Cost Measure	Episode Group Type
Elective Outpatient Percutaneous Coronary Intervention	Procedural
Intracranial Hemorrhage or Cerebral Infarction	Acute Inpatient Medical Condition
Knee Arthroplasty	Procedural
Revascularization for Lower Extremity Chronic Critical Limb Ischemia	Procedural
Routine Cataract Removal with Intraocular Lens Implantation	Procedural
Screening/Surveillance Colonoscopy	Procedural
Simple Pneumonia with Hospitalization	Acute Inpatient Medical Condition
ST-Elevation Myocardial Infarction with Percutaneous Coronary Intervention	Acute Inpatient Medical Condition
Acute Kidney Injury Requiring New Inpatient Dialysis	Procedural
Elective Primary Hip Arthroplasty	Procedural
Femoral or Inguinal Hernia Repair	Procedural
Hemodialysis Access Creation	Procedural
Inpatient Chronic Obstructive Pulmonary Disease Exacerbation	Acute Inpatient Medical Condition
Lower Gastrointestinal Hemorrhage	Acute Inpatient Medical Condition
Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels	Procedural
Lumpectomy, Partial Mastectomy, Simple Mastectomy	Procedural
Non-Emergent Coronary Artery Bypass Graft	Procedural
Renal or Ureteral Stone Surgical Treatment	Procedural

“Facility-based Scoring” for Quality and Cost Categories

- ▲ Facility-based scoring is an option for clinicians who meet certain criteria
 - Allows for certain clinicians to have their Quality and Cost performance category scores based on the performance of the hospitals at which they work
 - *Not applicable to clinicians participating in a MIPS APM*

Applicability: Individual

- MIPS eligible clinician furnishes 75% or more of their covered professional services in inpatient hospital (Place of Service code 21), on-campus outpatient hospital (POS 22), or an emergency room (POS 23), based on claims for a period prior to the performance period
- Clinician is required to have at least a single service billed with POS code used for inpatient hospital or emergency room

Applicability: Group

- A facility-based group would be one in which 75% or more of eligible clinicians billing under the group's TIN are eligible for facility-based measurement as individuals

“Facility-based Scoring” for Quality and Cost Categories

▲ Attribution

- Facility-based clinicians are attributed to the hospital where they provide services to most patients
- Facility-based groups are attributed to the hospital where most facility-based clinicians are attributed
- If unable to identify a facility with the Hospital Value-based Purchasing (VBP) score to attribute clinician’s performance, that clinician/group would not be eligible for facility-based measurement and would have to participate in MIPS via other methods

▲ Scoring – Special Rules

- Some hospitals do not receive a Total Performance Score in a given year in the Hospital VBP Program, whether due to insufficient quality measure data, failure to meet requirements under the Hospital In-patient Quality Reporting (IQR) Program, or other reasons
 - In these cases, CMS will be unable to calculate a facility-based score based on the hospital’s performance, and facility-based clinicians/groups would be required to participate in MIPS via another method

“Facility-based Scoring” for Quality and Cost Categories

▲ Election

- CMS will automatically apply facility-based measurement to MIPS eligible clinicians and groups who are eligible for facility-based measurement *and who would benefit from it*
- No submission requirements for individual clinicians in facility-based measurement, but a group would need to submit data for the Improvement Activities or Promoting Interoperability performance categories at the group level in order to be measured as a facility-based group
- From the Facility-based Scoring Fact Sheet:

To give MIPS eligible clinicians the greatest opportunity for success, if a clinician who is facility-based decides to submit data for the Quality performance category as an individual, group, or virtual group, we will only apply facility-based measurement if the combined facility-based Quality and Cost performance scores are higher than the combined MIPS Quality and Cost performance category scores received through another MIPS submission.

Improvement Activities Performance Category

Basics for 2020

- ▲ 15% of your MIPS Final Score
- ▲ Total of 105 Improvement Activities approved for use in 2020
- ▲ Each activity is “weighted” and earns points based on that weight
 - Medium: worth 10 points
 - High: worth 20 points
- ▲ Select an activity and attest “yes” to completing it for 90+ continuous days
- ▲ You must earn 40 points to receive the full Improvement Activities category score
 - Small practices, non-patient facing clinicians, and/or clinicians located in rural or health professional shortage areas (HPSAs) receive double-weighting and report on no more than 2 activities to receive the highest score

