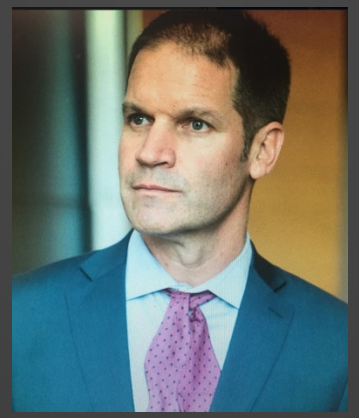

Chris Bruns
Product Manager

MACRA and The Quality Payment Program: Session 5
Summing It All Up: Determining Your Final Score

An ongoing series examining what the federal HIT initiatives mean to you and how MedInformatix will help you succeed.

Today's presentation and slide deck will be available on MICentral on 4/7/2017.

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MAJOR TOPICS COVERED

Quality Payment Program

Repeated Exposure: QPP

MIPS

Repeated Exposure: MIPS

MIPS Scoring Examples

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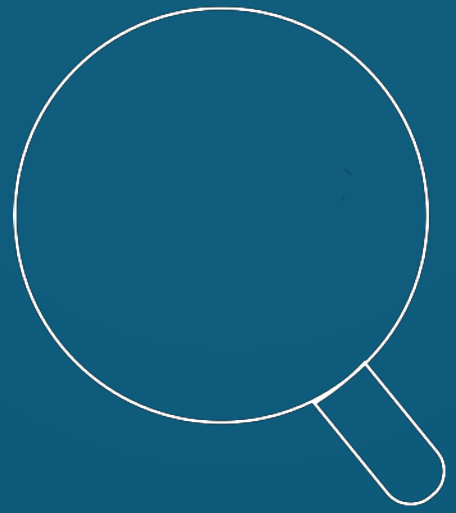

Repeated Exposure: The QPP

THE QUALITY PAYMENT PROGRAM

The Quality Payment Program policy will:

- Reform Medicare Part B payments for more than 600,000 clinicians
- Improve care across the entire health care delivery system

Clinicians have two tracks to choose from:

MIPS

The Merit-based Incentive Payment System (MIPS)

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

OR

Advanced APMs

Advanced Alternate Payment Models (APMs)

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

Graphics Courtesy of CMS

WHAT DOES THE QUALITY PAYMENT PROGRAM DO?

Creates Medicare payment methods that promote quality over volume by:

Repealing SGR formula

Creating two tracks:

MIPS — Merit-based Incentive Payment System (MIPS)

Advanced APMs — Advanced Alternative Payment Models (Advanced APMS)

Streamlining legacy programs

Providing 5% incentive to Advanced APM participants

Establishing PTAC, the Physician-focused Payment Model Technical Advisory Committee

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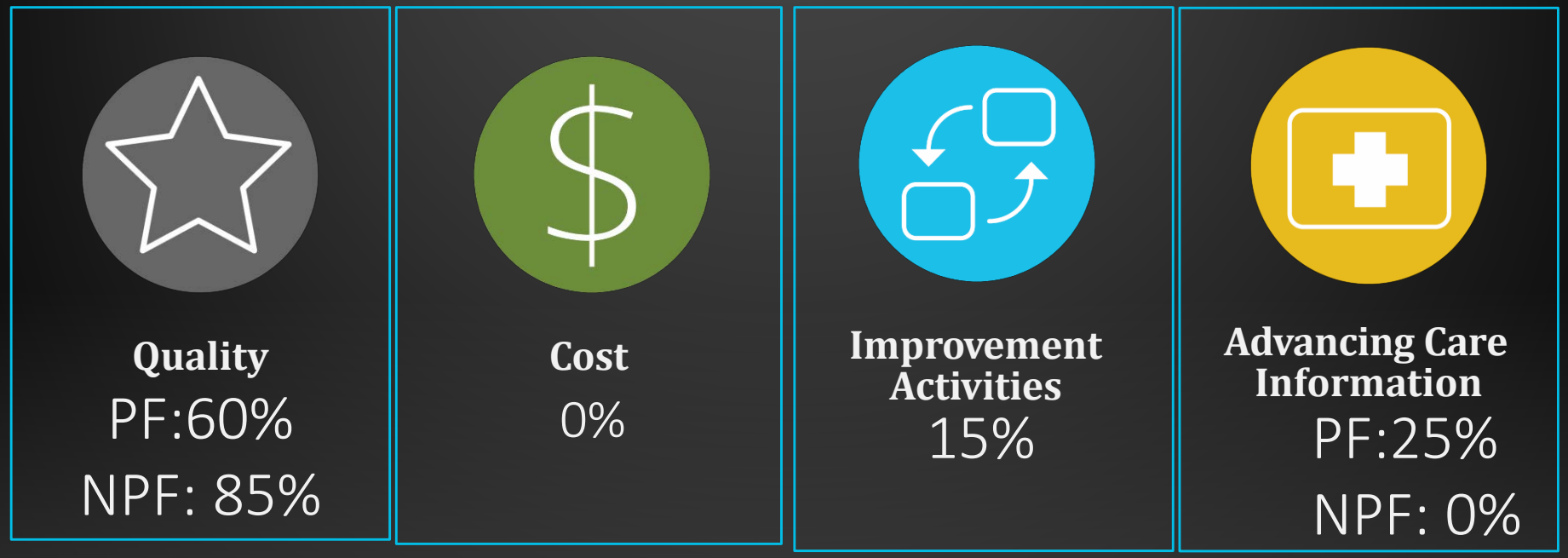
WHAT ARE THE PERFORMANCE CATEGORY WEIGHTS?

