Yay! I'm a MIPS QP in the DCE…Now What?

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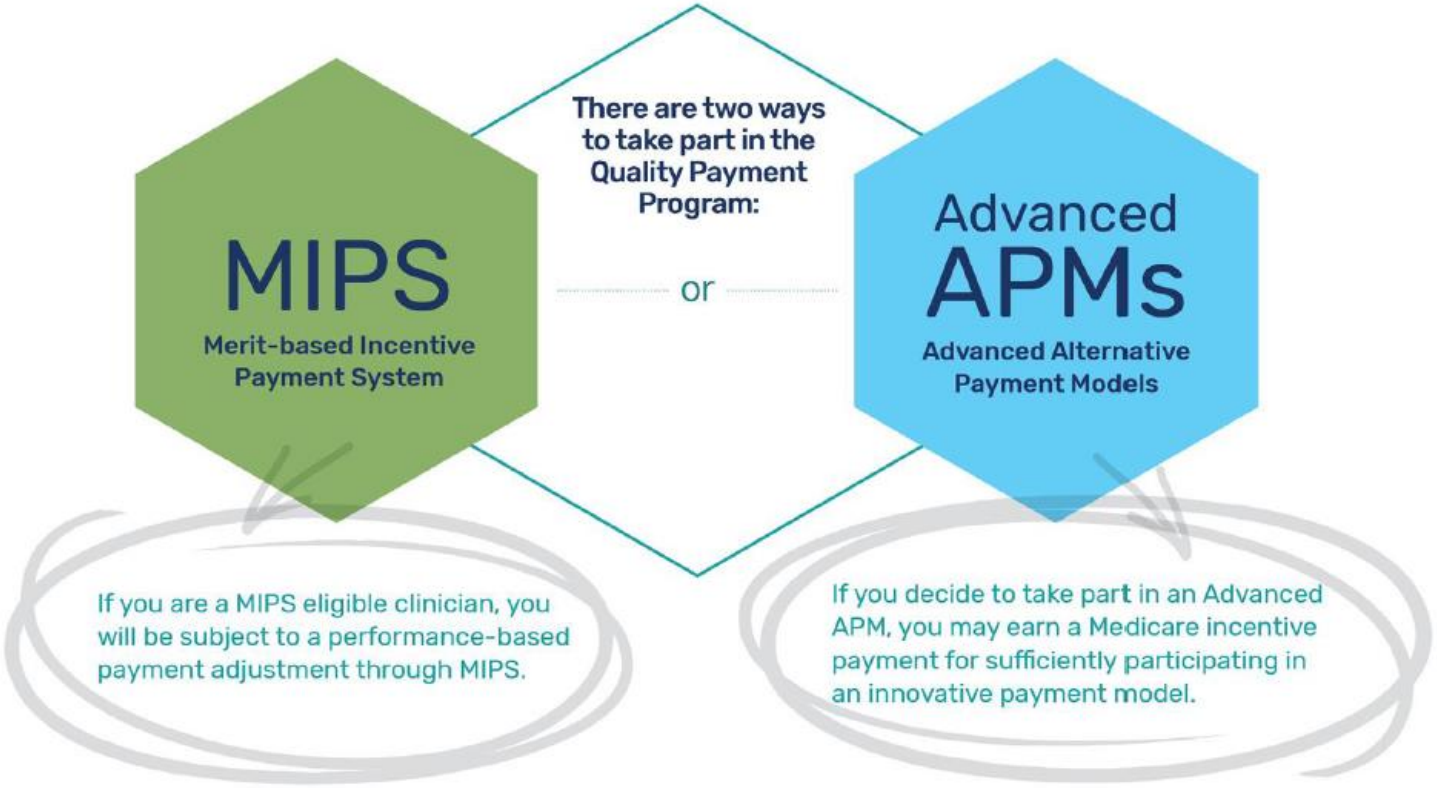
The Quality Payment Program – MIPS and Advanced APMs

