Quality Payment Program

MIPS: Quality Category for 2017

Wednesday, April 19, 2017
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Learning Objectives/Agenda

• Quick review of Quality Payment Program and MIPS (Slides 4-12)
• Focus is the Quality Category – 60 possible points
• How do I choose my Quality Measures? (Slides 13-17)
• Components of a Quality Measure (Slides 18-19)
• Scoring Your Quality Measures (Slides 20-27)
• Reporting Methods (Slides 28-30)
• Summary (Slides 31-33)
• Quality Insights Staff and Contact Information (Slide 34-35)
• Quality Insights Resources (Slide 36)
• Questions (Slide 37)
The Quality Payment Program (QPP)

• A payment system that rewards value and outcomes
• Key point: We are all part of the QPP
  – Eligible clinicians or ECs (new term)
  – Office staff including billers/coders
  – Patients and family members
  – CMS
  – EHR vendors
  – Quality Insights QIN

We all share a similar goal to improve patient outcomes.
QPP & MIPS Review
What is MIPS?

• Streamlines three legacy programs (PQRS, MU, VM) into one and adds a fourth component to promote improvement and innovation in clinical activities.

• Allows clinicians flexibility to choose measures and activities that are most meaningful to their practice.
Two Tracks in the QPP

- In 2017, clinicians and groups are ‘graded’ based on performance in 3 categories
- MIPS score determines Medicare Part B reimbursement in 2019

- Everyone must report MIPS in 2017. CMS cannot determine who is a qualifying Advanced APM participant until the reporting period ends on 12/31/17.
- Approximately 95 percent of clinicians will be subject to MIPS.

- Participate in programs that have shared risk, such as ACOs
- Qualified participants avoid MIPS penalties and receive a 5 percent payment increase
Who is a MIPS Eligible Clinician in 2017?

- "Physician" includes:
  - MD (doctor of medicine)
  - DO (doctor of osteopathy)
  - DDS (doctor of dental surgery)
  - DDM (doctor of dental medicine)
  - DPM (podiatrist)
  - OD (optometrist)
  - DC (chiropractor)
Calculating the MIPS Score

- The MIPS Score is calculated by adding the Quality, Advancing Care Information, and Improvement Activities scores together.
‘Pick Your Pace’ Participation in 2017

Test Pace
- Submit Something
- Submit some data
- Neutral or small positive payment adjustment

Partial Year
- Submit a Partial Year
- Report data for 90 days
- Small positive payment adjustment

Full Year
- Submit a Full Year
- Report data for full year
- Modest positive payment adjustment

Non-participation in the QPP in 2017 will result in a negative 4 percent payment adjustment in 2019.
## 2017 Payment Adjustments

<table>
<thead>
<tr>
<th>MIPS Score</th>
<th>Payment Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 points</td>
<td>4% negative payment adjustment</td>
</tr>
<tr>
<td>3 points</td>
<td>No payment adjustment</td>
</tr>
<tr>
<td>4-69 points</td>
<td>Positive payment adjustment up to 4%</td>
</tr>
<tr>
<td>≥ 70 points</td>
<td>Positive payment adjustment up to 4%</td>
</tr>
<tr>
<td></td>
<td>Eligible for exceptional performance bonus with minimum of additional 0.5%</td>
</tr>
</tbody>
</table>
Select Individual OR Group Reporting

• Practices must decide whether to report data at the individual clinician level or as a group
• All MIPS categories must be reported the same way
• If practice is in an ACO, group reporting must be done

OPTIONS

Individual
- Under an NPI number and TIN where they reassign benefits

Group
- 1) As a group with ≥ 2 clinicians (NPIs) who have reassigned their billing rights to a single TIN
- 2) As an APM entity, i.e. ACO
Group Reporting

• If a practice is going to report as a group, data will be reviewed and scored at the TIN level, so it doesn't matter which ECs report the data.

