Third Time's the Charm? Updates for Year Three of the QPP

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Quality Payment Program of Illinois

Visit our website at http://qpp-il.org! We will help you navigate the complexities of the new CMS payment models so you can focus on what you do best – taking extraordinary care of your patients.

When you sign up for the QPP Resource Center, you get access to resources that help you establish your baseline, identify goals, learn about requirements, and monitor progress. Plus, QPP Advisors are available to answer questions as they come up.

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Agenda

- QPP Overview
- Merit-Based Incentive Payment System (MIPS)
- Alternative Payment Models (APM)
- Impact on Payment

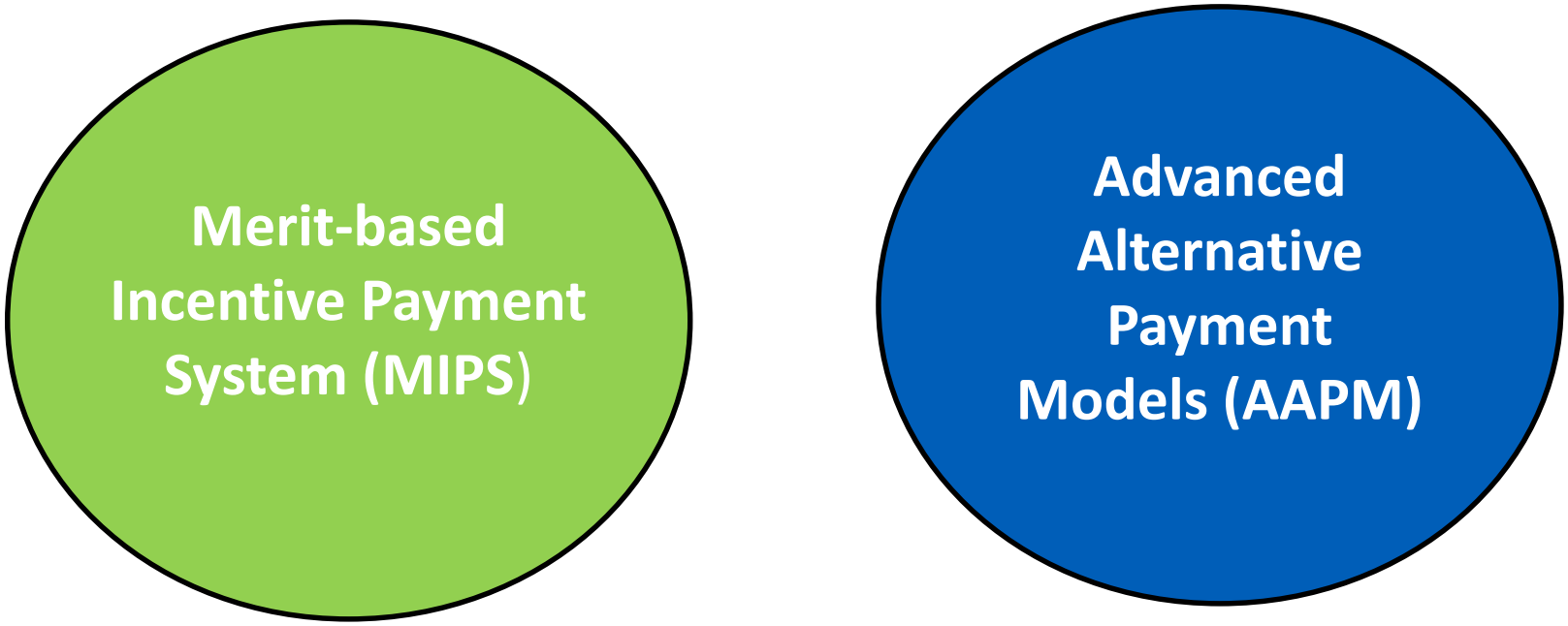
QPP Overview

MACRA (2015)

- Medicare Access and CHIP Re-Authorization Act
- Repeals “Sustainable Growth Rate”
- Streamlines multiple CMS programs into Quality Payment Program (QPP)
- Expands pathways for level of risk and reward
- Supports multi-payer initiatives

QPP Tracks

Clinicians have two tracks to choose from in the Quality Payment Program:

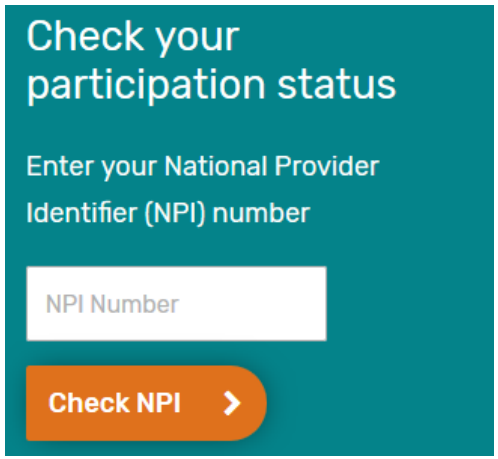


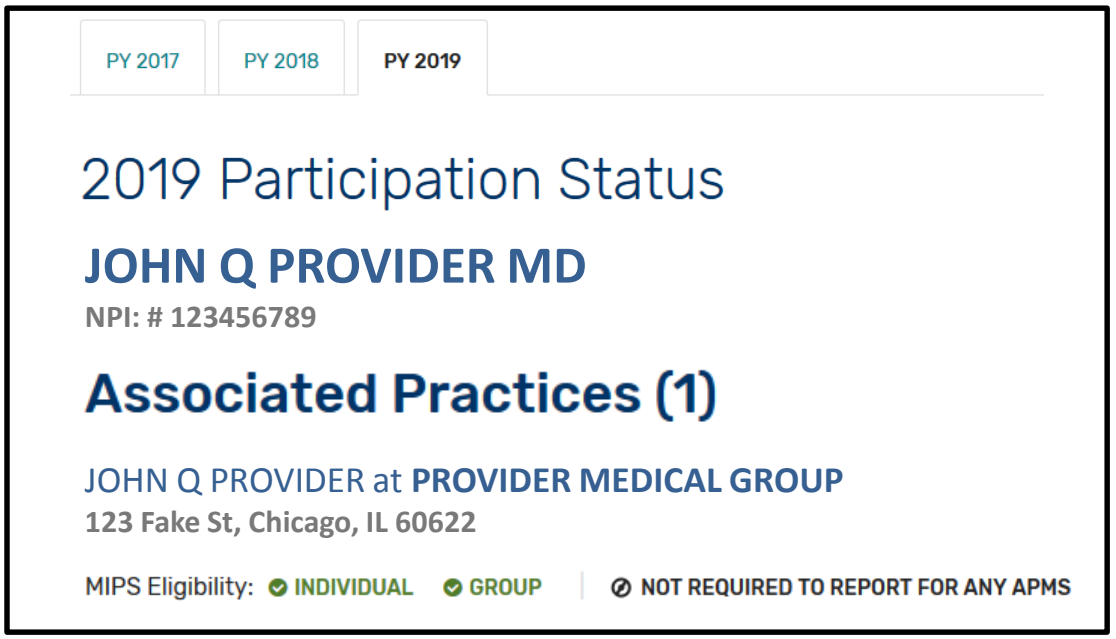
Score from 0-100 to receive a variable positive/negative adjustment on future Medicare payments

Accept downside risk to receive an automatic lump sum payment based on past Medicare billing volume

