Zero to Sixty: Reaching the MIPS Performance Threshold

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Quality Payment Program of Illinois
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Quality Payment Program of Illinois

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About Today's Presentation

- Materials are designed for clinicians currently at "zero"
- Recommendations are NOT a long-term strategy
- Assumes clinician is not using certified EHR effectively for MIPS
- Example Quality measures are primary care oriented
- Strategy can be tailored to your needs with our assistance

Agenda

- Quality Payment Program (QPP) Basics
- Take Advantage of Special Statuses
- Select Improvement Activities
- Report High Priority Quality Measures through Claims
- Automatic Cost Scoring
- Resources and Q&A

QPP Basics

QPP Participation Tracks

- MIPS is a Medicare “report card” assessing the value of care delivered
- Advanced APM (AAPM) are either Medical Home Models or require participants to bear a significant financial risk

What if I'm in an AAPM?

- Will be evaluated for "Qualifying Participant" (QP) status:

Status	Payments through AAPM	Patients through AAPM
QP	50%	35%
Partial QP	40%	25%

- QPs are exempt from MIPS, receive automatic 5% bonus, and higher physician fee schedule update beginning 2026
- Partial QPs may elect to opt into MIPS or stay exempt
- Non-QPs in an AAPM may be subject to MIPS participation requirements

I'm not in an AAPM, am I included in MIPS?

- Many believe MIPS does not apply because:
  - "I don't use electronic health records"
  - "I'm a solo/small practice"
  - "I work in nursing homes/home health"
  - "This isn't relevant to my subspecialty"

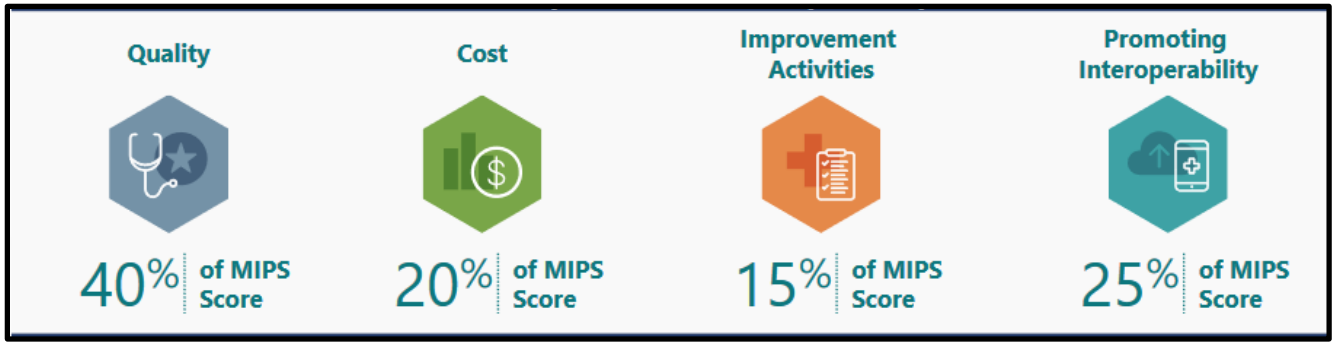
- Inclusion is based on annual Medicare volume thresholds:

Bill more than $90k in charges	See more than 200 patients	Provide more than 200 services

Visit https://qpp.cms.gov/participation-lookup to review MIPS participation status by searching individual NPI

How do I participate in *traditional* MIPS?

- Collect and report data on quality, cost, clinical improvements and EHR:

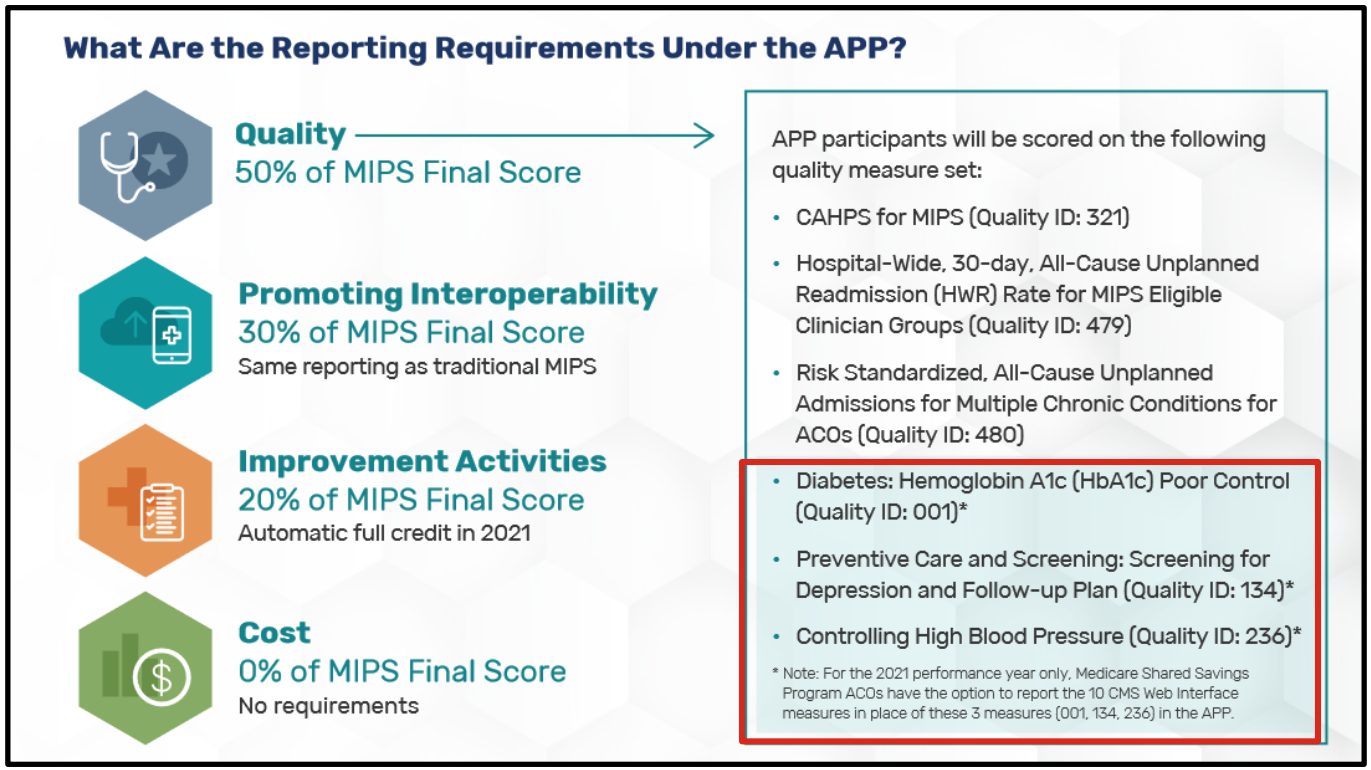


NOTE: MIPS category weights change over time and differ under MIPS APM

- Collect data through claims (Quality only), registry, or certified EHR
- Report data through same methods or the QPP website
- Reporting, scoring, and measures can vary by:
  - Special status
  - Specialty
  - MIPS APM participation

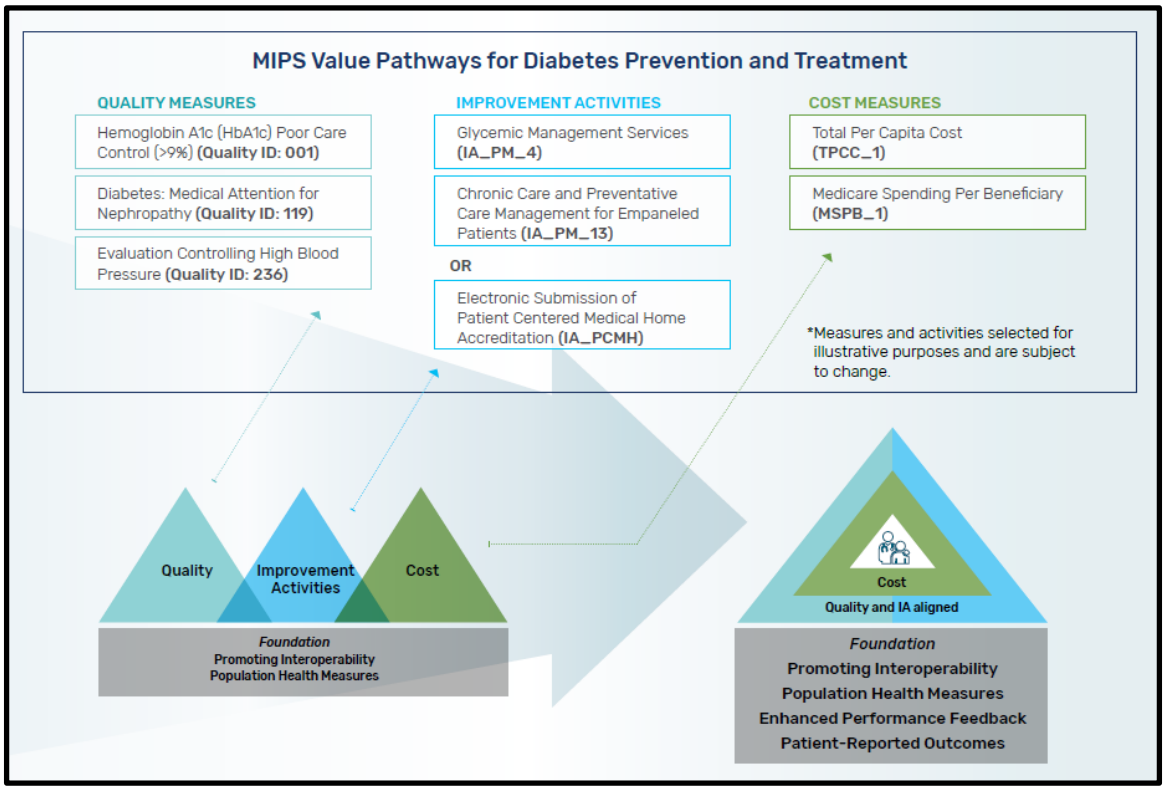
How else could I participate in MIPS?

- APM Performance Pathway (APP)
  - Optional for clinicians participating in MIPS APM
  - Single, pre-determined measure set



How else could I participate in MIPS?

- MIPS Value Pathway (MVP)
  - Beginning 2022 or later
  - Specialty-aligned Quality/Cost measures and Improvement Activities