• Although MIPS eligibility is determined by CMS at the individual clinician level (based on Medicare Part B claims from 9/1/15-8/31/16), non-ECs become MIPS eligible when their practice submits data at the group level.

• The group will receive one MIPS score and it will be applied to all of the providers that bill under the TIN.
Quality Category
Quality Category

- Replaces PQRS
- Select six quality measures, including one outcome measure or high priority measure
- 271 quality measures are available:

<table>
<thead>
<tr>
<th>Submission Method</th>
<th># of Available Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims</td>
<td>271</td>
</tr>
<tr>
<td>EHR</td>
<td>53</td>
</tr>
<tr>
<td>Registry</td>
<td>243</td>
</tr>
<tr>
<td>CMS Web Interface</td>
<td>15</td>
</tr>
<tr>
<td>CSV (CAHPS survey)</td>
<td>1</td>
</tr>
</tbody>
</table>
Quality Measure Selection Tips

• Review quality measure specifications.
• Check measure type to ensure you have selected at least one outcome or high priority measure.
• Check submission method for each measure. Submit all quality measures using the same method (claims or EHR or registry or web-based).
• Review numerators and denominators and codes for each measure.
• Check to see if benchmarks are available for each measure. You have the potential to earn more quality points if a benchmark exists.
• Is the measure is topped out? If so, it will be more difficult to earn quality points.
• You don’t need a certain number of domains with MIPS measures.
Quality Payment Program Website

- Measure sets are available to assist clinicians and groups in selecting measures.
Measure Selection Considerations

- What is the potential for high scoring for a “topped out” measure?
- Topped out measures show statistically indistinguishable performance at the 75th and 90th percentiles and provide little opportunity for high-scoring.
- Topped out measures are identified in the last column on the 2017 Quality Benchmarks list.

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Submission Method</th>
<th>Measure Type</th>
<th>Benchmark</th>
<th>Decile 3</th>
<th>Decile 4</th>
<th>Decile 5</th>
<th>Decile 6</th>
<th>Decile 7</th>
<th>Decile 8</th>
<th>Decile 9</th>
<th>Decile 10</th>
<th>Topped Out</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation of Current Medications in the Medical Record</td>
<td>Claims</td>
<td>Process Y</td>
<td></td>
<td>96.11 - 98.73</td>
<td>98.74 - 99.64</td>
<td>99.65 - 99.99</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>100</td>
<td>Yes</td>
</tr>
<tr>
<td>Documentation of Current Medications in the Medical Record</td>
<td>EHR</td>
<td>Process Y</td>
<td></td>
<td>76.59 - 87.88</td>
<td>87.89 - 92.73</td>
<td>92.74 - 95.35</td>
<td>95.36 - 97.08</td>
<td>97.09 - 98.27</td>
<td>98.28 - 99.12</td>
<td>99.13 - 99.75</td>
<td>&gt;= 99.76</td>
<td>Yes</td>
</tr>
<tr>
<td>Documentation of Current Medications in the Medical Record</td>
<td>Registry or QCDR</td>
<td>Process Y</td>
<td></td>
<td>61.27 - 82.11</td>
<td>82.12 - 91.71</td>
<td>91.72 - 96.86</td>
<td>96.87 - 99.30</td>
<td>99.31 - 99.99</td>
<td>--</td>
<td>--</td>
<td>100</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Example of Individual Registry Measure Specification

**Measure #134 (NQF 0418): Preventive Care and Screening: Screening for Depression and Follow-Up Plan – National Quality Strategy Domain: Community/Population Health**

**2017 OPTIONS FOR INDIVIDUAL MEASURES:**
**REGISTRY ONLY**

**MEASURE TYPE:**
Process

**DESCRIPTION:**
Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.

**INSTRUCTIONS:**
This measure is to be reported a minimum of **once per performance period** for patients seen during the performance period. This measure may be reported by eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. The follow-up plan must be related to a positive depression screening, example: “Patient referred for psychiatric evaluation due to positive depression screening”.