Weights assigned to each category based on a 1 to 100 point scale

Transition Year Weights



Note: These are defaults weights; the weights can be adjusted in certain circumstances

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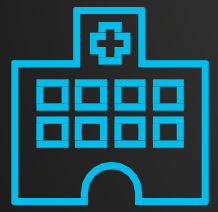
WHICH PICK YOUR PACE OPTIONS ARE SCORED?

Participate in an Advanced Alternative Payment Model



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

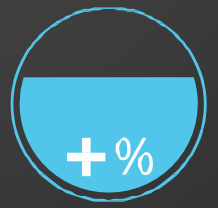
MIPS

Test Pace

Submit Something

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

Partial Year



Submit a Partial Year

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

Full Year

Submit a Full Year

- Fully participate starting January 1, 2017
- Modest positive payment adjustment

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

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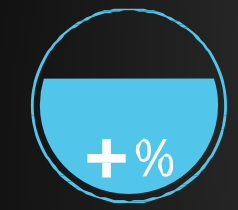
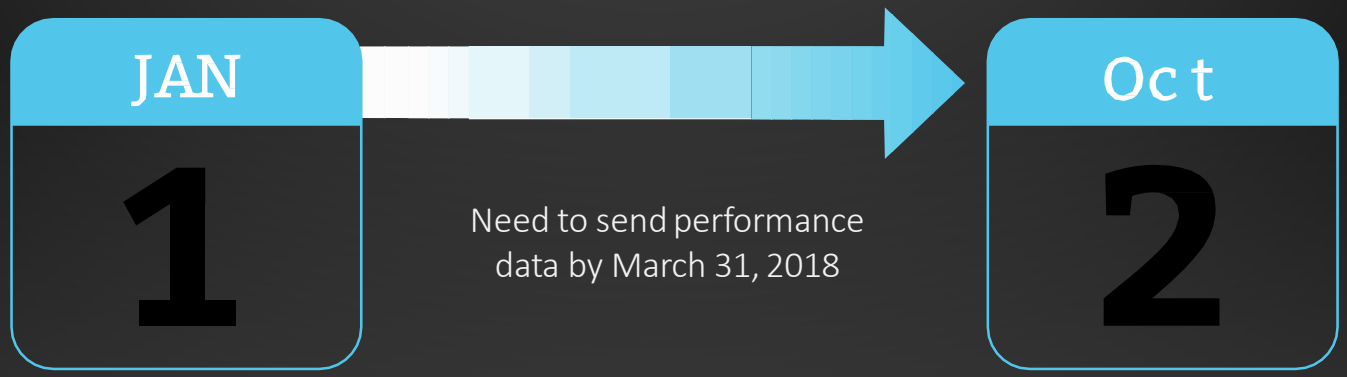
MIPS: PARTIAL PARTICIPATION FOR 2017



Submit a Partial Year

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

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



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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.

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GET YOUR DATA TO CMS

	Individual	Group
Quality	✓ **QCDR (Qualified Clinical Data Registry)** ✓ **Qualified Registry** ✓ **EHR** ✓ **Claims**	✓ **QCDR (Qualified Clinical Data Registry)** ✓ **Qualified Registry** ✓ **EHR** ✓ **Administrative Claims** ✓ **CMS Web Interface (groups of 25 or more)** ✓ **CAHPS for MIPS Survey**
Advancing Care Information	✓ Attestation ✓ QCDR ✓ Qualified Registry ✓ EHR Vendor	✓ Attestation ✓ QCDR ✓ Qualified Registry ✓ EHR Vendor ✓ CMS Web Interface (groups of 25 or more)
Improvement Activities	✓ Attestation ✓ QCDR ✓ Qualified Registry ✓ EHR Vendor	✓ Attestation ✓ QCDR ✓ Qualified Registry ✓ EHR Vendor

WORKING WITH A THIRD PARTY INTERMEDIARY ARE THERE ANY COSTS?

Intermediary	Approval Needed	Cost to Clinician
EHR Vendor	EHR Vendors Must be certified by ONC	x
QCDR	QCDRs must be approved by CMS	x
Qualified Registry	Qualified Registries must be approved by CMS	x
CMS Approved CAHPS Vendor	CAHPS Vendors must be approved by CMS	x

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REVIEWING THE MIPS PERFORMANCE CATEGORIES

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MIPS PERFORMANCE CATEGORY: QUALITY

- Category Requirements
  - Replaces PQRS and Quality Portion of the Value Modifier
  - *"So what?"*—Provides for an easier transition due to familiarity

of final score

Select 6 of about 300 quality measures (minimum of 90 days to be eligible for maximum payment adjustment); 1 must be:

- Outcome measure OR
- High-priority measure—defined as outcome measure, appropriate use measure, patient experience, patient safety, efficiency measures, or care coordination

Different requirements for groups reporting CMS Web Interface or those in MIPS APMs

May also select specialty-specific set of measures

Readmission measure for group submissions that have ≥ 16 clinicians and a sufficient number of cases (no requirement to submit)

