MACRA/Quality Payment Program: Getting Started

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What is "MACRA"?

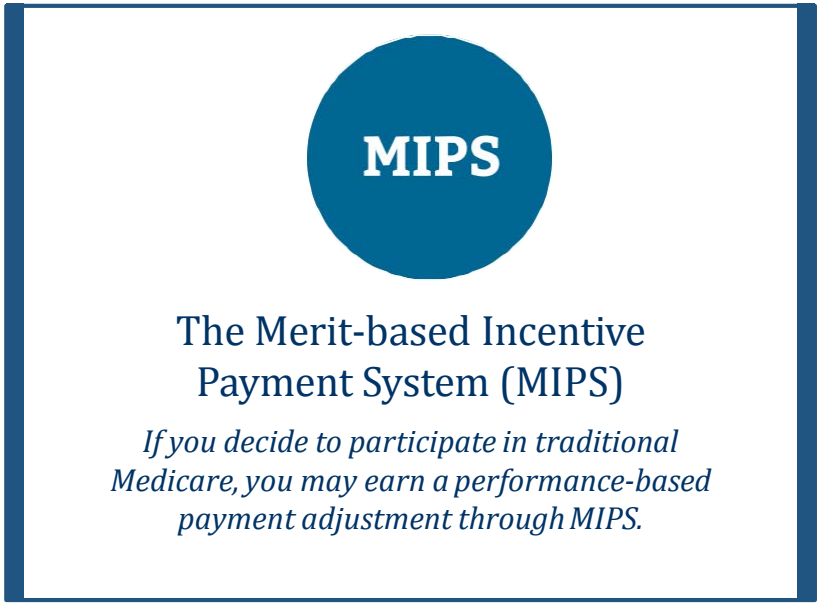
MACRA stands for the **Medicare Access and CHIP Reauthorization Act of 2015**, bipartisan legislation signed into law on April 16, 2015.

What does it do?

- **Repeals** the Sustainable Growth Rate (SGR) Formula
- **Changes the way that Medicare pays clinicians** and establishes a new framework to reward clinicians for **quality of services over quantity**
- **Streamlines** multiple quality reporting programs into 1 new system (MIPS)
- **Provides bonus payments** for participation in ***advanced*** **alternative payment models (APMs)**

The Quality Payment Program

Clinicians have two tracks from which to choose:



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 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.

Discussion Structure

- Part 1: What do I need to know about MIPS?
- Part 2: How do I prepare for and participate in MIPS?

Quality Payment Program Strategic Goals

- Improve beneficiary outcomes
- Enhance clinician experience
- Increase adoption of Advanced APMs
- Maximize participation
- Improve data and information sharing
- Ensure operational excellence in program implementation

Quick Tip:
For additional information on the Quality Payment Program, please visit QPP.CMS.GOV

Key Resources

Technical Assistance for Clinicians

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

PRIMARY CARE & SPECIALIST PHYSICIANS

Transforming Clinical Practice Initiative

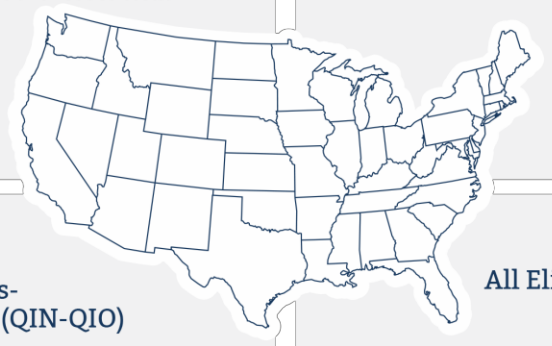
- Supports more than 140,000 clinician practices through active, collaborative and peer-based learning networks over 4 years.
- **Practice Transformation Networks (PTNs) and Support Alignment Networks (SANs)** are located in all 50 states to provide comprehensive technical assistance, as well as tools, data, and resources to improve quality of care and reduce costs.
- The goal is to help practices transform over time and move toward Advanced Alternative Payment Models.
- Contact TCPI.ISC@TruvenHealth.com for extra assistance.

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

SMALL & SOLO PRACTICES

Small, Underserved, and Rural Support (SURS)

- Provides outreach, guidance, and direct technical assistance to clinicians in **solo or small practices (15 or fewer), particularly those in rural and underserved areas**, to promote successful health IT adoption, optimization, and delivery system reform activities.
  - Assistance will be tailored to the needs of the clinicians.
  - Organizations selected to provide this technical assistance will be available in early 2017.



LARGE PRACTICES

Quality Innovation Networks-Quality Improvement Organizations (QIN-QIO)

- Supports clinicians in **large practices (more than 15 clinicians)** in meeting Merit- Based Incentive Payment System requirements through customized technical assistance.
- Includes one-on-one assistance when needed.
- There are 14 QIN-QIOs that serve all 50 states, the District of Columbia, Guam, Puerto Rico, and Virgin Islands.

Locate the QIN-QIO that serves your state

Quality Innovation Network (QIN) Directory

TECHNICAL SUPPORT

All Eligible Clinicians Are Supported By:

Quality Payment Program Website: qpp.cms.gov
Serves as a starting point for information on the Quality Payment Program.

Quality Payment Program Service Center
Assists with all Quality Payment Program questions.
1-866-288-8292 TTY: 1-877-715-6222 QPP@cms.hhs.gov

Center for Medicare & Medicaid Innovation (CMMI) Learning Systems
Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs.

Quality Payment Program Service Center

qppsupport@greatplainsqin.org | 1-402-817-7250 | www.greatplainsqin.org/qpp

Great Plains QIN Quality Payment Program Service Center

Serving Kansas, Nebraska, North Dakota and South Dakota

We can help you get ahead of the program and back to doing what you LOVE…taking care of people!

Let us study the legislation, analyze performance data and trends and become the experts in the requirements for success within the Quality Payment Program so you don't have to. We pride ourselves on delivering a great customer experience. We will make every effort to be timely, reliable and offer a service that meets your satisfaction. Contact a member of our team today to get the answers and assistance you need.

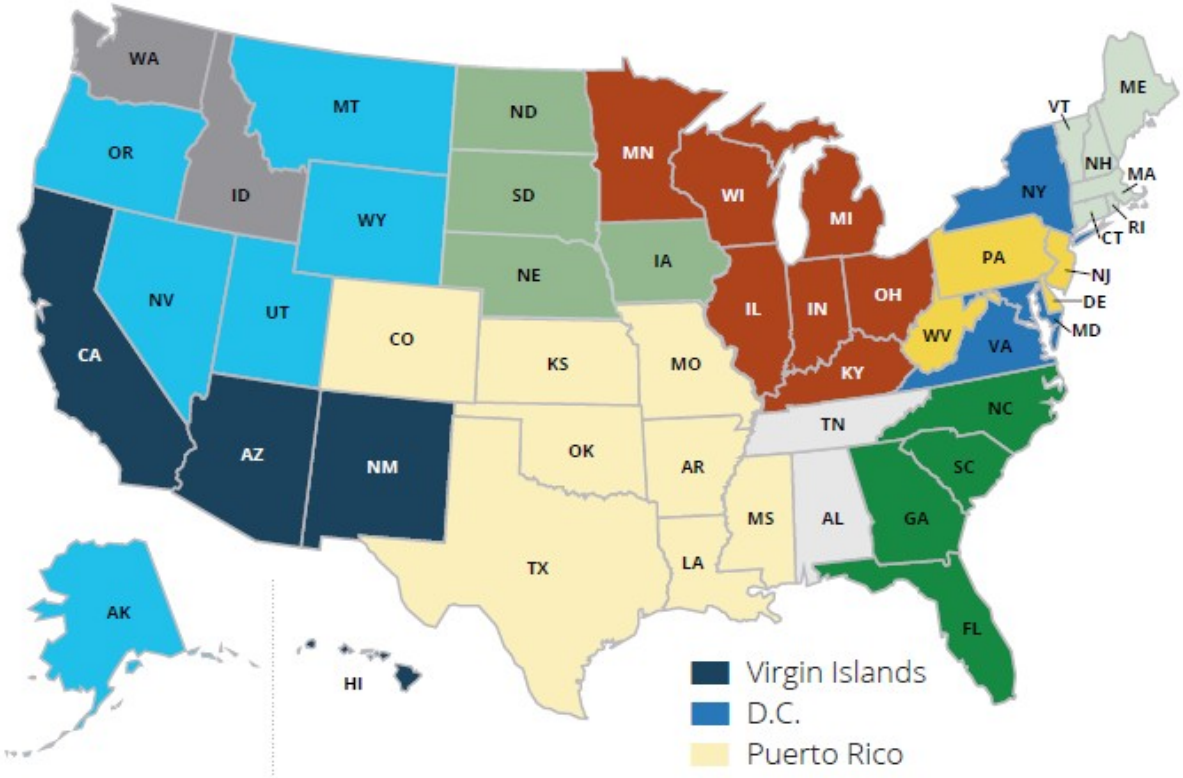
Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Great Plains
Quality Innovation Network

