• An ongoing process to engage clinical specialty societies and patient advocacy groups in quality measure development.
• Elicit feedback that will help CMS design toolkits and materials specifically for specialty societies and patient advocacy groups interested in measure development.

✓ Education
✓ Outreach
✓ Frequent Communication
✓ Enduring Materials
✓ Dedicated Websites
✓ Measure Development Roadmaps
✓ Targeted Newsletters and Communication
✓ Showcase Opportunities
Quality Payment Program

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JENNIFER HARRIS
SUSAN ARDAY

November 8, 2017
Webinar Agenda:

- Quality Payment Program Overview
- Needs and Priorities
- Existing Specialties Represented in the Program
- Requirements for Quality Measures Under Consideration
- Process for Adding New Measures
- Timeline for adding QPP Measures
- MAP Decision Criteria
- MAP Details
- Resources

- A full listing of existing Quality Performance Measures: https://qpp.cms.gov/mips/quality-measures
WHAT IS THE QUALITY PAYMENT PROGRAM
Quality Payment Program: Year 2 Final Rule Update

• CMS released the final rule for Year 2 of the Quality Payment Program on November 2

• For more information on the final rule, visit: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html

• To register for the CMS webinar on the Year 2 final rule on Tuesday, November 14 at 1:00 pm ET: https://engage.vevent.com/rt/cms/index.jsp?seid=938

• To submit a comment, see the final rule: https://www.federalregister.gov/documents/2017/11/16/2017-24067/medicare-programs-cy-2018-updates-to-the-quality-payment-program-and-quality-payment-program-extreme
Fee-for-service (FFS) payment system, where clinicians are paid based on volume of services, not value.

The Sustainable Growth Rate (SGR)
Established in 1997 to control the cost of Medicare payments to physicians

IF
Overall physician costs > Target Medicare expenditures

Physician payments cut across the board

Each year, Congress passed temporary “doc fixes” to avert cuts (no fix in 2015 would have meant a 21% cut in Medicare payments to clinicians)
Clinicians have two tracks to choose from:

**MIPS**

The Merit-based Incentive Payment System (MIPS)

If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS.

**OR**

**Advanced APMs**

Advanced Alternative Payment Models (APMs)

If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.
INTRODUCTION TO THE MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)
MIPS Phases Out Medicare Legacy Programs

Combines legacy programs into a single, improved program

- Physician Quality Reporting System (PQRS)
- Value-Based Payment Modifier (VM)
- Medicare EHR Incentive Program (EHR) for Eligible Professionals

Example of the Legacy Program Phase Out for PQRS

- Last Performance Period: 2016
- PQRS Payment End: 2018
What are MIPS Performance Categories?

**Performance Categories**

- Comprised of four performance categories.
- Provides MIPS clinician types included in the 2017 Transition Year with the flexibility to choose the activities and measures that are most meaningful to their practice.
How MIPS Relates to Legacy Programs

A visualization of how the legacy programs streamline into the MIPS performance categories:

<table>
<thead>
<tr>
<th>Participating in...</th>
<th>Is similar to...</th>
</tr>
</thead>
<tbody>
<tr>
<td>PQRS</td>
<td>Quality</td>
</tr>
<tr>
<td>VM*</td>
<td>Cost</td>
</tr>
<tr>
<td>EHR</td>
<td>Advancing Care Information</td>
</tr>
</tbody>
</table>

*Also includes elements of the PQRS quality data*
MIPS: Quality Performance Category
Requirements in 2017

• **60%** of Final Score in 2017

• 270+ measures available
  - You **select 6** individual measures
    - 1 must be an **Outcome** measure
      OR
    - **High-priority** measure
      - Defined as outcome measures, appropriate use measure, patient experience, patient safety, efficiency measures, or care coordination.
  - You may also select specialty-specific set of measures

• **Keep in mind:**

  Replaces PQRS and Quality portion of the Value Modifier

  Provides for an easier transition for those who have reporting experience due to familiarity
Select 6 of the approximately 300 available quality measures (minimum of 90 days)
  - Or a specialty set
  - Or CMS Web Interface measures
  - Readmission measure is included for group reporting with groups with at least 16 clinicians and sufficient cases

Clinicians receive 3 to 10 points on each quality measure based on performance against benchmarks

Failure to submit performance data for a measure = 0 points

Quick Tip:
Easier for a clinician that participates longer to meet case volume criteria needed to receive more than 3 points
MIPS: Quality Performance Category
Requirements in 2017

• Year 1 participants automatically receive 3 points for completing and submitting a measure

If a measure can be reliably scored against a benchmark, then clinician can receive 3 – 10 points

• Reliable score means the following:
  o Benchmarks exist (see next slide for rules)
  o Sufficient case volume (≥20 cases for most measures; ≥200 cases for readmissions)
  o Data completeness met (at least 50 percent of possible data is submitted)