Improvement Activities Performance Category

Basics for 2020

- ▲ Added (2) new Improvement Activities
 - IA_BE_25: Drug Cost Transparency
 - IA_CC_18: Tracking of clinician's relationship to and responsibility for a patient by reporting MACRA patient relationship codes (PRCs) [Voluntary now....Mandatory later]
- ▲ Modified (7) existing Improvement Activities
- ▲ Removed (15) existing Improvement Activities
- ▲ While you CAN use the same Improvement Activities from year to year, review changes and/or whether a prior Improvement Activity is still valid in 2020
- ▲ Review the 2020 “data validation file” once available to get additional vital information on your chosen Improvement Activities and CMS recommended audit documentation

Improvement Activities Performance Category



Overview:

- Modification of definition of rural areas
- Increased participation threshold for groups
- Modification of PCMH Criteria



Definition of Rural Area

2019 Final	2020 Final
<ul style="list-style-type: none">• Rural area means a ZIP code designated as rural, using the most recent Health Resources and Services Administration (HRSA) Area Health Resource File data set available.	Rural area means a ZIP code designated as rural by the Federal Office of Rural Health Policy (FORHP) using the most recent FORHP Eligible ZIP Code file available.

Improvement Activities Performance Category



Overview:

- Modification of definition of rural areas
- Increased participation threshold for groups
- Modification of PCMH Criteria



Requirement for Improvement Activity Credit for Groups

2019 Final	2020 Final
Group or virtual group can attest to an improvement activity if at least one clinician in the TIN participates.	Group or virtual group can attest to an improvement activity when at least 50% of the clinicians (in the group or virtual group) perform the same activity during any continuous 90-day period within the same performance year.

Improvement Activities Performance Category



Overview:

- Modification of definition of rural areas
- Increased participation threshold for groups
- Modification of PCMH Criteria



Patient-Centered Medical Home Criteria

2019 Final	2020 Final
<p>The practice must meet one of the following criteria:</p> <ul style="list-style-type: none">• Has received accreditation from one of four accreditation organizations that are nationally recognized:<ul style="list-style-type: none">• The Accreditation Association for Ambulatory Healthcare;• The National Committee for Quality Assurance (NCQA);• The Joint Commission; or• The Utilization Review Accreditation Commission (URAC); OR• Is participating in a Medicaid Medical Home Model or Medical Home Model; OR• Is a comparable specialty practice that has received the NCQA Patient-Centered Specialty Recognition.	<p>The practice must meet one of the following criteria:</p> <ul style="list-style-type: none">• Has received accreditation from an accreditation organization that is nationally recognized (such as the four organizations specified for PY 2019);• Is participating in a Medicaid Medical Home Model or Medical Home Model;• Is a comparable specialty practice that has received recognition through a specialty recognition program offered through a nationally recognized accreditation organization; OR• Has received accreditation from other certifying bodies that have certified a large number of medical organizations and meet national guidelines, as determined by the Secretary.

Promoting Interoperability Performance Category

Basics for 2020

- ▲ 25% of your MIPS Final Score
- ▲ Must use 2015 Edition Certified EHR Technology (CEHRT)
- ▲ Performance-based scoring at the individual measure level
- ▲ Four Objectives (with 7 measures in total to report on):
 - e-Prescribing
 - Query of Prescription Drug Monitoring Program (PDMP) measure is an optional Yes/No measure, available for bonus points (pts awarded for doing it once)
 - Removed the Verify Opioid Treatment Agreement measure
 - Health Information Exchange
 - Provider to Patient Exchange
 - Public Health and Clinical Data Exchange

Promoting Interoperability Performance Category “Reweighting”

▲ Automatic reweighting (applied without clinician action): PI 0% / Quality 70%

- Non-patient Facing
- Hospital-based
- ASC-based
- Physician Assistant
- Nurse Practitioner
- Clinical Nurse Specialist
- CRNA
- Physical Therapist
- Occupational Therapist
- Clinical Psychologist
- Speech-Language Pathologist
- Audiologist
- Registered Dietician or Nutrition Professional

- Override this automatic reweighting by submitting PI data anyway. If PI data is received, it will be scored accordingly

▲ Application-based reweighting also available for certain circumstances: PI 0% / Quality 70%

