

# Practice Management Series Part 1: *Quality Payment Program 101*

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Chief Compliance Officer

# Agenda

- **What is QPP?**
  - Program Overview
- **Does this Apply to Me?**
  - Eligibility and Participation
- **How do I participate?**
  - Reporting and Submission
- **What do I need to know?**
  - Performance Categories
- **Submitted Questions**

# Acronyms

- QPP – Quality Payment Program
- MACRA – Medicare Access and CHIP Reauthorization Act of 2015
- MIPS – Merit-based Incentive Payment System
- APM – Alternative Payment Model
- TIN – Tax ID Number
- NPI – National Provider Identifier

# What is the Quality Payment Program?



# Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

- MACRA was signed into law in 2015 as a way to reward clinicians for value over volume
- Created the Quality Payment Program
- Replaced Meaningful Use, Physician Quality Reporting System and Value-Based Modifier

# MACRA

- Goal to reward high value, high quality Medicare clinicians and reduce payment to those who aren't meeting performance standards
- Positive adjustments come from negative penalties determined by a score

# Program Tracks

- Merit-based Incentive Payment System (MIPS)
  - Replaces legacy programs → PQRS, Value-based Modifier program, and Meaningful Use
  - Evolving program: scoring and requirements updated annually
- Alternative Payment Model (APM)
  - For entities that participate in a Medicare-approved APM or payment arrangement with a non-Medicare payer
  - APMs can apply to a specific clinical condition, a care episode, or a population

# MIPS Payment Adjustments

Performance Period	Also referred to as...	Corresponding Payment Year	Corresponding Adjustment
2017	2017 "Transition" Year	2019	Up to +4%
2018	"Year 2"	2020	Up to +5%
2019	"Year 3"	2021	Up to +7%



# Merit-based Incentive Payment System (MIPS) Overview

- Payment adjustments based on scores in 4 “performance categories”
  - Quality
  - Cost
  - Promoting Interoperability
  - Improvement Activities

# Scoring

Performance Category	Performance Period	Score
Quality	12 Month	45%
Cost	12 Month	15%
Improvement Activities	90 days	15%
Promoting Interoperability	90 days	25%

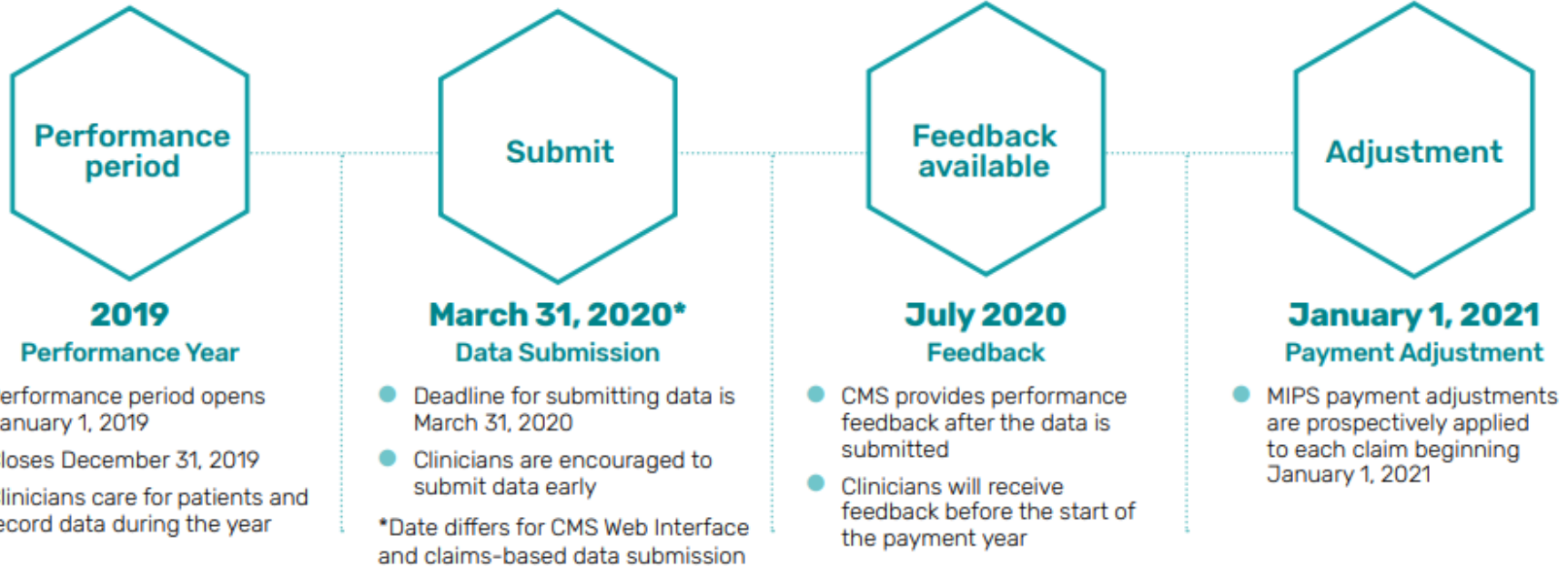
- Non-patient facing radiology practices are exempt from PI
  - PI's 25% is reweighted to Quality making it worth 70% of total composite score