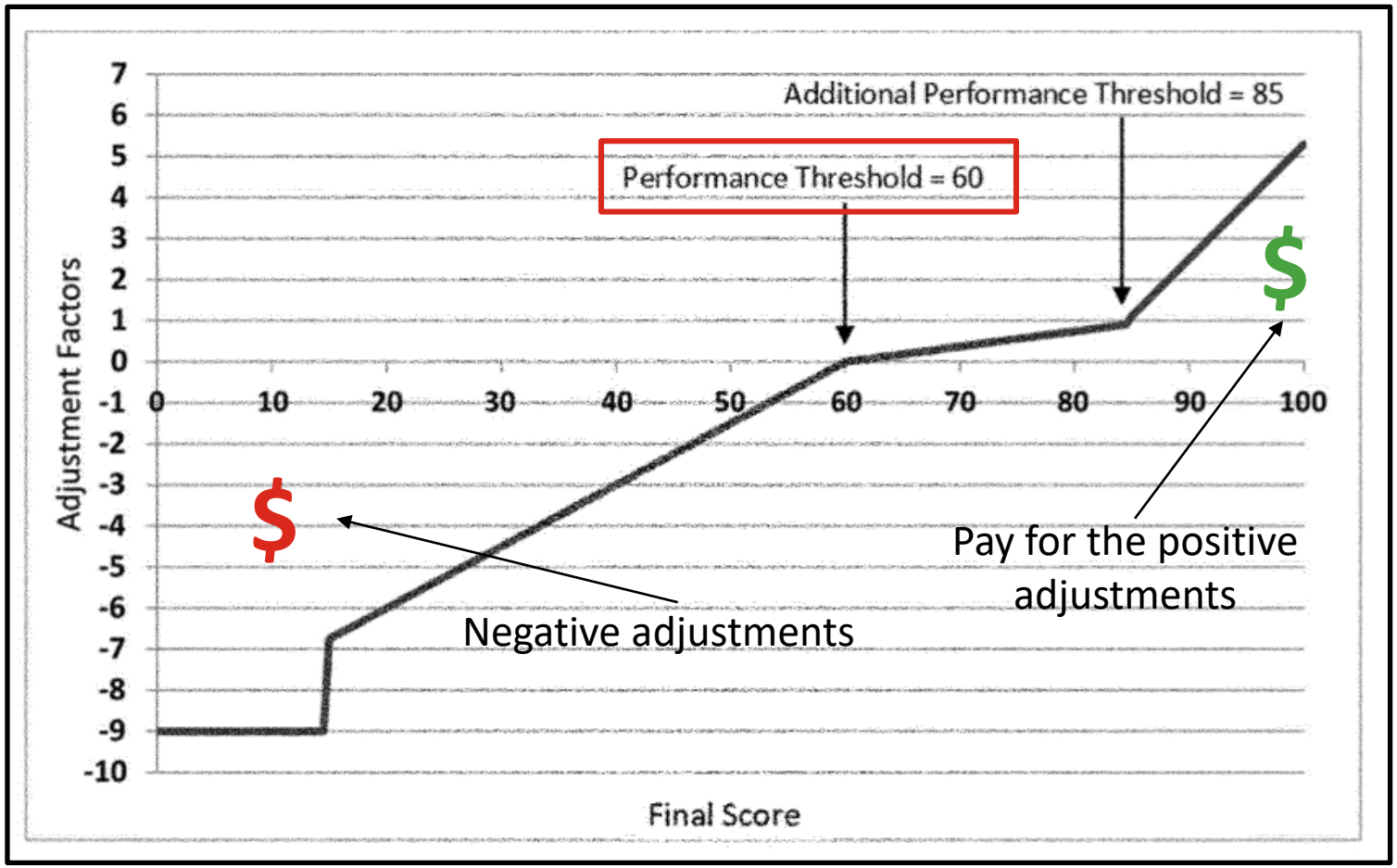
What if I don't participate in MIPS?

- "Negative adjustment" on Medicare payments
- Applied two years later:

2019 Non-Participant	2021 Non-Participant
• Adjusted -9% in 2021 • -2% for sequestration • -7% for MIPS	• Adjusted -11% in 2023 • -2% for sequestration • -9% for MIPS (maximum)

- Adjustments reset each year

Can I get a positive adjustment?



NOTE: this chart is an estimate for 2021 and will change over time

Take Advantage of Special Statuses

Small Practice

- Under 15 NPI billing to TIN
- May apply for hardship exception from Promoting Interoperability
  - Re-weighted to 0% by shifting extra 25% to Quality
  - Apply at qpp.cms.gov using HARP account
  - Typically auto-approved
- Earn 2x credit on Improvement Activities
  - One high-weight
  - Two-medium weight
- Quality benefits
  - Six bonus points if submitting 1+ measure
  - Earn 3 points per measure regardless of “data completeness”

Other Special Statuses

- Identified on NPI lookup tool
- Automatic re-weighting of Promoting Interoperability for:
  - Hospital-based
  - Ambulatory Surgery Center (ASC)-based
  - Non-patient facing
  - Facility-based
- Facility-based Quality + Cost scoring
  - If hospital participated in Medicare Value-Based Purchasing
  - May submit individual/group Quality data as well
  - Submit IA independently