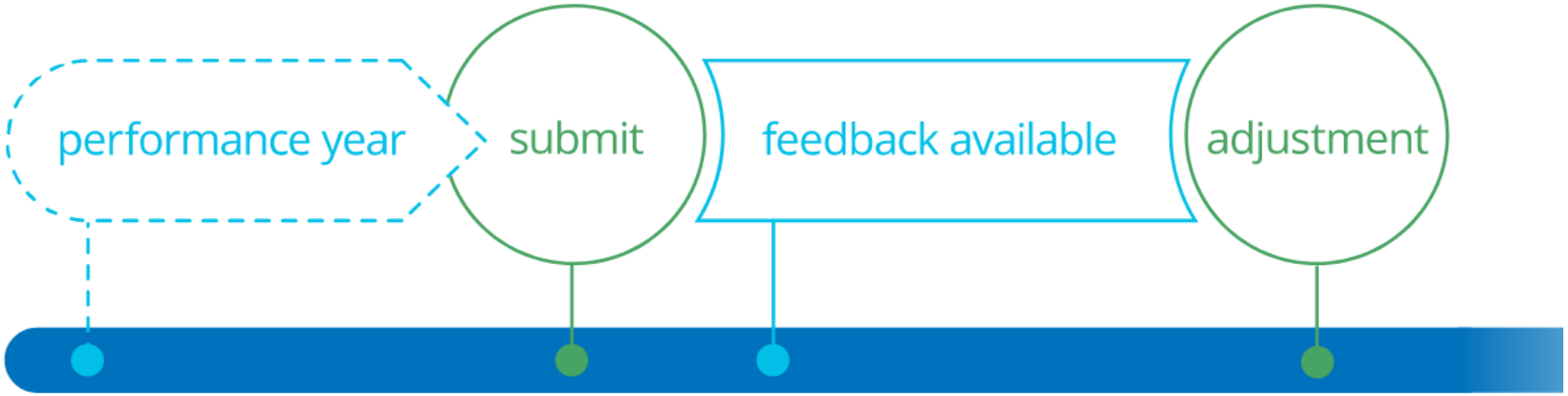
QPP Participation Lookup

- Check participation status at https://qpp.cms.gov/participation-lookup
  - Enter NPI into search box
  - Click Check NPI button
  - Review MIPS and APM participation status





2019 QPP Timeline



2019	March 31, 2020	2020	2021
Performance period begins 1/1/19 and ends on 12/31/19. During the year, record quality data, how you used CEHRT and implemented improvement activities.	Deadline to report QPP data to qualify for positive payment adjustment under MIPS or bonus under AAPM.	Medicare analyzes reported data and provides feedback on performance and MIPS payment adjustments or AAPM bonus.	MIPS payment adjustments applied to Medicare Part B reimbursements beginning 1/1/21. AAPM bonuses awarded in 2021.

MIPS Eligibility and Participation Options

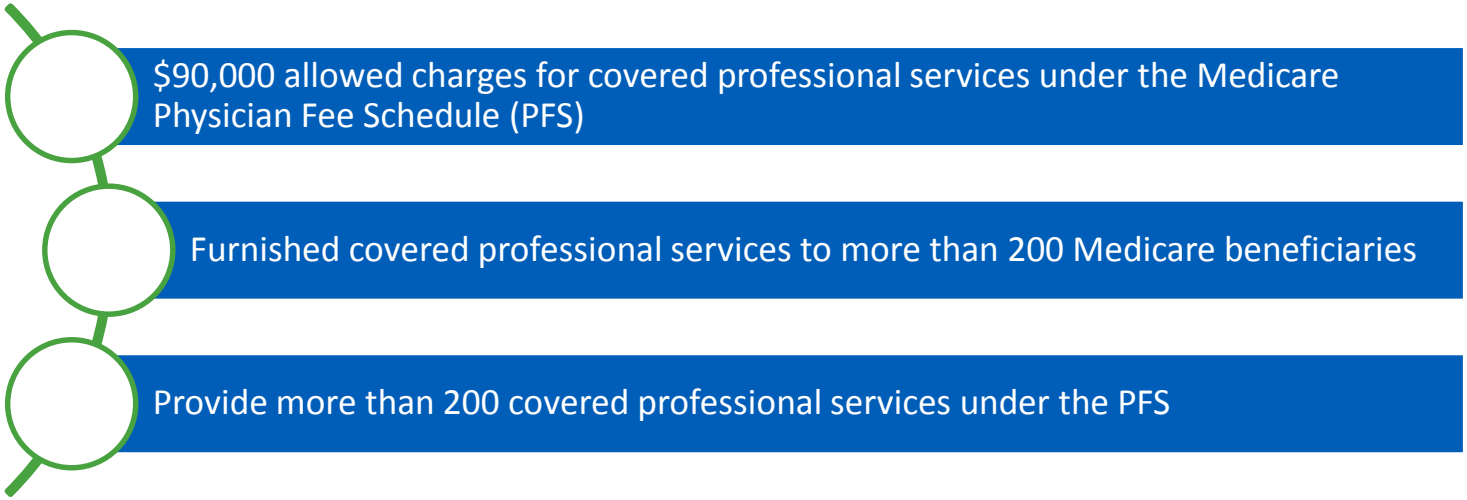
MIPS Eligible Clinicians

- Medicare eligible clinician (EC) types may be included and subject to payment adjustments:

- Practices of two or more such clinicians billing to same TIN are considered ECs at the group level

MIPS Eligibility Criteria

- MIPS ECs who enrolled in Medicare prior to 2019 are included if above all three Low-Volume Thresholds (LVT):