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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

Graphics Courtesy of CMS

MIPS PERFORMANCE CATEGORY: ADVANCING CARE INFORMATION

BASE SCORE	+	PERFORMANCE SCORE	+	BONUS SCORE	=	FINAL SCORE
Account for **50%** of the **total Advancing Care Information Performance** Category Score		Account for up to **90%** of the total **Advancing Care Information Performance** Category Score		Account for up to **15%** of the total **Advancing Care Information Performance** Category Score		Earn 100 or more percent and receive FULL 25 points of the total Advancing Care Information Performance Category Final Score

The overall Advancing Care Information score is made up of a base score, a performance score, and a bonus score for a maximum score of 100 percentage points

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EXAMPLE OF 2017 MIPS PARTICIPATION FOR A CARDIOLOGIST

Flexibility to CHOOSE WHAT and HOW you report

Payment adjustments according to composite score

Sample Quality Measures (6, Including 1 Outcome):

1. Closing the referral loop with referring provider
2. Documentation of current medications
3. Statins for primary prevention in high-risk patients and for treatment in patients with known CVD
4. *Chronic anticoagulation therapy for patients with non-valvular atrial fibrillation (AFib) based on CHADS2 risk score
5. *Avoidance of inappropriate cardiac stress imaging in low-risk patients
6. Controlling high blood pressure (outcome measure)

Sample Improvement Activities (2 High-Weighted):

1. Provide 24/7 access to eligible clinicians or groups who have real-time access to patient's medical record.
2. Use of QCDR for feedback reports that incorporate population health.

Advancing Care Information (Use of Technology) Measures (5 Base Score and 1 Performance Score):

1. Security Risk Analysis
2. e-Prescribing
3. Provide Patient Access
4. Send a Summary of Care
5. Request/Accept a Summary of Care
6. Secure Messaging (performance score)

**measure supported by American College of Cardiology Pinnacle QCDR*

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WHAT IS THE SCORING METHODOLOGY FOR THE MERIT-BASED INCENTIVE PAYMENT SYSTEM?

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MIPS SCORING FOR QUALITY (60% OF FINAL SCORE)

Select 6 of the approximately 300 available quality measures (minimum of 90 days)

- Or a specialty set
- Or CMS Web Interface measures
- Readmission measure is included for group reporting with groups with at least 16 clinicians and sufficient cases

Clinicians receive 3 to 10 points on each quality measure based on performance against benchmarks

Failure to submit performance data for a measure = 0 points

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

Bonus points are available

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MIPS SCORING FOR QUALITY (60% OF FINAL SCORE)

Year 1 participants automatically receive 3 points for completing and submitting a measure

If a measure can be reliably scored against a benchmark, then clinician can receive 3 – 10 points

- Reliable score means the following:
- Benchmarks exists (see next slide for rules)
- Sufficient case volume (>=20 cases for most measures; >=200 cases for readmissions)
- Data completeness met (at least 50 percent of possible data is submitted)

If a measure cannot be reliably scored against a benchmark, then clinician receives 3 points

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

Graphics Courtesy of CMS

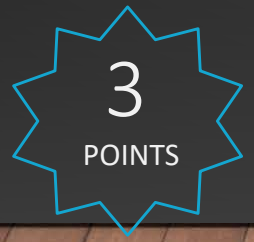
MIPS SCORING FOR QUALITY (60% OF FINAL SCORE)

More About Benchmarks

- Separate benchmarks for different reporting mechanisms
  - EHR, QCDR/registries, claims, CMS Web Interface, administrative claim measures, and CAHPS for MIPS

- All reporters (individuals and groups regardless of specialty or practice size) are combined into one benchmark

- Need at least 20 reporters that meet the following criteria:
  - Meet or exceeds the minimum case volume (has enough data to reliably measured)
  - Meets or exceeds data completeness criteria
  - Has performance greater than 0 percent



Why this matters? Not all measures will have a benchmark. If there is no benchmark, then a clinician only receives 3 points.

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MIPS SCORING FOR QUALITY (60% OF FINAL SCORE)

Bonus Points

Clinicians receive bonus points for either of the following:

1 Submitting an additional high-priority measure

- 2 bonus points for each additional outcome and patient experience measure
- 1 bonus point for each additional high-priority measure

2 Using CEHRT to submit measures to registries or CMS

- 1 bonus point for submitting electronically end-to-end

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MIPS SCORING FOR QUALITY (60% OF FINAL SCORE)

Total Quality Performance Category Score

$$= \frac{\{\text{Points earned on required 6 quality measures}\} + \{\text{Any bonus points}\}}{\text{Maximum number of points*}}$$

Quick Tip: Maximum score cannot exceed 100%

*Maximum number of points = # of required measures x 10

Graphics Courtesy of CMS

MIPS SCORING FOR QUALITY (60% OF FINAL SCORE)

Maximum Number of Points

CMS Web Interface Reporter total score

- for groups with complete reporting and the readmission measure

- for groups with complete reporting and no readmission measure

Other submission mechanisms total score

- for 6 measures + 1 readmission measure

- if readmission measure does not apply

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MIPS SCORING FOR QUALITY (60% OF FINAL SCORE)

Example: Assigning Points Vased on Deciles

DECILE	Decile 1	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Possible POINTS	1.0-1.9	2.0-2.9	3.0-3.9	4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10

0% 7% 16% 23% 36% 41% 62% 69% 79% 85% 100%

Example of decile breaks for a specific quality measure

Eligible clinician with 19% performance rate would get approximately 3.3 points (based on distribution within the decile).