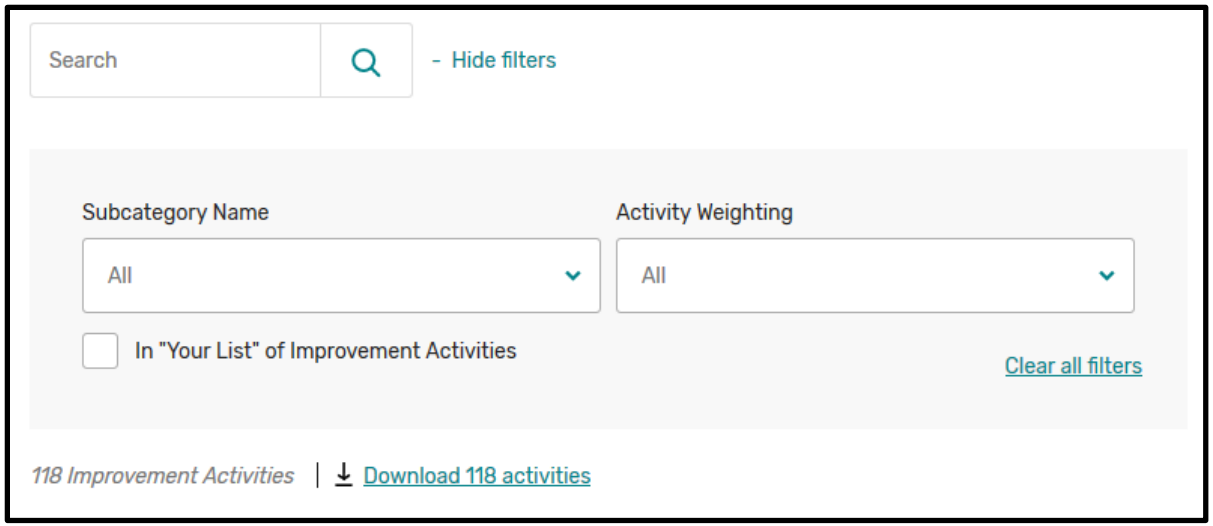
Implement Improvement Activities

Improvement Activities (IA) Category

- Measures participation in activities that improve clinical practice
- Worth 15% of MIPS score
- Implement activities for continuous 90-day performance period
- For group reporting, at least 50% of clinicians participated
- Report by:
  - Sign in and attest
  - Sign in and upload
  - Third-party direct
- No documentation required with submission, but maintain for audit

IA Inventory

- 105 activities across 8 subcategories
- Search by keyword/subcategory/weighting on QPP site



- Download spreadsheet/PDF including “data validation” guidance

Examples and Data Validation

- Potentially low-overhead options:
  - 24/7 access to clinicians with access to record (high)
  - Use of telehealth services (medium)
  - Specialist reports back to referring clinician (medium)
  - Participation in Maintenance of Certification (medium)
  - Consultation of Prescription Drug Monitoring Program (high)

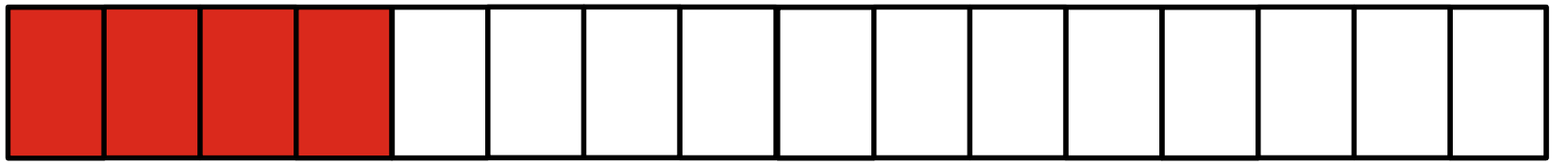
- Data validation example: 24/7 access

> 1) **Patient record from EHR** – A patient record from an EHR with date and timestamp indicating services provided outside of the practice's normal business hours for that eligible clinician (a certified EHR may be used for documentation purposes, but is not required unless attesting for the Promoting Interoperability bonus); OR
> 2) **Patient encounter/medical record/claim** – Patient encounter/medical record/claim indicating patient was seen or services provided outside of the practice's normal business hours for that eligible clinician including use of telehealth visits; OR
> 3) **Same or next-day patient encounter/medical record/claim** – Patient encounter/medical record/claim indicating patient was seen same-day or next-day by the eligible clinician or practice initially contacted for urgent or transitional care.

Progress to Goal

Category	Action	Weight	Points
PI	Small practice hardship	25% > 0%	NA
IA	Report one high-weight or two medium-weight	15%	15
Quality	Automatic PI re-weight	40% > 65%	NA
Cost	NA	20%	NA

Estimated adjustment: -6.5%



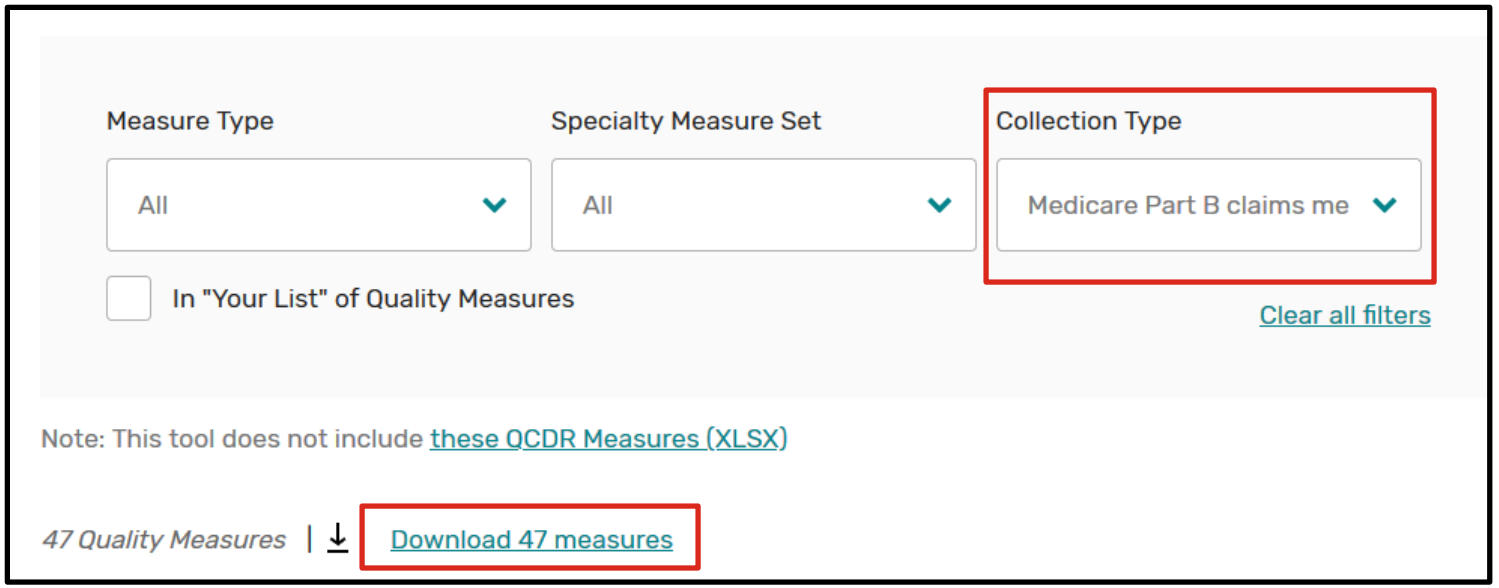
Report High Priority Quality Measures through Claims