# MIPS Scoring and Adjustments

## Year 3 (2019) Final

Final Score 2019	Payment Adjustment 2021
≥75 points	<ul style="list-style-type: none"><li>• Positive adjustment greater than 0%</li><li>• Eligible for additional payment for exceptional performance —minimum of additional 0.5%</li></ul>
30.01-74.99 points	<ul style="list-style-type: none"><li>• Positive adjustment greater than 0%</li><li>• Not eligible for additional payment for exceptional performance</li></ul>
30 points	<ul style="list-style-type: none"><li>• Neutral payment adjustment</li></ul>
7.51-29.99	<ul style="list-style-type: none"><li>• Negative payment adjustment greater than -7% and less than 0%</li></ul>
0-7.5 points	<ul style="list-style-type: none"><li>• Negative payment adjustment of -7%</li></ul>

# Timeline



# Does MIPS Apply to Me?



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Radiology Billing Specialists

# Eligibility

- MIPS-eligible clinician if all conditions met
  - Bill more than \$90,000 in Medicare allowable charges
  - Provide care for 200 or more Medicare patients a year
  - Provide 200 or more covered professional services to Medicare patients
- Opt-in option

# Checking Eligibility

## QPP Participation Status

Enter your 10-digit [National Provider Identifier \(NPI\)](#)  number to view your QPP participation status by performance year (PY).

QPP Participation Status includes APM Participation as well as MIPS Participation.

Check All Years →

# How Do I Participate?









# Reporting Options

- Group - sharing a TIN
- Individual – NPI/TIN combination
- Group and Individual
- Virtual group – combination of two or more TINs made up of small groups and individuals who come together virtually to participate

# Submission Methods

Data Submission for MIPS Eligible Clinicians Reporting as <u>Groups</u>			
Performance Category	Submission Type	Submitter Type	Collection Type
 Quality	<ul style="list-style-type: none"> <li>• Direct</li> <li>• Log-in and Upload</li> <li>• CMS Web Interface (groups of 25 or more eligible clinicians)</li> <li>• Medicare Part B Claims (small practices only)</li> </ul>	<ul style="list-style-type: none"> <li>• Group</li> <li>• Third Party Intermediary</li> </ul>	<ul style="list-style-type: none"> <li>• eCQMs</li> <li>• MIPS CQMs</li> <li>• QCDR Measures</li> <li>• CMS Web Interface Measures</li> <li>• CMS Approved Survey Vendor Measure</li> <li>• Administrative Claims Measures</li> <li>• Medicare Part B Claims (small practices only)</li> </ul>
 Cost	<ul style="list-style-type: none"> <li>• No data submission required</li> </ul>	<ul style="list-style-type: none"> <li>• Group</li> </ul>	-
 Improvement Activities	<ul style="list-style-type: none"> <li>• Direct</li> <li>• Log-in and Upload</li> <li>• Log-in and Attest</li> </ul>	<ul style="list-style-type: none"> <li>• Group</li> <li>• Third Party Intermediary</li> </ul>	-
 Promoting Interoperability	<ul style="list-style-type: none"> <li>• Direct</li> <li>• Log-in and Upload</li> <li>• Log-in and Attest</li> </ul>	<ul style="list-style-type: none"> <li>• Group</li> <li>• Third Party Intermediary</li> </ul>	-