This material was prepared by the Great Plains Quality Innovation Network - the Medicare Quality Improvement Organization for Kansas, Nebraska, North Dakota and South Dakota, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 11SOW-GPQIN-NE-D1-75/1216

National Coverage of Technical Assistance for Small, Underserved and Rural Clinicians

11 uniquely experienced organizations to provide national coverage to eligible clinicians in small practices.



Legend

- HealthCentric
- IPRO
- Quality Insights (WVMI)
- GMCF
- QSource
- Altarum
- TMF
- HSAG
- Telligen
- NRHI
- Qualis

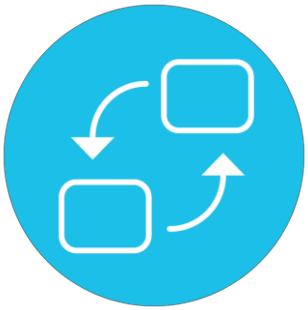
Part I:
MIPS Basics
What Do I Need to Know?

What is the Merit-based Incentive Payment System?

Performance Categories

Quality

Cost



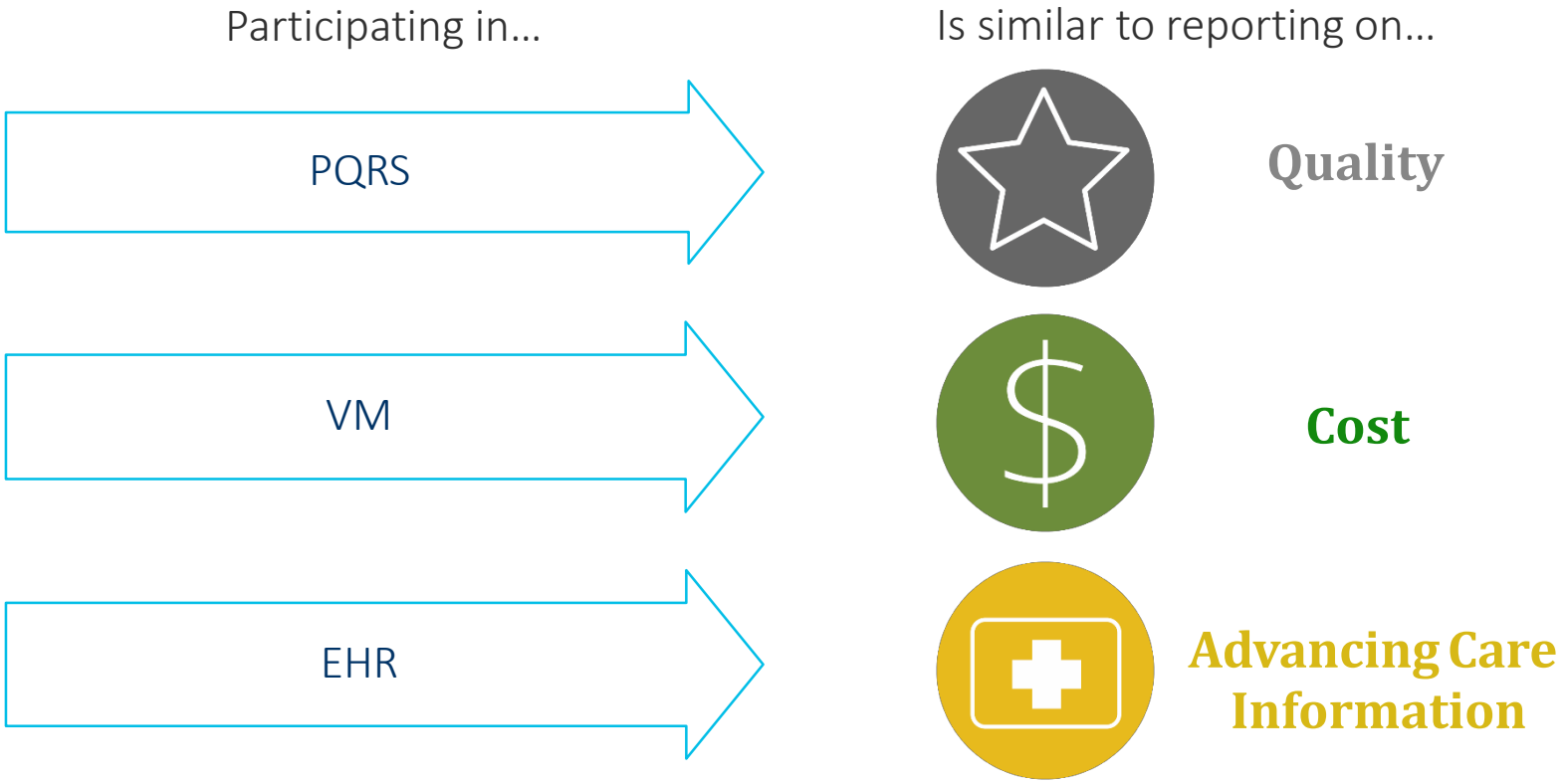
Improvement Activities

Advancing Care Information

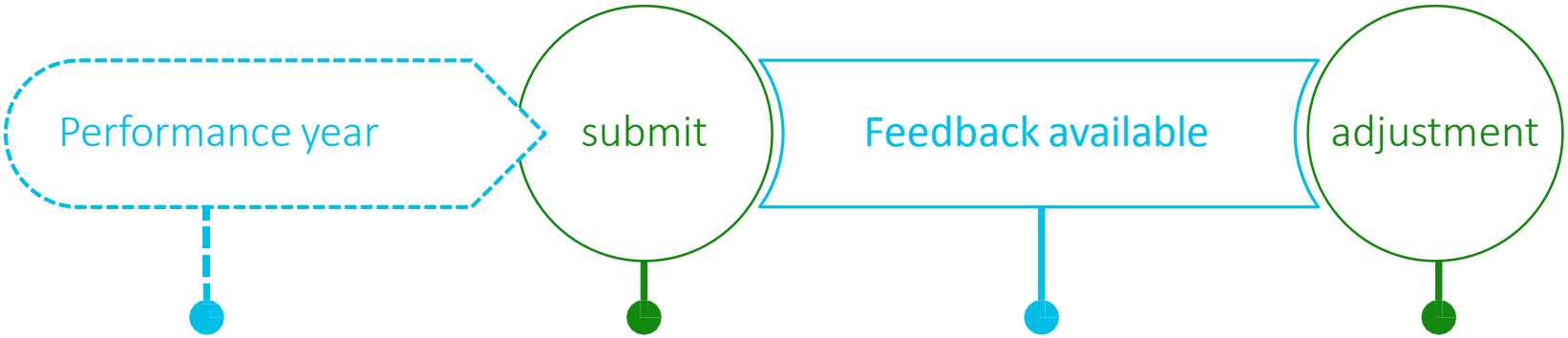
- Comprised of four performance categories
- Provides clinicians with flexibility to choose the activities and measures that are most meaningful to their practice

What is the Merit-based Incentive Payment System?