Quality Category

- Measurements of efficiency, outcomes, experience, processes or structures
- 209 “standard” measures; 47 available through claims
- Additional measures through Qualified Clinical Data Registry
- Worth 40% of MIPS score (65% after PI re-weight)
- Generally required to report a minimum of six measures
- Small practices earn minimum 3 points per measure

Claims Measures

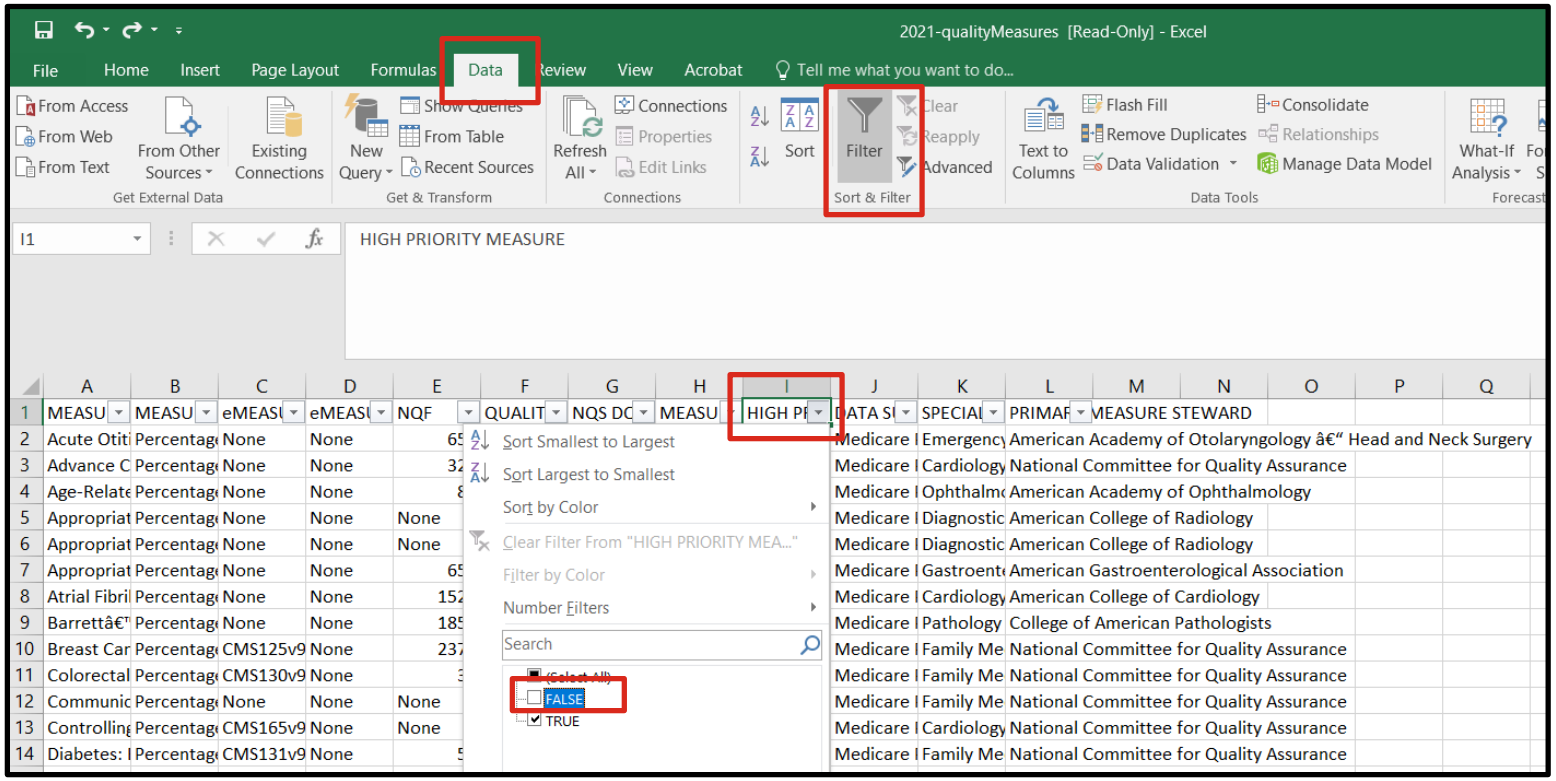
- 47 measures available through claims
- Visit the QPP Quality measures page and filter by claims collection type
- Click “Download 47 measures” then choose to open the file in Excel



High Priority Claims Measures

- Click “Data” then click the “Filter” button

- Click the down arrow in Column I, uncheck “FALSE” and click “OK”



High Priority Claims Measures

- Spreadsheet will now display 28 high priority claims measures
- Review column A to identify relevant measures
- Note the Quality ID in column F
- To review full details of a measure:
  - Download the 2021 CQM Specifications and Supporting Documents zip file
  - Open the “Part B Claims” folder
  - Open the “2021 Medicare Part B Claims Specifications” subfolder
  - Open the PDF file corresponding to the Quality ID

Specifications: Description and Instructions

Quality ID #47 (NQF 0326): Advance Care Plan
– National Quality Strategy Domain: Communication and Care Coordination
– Meaningful Measure Area: Care is Personalized and Aligned with Patient's Goals

