



Quality Payment Program: Year 2

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Year 2 MIPS Performance Categories



Source: www.qpp.cms.gov

Low-Volume Threshold Increase

Transition Year 1 (2017) Final



AND



Year 2 (2018) Final



AND





Small Practice Flexibilities

- Groups of ≤ 15 clinicians
- Low-volume threshold increased
- 5 bonus points added to total composite score
- Option to join a Virtual Group
- 3 points for Quality measures that do not meet data completeness
- Hardship exception for Advancing Care Information performance category

Who is Exempt in Year 2?



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 **\$90,000** a year OR
- See **200** 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



Year 2 Non-Patient Facing Criteria

Transition Year 1 (2017) Final

- Individual – If you have ≤ 100 patient facing encounters.
- Groups – If your group has $>75\%$ of NPIs billing under your group's TIN during a performance period are labeled as non-patient facing.



Year 2 (2018) Final

- **No Change to Individual and Group policy.**
- **NEW - Virtual Groups** are included in the definition.
 - Virtual Groups that have $>75\%$ of NPIs within a virtual group during a performance period are labeled as non-patient facing







Patient-Facing Codes

- CMS removed the following procedures/codes from the list used to determine patient-facing status:
 - Paracentesis (49082, 49083)
 - Thoracentesis (32554, 32555)
 - Joint injections (64490, 64493)
 - Lumbar puncture (62270)
 - Myelography (62284)


Reporting Period Changes

Transition Year 1 (2017) Final





Performance Category	Minimum Performance Period
 Quality	90-days minimum; full year (12 months) was an option
 Cost	Not included. 12-months for feedback only.
 Improvement Activities	90-days
 Advancing Care Information	90-days



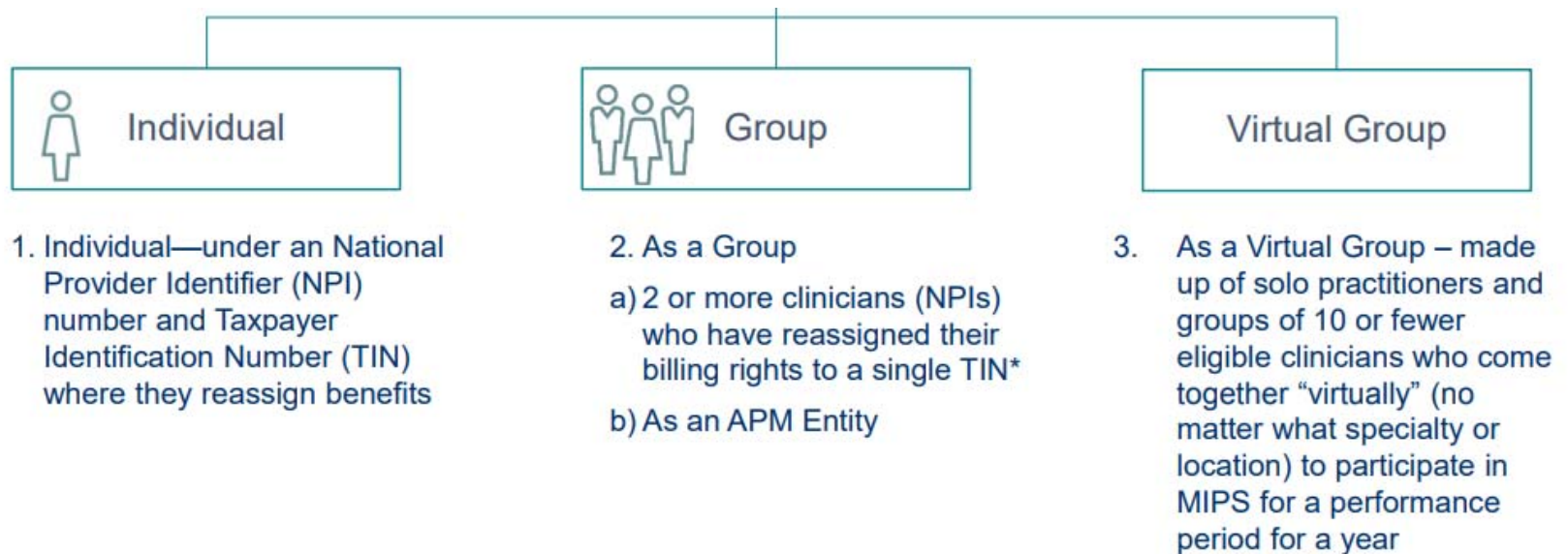
Year 2 (2018) Final

Performance Category	Minimum Performance Period
 Quality	12-months
 Cost	12-months
 Improvement Activities	90-days
 Advancing Care Information	90-days