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

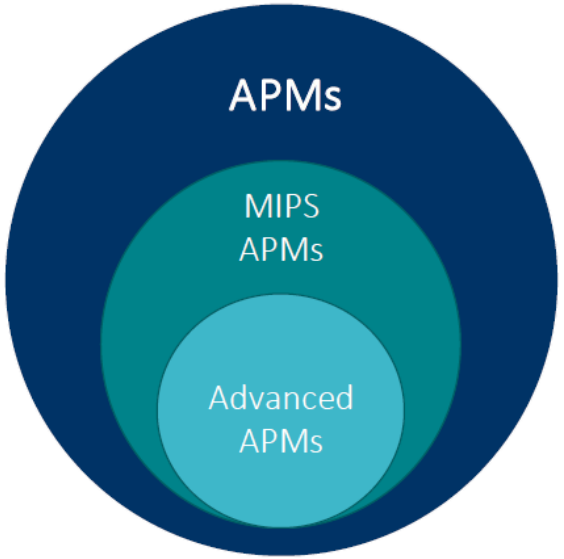


- Repealed the Sustainable Growth Rate (SGR) formula
- Changed the way Medicare pays clinicians and establishes a new framework to reward clinicians for value over volume (transitioning away from the Fee for Service payment model)

WWW.QPP.CMS.GOV

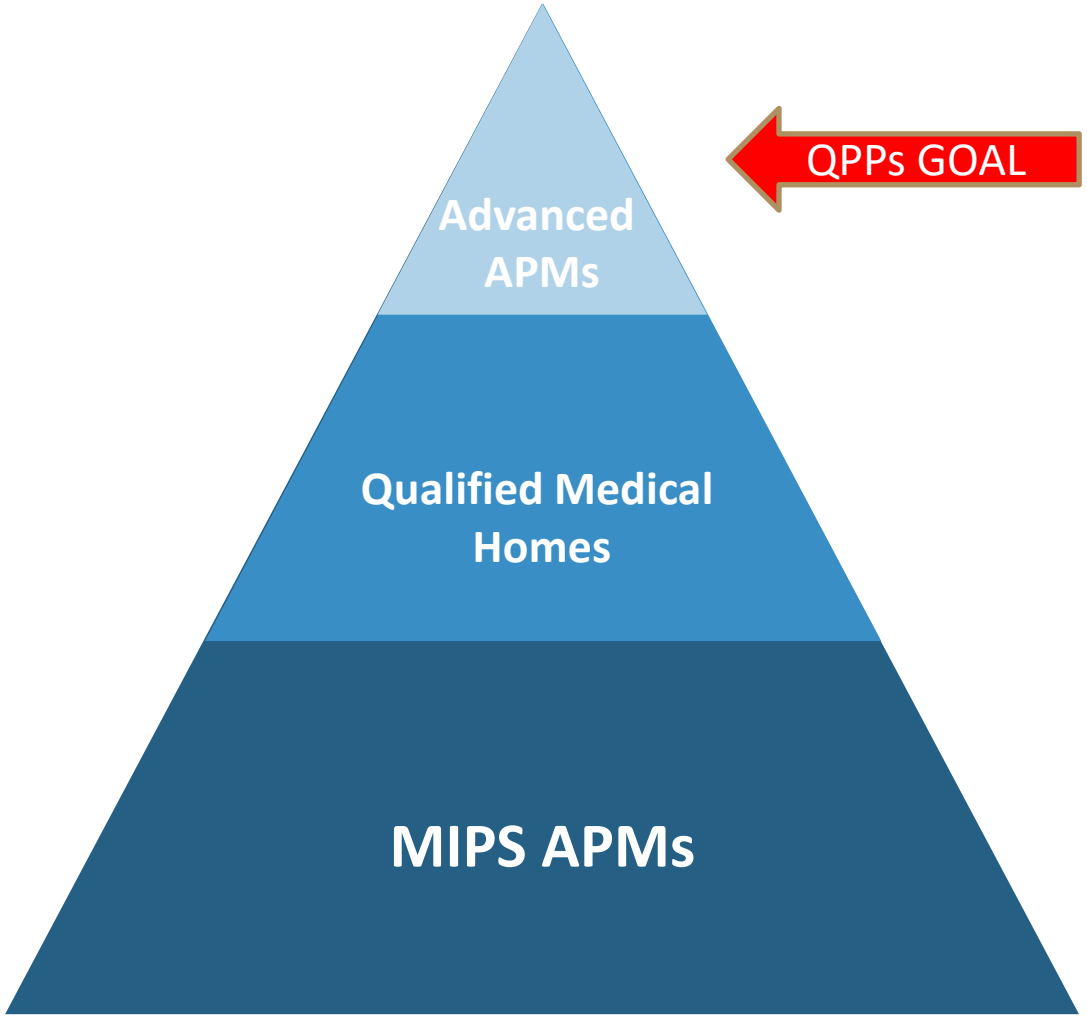
Alternative Payment Models (APMs) – Quick Overview