Eligible clinician with 95% performance rate would get 10 points.

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MIPS SCORING FOR IMPROVEMENT ACTIVITIES (15% OF FINAL SCORE)

Total points = 40

Activity Weights

- Medium = 10 points
- High = 20 points

Alternate Activity Weights*

- Medium = 20 points
- High = 40 points

*For clinicians in small, rural, and underserved practices or with non-patient facing clinicians or groups

Full credit for clinicians in a patient-centered medical home, Medical Home Model, or similar specialty practice

Graphics Courtesy of CMS

MIPS SCORING FOR IMPROVEMENT ACTIVITIES (15% OF FINAL SCORE)

Improvement Activities Performance Category Score

$$= \left\{ \frac{\text{Total number of points scored for completed activities}}{\text{Total maximum number of points (40)}} \right\} \times 100$$

Quick Tip: Maximum score cannot exceed 100%

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MIPS SCORING FOR ADVANCING CARE INFORMATION (25% OF FINAL SCORE): BASE SCORE

50% Base score (worth 50%)

Clinicians must submit a numerator/denominator or Yes/No response for each of the following required measures:

Advancing Care Information Measures

- Security Risk Analysis
- e-Prescribing
- Provide Patient Access
- Send a Summary of Care
- Request/Accept a Summary of Care

2017 Advancing Care Information Transition Measures

- Security Risk Analysis
- e-Prescribing
- Provide Patient Access
- Health Information Exchange

0% Failure to meet reporting requirements will result in base score of zero, and an advancing care information performance score of zero.

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MIPS SCORING FOR ADVANCING CARE INFORMATION (25% OF FINAL SCORE): PERFORMANCE SCORE

90% Performance Score (worth up to 90%)

- Report up to **7** 2017 Advancing Care Information Transition Measures

Each measure is worth 10-20%.
The percentage score is based on the performance rate for each measure:

Performance Rate 1-10	1%
Performance Rate 11-20	2%
Performance Rate 21-30	3%
Performance Rate 31-40	4%
Performance Rate 41-50	5%
Performance Rate 51-60	6%
Performance Rate 61-70	7%
Performance Rate 71-80	8%
Performance Rate 81-90	9%
Performance Rate 91-100	10%

MIPS SCORING FOR ADVANCING CARE INFORMATION (25% OF FINAL SCORE): BONUS SCORE

5% BONUS

for reporting on any of these Public Health and Clinical Data Registry Reporting measures:

- Syndromic Surveillance Reporting
- Electronic Case Reporting
- Public Health Registry Reporting
- Clinical Data Registry Reporting

10% BONUS

for using CEHRT to report certain Improvement Activities

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MIPS SCORING FOR ADVANCING CARE INFORMATION (25% OF FINAL SCORE)

Advancing Care Information Performance Category Score =

Base Score + Performance Score + Bonus Score

Quick Tip:
Maximum score will be capped at 100%

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SCORING SCENARIOS

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CALCULATING THE FINAL SCORE UNDER MIPS:

THE TWO SCENARIOS: PATIENT AND NON-PATIENT FACING

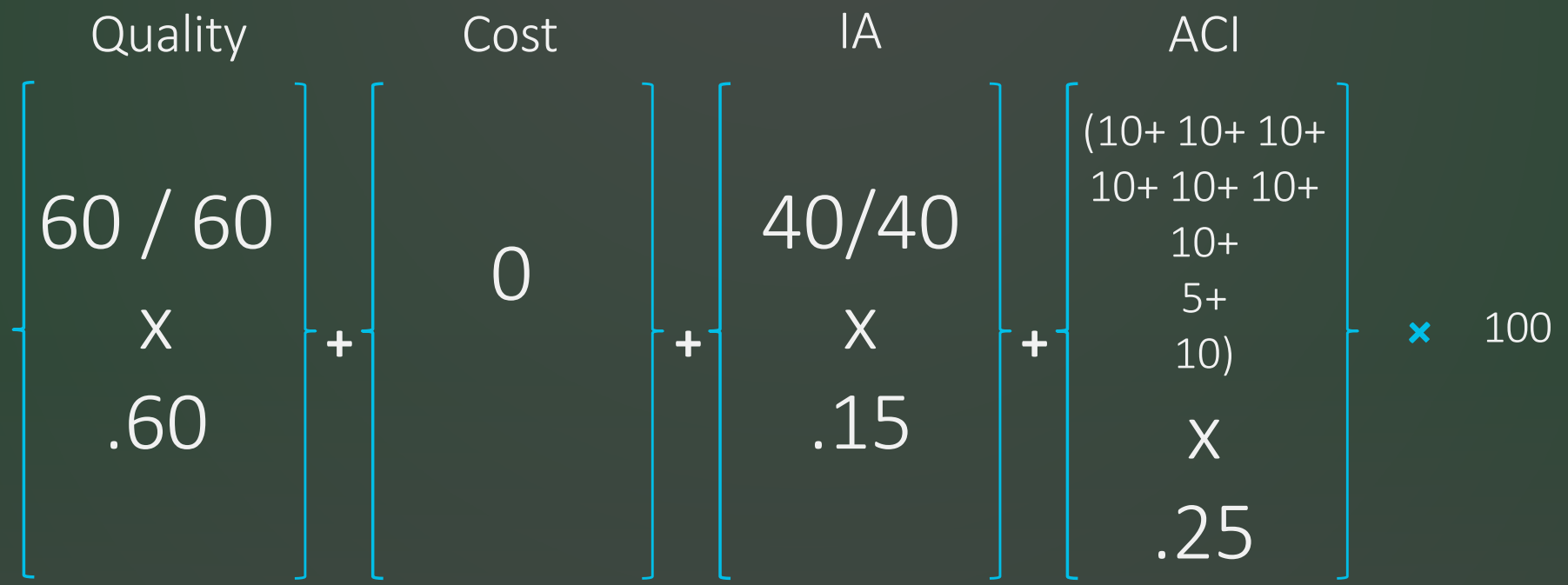
Final Score =

[Clinician Quality performance category score x actual Quality performance category weight] + [Clinician Cost performance category score x actual Cost performance category weight] + [Clinician Improvement Activities performance category score x actual Improvement Activities performance category weight] + [Clinician Advancing Care Information performance category score x actual Advancing Care Information performance category weight] × 100