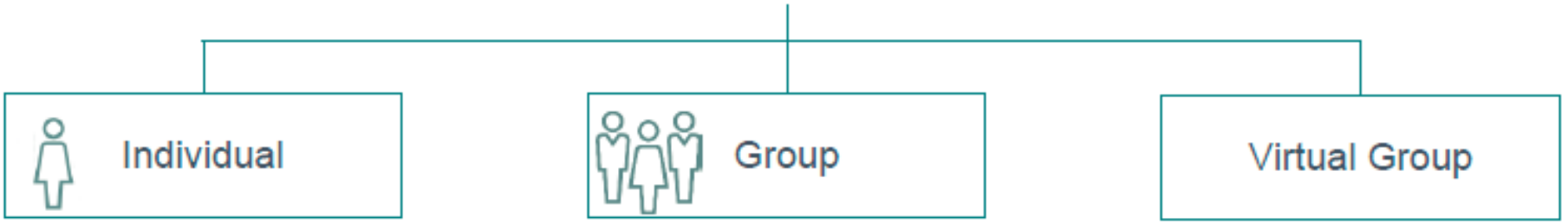


New for 2019

- ECs who are above at least one of the LVT can elect to opt-in

- ECs who participate sufficiently in AAPMs are excluded from MIPS

Participation Options



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

2. As a Group
   a) 2 or more clinicians (NPIs) who have reassigned their billing rights to a single TIN*
   b) As an APM Entity

3. As a Virtual Group – made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together "virtually" (no matter what specialty or location) to participate in MIPS for a performance period for a year

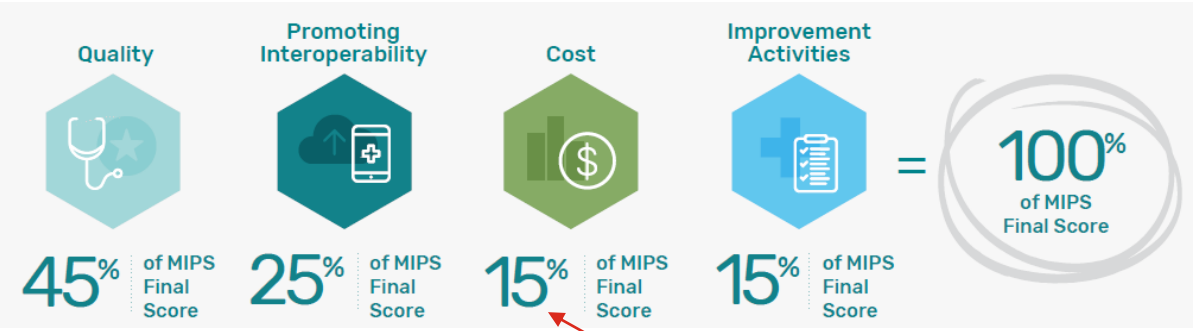
* If clinicians participate as a group, they are assessed as a group across all 4 MIPS performance categories. The same is true for clinicians participating as a Virtual Group.

MIPS Categories

MIPS Categories and Weighting

- MIPS has Four Categories
  - Quality (replaces PQRS)
  - Promoting Interoperability (replaces Meaningful Use*)
  - Cost (replaces Value-Based Modifier)
  - Improvement Activities (new)

- Category weights change over time



Decreased from 50% in 2018

Increased from 10% in 2018

* The Medicaid Promoting Interoperability Program continues through 2021. You may be eligible to report separately to both MIPS and Medicaid PI

MIPS Performance Period

Quality

Newly allowed to submit through multiple mechanisms in 2019

- Participants report measures via one or more mechanisms:
  - Claims (practices of 15 or fewer clinicians only)
  - QCDR or Qualified Registry
  - EHR
  - CMS Web Interface

Newly available for group submission in 2019

- Scored against benchmark (if meeting data completeness) on up to six measures or all measures from a measure set
- Submit at least one “high priority” (bonus points for extra)
- Example measures: depression screen, foot exam, A1c poor control, colorectal cancer screen

Promoting Interoperability

Re-named from "Advancing Care Information" in 2018

- Promotes the electronic exchange of information using 2015 Edition certified EHR technology (CEHRT)

2015 CEHRT optional in 2018

- Performance-based scoring on measures across four objectives:
  - e-Prescribing
  - Health Information Exchange
  - Provider to Patient Exchange
  - Public Health and Clinical Data Exchange

Multiple objective sets with more measures in 2018; all measures now required (unless excluded)

- HIPAA Risk Analysis is a required measure without scoring
- New EC types (physical therapist, clinical psychologist, etc.) can elect to re-weight 25% to Quality category