- Alternative Payment Model or APM is a **generic term** describing a payment model in which providers take **responsibility for cost and quality performance** and **receive payments to support** the services and activities designed to achieve high value
- Most common type of APM is an ACO, but several other types exist as well
  - Direct Contracting Entity (DCE) is a new type of APM
- The QPP does not change how any APM pays for medical care and rewards value; instead, the program adds *additional* incentives
- APM participants also participating in MIPS may receive favorable scoring under certain MIPS performance categories
- **Some** APMs are deemed "**Advanced**" APMs (A-APMs)



Alternative Payment Models (APMs)

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

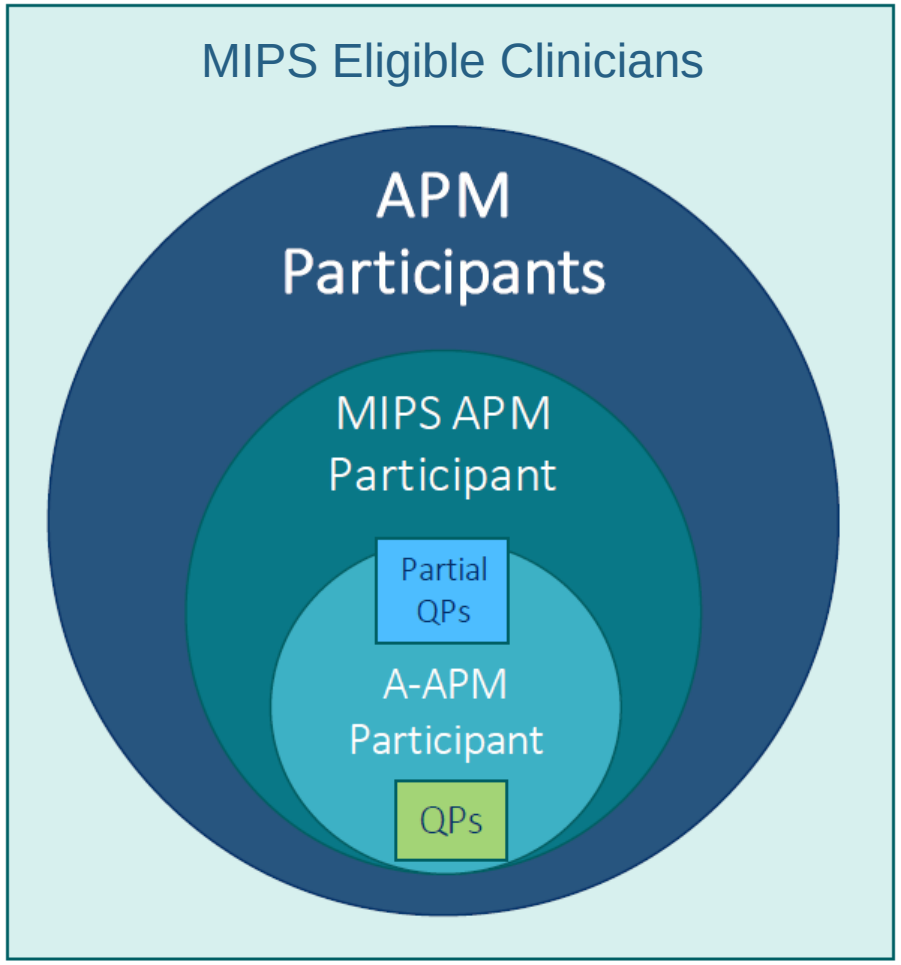


Volume Thresholds Required for Advanced APMs

Qualifying APM Participant (QP) Status

(link to 2021 QP Quick Start Guide)