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This segment includes a high-level description of the measure.

This is the official measure title.

The overall classification of the measured clinical action.
Example of Individual Registry Measure Specification (cont.)

**Measure Reporting:**
The listed denominator criteria is used to identify the intended patient population. The numerator options included in this specification are used to submit the quality actions allowed by the measure. The quality-data codes listed do not need to be submitted for registry-based submissions, however, these codes may be submitted for those registries that utilize claims data.

**DENOMINATOR:**
All patients aged 12 years and older

**Denominator Criteria (Eligible Cases):**
Patients aged ≥ 12 years on date of encounter

**AND**
Patient encounter during the performance period (CPT or HCPCS): 90791, 92625, 96116, 96118, 96160, 96151, 97165, 97166, 97167, 99201, 99202, 99213, 99214, 99215, G0101, G0402, G0438, G0439, G0444

**WITHOUT**
Telehealth Modifier: GQ, GT

**AND NOT**

**DENOMINATOR EXCLUSION:**
Documentation stating the patient has a disorder, therefore screening or follow-up is unnecessary.

**NUMERATOR:**
Patients screened for depression, a follow-up plan is documented on the date of the positive screen

**Numerator Instructions:**
The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record. The depression screening must be reviewed and addressed in the office of the provider filing the code on the date of the encounter.

**Definitions:**
- Measures may or may not contain definitions.
- Screening - A tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.

Helpful Hint: Some QPP measures have similar denominator criteria or encounter type coding. Review other QPP measures to determine if there are more measures applicable to the type of patients/procedures evaluated.
Quality Scoring
Quality Scoring in 2017

- Each measure is scored with a decile range of between one and ten – higher is better.
- At least three points are awarded for each of the six measures that are successfully submitted.
- If a measure cannot be “reliably scored” against a benchmark, only three points will be awarded.
- If a measure can be “reliably scored” against a benchmark, three to ten points will be awarded.
- There are separate benchmarks for the quality measures based on the data submission method.
- All measure reporters (individuals and groups) are combined into one benchmark.
Reliable Scoring

• Reliable scoring requires the following:
• A benchmark must exist
• There is sufficient case volume (≥ 20 cases for most measures)
• Data completeness is met (≥ 50 percent of possible data is submitted)
  – All payors’ patients for the following submission methods:
    • EHR
    • Registry or QCDR
  – Only Medicare patients for the following submission methods:
    • Claims
    • CMS Web Interface
Bonus Points for the Quality Category

- **Two bonus points** are awarded for each additional outcome or patient experience measure reported in addition to the one required outcome measure.
- **One bonus point** is awarded for each additional high-priority measure reported in addition to the one required outcome/high-priority measure.
- **One bonus point** is awarded for submitting quality measures electronically end-to-end, i.e. via registry, QCDR, EHR, or CMS Web Interface.
Bonus Points Scenarios:

• Examples:
  – **Office #1:** 6 Measures with 1 Outcome and 5 Process = 0 Bonus Points
  – **Practice #2:** 6 Measures with 2 Outcome and 4 Process = 2 Bonus Points
  – **Office #3:** 6 Measures with 4 Outcome and 2 Process = 6 Bonus Points
  – **Practice #4:** 6 Measures with 1 Outcome, 1 High Priority and 4 Process = 1 Bonus Point
Maximum Quality Score

- The maximum number of points available for the quality category is based on the submission method and whether the readmission measure was calculated.
- CMS calculates the readmission measure for groups with >15 ECs that have more than 200 cases.