Cost

- No reporting; assessed automatically via claims analysis:
  - Medicare spending per beneficiary (MSPB)
  - Total cost per capita (TPCC)
  - Eight episode-based measures ← New for 2019
- TPCC measure attributed to single clinician by plurality of primary care services
- MSPB measure attributed to single clinician by plurality of Part B services during admission
- Episode-based measures attributed to each involved clinician

Improvement Activities

- New concept; not based on existing CMS program
- Assesses participation in activities that improve clinical practice
- Drive participation in APM and Patient-Centered Medical Home
- Choose from a wide scope of activities from nine categories relevant to improving clinical practice
- Example activities: anticoagulant management improvement, care transition operational improvement, use of patient-safety tools

Facility-Based Quality and Cost Scoring

- Applicable to ECs furnishing 75% or more covered services in Inpatient hospital (POS 21), On-campus outpatient hospital (POS 22), or Emergency room (POS 23)
- Must have at least one service billed in POS 21 or 23
- EC attributed to hospital at which they provide services to the most Medicare patients (identified in QPP lookup tool)
- Automatically receive facility-based scoring for Quality + Cost if hospital Total Performance Score (TPS) in Value-Based Purchasing (VBP) is higher percentile than MIPS submission
- Facility-based preview available through QPP submission site

New for 2019

Special Statuses

- Automatically assigned based on claims
- Affect reporting requirements

Ambulatory Surgical Center (ASC) based	Hospital-based	Non-patient-facing	Small practice	Health Provider Shortage Area (HPSA)	Rural
Re-weight 25% from PI to Quality (optional)	Re-weight 25% from PI to Quality (optional)	Re-weight 25% from PI to Quality (optional) Earn 2x points for each IA	Earn 2x points for each IA Receive 6 bonus points in Quality 3 points for Quality measures not meeting data completeness	Earn 2x points for each IA	Earn 2x points for each IA

Previously applied as 5 point bonus to final MIPS score

Hardship Exceptions

- Application-based process

- Promoting Interoperability Hardship Exception allows re-weight of 25% from PI to Quality based on:
  - Small practice
  - De-certified CEHRT
  - Insufficient internet connectivity
  - Extreme and uncontrollable circumstances (disaster, practice closure, severe financial distress, vendor issues)
  - Lack control over availability of CEHRT

- Extreme and Uncontrollable Circumstances Exception to re-weight any or all MIPS categories beyond PI

Alternative Payment Models

Alternative Payment Models

- APMs are a payment approach that gives added incentive payments for providing high-quality, cost-efficient care

- APMs can apply to a specific clinical condition, a care episode, or a population

- Two types of APMs:
  - MIPS APM have no downside risk and participate in MIPS at the APM-level (aggregate participant data)
  - Advanced APM carry downside risk and may exclude participants from MIPS

MIPS APM

- APM Entity collects Quality data from participating groups and submits to CMS on their behalf
- Participants submit Promoting Interoperability data independently of APM Entity
- Automatically receive credit for Improvement Activities
- Not scored on cost (baked into APM arrangement)
- Each participating group receives adjustment based on MIPS performance of entire APM Entity

Advanced APM

- Provides payment based on CEHRT use (75% of participants) and reporting quality measures comparable to those used in MIPS

Increased from 50% in 2018

- AAPM must be either:
  - Medical Home Model expanded under CMS Innovation Center
  - Requires participants to bear significant financial risk

- Qualifying Participant (QP) levels:
  - Full QP - 50% payments or 35% patients through AAPM (MIPS excluded)
  - Partial QP - 40% payments or 25% patients (MIPS optional)