If a measure cannot be reliably scored against a benchmark, then clinician receives 3 points

• Easier for a clinician that participates longer to meet case volume criteria needed to receive more than 3 points
More About Benchmarks

- Separate benchmarks for different reporting mechanisms
  - EHR, QCDR/registries, claims, CMS Web Interface, administrative claim measures, and CAHPS for MIPS

- All reporters (individuals and groups regardless of specialty or practice size) are combined into one benchmark

- Need at least 20 reporters that meet the following criteria:
  - Meet or exceeds the minimum case volume (has enough data to reliably measured)
  - Meets or exceeds data completeness criteria
  - Has performance greater than 0 percent

Why this matters? Not all measures will have a benchmark. If there is no benchmark, then a clinician only receives 3 points.
## MIPS: Performance Threshold & Payment Adjustment

### Transition Year 1 (2017) Final

<table>
<thead>
<tr>
<th>Final Score 2017</th>
<th>Payment Adjustment 2019</th>
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</thead>
<tbody>
<tr>
<td>&gt;70 points</td>
<td>Positive adjustment</td>
</tr>
<tr>
<td></td>
<td>Eligible for exceptional performance bonus—minimum of additional 0.5%</td>
</tr>
<tr>
<td>4-69 points</td>
<td>Positive adjustment</td>
</tr>
<tr>
<td></td>
<td>Not eligible for exceptional performance bonus</td>
</tr>
<tr>
<td>3 points</td>
<td>Neutral payment adjustment</td>
</tr>
<tr>
<td>0 points</td>
<td>Negative payment adjustment of -4%</td>
</tr>
<tr>
<td></td>
<td>0 points = does not participate</td>
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</tbody>
</table>
MIPS Participation Basics

Must be a **MIPS clinician type** billing more than $30,000 a year in Medicare Part B allowed charges **AND** providing care for more than 100 Medicare patients a year.

**BILLING**

> $30,000

**AND**

> 100

**MIPS clinician types include:**

- Physicians
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
Participation Basics: Physicians

The definition of Physicians include:

- Doctors of Medicine
- Doctors of Osteopathy (including Osteopathic Practitioners)
- Doctors of Dental Surgery
- Doctors of Dental Medicine
- Doctors of Podiatric Medicine
- Doctors of Optometry
- Chiropractors
  - With respect to certain specified treatment, a Doctor of Chiropractic legally authorized to practice by a State in which he/she performs this function.
Who is Exempt from MIPS?

Clinicians who are:

- 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 $30,000 a year
  - See 100 or fewer Medicare Part B patients a year

- Significantly participating in Advanced APMs
  - Receive 25% of their Medicare payments
  - See 20% of their Medicare patients through an Advanced APM
If You Are Exempt from MIPS

• You may choose to voluntarily submit quality data to CMS to prepare for future participation, but you will not qualify for a payment adjustment based on your 2017 performance.

• Voluntarily participating will help you hit the ground running when you are eligible for payment adjustments in future years.
The Quality Payment Program is helping small practices successfully participate by:

- Reducing the time and costs to participate
- Providing an on-ramp to participating through Pick Your Pace
- Increasing the opportunities to participate in Advanced APMs
- Including a practice-based option for participation in Advanced APMs as an alternative to total cost-based
- Providing technical support and outreach to small practices through QPP Small, Rural and Underserved Support (QPP-SURS) and the Transforming Clinical Practice Initiative
MEASURE DEVELOPMENT PROCESS FOR SPECIALTY SOCIETIES & PATIENT ADVOCACY GROUPS

Quality Measure Evaluation Process for the Merit-based Incentive Payment System (MIPS)
MIPS Program Priorities and Needs

- Measures should not be duplicative of current measures in MIPS
- Measures must prove to be clinically relevant and fill a gap in care
- Measures should have a performance gap to allow for an opportunity for improvement
- Priority will be given to measures that are “high priority” status as follows:
  - Outcome Measures
  - Appropriate Use
  - Patient Safety
  - Communication and Care Coordination
  - Person and Caregiver-centered Experience and Outcomes
  - Efficiency/Cost Reduction
- Additional guidance can be found within the 2017 Program-Specific Measure Priorities and Needs
  - MIPS 2018 Priorities and Needs document should be released by May 2018
Current Specialties Represented in MIPS
(*specialties currently have less than 6 available quality measures)