# Submission Methods

- Claims based
  - Can only be submitted by small practices
  - Small Practice – 15 or fewer clinicians (NPIs) billing under the practice (TIN) during the MIPS determination period
- Qualified Registry

# Submission Requirements

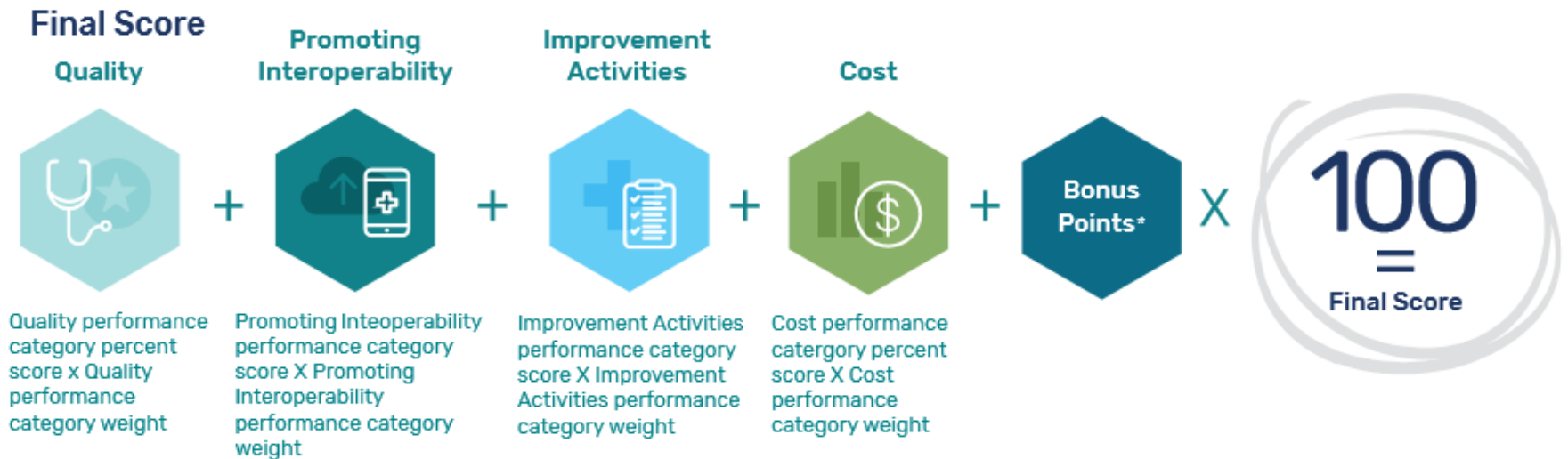
- Quality – claims or registry
- Cost – no action needed
- Improvement Activities – attest
- Promoting Interoperability – attest
  - Majority of radiologists are exempt
  - Reweighted to Quality category

Year 3 (2019) Final - No Change

Performance Category	Performance Period
 Quality	12-months
 Cost	12-months
 Improvement Activities	90-days
 Promoting Interoperability	90-days

# What Do I Need to Know?

# What Do I Need to Know?



# Quality Performance Category

- 45% of Final Score
- Based on quality measures approved by CMS
- Choose 6 measures that best fit your practice for the 12 month performance period
- If less than 6 measures apply then report on all applicable measures
- Bonus points:
  - 1 must be an outcome measure OR high-priority if not applicable

# Quality Scoring

- Compare performance percentage to an established benchmark for each measure
  - Case minimum: 20
  - Data completeness: 60%
- Small practice exceptions
  - 3 points awarded if measure does not meet thresholds