Increased from 25%/20% in 2018

Increased from 20%/10% in 2018

Impact on Payment

QPP Payment Structure

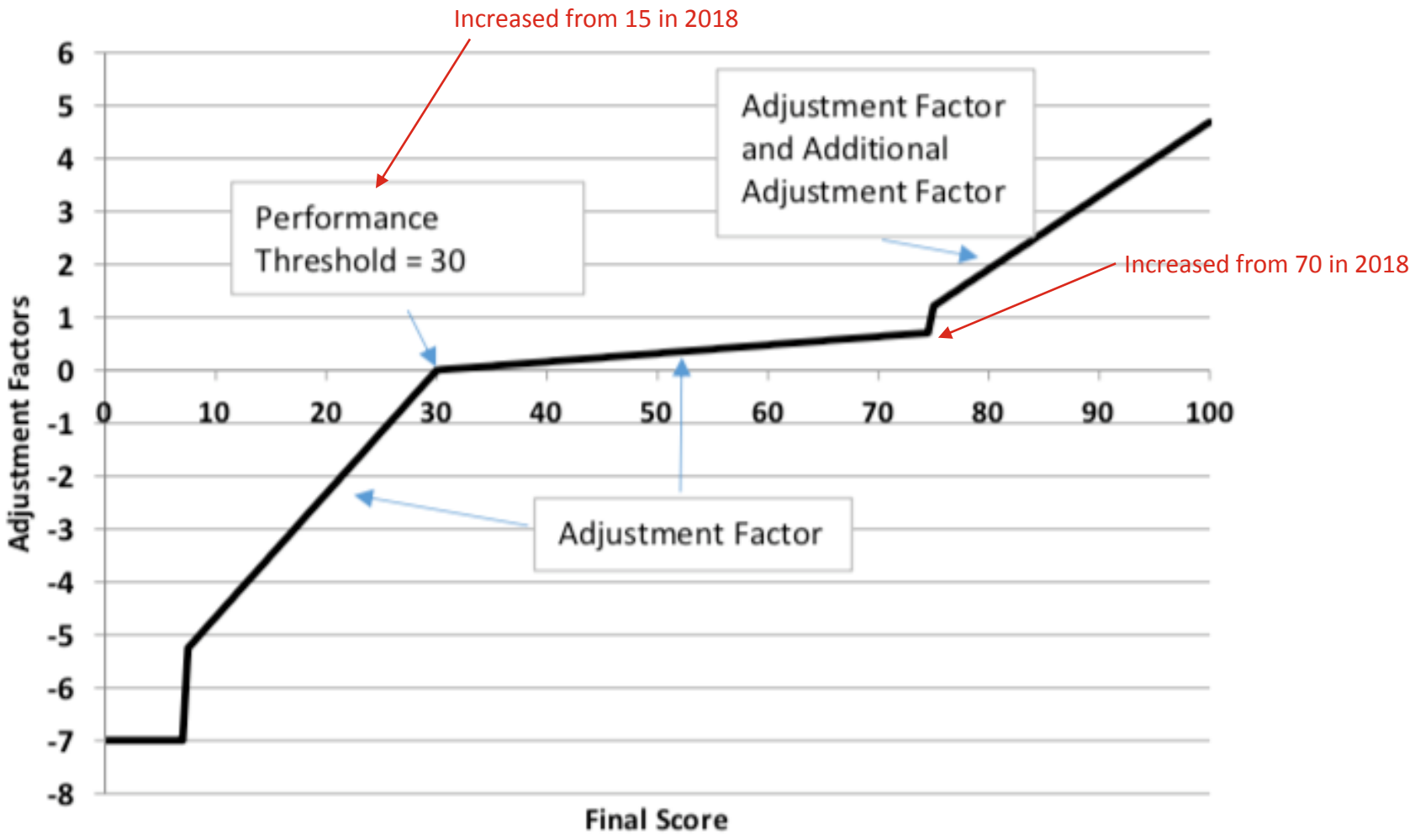
- Participate in QPP during “performance year” (i.e. 2019)
- Receive payment adjustment during “payment year” (i.e. 2021)
- Payment adjustment “follows the clinician”
- MIPS payments based on score relative to all other participants, applied as adjustments against fee schedule
- AAPM payments applied as lump sum incentive for full QPs (partial QPs get no incentive unless electing MIPS)

MIPS Max Penalty/Incentive

PERFORMANCE YEAR	PAYMENT YEAR	MAXIMUM PENALTY	MAXIMUM BASE INCENTIVE	MAXIMUM EXCEPTIONAL PERFORMANCE BONUS
2017	2019	-4%	+4%*X (Actual 0.29%)	+10%*Y (Actual 1.59%)
2018	2020	-5%	+5%*X (CMS predicts 0.30%)	+10%*Y (CMS predicts 1.75%)
2019	2021	-7%	+7%*X (CMS predicts 1.11%)	+10%*Y (CMS predicts 3.58%)

- CMS calculates X (the "budget-neutrality factor") such that the national base incentive pool is set equal to the national penalty dollars assessed
- CMS calculates Y by allocating $500M per year (available each year through 2022) to an exceptional performance bonus pool for high performers

MIPS Adjustment by 2019 Performance



AAPM Payment Adjustment

- Automatic 5% bonus in payment years 2019-2025
- .75% annual increase to fee schedule payments starting 2026 (vs .25% for non-AAPM)
- May earn additional rewards based on cost savings
- May end up net negative due to shared losses (risk)

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