- Small practice (15 or fewer Medicare billing clinicians)
- You have decertified EHR technology
- You have insufficient Internet connectivity
- You face extreme and uncontrollable circumstances such as disaster, practice closure, severe financial distress or vendor issues
- You lack control over the availability of Certified EHR Technology (CEHRT)
- Additional information as well as the application (when available) are located here:
<https://qpp.cms.gov/mips/exception-applications> (due by 12/31/20)

Promoting Interoperability Performance Category

▲ Using PI Measure Exclusions Reallocates That Measure's Points

Exclusion Point Reallocation

Claiming This Measure's Exclusion:	Reallocates Its Points To:
e-Prescribing (10pts)	Support Electronic Referral Loops by Sending Health Information (now 25pts) & Support Electronic Referral Loops by Receiving and Incorporating Health Information (now 25pts)
Support Electronic Referral Loops by Sending Health Information (20pts)	Provide Patients Electronic Access to Their Health Information (now 60pts)
Support Electronic Referral Loops by Receiving and Incorporating Health Information (20pts)	Support Electronic Referral Loops by Sending Health Information (now 40pts)
Public Health & Clinical Data Exchange (10pts)	Provide Patients Electronic Access to Their Health Information (still 40pts if one exclusion claimed, but now 50pts if two exclusions) [If 1 exclusion is claimed, the remaining registry earns all 10 objective pts]

Point Distribution if ALL Measure Exclusions are Claimed

Objective	Measure(s)	Maximum Points
e-Prescribing	e-Prescribing	0 points exclusion claimed
	Bonus: Query of Prescription Drug Monitoring Program (PDMP)	5 bonus points
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	0 points exclusion claimed
	Support Electronic Referral Loops by Receiving and Incorporating Health Information	0 points exclusion claimed
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	100 points
Public Health and Clinical Data Exchange	Report to two different public health agencies or clinical data registries for any of the following: Immunization Registry Reporting Electronic Case Reporting Public Health Registry Reporting Clinical Data Registry Reporting Syndromic Surveillance Reporting	0 points 2 exclusions claimed

Promoting Interoperability Performance Category

▲ Change in definition of Hospital-based MIPS Eligible Clinicians in Groups

2019 Final	2020 Final
A group is identified as hospital-based and eligible for reweighting when 100% of the MIPS eligible clinicians in the group meet the definition of a hospital-based MIPS eligible clinician.	<p>A group is identified as hospital-based and eligible for reweighting when more than 75% of the NPIs in the group meet the definition of a hospital-based individual MIPS eligible clinician.</p> <p>No change to definition of an individual hospital-based MIPS eligible clinician.</p>



2020 Performance Threshold & Payment Adjustments

Performance Threshold & Payment Adjustments

2019 Final Performance Threshold

- 30 point performance threshold.
- Additional performance threshold for exceptional performance set at 75 points.
- Payment adjustment could be up to **+7%** or as low as **-7%**.



2020 Final Performance Threshold

- 45 point performance threshold
- Additional performance threshold for exceptional performance set at 85 points.
- Payment adjustment could be up to **+9%** or as low as **-9%**.

- ▲ To ensure budget neutrality, positive MIPS payment adjustment factors will be increased or decreased by an amount called a “scaling factor.” The amount of the scaling factor depends on the distribution of final scores across all MIPS eligible clinicians

Performance Threshold & Payment Adjustments

Point Breakdown and Payment Adjustment

Final Score 2020	Payment Adjustment 2022
≥85 points	<ul style="list-style-type: none">Positive adjustment greater than 0%Eligible for additional payment for exceptional performance — minimum of additional 0.5%
45.01 84.99 points	<ul style="list-style-type: none">Positive adjustment greater than 0%Not eligible for additional payment for exceptional performance
45 points	<ul style="list-style-type: none">Neutral payment adjustment
11.26 44.99	<ul style="list-style-type: none">Negative payment adjustment greater than -9% and less than 0%
0 11.25 points	<ul style="list-style-type: none">Negative payment adjustment of -9%

Note:

- ▲ The performance threshold has incrementally increased each program year
- ▲ For the 2022 program year, the performance threshold (the number in the green box) will be based on the mean or median of the final scores for all MIPS eligible clinicians in a previous year
- ▲ This means we will likely see a 2022 **minimum** performance threshold somewhere in the range of 70-85 points
- ▲ In 2022, participants will need to achieve scores that were previously considered “exceptional performance” in order to avoid a significant Medicare penalty!