2019 COLLECTION TYPE:
MEDICARE PART B CLAIMS

MEASURE TYPE:
Process – High Priority

DESCRIPTION:
Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

INSTRUCTIONS:
This measure is to be submitted a minimum of **once per performance period** for patients seen during the performance period. There is no diagnosis associated with this measure. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

NOTE: *This measure is appropriate for use in all healthcare settings (e.g., inpatient, nursing home, ambulatory) except the emergency department. For each of these settings, there should be documentation in the medical record(s) that advance care planning was discussed or documented.*

Specifications: Denominator/Numerator

DENOMINATOR:
All patients aged 65 years and older

DENOMINATOR NOTE: *MIPS eligible clinicians indicating the Place of Service as the emergency department will not be included in this measure.*

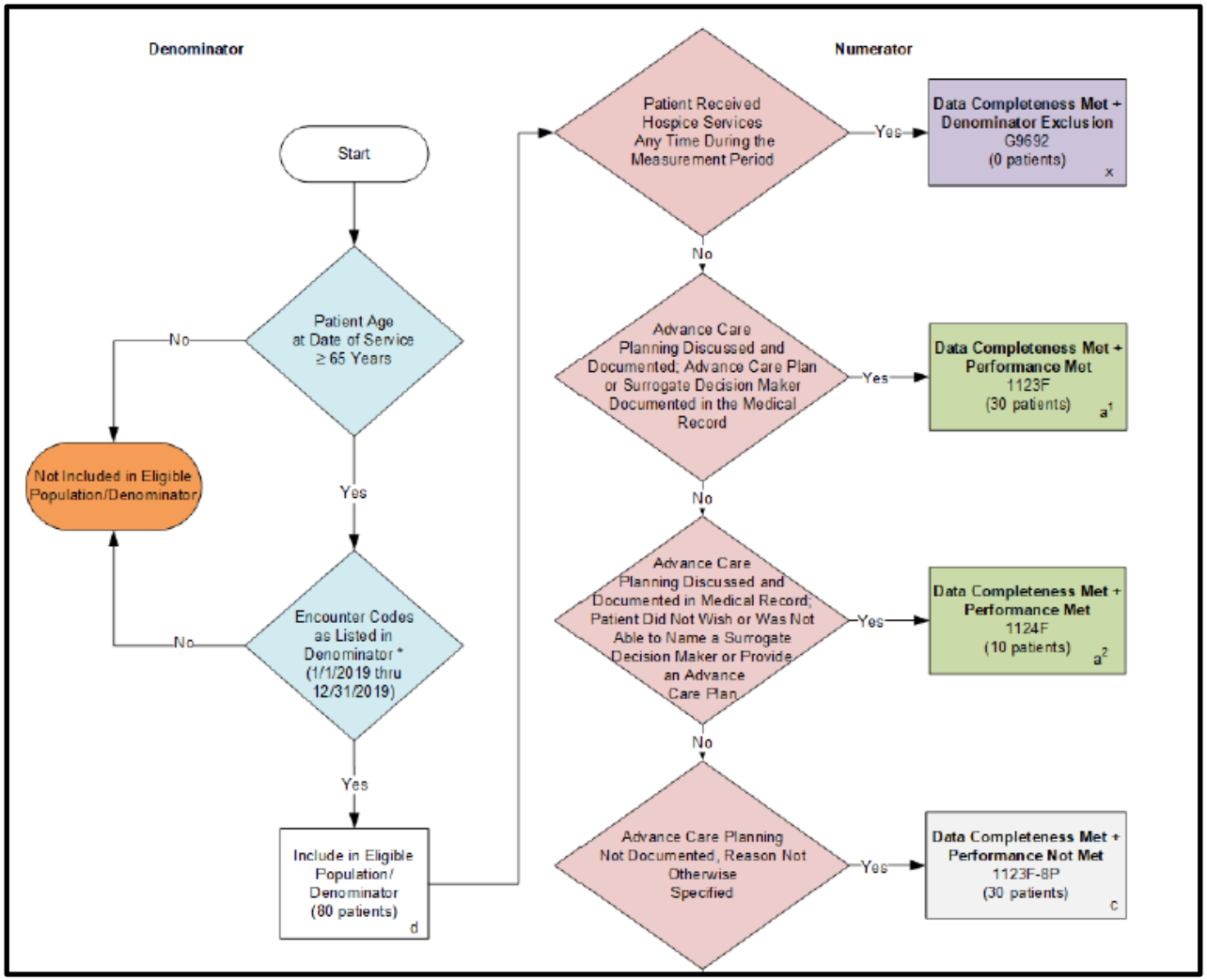
Denominator Criteria (Eligible Cases):
Patients aged ≥ 65 years on date of encounter
AND
Patient encounter during the performance period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205,99212, 99213, 99214, 99215, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99291, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402, G0438, G0439