Data Submission Options

Performance Category	Submission Mechanisms for Individuals	Submission Mechanisms for Groups (Including Virtual Groups)
 <p>Quality</p>	QCDR Qualified Registry EHR Claims	QCDR Qualified Registry EHR CMS Web Interface (groups of 25 or more)
 <p>Cost</p>	Administrative claims (no submission required)	Administrative claims (no submission required)
 <p>Improvement Activities</p>	Attestation QCDR Qualified Registry EHR	Attestation QCDR Qualified Registry EHR CMS Web Interface (groups of 25 or more)
 <p>Advancing Care Information</p>	Attestation QCDR Qualified Registry EHR	Attestation QCDR Qualified Registry EHR CMS Web Interface (groups of 25 or more)

Participation Options





Virtual Groups

- Formal written agreement
- Election process
 - Prior to performance period
 - Virtual group representative
 - CMS confirmation of eligibility
- Virtual Group Toolkit



Quality Performance Category

- No new radiology measures
- Benchmarks for measures 21, 23, 405, 406, 418, 436
- Data completeness 60% for all submission mechanisms except CMS Web Interface
- Bonus point criteria remains the same



Quality Performance Category: Scoring

- Measures that do not meet data completeness criteria will earn 1 point
 - Exception: small practices will earn 3 points
- 7-point scoring policy for 6 topped out measures
 - Measure #21: Selection of prophylactic antibiotics
 - Measures #23: Venous Thromboembolism (VTE) Prophylaxis
- 3 points for measures that do not meet case minimum (20) or do not have a benchmark
- In order to receive bonus points, eligible measures **MUST** meet case minimum and data completeness



Cost Performance Category

- 2 measures
 - Medicare Spending per Beneficiary (MSPB)
 - Total per Capita Cost (TPCC)
- Calculated based on administrative claims
- Feedback for MIPS Year 1
- No action required by MIPS EC's



Medicare Spending per Beneficiary (MSPB)

- Determines what Medicare pays for services performed by a MIPS EC during an episode: the period immediately before, during, and after a patient's hospital stay
- Includes all Medicare Part A and Part B claims during the episode
 - 3 days before a hospital admission (the "index admission" for the episode) through 30 days after hospital discharge
- MSPB measure is assigned to individual clinicians but can be reported as a group



Total per Capita Cost (TPCC)

- Measure of all Medicare Part A and Part B costs during the MIPS performance period
- Beneficiaries are assigned to a single Medicare TIN-NPI in a two-step process that considers
 - The level of primary care services they received (as measured by Medicare allowed charges during the performance period).
 - The clinician specialties that performed these services
- Only beneficiaries who received a primary care service during the performance period are assigned to the TIN-NPI



Improvement Activity Performance Category

- New activities added; 112 activities available now
- Requirements for small practices and non-patient facing MIPS ECs remain the same



Advancing Care Information Performance Category

- A 10% bonus is available if only use 2015 Edition CEHRT
- Automatic reweighting for:
 - Groups of ≤ 15 MIPS EC's
 - Hospital-based MIPS EC's
 - Now includes off-campus-outpatient hospital (POS 19)
 - Ambulatory Surgical Center-based EC's



Advancing Care Information Performance Category: Scoring

- No change in base score requirements
- Can earn 10% in performance score for reporting to any single public health agency or clinical data registry
 - 5% bonus score available for additional reporting
- Additional Improvement Activities are eligible for a 10% Advancing Care Information bonus if use CEHRT to complete at least 1 of the specified Improvement Activities



Complex Patient Bonus

- MIPS EC's can earn up to 5 bonus points for treatment of complex patients
- Combination of Hierarchical Condition Categories (HCCs) and # of dually eligible patients treated
 - Average HCC risk score

Payment Adjustment Threshold

Transition Year 1 (2017) Final

- 3 point threshold
- Exceptional performer set at 70 points
- Payment adjustment set at +/- 4%



Year 2 (2018) Final

- 15 point threshold
- Exceptional performer set at 70 points
- Payment adjustment set at +/- 5%

NOTE: MIPS score and associated adjustment will follow the MIPS EC



Advanced Alternative Payment Model

- Extends the 8% generally applicable revenue based nominal amount standard that allows APMs to qualify as Advanced APM through performance year 2020
- Changes the requirement for Medical Home Models so that the minimum required amount of total financial risk increases more slowly
- Easier for clinicians to qualify for incentive payments by participating in Advanced APMs that begin or end in the middle of a year.
- All-Payer Combination Option available in 2019



MIPS APM Track

- Total composite score weight
 - Quality: 50%
 - Improvement Activities: 20%
 - Advancing Care Information: 30%
 - Cost: 0%
- Medicare Shared Savings Program Track 1 is still an APM



MACRA ready

Advocate's QPP/MACRA experience is deep and complete. Our clients maintain Composite Scores in the upper 90's placing them in the ideal position for bonus payments. We provide timely information to radiologists on measure performance, composite scoring and provide dictation templates to achieve higher Composite Scoring.

- Complete Penalty Avoidance
- Ideal Bonus Positioning With Client Composite Scores in Excess of 95
- Assistance With Measure Selection
- Proven Methods to Analyze & Improve Performance
- Templates and Guidance
- Accurate Medicare and Registry Submissions
- Comprehensive Individual and Group Monthly Reporting
- Expert Guidance at Every Step



Questions



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