Reweighting Due to Data Integrity Issues

2019 Final Performance Category Reweighting

- No formal policy to account for data integrity concerns.
- Several scenarios for reweighting have previously been finalized, including extreme and uncontrollable events (all performance categories) and hardship exemptions specific to the Promoting Interoperability performance category.



2020 Final Performance Category Reweighting

Beginning with the 2018 performance period and 2020 payment year:

- We will reweight performance categories for a MIPS eligible clinician who we determine has data for a performance category that are **inaccurate, unusable or otherwise compromised** due to circumstances outside of the control of the clinician or its agents if we learn the relevant information prior to the beginning of the associated MIPS payment year. MIPS eligible clinicians or third party intermediaries should inform CMS of such circumstances. (CMS may also independently learn of qualifying circumstances).
- If we determine that reweighting is appropriate, we will follow our existing policies for reweighting.



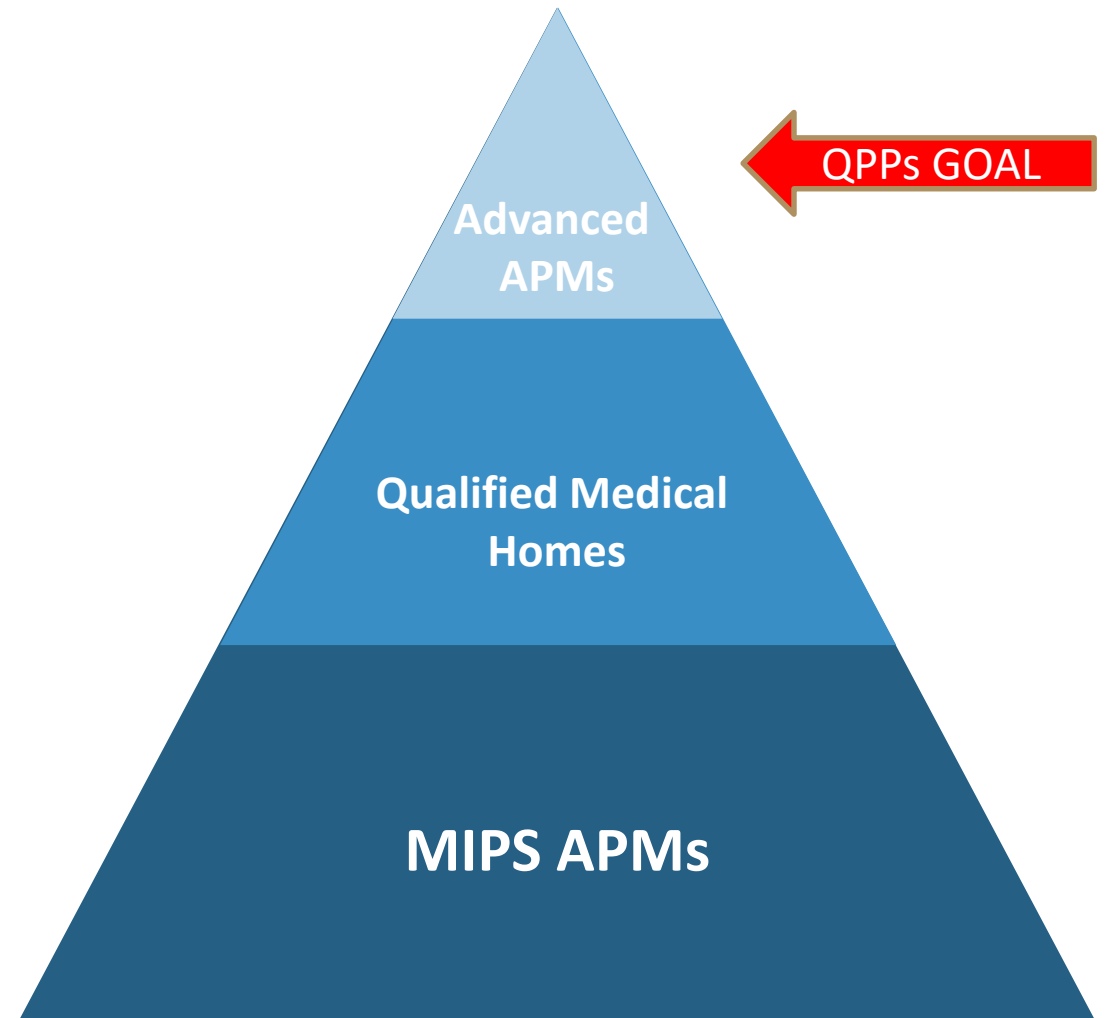
Alternative Payment Models (APMs) Overview