NUMERATOR:
Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

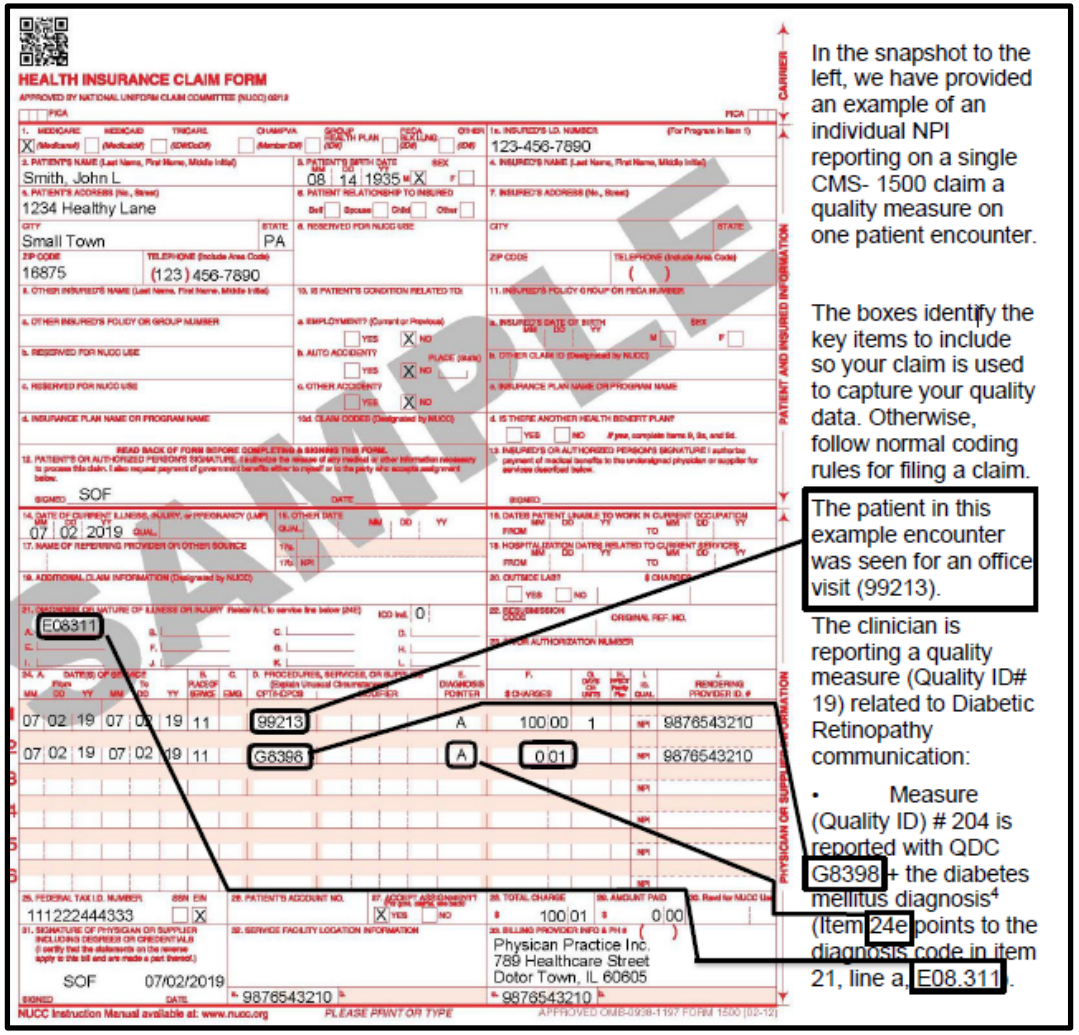
Advance Care Planning Discussed and Documented
Performance Met: **CPT II 1123F:** → Advance Care Planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record

OR
Performance Met: **CPT II 1124F:** → Advance Care Planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

Specifications: Flow Diagram



Add Codes to Form CMS 1500



In the snapshot to the left, we have provided an example of an individual NPI reporting on a single CMS- 1500 claim a quality measure on one patient encounter.

The boxes identify the key items to include so your claim is used to capture your quality data. Otherwise, follow normal coding rules for filing a claim.

The patient in this example encounter was seen for an office visit (99213).

The clinician is reporting a quality measure (Quality ID# 19) related to Diabetic Retinopathy communication:

- Measure (Quality ID) # 204 is reported with QDC G8398 + the diabetes mellitus diagnosis[4] (Item 24e points to the diagnosis code in item 21, line a, E08.311.

Primary Care Measure Sample

- Earn 50% category credit (30 out of 60 possible points)

- Code at least one claim per measure before 12/31

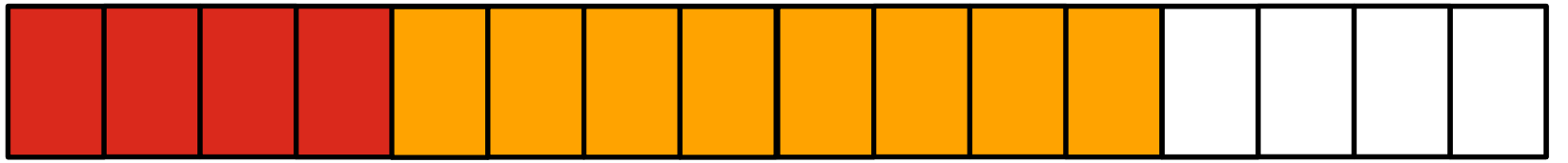
Measure	ID	Eligible Population	Suggested Code(s)
Advance Care Plan	47	Ages 65+	1123F – Advance Care Planning discussed and documented; OR 1124F – Discussed and patient did not want to name a surrogate or provide a plan
Controlling High Blood Pressure	236	Ages 18-85 with Dx of HTN	G8752 – Systolic BP < 140; AND G8754 – Diastolic BP < 90
Hemoglobin A1c Poor Control	1	Ages 18-75 with Dx of DM	3044F – A1c level < 7%; OR 3051F – A1c level >= 7% and < 8% 3052F – A1c level >= 8% and < 9%
Documentation of Current Medications in the Medical Record	130	Ages 18+	G8427 – Obtained, updated, or reviewed the patient's current medications
Falls: Risk Assessment	154	Ages 65+	3288F – Fall risk assessment documented; AND 1100F – Documentation of two or more falls, or any fall with injury, in the last year
Falls: Plan of Care	155	Ages 65+	0518F – Falls plan of care documented

* Review specification sheets to ensure you understand measure and coding details!