- A "Qualifying APM" is one that meets increasing thresholds for the percentage of charges *from attributed beneficiaries* that pass through the APMs payment methodology
- An individual EC in a qualifying APM is a "Qualifying APM Participant" or "QP"
- QPs are not required to report for MIPS
  - A QP is not considered a "MIPS Eligible Clinician"
- **Your QP status applies to <u>every</u> TIN you bill under**



Becoming a Qualifying APM Participant (QP)

Payment Amount Method

$$\frac{\text{\$\$\$ for Part B professional services to attributed beneficiaries}}{\text{\$\$\$ for Part B professional services to attribution-eligible beneficiaries}} = \text{Threshold Score \%}$$

Patient Count Method

$$\frac{\text{\# of attributed beneficiaries given Part B professional services}}{\text{\# of attribution-eligible beneficiaries given Part B professional services}} = \text{Threshold Score \%}$$

Requirements for Incentive Payments for Significant Participation in Advanced APMs (Clinicians must meet payment or patient requirements)						
Performance Year	2017	2018	2019	2020	2021	2022 ~~and later~~
Percentage of Payments through an Advanced APM	25%	25%	50%	50%	50%	50%
Percentage of Patients through an Advanced APM	20%	20%	35%	35%	35%	35%

▲ Check APM participation and QP status with the participation status look-up tool

Volume Thresholds Required for Advanced APMs

What if the threshold for QP status is not met?

- If QP status is not met, A-APM participants meeting slightly lower minimum thresholds (i.e. -10%), are considered "Partially Qualifying APM Participants" or "PQPs"
- If a PQP chooses to stay in the A-APM track, s/he will not receive the A-APM bonus (see next slide), but will not be subject to MIPS (no data submission, no financial adjustments)
- If PQP chooses, s/he can report MIPS measures and participate in the MIPS incentive track
- **If the APM participant does not meet QP or PQP thresholds, the participant is subject to MIPS eligibility requirements, reporting, and scoring (i.e., must report in the same way as a MIPS APM participant)**

Incentives for Advanced APM Participation (as a QP)

- **Model design**
  - A-APMs have shared savings, flexible payment bundles, and other desirable features; these are not affected by the QPP
- **Bonuses**
  - In program years 2017-2022 (payment years 2019-2024), 5% lump sum bonus payments made to ECs significantly participating in Advanced APMs (aka QPs)
- **Higher reimbursement updates**
  - Annual baseline payment updates will be higher (0.75%) for A-APM participants than for MIPS participants (0.25%) starting in 2026
- **MIPS exemption**
  - QPs in Advanced APMs do not participate in MIPS (models include their own EHR use and quality reporting requirements)

So as a QP, what DO I need to do?

Being a QP in NPO's DCE

- Comply with MIPS Promoting Interoperability (PI) requirements (no reporting)
- Review PI requirements via this Quick Start Guide
- Must use 2015 Edition Certified EHR Technology (CEHRT) (CHPL)
- Complete/Update your annual SRA (Security Risk Analysis) ← **DCE REQUIREMENT!**
- Four Objectives (with up to 7 measures in total to report on):
  - e-Prescribing
  - Health Information Exchange ← **VITAL FOR MAINTAINING QP STATUS!**
  - Provider to Patient Exchange
  - Public Health and Clinical Data Exchange

2021 Promoting Interoperability Measure Specifications

PI Category Changes in 2021

- Query of Prescription Drug Monitoring Program (PDMP) measure is still available as an optional Yes/No measure (now worth 10 bonus points)
- New optional Health Information Exchange (HIE) bi-directional measure
  - Either report (2) existing HIE measures or this new single HIE measure
  - Reported by attestation with a yes/no response to the following statements:

> – I participate in an HIE to enable secure, bi-directional exchange to occur for every patient encounter, for every patient transition or referral during the performance period, and the record is stored or maintained in the EHR.
>
> – The HIE that I participate in is capable of exchanging information across a broad network of unaffiliated exchange partners, including those using disparate electronic health records (EHRs), and does not engage in exclusionary behavior when determining exchange partners.
>
> – I use the functions of Certified EHR Technology (CEHRT) for this measure, which may include technology certified to criteria at 45 CFR 170.315(b)(1), (b)(2), (g)(8), or (g)(10).