Alternative Payment Models (APMs) – Quick Overview

- ▲ Alternative Payment Model or APM is a **generic term** describing a payment model in which providers take **responsibility for cost and quality performance** and **receive payments to support** the services and activities designed to achieve high value
- ▲ According to MACRA, APMs in general include:
 - Medicare Shared Savings Program (MSSP) ACOs
 - Demonstrations under the Health Care Quality Demonstration Program
 - CMS Innovation Center Models
 - Demonstrations required by Federal Law
- ▲ MACRA does not change how any particular APM pays for medical care and rewards value; program adds incentives to existing model
- ▲ APM participants also participating in MIPS may receive favorable scoring under certain MIPS performance categories
- ▲ Only **some** APMs are “**Advanced**” APMs

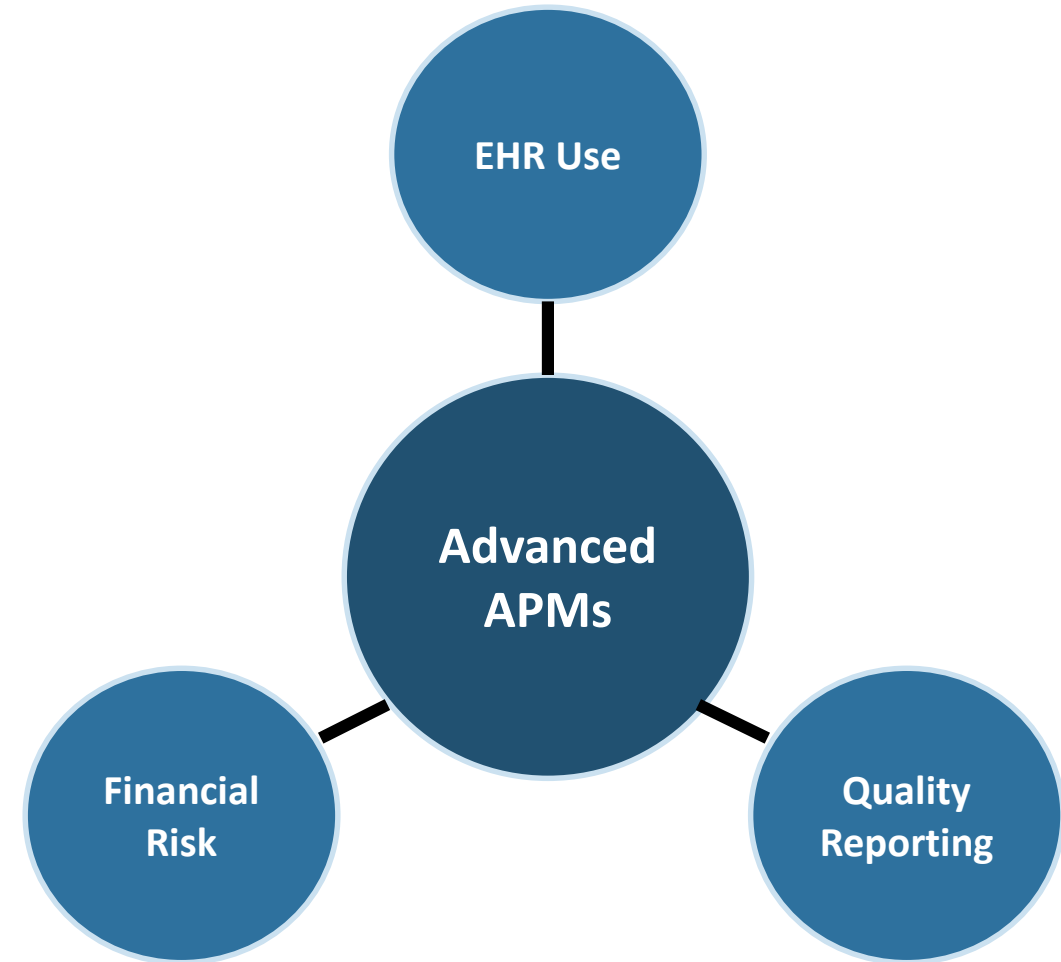
Alternative Payment Models (APMs)