PF: 60% + 0% + 15% + 25%

NPF: 85% + 0% + 15% + 0%

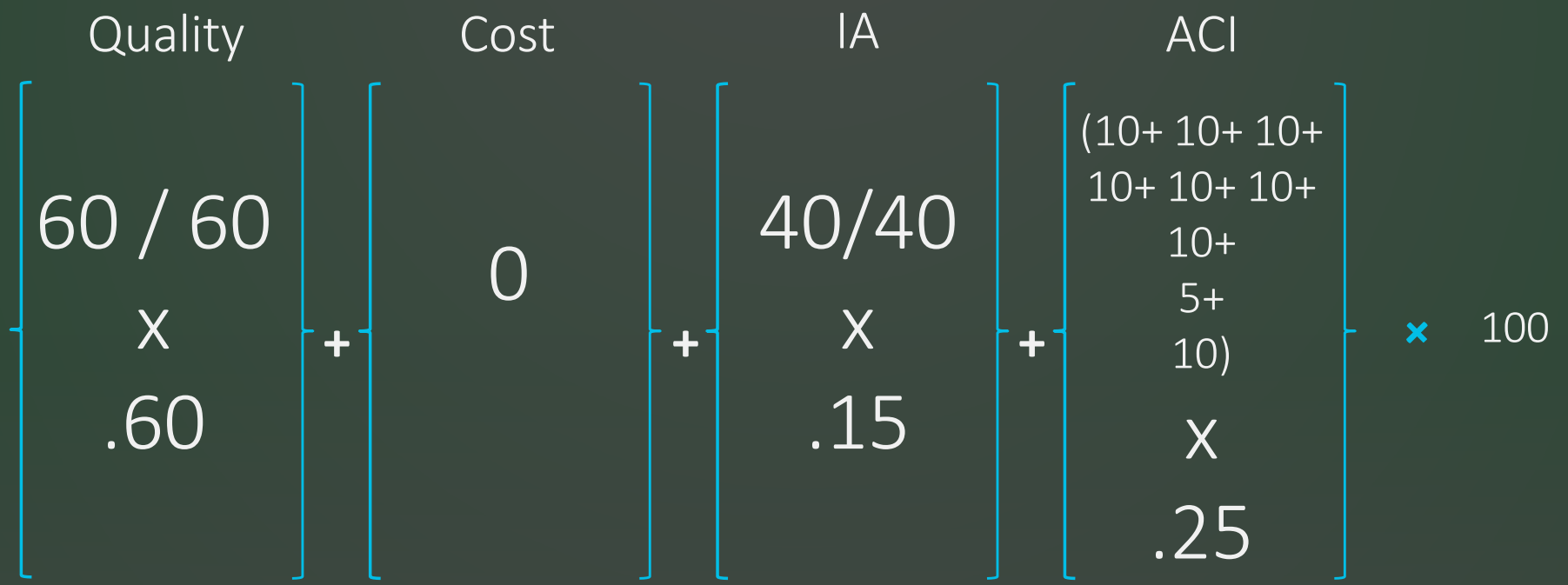
CALCULATING THE FINAL SCORE UNDER MIPS PATIENT-FACING, FULL YEAR REPORTING



Final Score: 100%

Results in: Maximum positive adjustment

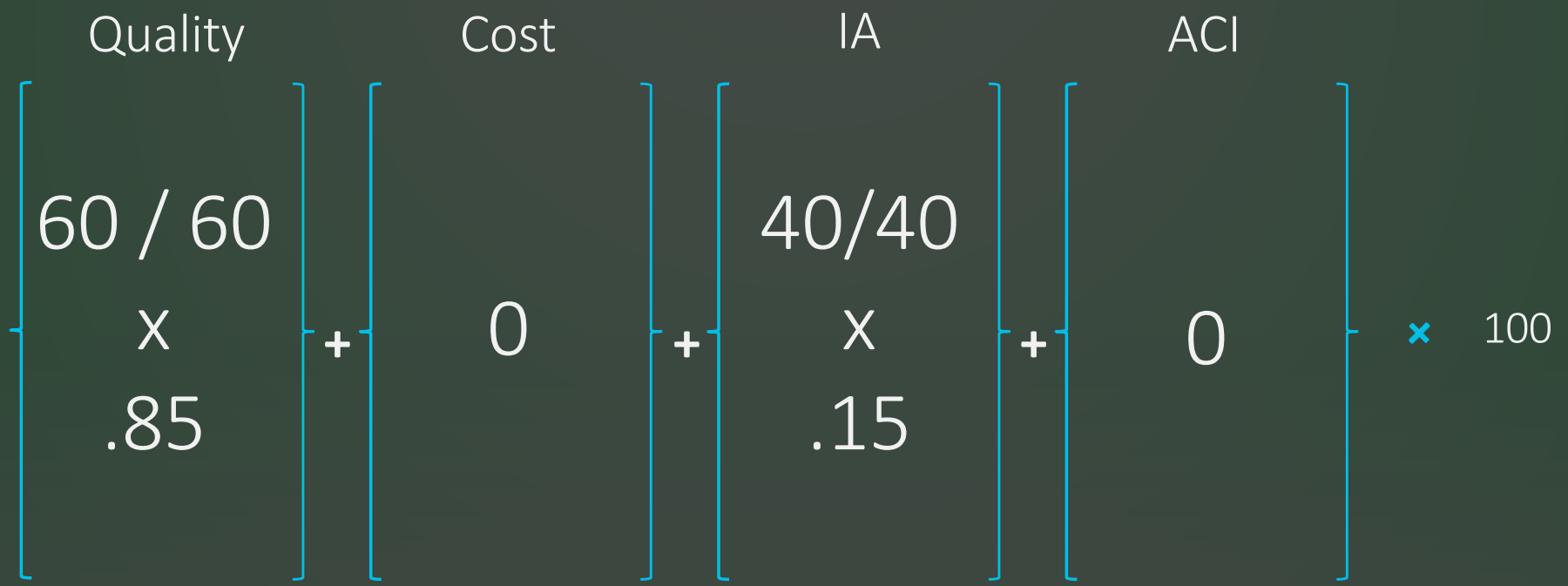
CALCULATING THE FINAL SCORE UNDER MIPS PATIENT-FACING, 90-DAY REPORTING



Final Score: 100%

Results in: "Some" positive adjustment

CALCULATING THE FINAL SCORE UNDER MIPS
NON-PATIENT-FACING, FULL YEAR REPORTING



Final Score: 100%

Results in: Maximum positive adjustment

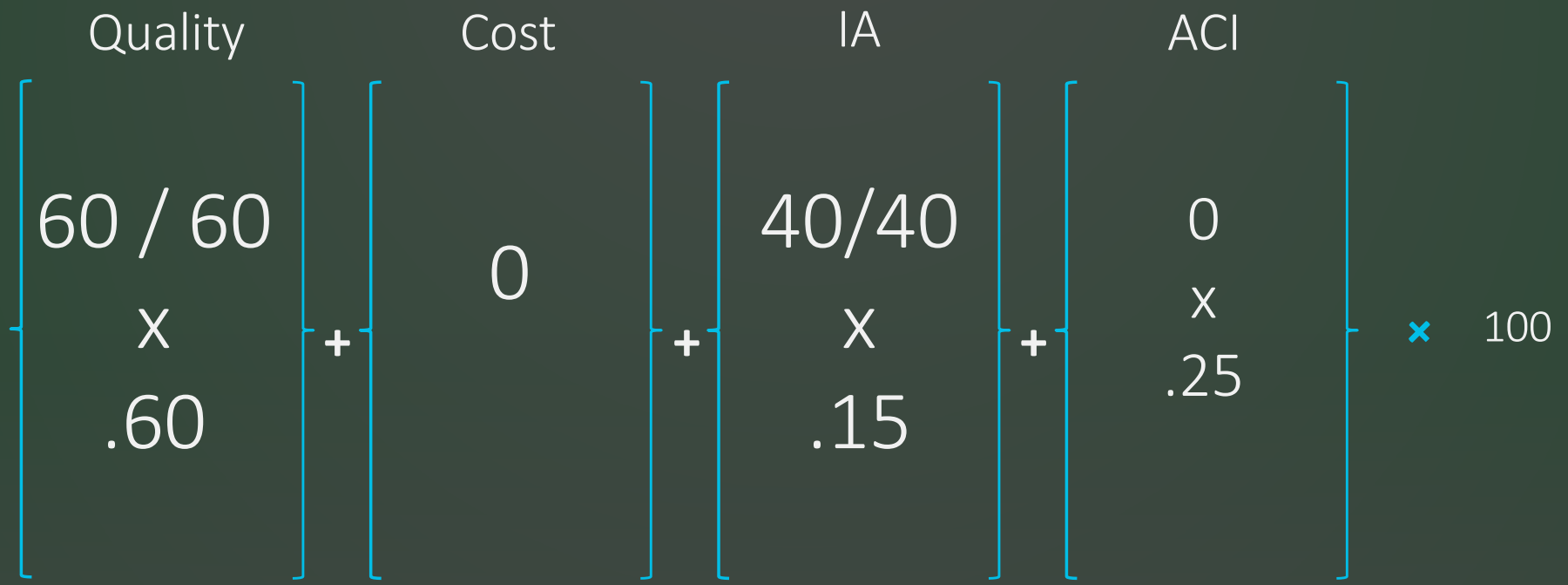
CALCULATING THE FINAL SCORE UNDER MIPS PATIENT-FACING, 90-DAY REPORTING