Being a QP in NPO's DCE

- Quality data reporting as a DCE participant
- Most Quality data is pulled from claims
- CAHPS Survey will be administered via NPO

Domain	Measure Title	Method of Data Submission	Pay for Performance Phase In R—Reporting P—Performance
Care Coordination/Patient Safety	Risk-Standardized, All Condition Readmission	Claims	PY2021: P & R PY2022: P & R PY2023-2026: P
	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	Claims	PY2021: P & R PY2022: P & R PY2023-2026: P
	Days at Home (for High Needs Population DCE)	Claims	PY2021-2022: R PY2023-2026: P
	Timely Follow-Up After Acute Exacerbations of Chronic Conditions (for Standard DCE or New Entrant DCE)	Claims	PY2021: N/A PY2022: R PY2023-2026: P
Patient/Caregiver Experience	Consumer Assessment of Healthcare Providers and Systems® (CAHPS)	Survey	PY2021: N/A PY2022: R PY2023-2026: P

Be Prepared for MIPS…Regardless of Status

- PI Category: Covered on previous slides
- Improvement Activities (IA) Category: Automatic full credit in 2021 and 2022 for being in the APM. At least 50% credit will be awarded to APM participants in future years
  - Continue with PCMH processes as many IAs were created from PCMH activities
- Cost Category: Data comes from claims. Only relevant if you're no longer in the DCE/APM
- Quality Category:
  - Review requirements via this Quick Start Guide
  - Select (6) clinically relevant measures to track and improve on throughout the year
    - 1 must be an outcome measure or a high-priority measure (if an outcome measure is not available)
    - May also select a specialty-specific measure set
      - If selected measure set has fewer than 6 measures, denominator will be automatically lowered
  - Consider/investigate how you will report data if required to report for MIPS
- **Configure your MIPS Dashboard at the beginning of the year!**

Looking Ahead: QPP in 2022

One 2022 Update for A-APMs

In the 2021 PFS Final Rule, CMS finalized a hierarchy that can be used to identify potential payee TINs using base year claims if the Qualifying APM Participant's (QP) original TIN is no longer active and associated with the QP.

In this year's rule, CMS is finalizing a policy to extend the hierarchy to include billing TINs that are active only during the payment year. Adding this step to the processing hierarchy will make it easier for CMS to complete payments to more QPs in the first round of QP Incentive Payments.

CMS is finalizing their proposal to add this step to the current regulatory hierarchy for processing the QP Incentive Payment. This will enable CMS to look for payee TINs that are active in the base year or the payment year for each step of the hierarchy.

New MIPS Eligible Clinician (EC) Types

- Adds Clinical Social Workers and Certified Nurse Midwives
- Specialty measure sets for both types
- Automatic re-weighting of PI category to 0% for Clinical Social Workers

Physicians	Osteopaths	Occupational Therapists
Chiropractors	Physician Assistants	Clinical Psychologists
Nurse Practitioners	Clinical Nurse Specialists	Qualified Speech-Language Pathologists
Certified Registered Nurse Anesthetists	Physical Therapists	Qualified Audiologists
Registered Dietitians or Nutrition Professionals	**Clinical Social Workers***	**Certified Nurse Midwives***