<table>
<thead>
<tr>
<th>Submission via claims, EHR, or registry AND</th>
<th>Submission via CMS Web Interface</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-15 MIPS clinicians in practice *NO readmission measure</td>
<td>In 2017, must have ≥ 25 MIPS clinicians *Readmission measure (if &gt; 200 cases)</td>
</tr>
<tr>
<td>60 points</td>
<td>120 points</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Submission via claims, EHR, or registry AND</td>
</tr>
<tr>
<td></td>
<td>&gt;15 MIPS clinicians in practice</td>
</tr>
<tr>
<td></td>
<td>*Readmission measure (if &gt; 200 cases)</td>
</tr>
<tr>
<td></td>
<td>70 points</td>
</tr>
</tbody>
</table>
Exceptional Performers – 70+ Points

- MIPS has an "additional performance threshold" to reward exceptional performance through another positive MIPS adjustment factor.
- $500 million will be distributed as a bonus to those whose final scores exceed an additional performance threshold.
- For the first year, the additional performance threshold is set at 70 points.
- In future years, the additional performance threshold will be equal to the 25th percentile of the range of possible final scores above the performance threshold.
Calculating the Quality Score

Points earned on required 6 quality measures + Any bonus points = Quality Score

*The maximum # of points is based on submission method and whether readmission measure was calculated.*
# Quality Submission Methods

<table>
<thead>
<tr>
<th>INDIVIDUAL</th>
<th>GROUP</th>
</tr>
</thead>
<tbody>
<tr>
<td>QCDR (Qualified Clinical Data Registry)</td>
<td>QCDR (Qualified Clinical Data Registry)</td>
</tr>
<tr>
<td>Qualified Registry</td>
<td>Qualified Registry</td>
</tr>
<tr>
<td>EHR</td>
<td>EHR</td>
</tr>
<tr>
<td>Claims</td>
<td>Administrative Claims</td>
</tr>
<tr>
<td></td>
<td>CMS Web Interface</td>
</tr>
<tr>
<td></td>
<td>CAHPS for MIPS Survey*</td>
</tr>
</tbody>
</table>

*The CAHPS for MIPS Survey counts as one patient experience measure. Five other measures must be submitted using a different reporting method.*
Registry Reporting

- CMS released the list of 2017 CMS Approved Qualified Registries on 4/14/17.
- Registries on the list can report data for the Quality, Advancing Care Information, or Improvement Activity categories in 2017.
- The list is located on the QPP website. Click on the Education & Tools link in the top right corner. The MIPS 2017 Qualified Registries link is located in the clinician section.
Reporting MIPS

- Attesting will be January 2 – March 31, 2018.
- No decisions need to be reported now on which measures you want to report or the method (unless you are a large group using the CMS web-based interface and you did not use the web interface last year).
- MIPS categories can be different date ranges.
- Reporting path information coming later this year.
Summary and Closing
Summary and Closing 1 of 2

Preparation:

• Review your 2016 Clinical Quality Measures, PQRS and QRUR reports to see what you do well.
• You need six measures, and one of them must be an outcome or high priority measure.
• Over-select measures so you have some back-ups (8-10).
• Select the submission method (EHR, Registry, QCDR, Claims, CMS web-based interface).
  – *Must be the same for all measures*
• - Select individual or group reporting.
  – *Must be the same for all MIPS categories*
Summary and Closing 2 of 2:

- Look at each measure in detail and get details on each measure from your EHR on-line manual or Help Desk.
- Understand what is required.
- Include everyone in the office. Identify who is responsible for what.
- Tell your doctors and staff, including billers, what measures were chosen and discuss workflow to capture data.
- Review “2017 Quality Benchmarks” tool from QPP website.
- Use a MIPS Calculator app to generate a mock score now.
- Monitor each measure monthly.
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Quality Insights Resources

- **Quality Insights website:** [www.qualityinsights-qin.org](http://www.qualityinsights-qin.org)

- **Resources and Tools:**
  - Click on “Resources” tab
  - Material Type: Provider Tools
  - Category: MACRA/MIPS
  - State: Leave blank

- **Webinars**
  - Events
  - Archived Events
Questions
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