A visualization of how the legacy programs streamline into the MIPS performance categories:



When Does the Merit-based Incentive Payment System Officially Begin?



2017
Performance Year

- Performance period opens January 1, 2017.
- Closes December 31, 2017.
- Clinicians care for patients and record data during the year.

March 31, 2018
Data Submission

- Deadline for submitting data is March 31, 2018.
- Clinicians are encouraged to submit data early.

Feedback

- CMS provides performance feedback after the data is submitted.
- Clinicians will receive feedback before the start of the payment year.

January 1, 2019
Payment Adjustment

- MIPS payment adjustments are prospectively applied to each claim begin January 1, 2019.

MIPS Eligibility
What Do I Need to Know?

Eligible Clinicians:

Clinicians 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

Eligibility Example

Dr. "A." is:

- An eligible clinician
- Billed $100,000 in Medicare Part B charges
- Saw 110 patients

Therefore, Dr. A. would be *ELIGIBLE* for MIPS.

Remember: To be eligible

Who is Exempt from MIPS?

Clinicians who are:

Newly-enrolled in Medicare

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

Below the low-volume threshold

- Medicare Part B allowed charges less than or equal to $30,000 a year

OR

- See 100 or fewer Medicare Part B patients a year

Significantly participating in Advanced APMs

- Receive 25% of their Medicare payments

OR

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

Exempt Example

Dr. "B." is:

- An eligible clinician
- Billed $100,000 in Medicare Part B charges
- Saw 80 patients

Dr. B. would be *EXEMPT* from MIPS due to seeing less than 100 patients.

Remember: To be eligible

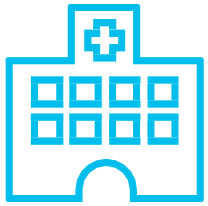
Eligibility for Non-Patient Facing Clinicians

- Non-patient facing clinicians are eligible to participate in MIPS as long as they exceed the low-volume threshold, are not newly enrolled, and are not a Qualifying APM Participant (QP) or Partial QP that elects not to report data to MIPS
- The non-patient facing MIPS-eligible clinician threshold for individual MIPS-eligible clinicians is ≤ 100 patient facing encounters in a designated period
- A group is non-patient facing if > 75% of NPIs billing under the group's TIN during a performance period are labeled as non-patient facing
- There are more flexible reporting requirements for non-patient facing clinicians

MIPS Participation
What Do I Need to Know?

Pick Your Pace for Participation for the Transition Year

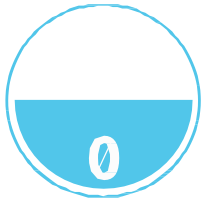
Participate in an Advanced Alternative Payment Model



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

MIPS

Test



Submit Something

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

Partial Year

Submit a Partial Year

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

Full Year

Submit a Full Year

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

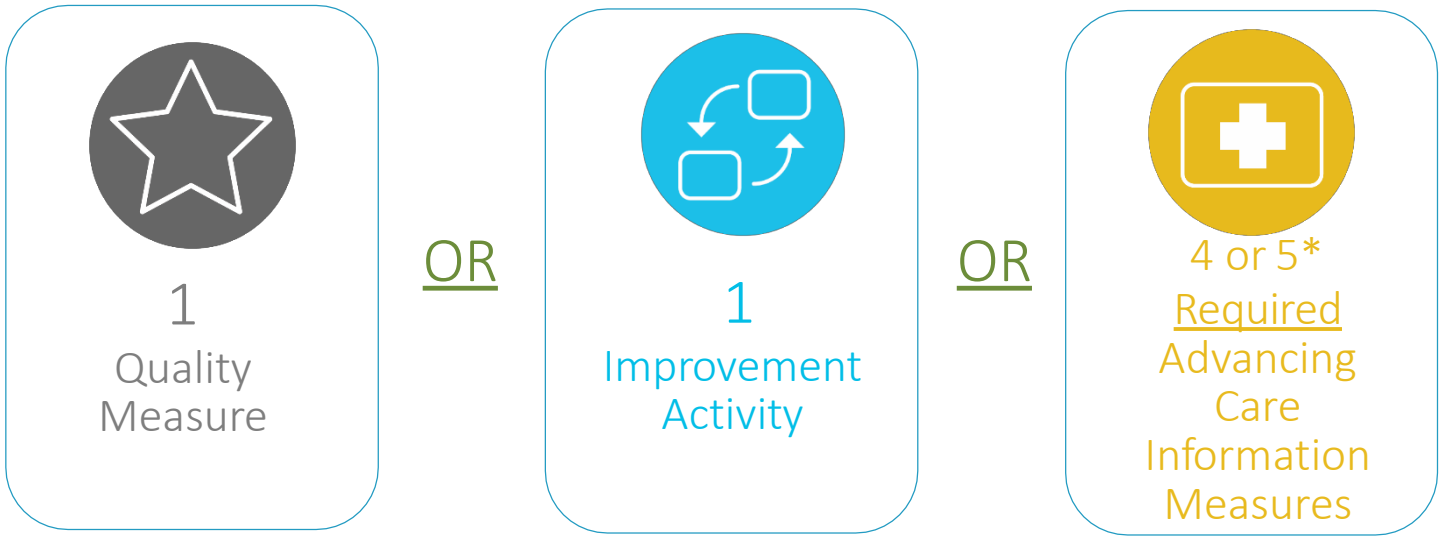
Note: Clinicians do not need to tell CMS which option they intend to pursue.

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



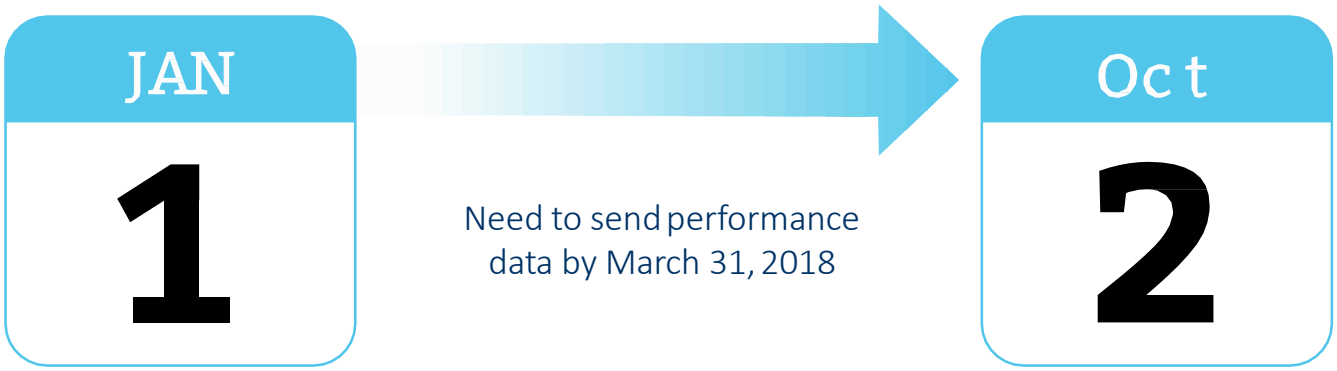
*Depending on CEHRT edition

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



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.

MIPS Reporting
What Do I Need to Know?

Individual vs. Group Reporting

OPTIONS

Individual

1. Individual—under an National Provider Identifier (NPI) number and Taxpayer Identification Number (TIN) where they reassign benefits

Group

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

MIPS Submission Methods
What Do I Need to Know?

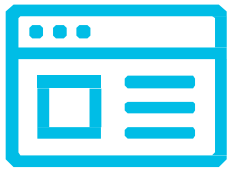
Submission Methods

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

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

Group Registration

Registration is required for eligible clinicians participating as a group that wish to report via:



Web Interface

CAHPS for MIPS survey

- *Group registration closes on June 30, 2017.*

MIPS Scoring Methodology
What Do I Need to Know?