Performance Thresholds

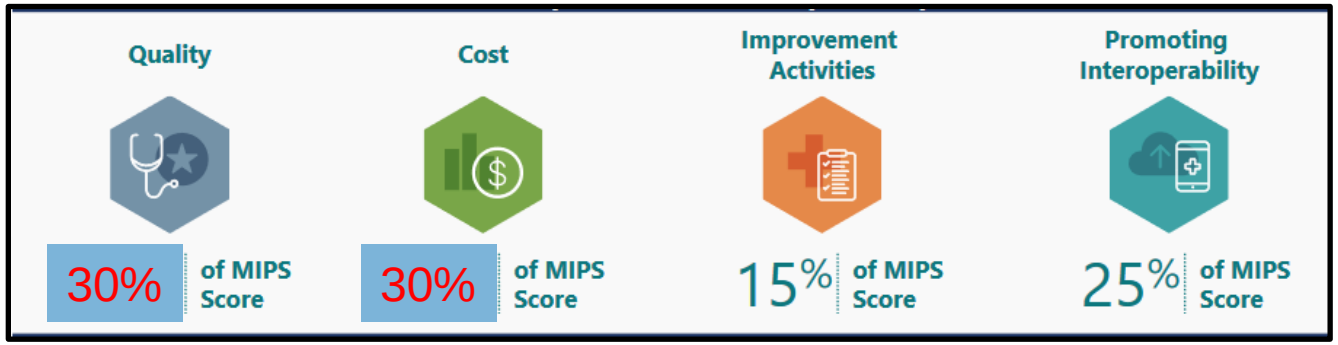
- Statutory requirements for 2022 (year 6):
  - Performance threshold must be mean or median from prior period
  - Exceptional performance threshold must be 25th percentile of possible or actual scores above performance threshold from prior period
  - Must be final year of additional performance threshold

- Finalized using mean performance from 2017:

Threshold	Outcome	2021	2022
Scoring floor	Avoid maximum -9% penalty	15 →	18.75
Performance	Avoid any penalty	60 →	75
Exceptional performance	Extra rewards	85 →	89

Category Weights

- By law, Cost and Quality must be equally weighted in 2022+
  - Quality decreases from 40% to 30%
  - Cost increases from 20% to 30%



- No change to MIPS APM or APP (APM Performance Pathway) weighting

Other Updates

- Complex patient bonus criteria
- Facility-based measurement only if best available score
- Updates public reporting through Medicare's Care Compare
- Improves identification of payee TINs for QP bonus
- Plans transition to digital quality measures by 2025

Performance Category Reweighting

- Automatic PI re-weighting for small practices (application no longer needed)
- Depending on which categories are left, reweighting looks like:

Reweighting Scenario	Quality	Cost	Improvement Activities	Promoting Interoperability
No Reweighting Needed				
- Scores for all four performance categories	30%	30%	15%	25%
Reweight One Performance Category				
-No Cost	55%	0%	15%	30%
-No Promoting Interoperability*	40%	30%	30%	0%
-No Quality	0%	30%	15%	55%
-No Improvement Activities	45%	30%	0%	25%
Reweight Two Performance Categories				
-No Cost and no Promoting Interoperability*	50%	0%	50%	0%
-No Cost and no Quality	0%	0%	15%	85%
-No Cost and no Improvement Activities	70%	0%	0%	30%
-No Promoting Interoperability and no Quality	0%	50%	50%	0%
-No Promoting Interoperability and no Improvement Activities	70%	30%	0%	0%
-No Quality and no Improvement Activities	0%	30%	0%	70%

*The finalized redistribution policy specifically for MIPS eligible clinicians in small practices.

2022 MIPS Performance Category Updates

Quality Performance Category Updates

- 200 total measures
  - Substantive changes to 87 existing
  - Removes 13
  - Adds 4, including 1 administrative claims
- Maintains data completeness threshold of 70%
- Removes bonus points for:
  - High-priority and outcome measures
  - End-to-end electronic reporting
- Extends use of CMS Web Interface for 2022
- No group scoring from claims unless group submits another category
- Modifies policies for measures with significant changes or errors

Quality: Benchmarking

- Confirms use of 2020 performance data is appropriate
- Establishes floor for new measures
  - 7-point floor for first year of new measure
  - 5-point floor for second year of new measure
  - Requires data completeness and case minimum to be met
- Retains 3-point floor for existing measures regardless of benchmark, data completeness or case minimum
- Reduces floor for existing measures beginning 2023:
  - 1-point for measures with benchmark
  - 0-point for measures without benchmark or if data completeness/case minimum not met
  - Does not apply to small practices (3-point floor for all)

Improvement Activities Performance Category Updates

- Inventory update
  - Add 7 new activities
  - Remove 6 activities
  - Modify 15 activities
- Focus on health equity subcategory
  - 3 of 7 new activities
  - 11 of 15 modified activities
- New activities must meet 2 new criteria:
  - Not duplicative
  - Beyond standard clinical practice
- Process to suspend activities that may present safety or other risk