Quality		Cost		IA		ACI		
30 / 60 x .60	+	0	+	20/40 x .15	+	(5+ 5+ 5+ 5+ 5+ 5+ 5+) x .25	×	100

Final Score: 46.25%

Results in: "Some" positive adjustment

CALCULATING THE FINAL SCORE UNDER MIPS
PATIENT-FACING, FULL YEAR REPORTING
FAILED TO PERFORM SECURITY RISK ANALYSIS

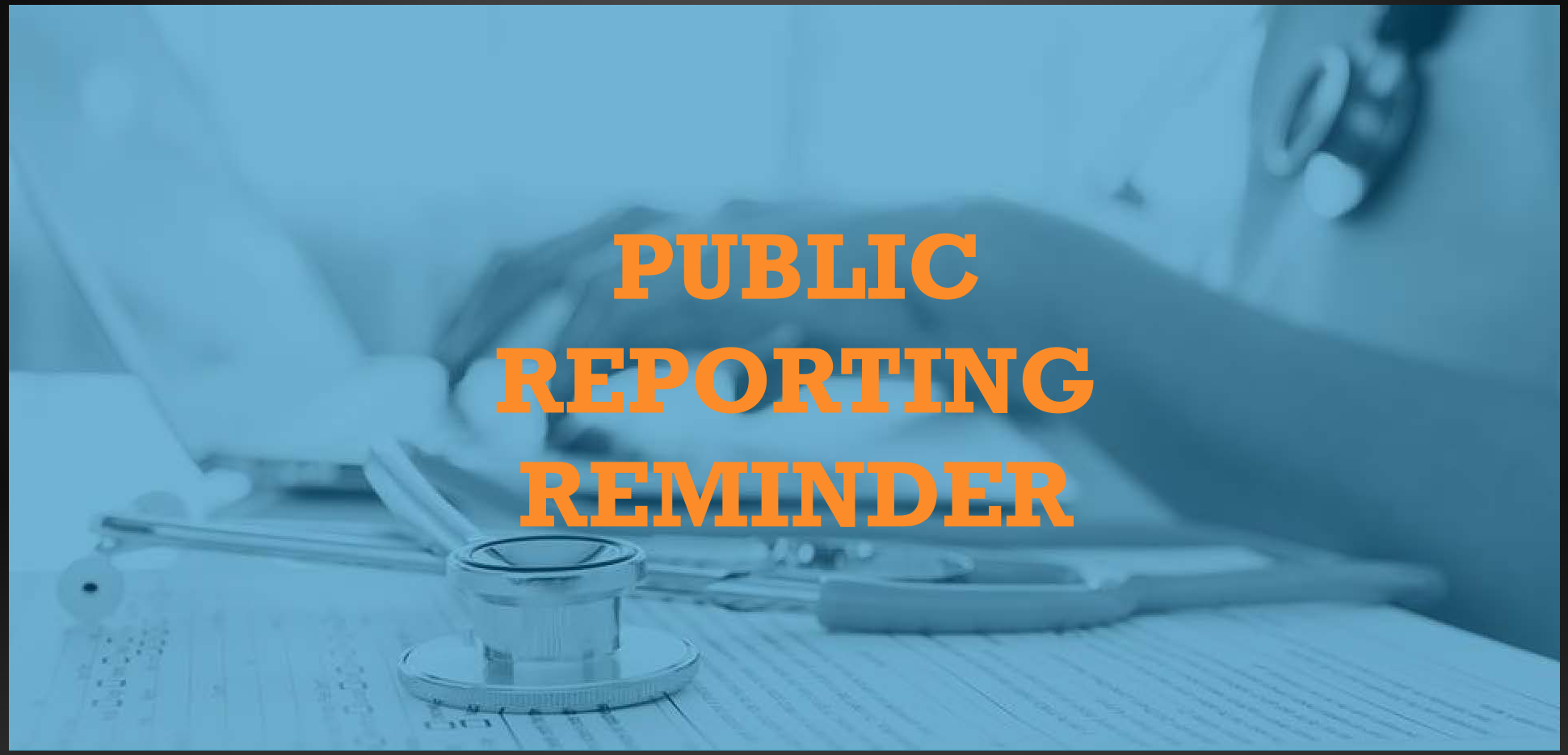


Final Score: 75%

Results in: "Some" positive payment adjustment

CALCULATING THE FINAL SCORE UNDER MIPS
USE A SPREADSHEET TO TRY SCENARIOS OR TRACK ONGOING SCORES

Scenario	Quality	Cost	IA	ACI	Final Score
PF, Full Year, High Performance	0.6	0	0.15	0.25	**100**
PF, 90 Days, High Performance	0.6	0	0.15	0.25	**100**
NPF, Full Year, High Performance	0.85	0	0.15	0	**100**
PF, 90 Days, Low Performance	0.3	0	0.075	0.0875	**46.25**
PF, Full Year, Failed Security Risk Analysis	0.6	0	0.15	0	**75**