MIPS Scoring for Quality
(60% of Final Score in Transition Year)

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

- Or a specialty set
- Or CMS Web Interface measures

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

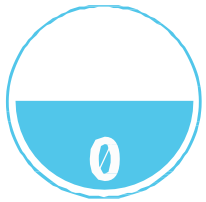
Failure to submit performance data for a measure = 0 points

Quick Tip:
Easier for a clinician who participates longer to meet case volume criterion needed to receive more than 3 points.

Bonus points are available

- 2 points for submitting an additional outcome measure
- 1 point for submitting an additional high-priority measure
- 1 point for using CEHRT to submit measures electronically end-to-end

Quality: Requirements for the Transition Year



Submit Something

- Test means:
  - Submitting 1 Quality measure

Submit a Partial Year

Submit a Full Year

- Partial and Full means:
  - Submitting at least 6 quality measures, including 1 Outcome or 1 High-Priority measure
    - 90 days for Partial Year
    - 1 year for Full Year

For a full list of measures, please visit QPP.CMS.GOV

MIPS Scoring for Cost
(0% of Final Score in Transition Year)

No submission requirements

Clinicians assessed through claims data	Clinicians earn a maximum of 10 points per episode cost measure

MIPS Scoring for Improvement Activities
(15% of Final Score in Transition Year)

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

Improvement Activity: Requirements for the Transition Year

Submit Something

Test means:

- Attesting to 1 Improvement Activity
  - Activity can be high or medium weight
  - In most cases, to attest you need to indicate that you have done the activity for 90 days.

Submit a Partial Year

Submit a Full Year

Partial and Full means:

- Attesting to 1 of the following combinations:
  - 2 high-weighted activities
  - 1 high-weighted activity and 2 medium-weighted activities
  - At least 4 medium-weighted activities
- Clinicians with special considerations:
  - 1 high-weighted activity
  - 2 medium-weighted activities

For a full list of activities, please visit QPP.CMS.GOV

MIPS Performance Category: Advancing Care Information (25% of Final Score in Transition Year)

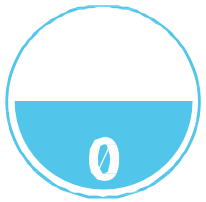
- Earn up to 155% maximum score, which will be capped at 100%

Advancing Care Information category score includes:

50%	90%	15%
Required Base score (50%)	Performance score (up to 90%)	Bonus score (up to 15%)

Keep in mind: You need to fulfill the Base score or you will get a zero in the Advancing Care Information Performance Category

Advancing Care Information: Requirements for the Transition Year



Submit Something

Test means:

- Submitting 4 or 5 base score measures
  - Depends on use of 2014 or 2015 Edition
- Reporting *all* required measures in the base score to earn any credit in the Advancing Care Information performance category

Submit a Partial Year

Submit a Full Year

Partial and Full means:

- Submitting more than the base score in the Transition Year

For a full list of measures, please visit QPP.CMS.GOV

Calculating the Final Score Under MIPS

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

Transition Year 2017

Final Score	Payment Adjustment
≥70 points	• Positive adjustment • Eligible for exceptional performance bonus—minimum of additional 0.5%
4-69 points	• Positive adjustment • Not eligible for exceptional performance bonus
3 points	• Neutral payment adjustment
0 points	• Negative payment adjustment of -4% • 0 points = does not participate

Part 2:
Checklist for Preparing and Participating in MIPS

Preparing and Participating in MIPS: A Checklist

- Determine your eligibility and understand the requirements.
- Choose whether you want to submit data as an individual or as a part of a group.
- Choose your submission method and verify its capabilities.
- Verify your EHR vendor or registry's capabilities before your chosen reporting period.
- Prepare to participate by reviewing practice readiness, ability to report, and the Pick Your Pace options.
- Choose your measures. Visit qpp.cms.gov for valuable resources on measure selection and remember to review your current billing codes and Quality Resource Use Report to help identify measures that best suit your practice.
- Verify the information you need to report successfully.
- Care for your patients and record the data.
- Submit your data by March 2018.

❑ Determine Your Eligibility

How Do I Do This?

1. Calculate your annual patient count and billing amount for the 2017 transition year.
   - Review your claims for service provided between September 1, 2015 and August 31, 2016, and where CMS processed the claim by November 4, 2016.
   - Did you bill more than $30,000 AND provide care for more than 100 Medicare patients a year?
     - Yes: You're eligible.
     - No: You're exempt.
1. CMS will provide additional guidance on eligibility in Winter/Early Spring 2017.

❑ Choose to Submit Data as an Individual or as a Part of a Group

How Do I Do This?

1. Individual:
   - Submit your data under your unique TIN/NPI combination using your chosen submission method(s).

2. Group:
   - You and the other eligible clinicians in the group collectively submit performance data under a single TIN.

❑ Choose a Submission Method and Verify its Capabilities

How Do I Do This?

1. Review the available submission options for 2017.
   - Speak with your specialty society about your options.
   - Consider using a Technical Assistance program (TCPI, QIN-QIOs, QPP-SURS) for decision support.
   - Visit qpp.cms.gov for information on submission options.
2. Choose a data submission option.
   - For Qualified Registries, QCDRs, and CAHPS for MIPS Survey:
     - Check that each of the submission options are approved by CMS.
   - For EHR reporting:
     - Check that your EHR is certified by the Office of the National Coordinator for Health Information Technology.

❑ Prepare to Participate

How Do I Do This?

1. Consider your practice readiness.
   - Have you previously participated in a quality reporting program?
2. Evaluate your ability to report.
   - What is your data submission method?
   - Are you prepared to begin reporting data between January 1, 2018 and March 31, 2018?
3. Review the Pick Your Pace options for Transition Year 2017.
   - Test
   - Partial Year
   - Full Year

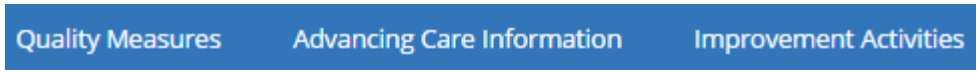
❑ Choose Your Measures/Activities

How Do I Do This?

1. Go to qpp.cms.gov.

2. Click on the **Explore Measures** tab at the top of the page.

3. Select the performance category of interest.



4. Review the individual Quality and Advancing Care Information measures as well as Improvement Activities.

❑ Choose Your Measures/Activities

Tips for Reviewing and Selecting Measures/Activities

Consider the following:

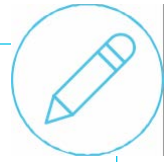
- Your patient population and the clinical conditions that you treat
- Your practice location
- Your practice improvement goals
- Quality data that you may submit to other payers
- If you're currently participating in one the legacy quality programs, consider your current billing codes and Quality Resource Use Report (QRUR) to help identify suitable measures

❑ Verify the Information You Need to Report Successfully

How Do I Do This?

Review the specifications for any Quality measure you intend to report, including:

- ✓ Measure number, NQF number (if applicable), Measure title and domain
- ✓ Submission method option
- ✓ Measure type
- ✓ Measure description
- ✓ Instructions on reporting including frequency, timeframes, and applicability
- ✓ Denominator statement, denominator criteria and coding
- ✓ Numerator statement and coding options (denominator exclusion, performance met, denominator exception, performance not met)
- ✓ Definition(s) of terms where applicable
- ✓ Rationale
- ✓ Clinical recommendations statement or clinical evidence supporting the measure intent



Quick Tip:
Measure specifications can be downloaded at qpp.cms.gov

❑ Submit Your Data Early

How Do I Do This?

1. Care for your patients and record the data.
2. Submit your data to CMS prior to the March, 2018 deadline using your chosen submission method.
   - CMS anticipates the data submission window to open January 1, 2018.
   - You are encouraged to submit as early as possible following this date to ensure the timely receipt and accuracy of your data.