Promoting Interoperability Performance Category Updates

- Adds automatic re-weighting for:
  - Clinical social workers
  - Small practices
- Modifies Public Health and Clinical Data Exchange
  - Requires immunization registry and electronic case reporting
  - For 2022 only, exclude from case reporting if CEHRT vendor is not certified for standard
  - 5 bonus points for reporting one or more other measures
- Does not modify Provide Patients Electronic Access to Health Information
- Newly requires Safety Assurance Factors for EHR Resilience (SAFER) Guide measure
  - Attest to conducting self-assessment using the High Priority Practices Guide
- Modifies Prevention of Information Blocking attestation statement

Cost Performance Category Updates

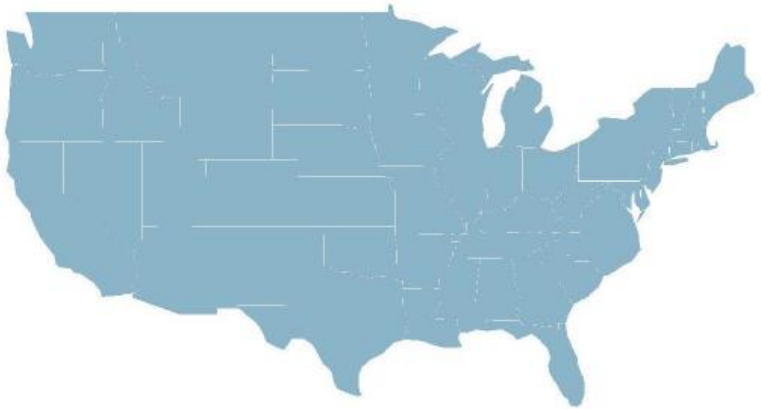
- Adds 5 new episode-based measures
  - Procedural:
    - Melanoma Resection
    - Colon and Rectal Resection
  - Acute inpatient:
    - Sepsis
  - Chronic condition:
    - Diabetes
    - Asthma/COPD
- Calls for stakeholder Cost measure development to expand inventory:
  - Development previously limited to CMS contractor
  - Adoption of stakeholder measures in 2024 or later

Overall Takeaways

- The patient-centered care you deliver is work that contributes to the success of all FFV (Fee for Value) agreements
- By being in NPO's CIN (Clinically Integrated Network) you're expected to meet all Medicare requirements
- The benefit to being a QP in the Advanced APM is the significant reduction in reporting burden
- Continue working WITHIN this network to ensure you continue to reach QP status
- Although you're not MIPS eligible, BE PREPARED to report for MIPS regardless
  - Minimum threshold to avoid a penalty is high and likely unreachable if not actively working on it
  - Complete an SRA
  - Focus on improving PI measures and workflows
  - Choose (6) quality measures to track and improve (and consider a reporting method)
- Being in the A-APM is the more financially beneficial path of the QPP
  - 5% bonus versus >2% increase
  - Annual +.75% vs +.25% increases to PFS beginning in 2026

Free Technical Assistance

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



Small & Solo Practices

Small, Underserved, and Rural Support (SURS)

- Provides outreach, guidance, and direct technical assistance to clinicians in solo or small practices (15 or fewer), particularly those in rural and underserved areas, to promote successful health IT adoption, optimization, and delivery system reform activities.
- Assistance will be tailored to the needs of the clinicians.
- There are 11 SURS organizations providing assistance to small practices in all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands.
- For more information or assistance getting connected, contact QPPSURS@IMPAQINT.com.

Technical Support

All Eligible Clinicians Are Supported By:

- **Quality Payment Program Website: qpp.cms.gov**
  Serves as a starting point for information on the Quality Payment Program.
- **Quality Payment Program Sevice Center**
  Assists with all Quality Payment Program questions.
  1-866-288-8292 TTY: 1-877-715-622 QPP@cms.hhs.gov
- **Center for Medicare & Medicaid Innovation (CMMI) Learning Systems**
  Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs. More information about the Learning Systems is available through your model's support inbox.

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