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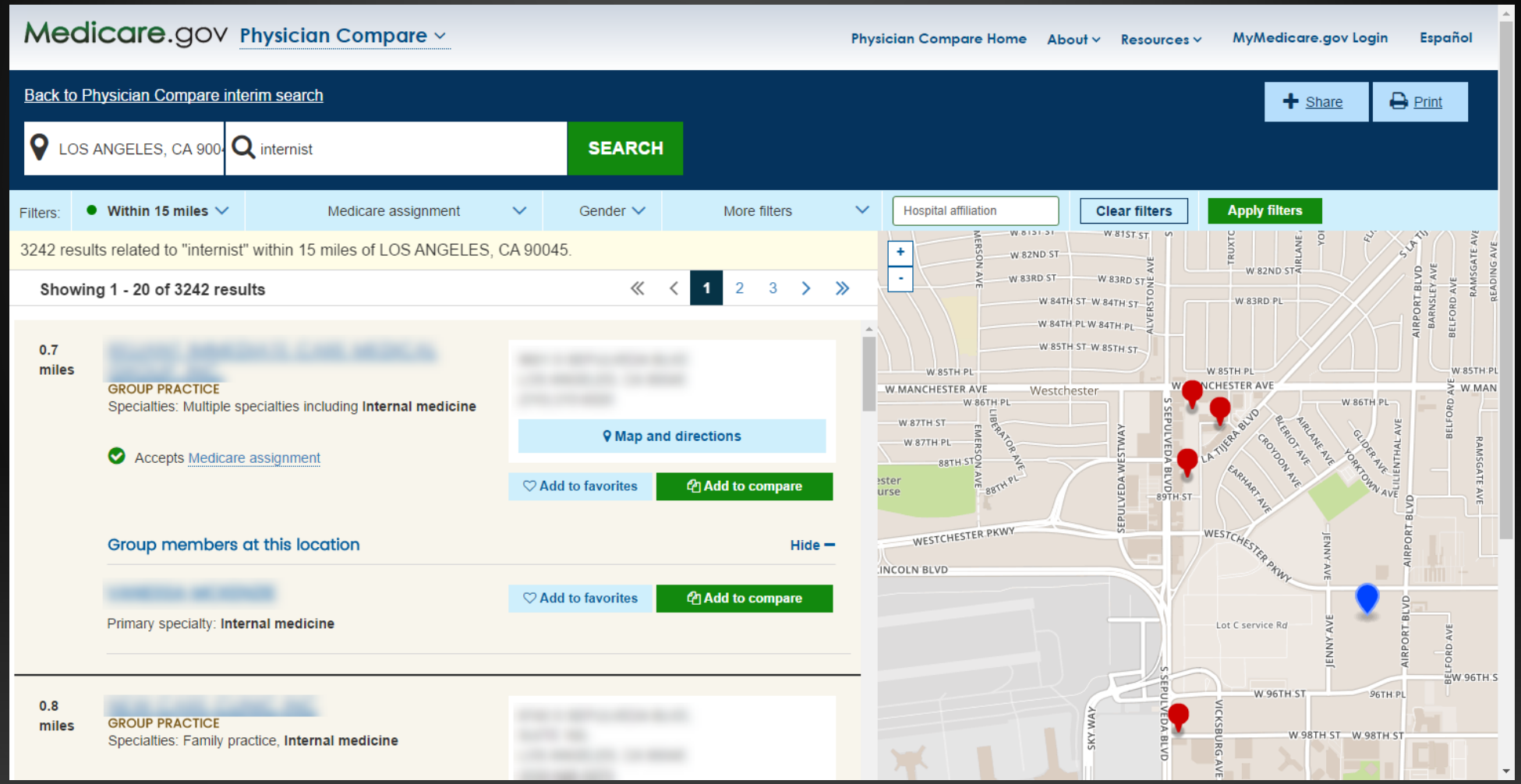
PUBLIC REPORTING



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WHERE CAN I GO TO LEARN MORE?

TECHNICAL ASSISTANCE

CMS has organizations on the ground to provide help to clinicians who are eligible for the Quality Payment Program:

Quality Payment Program Portal

- Learn about the Quality Payment Program, explore the measures, and find educational tools and resources.

Transforming Clinical Practice Initiative (TCPI):

- Designed to support more than 140,000 clinician practices over the next 4 years in sharing, adapting, and further developing their comprehensive quality improvement strategies.

Quality Innovation Network (QIN)-Quality Improvement Organizations (QIOs):

- Includes 14 QIN-QIOs
- Promotes data-driven initiatives that increase patient safety, make communities healthier, better coordinate post-hospital care, and improve clinical quality.

The Innovation Center's Learning Systems provides specialized information on:

- Successful Advanced APM participation
- The benefits of APM participation under MIPS

Graphics Courtesy of CMS

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Do you need technical assistance to help you participate in the Quality Payment Program? The Centers for Medicare & Medicaid Services has specialized programs and resources for eligible clinicians across the country.

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.

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

SMALL & SOLO PRACTICES

Small, Underserved Rural Support Technical Assistance

- 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.
  - Organizations selected to provide this technical assistance will be available in late 2016.

LARGE PRACTICES

Quality Innovation Network-Quality Improvement Organizations (QIN-QIO) Education and Support

- 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

Advanced Alternative Payment Model (APM) Learning Networks
Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs.

Q&A

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