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Supplemental Slides

Submission Methods: Helpful Information

Submission Mechanism	How does it work?
Qualified Clinical Data Registry (QCDR)	A QCDR is a CMS-approved entity that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients. Each QCDR typically provides tailored instructions on data submission for eligible clinicians.
Qualified Registry	A Qualified Registry collects clinical data from an eligible clinician or group of eligible clinicians and submits it to CMS on their behalf.
Electronic Health Record (EHR)	Eligible clinicians submit data directly through the use of an EHR system that is considered certified EHR technology (CEHRT). Alternatively, clinicians may work with a qualified EHR data submission vendor (DSV) who submits on behalf of the clinician or group.
Attestation	Eligible clinicians prove (attest) that they have completed measures or activities.
CMS Web Interface	A secure internet-based application available to pre-registered groups of clinicians. CMS loads the Web Interface with the group's patients. The group then completes data for the pre-populated patients.
Claims	Clinicians select measures and begin reporting through the routine billing processes.

What is the Merit-based Incentive Payment System?

Combines legacy programs into single, improved reporting program

- Physician Quality Reporting System (PQRS)
- Value-Based Payment Modifier (VM)
- Medicare EHR Incentive Program (EHR)

MIPS

Legacy Program Phase Out

- Last Performance Period — 2016
- PQRS Payment End — 2018

MIPS for First-Time Reporters

You Have Asked: *"What if I do not have any previous reporting experience?"*

CMS has provided options that may reduce participation burden to first time reporters by:

Adjusting the low-volume threshold to exclude more individual clinicians and groups

Allowing clinicians to pick their pace of participation for Transition Year 2017 by lowering the performance threshold to avoid a negative adjustment

Eligibility for Clinicians in Specific Facilities

- Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC)
  - Eligible clinicians billing under the RHC or FQHC payment methodologies are not subject to the MIPS payment adjustment.

    However…

  - Eligible clinicians in a RHC or FQHC billing under the Physician Fee Schedule (PFS) are required to participate in MIPS and are subject to a payment adjustment.

Eligibility for Clinicians in Specific Facilities

- Critical Access Hospitals (CAH)

1 For eligible clinicians practicing in Method I:

- MIPS payment adjustment would apply to payments made for items and services that are Medicare Part B charges billed by the MIPS eligible clinicians.
- Payment adjustment would not apply to the facility payment to the CAH itself.

2 For eligible clinicians practicing in Method II (who assigned their billing rights to the CAH):

- MIPS payment adjustment would apply to the Method II CAH payments

3 For eligible clinicians practicing in Method II (who have not assigned their billing rights to the CAH):

- MIPS payment adjustment would apply similar to Method I CAHs.

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.

MIPS Performance Categories What Do I Need to Know?

MIPS Performance Category: Quality

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

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

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.
- *Keep in mind:*

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: Improvement Activities

- 15% of Final Score in 2017
- 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

MIPS Performance Category: Improvement Activities

- *Special consideration for:*

Groups with 15 or fewer participants, non-patient facing clinicians, or if you are in a rural or health professional shortage area: Attest that you completed up to 2 activities for a minimum of 90 days.

Participants in certified patient-centered medical homes, comparable specialty practices, or an APM designated as a Medical Home Model: You will automatically earn full credit.

Participants in certain APMs, such as Shared Savings Program Track 1 or the Oncology Care Model: You will automatically receive points based on the requirements of participating in the APM. For all current APMs under the APM scoring standard, this assigned score will be full credit. For all future APMs under the APM scoring standard, the assigned score will be at least half credit.

MIPS Performance Category: Advancing Care Information

- 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: Advancing Care Information

- Clinicians must use certified EHR technology to report

For those using EHR Certified to the 2015 Edition:

Option 1

Advancing Care Information Objectives and Measures

Option 2

Combination of the two measure sets

For those using 2014 Certified EHR Technology:

Option 1

2017 Advancing Care Information Transition Objectives and Measures

Option 2

Combination of the two measure sets

Advancing Care Information: Flexibility

1

CMS will automatically reweight the Advancing Care Information performance category to zero for Hospital-based MIPS clinicians, clinicians who lack of Face-to-Face Patient Interaction, NP, PA, CRNAs and CNS

- Reporting is optional although if clinicians choose to report, they will be scored.

2

A clinician can apply to have their performance category score weighted to zero and the 25% will be assigned to the Quality category for the following reasons:

1. Insufficient internet connectivity
2. Extreme and uncontrollable circumstances
3. Lack of control over the availability of CEHRT

Bonus Payments and Reporting Periods

MIPS payment adjustment is based on data submitted. Clinicians should pick what's best for their practice.

Submit a Full Year

Full year participation

- Is the best way to get the max adjustment
- Gives you the most measures to choose from
- Prepares you the most for the future of the program

Submit a Partial Year

Partial participation (report for 90 days)

- You can still earn the max adjustment

Transforming Clinical Practice Initiative (TCPI) for rural and underserved locations

TCPI is designed to support more than 140,000 clinical practices achieve large-scale transformation by sharing, adapting and further developing their comprehensive quality improvement strategies.

Funding for practice transformation networks (PTNs) is contingent upon minimum 20% of clinicians served are from rural or underserved locations.

Several PTNs have committed greater than 50% of clinicians who participate stem from rural areas, including:

- Rural health clinics
- Rural community health centers
- Health profession shortage areas
- Supporting medically underserved populations

Small, Underserved, and Rural Support

- Five-year technical assistance program authorized under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).
- Designed for practices with 15 or fewer eligible clinicians.
  - Includes small practices in: rural locations, health professional shortage areas (HPSAs), and medically underserved areas (MUAs).
- Goal is to provide on-the-ground support to eligible clinicians by:
  - Assisting in the selection and reporting of appropriate Merit-based Incentive Payment System (MIPS) Quality measures and Improvement Activities;
  - Optimizing their Health Information Technology (HIT);
  - Supporting change management and strategic planning; and
  - Evaluate their options for joining an Advanced Alternative Payment Model (APM).
- Support is available immediately and is FREE to clinicians in small practices.

Summary of Small, Rural and Health Professional Shortage Areas (HPSAs) Considerations

- Established low-volume threshold
  - Less than or equal to $30,000 in Medicare Part B allowed charges or less than or equal to 100 Medicare patients
- Reduced requirements for Improvement Activities performance category
  - One high-weighted activity or
  - Two medium-weighted activities
- Increased ability for clinicians practicing at Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), and Federally Qualified Health Centers (FQHCs) to qualify as a Qualifying APM Participant (QP).
- Enhanced Technical Assistance
- Advanced APM opportunities
- Exploring Virtual Groups

Easier Access for Small Practices

Small practices will be able to successfully participate in the Quality Payment Program

Why?