- ▲ “Advanced” APMs – Term established by CMS; these have the greatest risks and offer potential for greatest rewards
- ▲ Qualified Medical Homes (must be expanded under CMS authority) have different risk structure but are otherwise treated as Advanced APMs
- ▲ MIPS APMs receive favorable MIPS scoring, but participants must still participate in MIPS track of the Quality Payment Program



Criteria for Advanced APMs

- ▲ 75% of participants must use certified EHR Technology (CEHRT)
- ▲ Must report and at least partially base clinician payments on quality measures comparable to MIPS
- ▲ Bear “more than nominal risk” for monetary losses
 - Defined as the lesser of 8% of total Medicare revenues or 3% of total Medicare expenditures



Volume Thresholds for Advanced APMs

Qualifying APM Participant (QP) Status

- ▲ A “Qualifying APM” is one that meets increasing thresholds for the percentage of charges *from attributed beneficiaries* that pass through the APMs payment methodology
- ▲ An individual Eligible Clinician (EC) in a qualifying APM is a “Qualifying APM Participant” or “QP”
- ▲ QP status is awarded to all Advanced APM participants collectively (or to none as the case may be)

What if the threshold for QP status is not met?

- ▲ If the Advanced APM does not meet the volume threshold to qualify its members for QP status, members meeting lower, minimum thresholds are considered “Partially Qualifying APM Participants” or “PQPs”
- ▲ If a PQP chooses to stay in the APM track, s/he will not receive the 5% bonus, but will not be subject to MIPS
- ▲ If PQP chooses, s/he can report MIPS measures and participate in the MIPS incentive track
- ▲ If the APM does not meet PQP thresholds, the participants are subject to MIPS reporting and scoring under the APM Scoring Standard (report in the same way as a MIPS APM Participant)

Becoming a Qualifying APM Participant (QP)



Payment Amount Method

\$\$\$ for Part B professional services to **attributed beneficiaries**

=

Threshold Score %

\$\$\$ for Part B professional services to **attribution-eligible beneficiaries**



Patient Count Method

of attributed beneficiaries given Part B professional services

=

Threshold Score %

of attribution-eligible beneficiaries given Part B professional services

**Requirements for Incentive Payments
for Significant Participation in Advanced APMs
(Clinicians must meet payment or patient requirements)**



Performance Year	2017	2018	2019	2020	2021	2022 and later
Percentage of Payments through an Advanced APM	25%	25%	50%	50%	75%	75%
Percentage of Patients through an Advanced APM	20%	20%	35%	35%	50%	50%

Incentives for Advanced APM Participation (as a QP)

▲ Model design

- APMs have shared savings, flexible payment bundles, and other desirable features; these are not affected by the QPP

▲ Bonuses

- In 2019-2024, 5% lump sum bonus payments made to ECs significantly participating in Advanced APMs

▲ Higher reimbursement updates

- Annual baseline payment updates will be higher (0.75%) for Advanced APM participants than for MIPS participants (0.25%) starting in 2026

▲ MIPS exemption

- QPs in Advanced APMs do not participate in MIPS (models include their own EHR use and quality reporting requirements)

MIPS APMs (non-advanced)

▲ 2020 Qualified Models

- MSSP Track 1, BASIC Levels A, B, C, D are included
- Still constitute the majority of Medicare's ACOs