Progress to Goal

Category	Action	Weight	Points
PI	Small practice hardship	0%	NA
IA	Report one high-weight or two medium-weight	15%	15
Quality	Report six high priority including two outcome measures	65%	32.5
Cost	NA	20%	NA

Estimated adjustment: -2%



Automatic Cost Scoring

Cost Measure Types

- 20 measures across 3 types; scored automatically
- Adjusted for geography, specialty (TPCC only) and patient risk
- Worth 20% of MIPS score

TPCC	MSPB Clinician	Episode-Based (18)
• Total Per Capita Cost • Measures overall care	• Medicare Spending Per Beneficiary Clinician • Measures care for services related to inpatient stay	• Measures care during an episode time frame • Acute inpatient or procedural

Measure Applicability

- Billing primary care services? TPCC likely applies
- Treating patients during inpatient stay? MSPB Clinician may apply
- Performing inpatient or surgical procedures? Episode-Based may apply

Episode-Based Measures for 2020 Performance Year		
Elective Outpatient PCI	AKI w/ New Dialysis	Lumpectomy/Mastectomy
Knee Arthroplasty	Elective Hip Arthroplasty	Non-Emergent CABG
Revascularization of Lower Extremity	Femoral/Inguinal Hernia Repair	Intracranial Hemorrhage or Cerebral Infarction
Routine Cataract Removal	Hemodialysis Access Creation	Renal or Ureteral Stone
Colonoscopy	Lumbar Spine Fusion	Simple Pneumonia
STEMI with PCI	COPD Exacerbation	Lower GI Hemorrhage

Cost Category Scoring

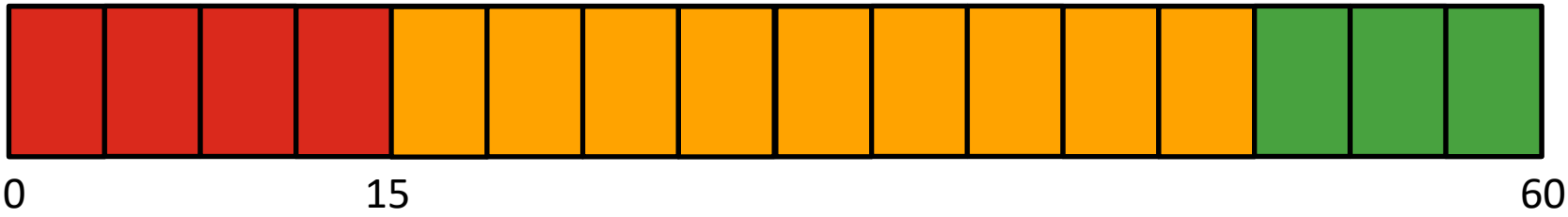
- Measures scored from 1-10 based on benchmark
  - If only 1 measure can be scored, category is based on that measure
  - If 2+ measures can be scored, uses equally-weighted average
- Category scored from 0-100% then multiplied by 20-point weight
- Earning 12.5 points would require high performance (~63rd percentile)

Measure	Score
TPCC	6/10
MSPB	8/10
Episode-Based 1	5/10
Episode-Based 2	6/10
TOTAL	**25/40 (0.625) * 20 = 12.5 points**

Progress to Goal

Category	Action	Weight	Points
PI	Small practice hardship	0%	NA
IA	Report one high-weight or two medium-weight	15%	15
Quality	Report six high priority including two outcome measures	65%	32.5
Cost	~63rd percentile performance	20%	~12.5

Adjustment: 0%

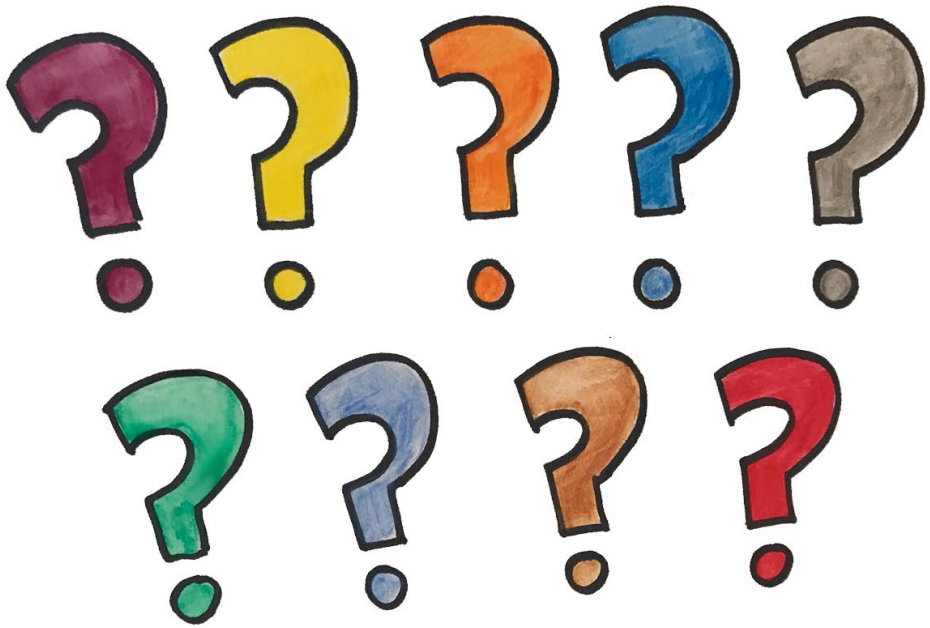


Resources and Q & A

Resources

- 2021 Promoting Interoperability Hardship Exception Application Guide
- 2021 Improvement Activities User Guide
- 2021 Part B Claims Reporting Quick Start Guide
- 2021 Cost User Guide
- CHITREC QPP Webinar Archive

Q&A



THANK YOU!!

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