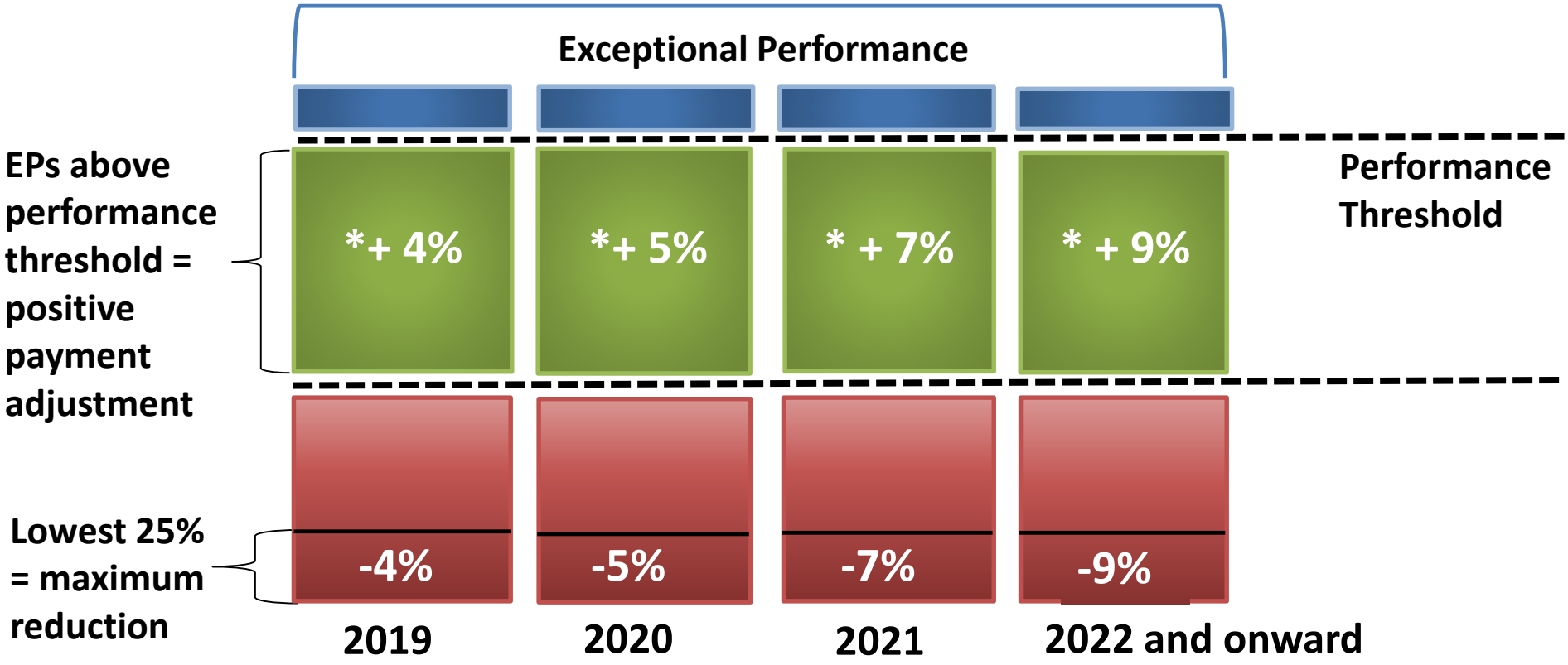
- Reducing the time and cost to participate
- Providing an on-ramp to participating through Pick Your Pace
- Increasing the opportunities to participate in Advanced APMs
- Including a practice-based option for participation in Advanced APMs as an alternative to total cost-based
- Conducting technical support and outreach to small practices through the forthcoming QPP Small, Rural and Underserved Support (QPP-SURS) as well as through the Transforming Clinical Practice Initiative.

The Merit-based Incentive Payment System:

- Streamlines the Legacy Programs
- Moves Medicare Part B clinicians to a performance-based system
- Measures clinicians on four Performance Categories:
  - Quality, Cost, Improvement Activities, and Advancing Care Information
- Calculates a Final Score for clinicians based on their performance in the four Performance Categories
- Adjusts payments based on the Final Score

MIPS Incentive Payment Formula

Exceptional performers receive additional positive adjustment factor – up to $500M available each year from 2019 to 2024



**MACRA allows potential 3x upward adjustment BUT unlikely*

Support for Small Practices

Small practices with 15 or fewer clinicians, including those in rural locations, health professional shortage areas, and medically underserved areas are a crucial part of the health care system. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) provides direct technical assistance to help individual Merit-based Incentive Payment System (MIPS) eligible clinicians and small practices in these settings participate in the Quality Payment Program.

This initiative is comprised of local, experienced organizations that will help clinicians in small and rural practices:

- Select and report on appropriate measures and activities to satisfy the requirements of each performance category* under MIPS
- Engage in continuous quality improvement
- Optimize their health information technology (HIT)
- Evaluate their options for joining an Advanced Alternative Payment Model (APM)

Providing this support to clinicians will help them navigate the Quality Payment Program, while making sure they are able to focus on the needs of their patients.

*Quality, Cost, Improvement Activities, and Advancing Care Information

Participating Organizations

Altarum
qppinfo@altarum.org

Alliant GMCF
QPPsupport@alliantquality.org

Healthcentric Advisors
NEQPPSURS@healthcentricadvisors.org

Health Services Advisory Group (HSAG)
HSAGQPPSupport@hsag.com
or Toll Free at 1-844-472-4227

IPRO
NY: ny-qppsupport@atlanticquality.org;
DC: dc-qppsupport@atlanticquality.org;
MD: md-qppsupport@atlanticquality.org;
VA: va-qppsupport@atlanticquality.org
or Toll Free at 1-866-333-4702

Network for Regional Healthcare Improvement (NRHI)
UT, OR, and NV: qpp@healthinsight.org
MT, WY, AK: QualityPaymentHelp@mpqhf.org

QSource
techassist@qsource.org

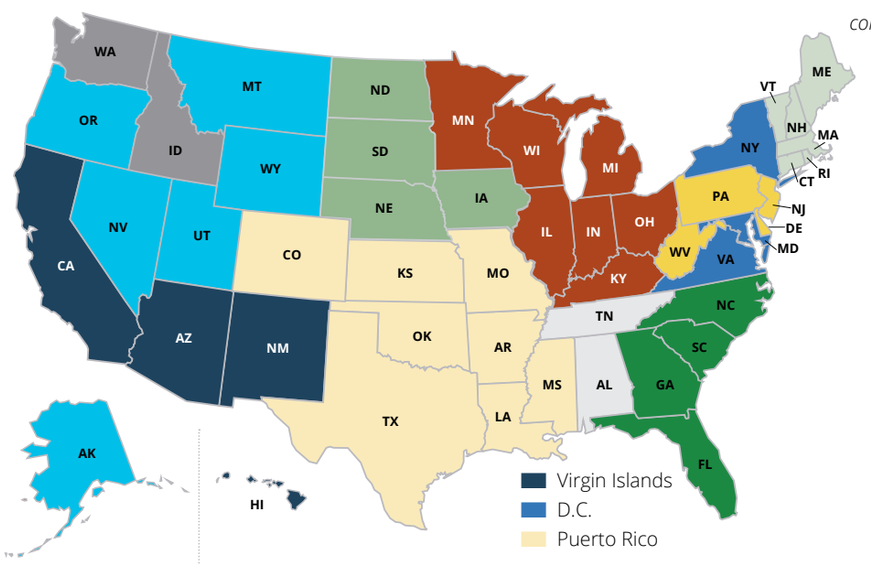
Qualis
QPP-SURS@qualishealth.org
or Toll Free at 1-877-560-2618

Quality Insights (WVMI)
qpp-surs@qualityinsights.org
or Toll Free at 1-877-497-5065

Telligen
qpp-surs@telligen.com
or Toll Free at 1-844-358-4021

TMF
QPP-SURS@tmf.org

For general information or for help getting connected, contact QPPSURS@IMPAQINT.COM



Coverage by Organization

- Healthcentric Advisors
- IPRO
- Quality Insights (WVMI)
- Alliant GMCF
- QSource
- Altarum
- TMF
- HSAG
- Telligen
- NRHI
- Qualis

Additional Resources

Quality Payment Program:
qpp.cms.gov
1-866-288-8292
TTY: 1-877-715-6222
QPP@cms.hhs.gov

APM Learning Model Support List:
http://innovation.cms.gov

Transforming Clinical Practice Initiative (TCPI):
PTN Map: https://innovation.cms.gov/initiatives/Transforming-Clinical-Practices
To enroll in TCPI, contact:
TCPI.ISC@Truvenhealth.com

Quality Improvement Organizations:
QIN-QIO Map:
http://qioprogram.org/

Practice Transformation Network

Rosanne Rutkowski, MPH, BSN, RN
March 21, 2017

Kansas Healthcare Collaborative

KANSAS MEDICAL SOCIETY Established 1859

COMPASS Practice Transformation Network

KANSAS HOSPITAL ASSOCIATION


KANSAS
MEDICAL
SOCIETY
Established 1859


Kansas Healthcare
COLLABORATIVE


KANSAS HOSPITAL
KHA
ASSOCIATION

Kansas Healthcare Collaborative

KHC Vision

KHC will be *THE* trusted source for relevant and meaningful health care quality improvement education, evaluation and measurement.