▲ Advanced APM benefits do not apply

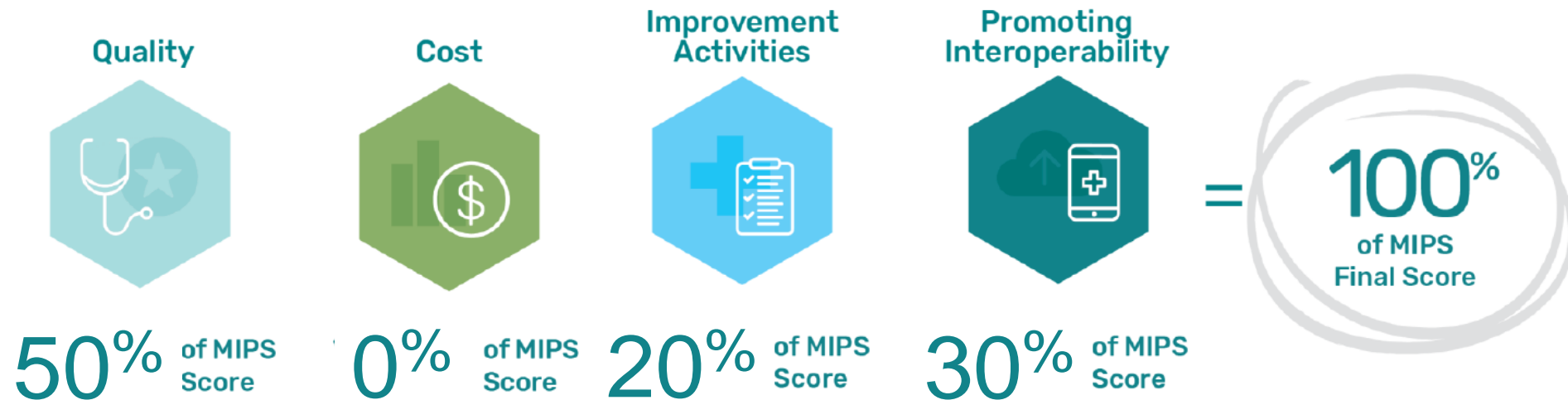
- Must participate in MIPS to receive any favorable payment adjustments
- APM entity participates as a single large group with all data aggregated to the APM entity level
- All MIPS APM participants receive the same MIPS Final Score and payment adjustment
- Do not qualify for 5% APM bonus payments 2019-2024
- Not eligible for higher baseline annual updates beginning 2026

▲ MIPS APM Benefits

- “Strength in Numbers” by participating in MIPS as a large group (APM entity)
- 2020 MIPS APMs receive full credit in the Improvement Activities performance category
- As cost is already assessed as part of the APM, no additional MIPS Cost category considerations
- APM-specific rewards (e.g., shared savings)
- Eligible for annual MIPS bonuses, which continue indefinitely (vs. 6 years for 5% APM bonuses)

APM Scoring Standard (MIPS APMs)

- ▲ The APM scoring standard offers a special, minimally-burdensome way of participating in MIPS for eligible clinicians in APMs who do not meet the requirements to become QPs and are therefore subject to MIPS, or eligible clinicians who meet the requirements to become a Partial QP and therefore able to choose whether to participate in MIPS



Alternative Payment Models (APMs)

2019 Final Quality Scoring

MIPS APMs receive quality scores based on their participation in the model. If no data is available for scoring, the category is reweighted to:

- **75%** Promoting Interoperability and **25%** Improvement Activities

Exception: We will use data submitted by the Participant TIN in a Shared Saving Program ACO in the rare event that no data is submitted by the Entity.

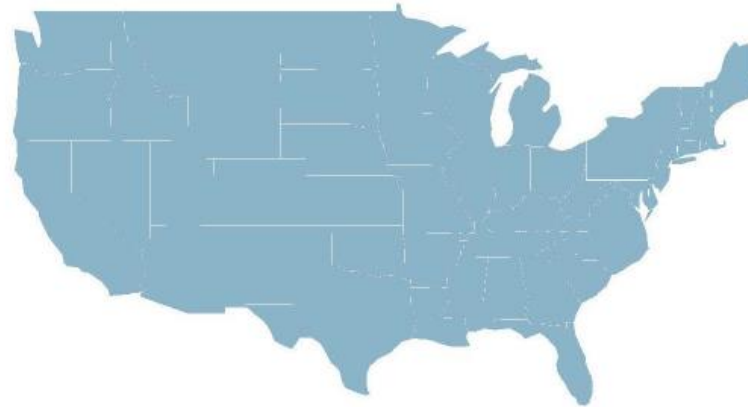


2020 Final Quality Scoring

- Allow MIPS eligible clinicians participating in MIPS APMs to report on MIPS quality measures in a manner similar to the Promoting Interoperability under the APM Scoring Standard for purposes of the MIPS Quality performance category.
- Allow MIPS eligible clinicians in MIPS APMs to receive a score for the Quality performance category either through individual or TIN-level reporting based on the generally applicable MIPS reporting and scoring rules for the Quality performance category.
- Apply a minimum score of 50 percent, or an **“APM Quality Reporting Credit”** under the MIPS Quality performance category for certain APM entities participating in MIPS, where APM quality data are not used for MIPS purposes.

Free Technical Assistance

CMS has no cost resources and organizations on the ground to provide help to clinicians who are participating in the Quality Payment Program:



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 assistance getting connected, contact QPPSURS@IMPAQINT.com.

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: 1-877-715-622 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.

Go to www.qppresourcecenter.org and click “Join Now”



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