# Other Quality Considerations

- Topped-out measures
- 7-point capped measures
- Bonus points
- Small practice

# Cost

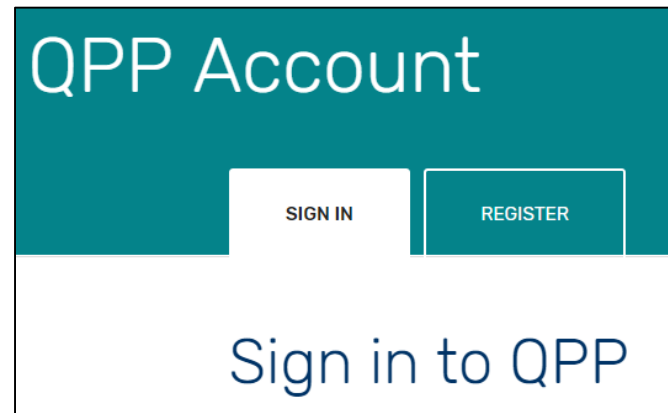
- 15% of Final Score
- CMS uses Medicare claims data to calculate
  - Requires no additional action by providers
- Total per capita cost (TPCC)
- Medicare spending per beneficiary (MSPB)
- 8 episode-based cost measures

# Cost measures

- Elective Outpatient Percutaneous Coronary Intervention
- Intracranial Hemorrhage or Cerebral Infarction
- Knee Arthroplasty
- Revascularization for Lower Extremity Chronic Critical Limb Ischemia
- Routine Cataract Removal with Intraocular Lens (IOL) Implantation
- Screening/Surveillance Colonoscopy
- Simple Pneumonia with Hospitalization
- ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)

# Improvement Activities

- 15% of Final Score
- Assess how practices improve their care processes, enhance patient engagement, and increase access to care
- Practices choose the activities that are appropriate for their practice
- Activities are attested by provider or security official through QPP Portal



# Promoting Interoperability

- 25% of Final Score
- Focus is on patient engagement and the electronic exchange of health information using certified electronic health record technology (CEHRT)

# Promoting Interoperability

- Exempt if non-patient facing or hospital-based
  - Individual – If you have 100 or fewer patient facing encounters
  - Groups – If >75% of NPIs billing under TIN during a performance period are labeled as non-patient facing
- 25% is reweighted to Quality making it worth 70% (45+25%)

# Final Score Example

- **Quality:** 53 out of 60 points  $\times 100 = 88.333$  *subtotal*
  - $88.33 \times .7$  (for the 70% weight) = **61.833** final score points for Quality
- **IA:** 40 out of 40 points  $\times .15(15\%) \times 100 =$  **15** final score points
- **Cost:** CMS Calculates = **??**
- **PI:** exempt so 25% reweighted to Quality = **0**

# Final Score Example

- Total Composite Score = **76.833** (not including possible 10 point for Cost category)
- Will avoid the *penalty* (below 30)
- Score > 75 so will get *exceptional performance* bonus
- Estimated composite score does not include improvement scoring bonus, complex patient bonus, small practice bonus



# Performance Feedback



## Performance Year (PY) 2018 Submission Reporting Window is Now Open

START REPORTING

You are now able to start your reporting for the PY 2018 submission year.



## View PY 2017 Final Performance Feedback

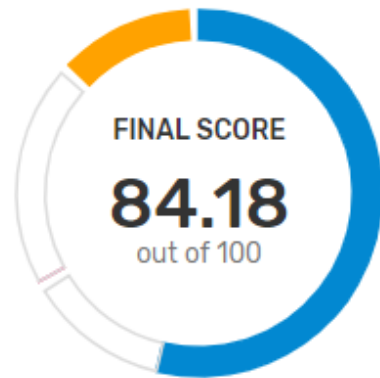
You are able to access your PY 2017 Final Feedback at any time.

[View Feedback](#)

# Performance Feedback

## The Final Score At A Glance

The Final Score is achieved by adding the points you earned in each Performance Category



### Performance Category Scores

● Quality	69.19 of 85
● Advancing Care Information	N/A
● Improvement Activities	15 of 15

[How is the score calculated?](#)

Payment Adjustment **0.24%**

Exceptional Performance Adjustment **0.79%**

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Total MIPS Adjustment(s) **+1.03%**

Payment Adjustment Date  
**January 1, 2019**

# SUBMITTED QUESTIONS

# THANK YOU!

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