KHC Mission

Engaging and aligning providers and stakeholders to establish Kansas as a role model for health care quality and a top-performer in health care outcomes.

KHC Values

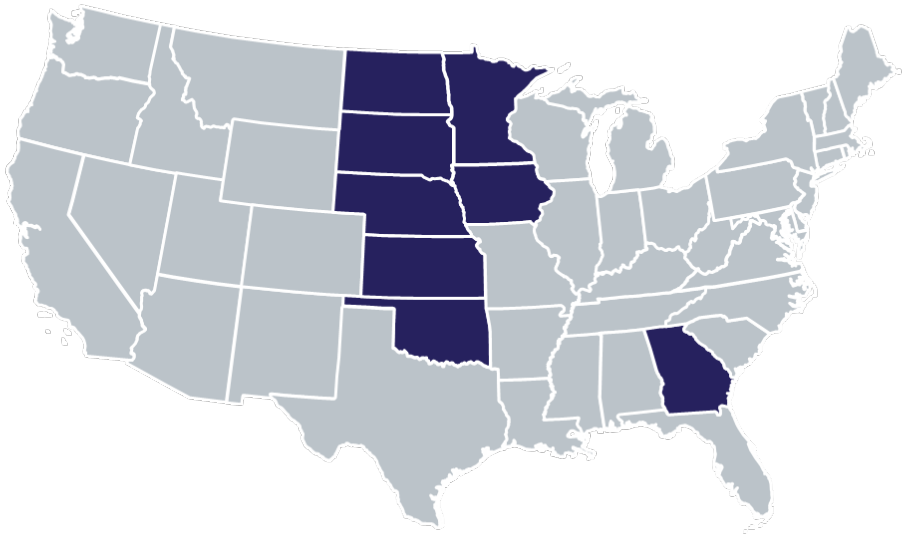
We believe those who deliver health care are responsible for leading quality improvement.

We believe collaboration leads to developing, sharing, teaching and learning effective approaches proven to deliver the best possible health care.

We believe effective utilization of meaningful, patient-oriented analytics and objective reporting promotes excellence in health care.

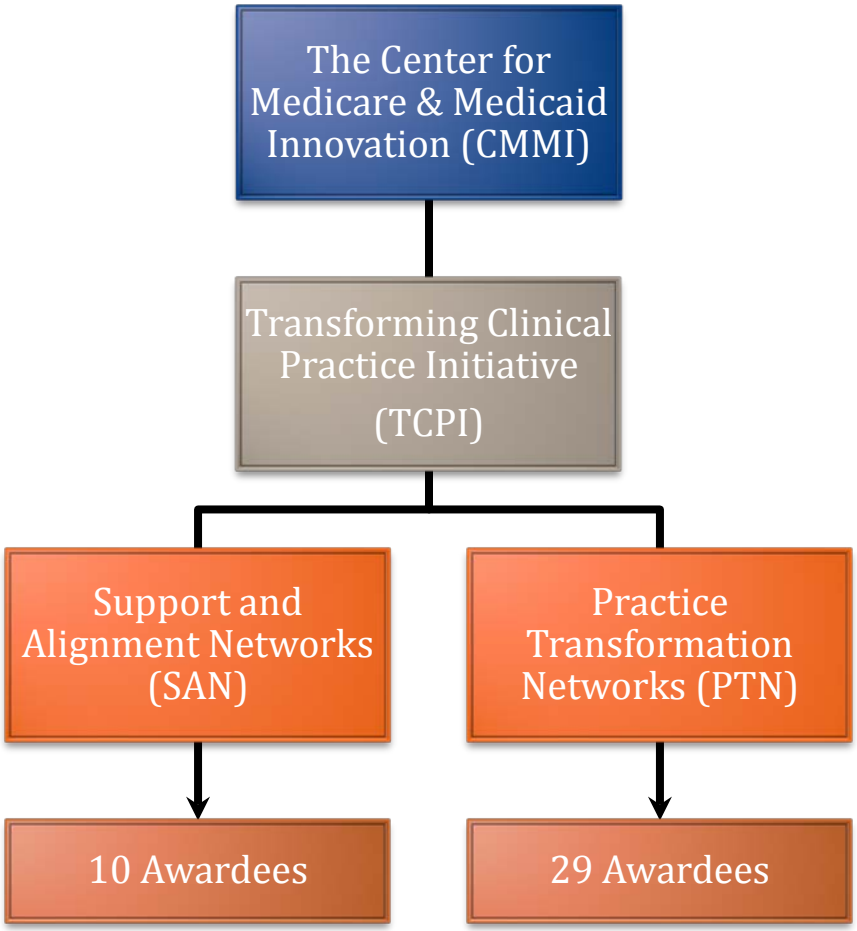
Compass PTN
Participating States and Lead Organizations

COMPASS
Practice Transformation Network



ENHANCE Health Network
GHA Georgia Hospital Association Research and Education Foundation
healthPOINT at Dakota State University
Iowa Healthcare Collaborative
KHC Kansas Healthcare Collaborative
OU Physicians
SANFORD HEALTH
Telligen

Transforming Clinical Practice Initiative (TCPI)



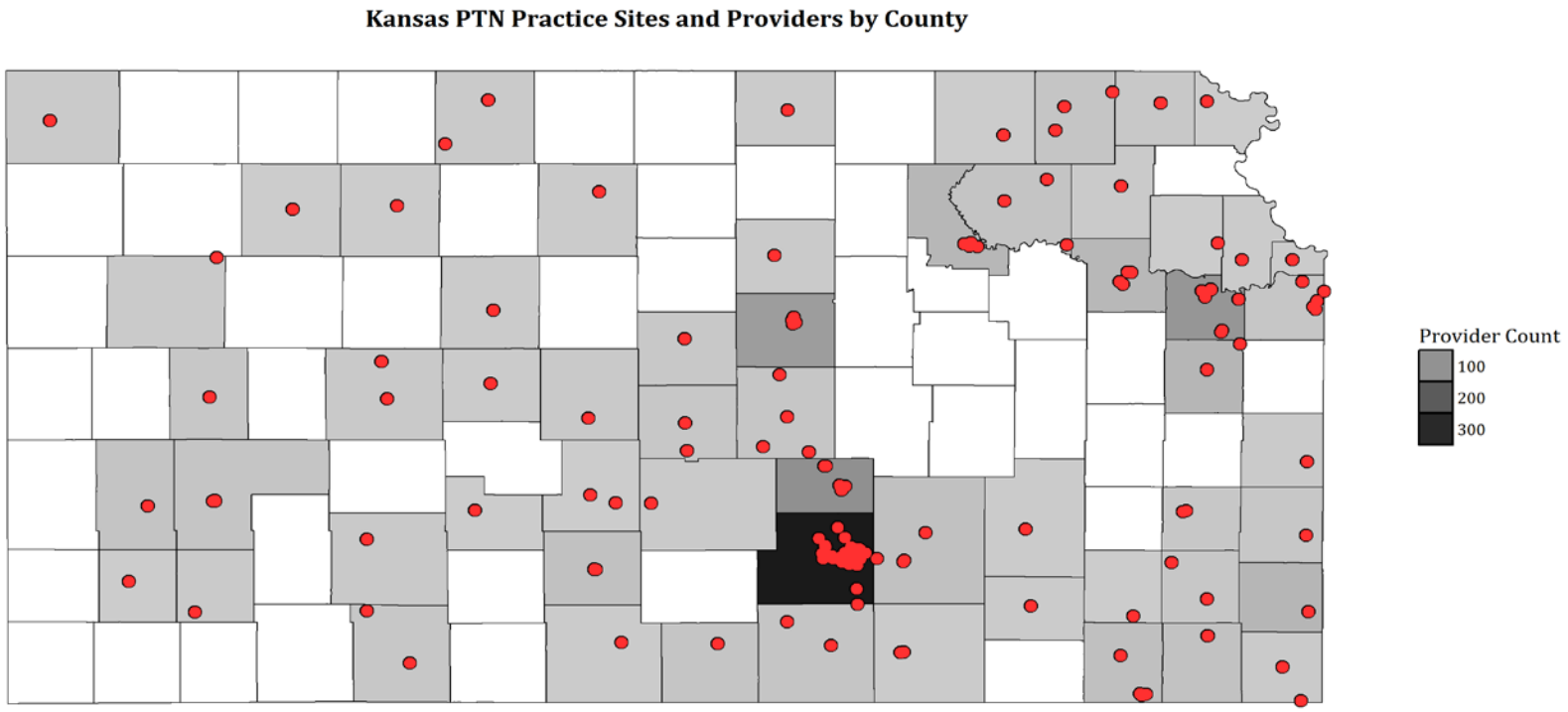
Support & Alignment Networks (SANS)

- American College of Physicians
- American Board of Family Medicine
- American College of Radiology
- American Medical Association
- American Psychiatric Association
- American College of Emergency Physicians
- Patient-Centered Primary Care Foundation
- Network for Regional Healthcare Improvement
- National Nursing Centers Consortium

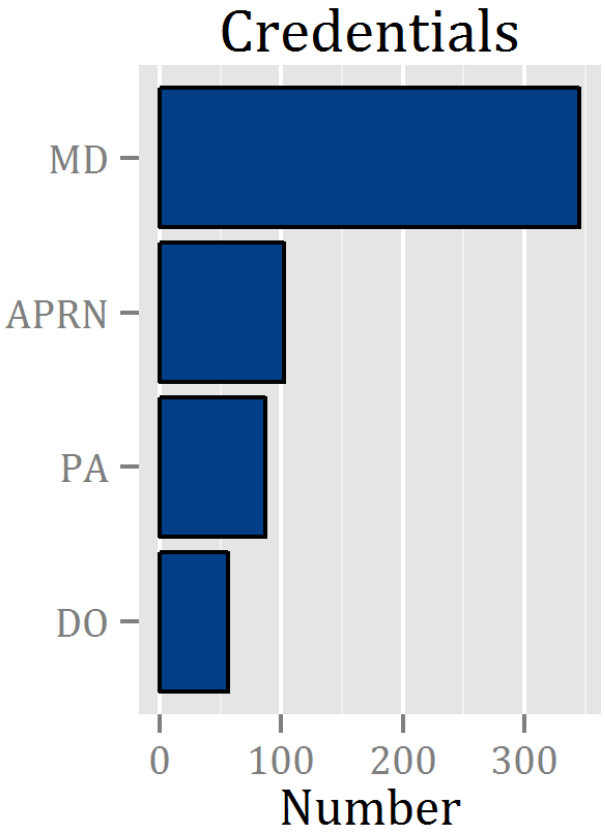
Resources:

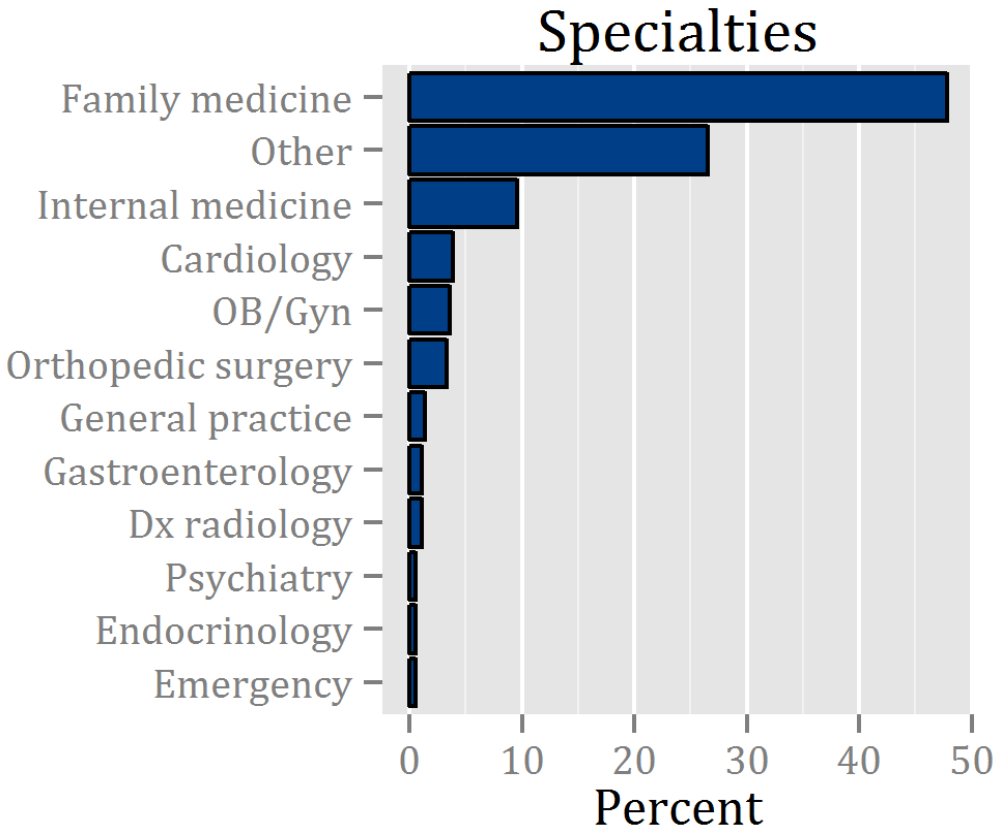
- Technical Assistance
- Training/education
- Linkages between clinicians & community based organizations
- Prime Registry software for clinicians/practices
- Practice Advisor Tool
- R-SCAN
- Steps Forward- AMA
- Sharing of successful models/strategies

Kansas PTN Practices



Kansas PTN Providers





5 Phases of Transformation

Source: CMS TCPI PTN Information Webinar, November 20, 2014.

PTN Activities:

- Baseline Practice Assessments
- Develop strategic plans, setting priorities
- Monitor progress on priorities
- Implement QI activities on operations/patient care
- Develop/implement persons & family engagement strategies
- Identify pts w/ chronic conditions & manage care
- Coordinate w/other providers to manage transitions in care
- Implement/optimize AWV, chronic care management & transitional care management

Compass PTN Measures Menu

Outcome Measures:

- Diabetes: Hemoglobin A1c Poor Control (PQRS 001)
- Controlling High Blood Pressure (PQRS 236)
- All-Cause 30-day Readmission Rate

Process Measures/Efficient Use of Health Resources:

- Use of Appropriate Medications for Asthma (PQRS 311)
- Heart Failure Beta-Blocker Therapy for LVSD (PQRS 008)
- Use of Imaging Studies for Low Back Pain (PQRS 312)
- Appropriate Treatment for Children with Upper Respiratory Infection (PQRS 065)
- Overuse of Diagnostic Imaging for Uncomplicated Headache (Choosing Wisely)
- Overuse of Diagnostic Imaging for Simple Syncope (Choosing Wisely)
- Avoidance of Unnecessary Use of CT in Immediate Evaluation of Minor Head Injury (CW)
- Overuse of Diagnostic Imaging for Uncomplicated Sinusitis (Choosing Wisely)

Communication and Care Coordination

- Closing the Referral Loop: Receipt of Specialist Report (PQRS 374)

Patient Safety

- Documentation of Current Medications in the Medical Record (PQRS 130)

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Thank you.

KaMMCO Health Solutions

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Dashboard Analytics Demonstration: Wednesday, March 29

Equipping Physicians for the Shift to QPP: Employing Data Analytics to Empower Physicians and Enhance Patient Care: Tuesday, March 28

Using Data to Improve Care Delivery: Monday, April 24

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