- Allergy/ Immunology
- Anesthesiology
- Cardiology
- Dentistry* NEW
- Dermatology
- Diagnostic Radiology
- Electro-physiology Cardiac Specialist*
- Emergency Medicine
- Gastro-enterology
- General Oncology
- General Practice/ Family Medicine
- General Surgery
- Hospitalists
- Infectious Disease NEW
- Internal Medicine
- Interventional Radiology
- Mental/ Behavioral Health
- Nephrology NEW
- Neurology
- Neurosurgical NEW
- Obstetrics/Gynecology
- Ophthalmology
- Orthopedic Surgery
- Otolaryngology
- Pathology
- Pediatrics
- Physical Medicine
- Plastic Surgery
- Podiatry NEW
- Preventive Medicine
- Radiation Oncology*
- Rheumatology
- Thoracic Surgery
- Urology
- Vascular Surgery
Requirements for Quality Measures under Consideration

- Fully developed at the time of submission
- Include reliability and validity testing information (feasibility testing must also be included for eCQMs)
  - Include information regarding the details of test (number of participants, performance data, length of analysis, etc.)
  - eCQMs submissions must include additional testing materials (i.e. MAT ID, MAT output, Bonnie test cases, etc.)
  - CMS aligns with NQF Submitting Standards
- Submitted in JIRA prior to the submission deadline
- Include a completed Peer Review Form Template
- Include scientific rationale and have a performance gap (not be topped out)
- Reportable via Registry, claims, or eCQM (claims-based measures will only be accepted in conjunction with another data submission method)

- The posted CMS Blueprint assists with explaining quality measure details
- Additional Helpful Link: JIRA for Quality Measures
MIPS Measure Process Flowchart
2018 Performance Period

“Measure steward” (individual, professional association, etc.) proposes measure through CMS system

CMS reviews measures against criteria, generates Draft MUC List for internal review

CMS hosts Federal only Stakeholder meeting to preview MUC List

2016 MUC List is published on CMS website, CMS submits MUC list to National Quality Forum

National Quality Forum Measure Applications Partnership (MAP) reviews MUC list

National Quality Forum Final Report

Publish Proposed Rule with Measures, 60 day public comment period

Publish 2018 Final Rule including Measures

Jan–June 2016

May–July 2016

August 2016

Dec 2016

Dec 2016–Jan 2017

March 2017

June–August 2017

Late 2017
High-Level Quality Measure Lifecycle – Future Measures

• Submitted through the Call for Measures (February 2018)
• Approved in JIRA and for consideration on the 2018 MUC List
• Final 2018 MUC List published by Dec. 1st
• The final 2018 MUC List is reviewed by the MAP (Measures Application Partnership) on an annual basis. (December 2018)
• Reviewed by CMS during Pre-Rulemaking. Included on the PY2020 Proposed Rule (Spring/Summer 2019)
• Open comment period (for 60 days after the posting of the Proposed Rule) (Summer 2019)
• Added to the Final Rule (published November 2019) for Inclusion in PY2020 MIPS
Timeline for Adding New Quality Payment Program Measures

- Measures submitted to the 2018 MUC List would be available for reporting during the 2020 performance period

<table>
<thead>
<tr>
<th>MUC List/ Call for Measures Cycle</th>
<th>MAP Meeting</th>
<th>Proposed Rule Published In</th>
<th>Final Rule</th>
<th>Available for MIPS Submission</th>
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Measures Application Partnership

• If the submitted measure is on the Final MUC List, the MAP evaluates the measures for appropriateness for inclusion in the intended CMS program

• **MAP Measure Selection Criteria:**
  - NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective
  - Program measure set adequately addresses each of the National Quality Strategy’s three aims
  - Program measure set is responsive to specific program goals and requirements
  - Program measure set includes an appropriate mix of measure types
  - Program measure set enables measurement of person-and family-centered care and services
  - Program measure set includes considerations for healthcare disparities and cultural competency
  - Program measure set promotes parsimony and alignment
Additional information regarding the Measures Management System and an Inventory of Quality Measures is located on the CMS website: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/index.html

Additional Pre-Rulemaking guidance is located on the CMS website including the following materials:

- Overview of the Rulemaking Process
- Annual Timeline for the Pre-Rule Making Activities including Call for Measures
- CMS Measure Priorities and Needs Document
- Posted MUC Kick Off Materials and Open Forum Discussions
- Multi-Stakeholder Group Input Requirements
  - Measure Applications Partnership
- Information on the JIRA System and how to Submit Measures for Consideration
  - Templates for Peer Review and JIRA MUC submissions
- Historical MUC List and MAP reports
- Webinars and Additional Information
MIPS Measures Resources

- CMS MAT
  - [https://www.emeasuretool.cms.gov](https://www.emeasuretool.cms.gov)
- NQF
  - [http://www.qualityforum.org/Home.aspx](http://www.qualityforum.org/Home.aspx)
- MAP
  - [http://www.qualityforum.org/Setting_Priorities/Partnership/Measure_Applications_Partnership.aspx](http://www.qualityforum.org/Setting_Priorities/Partnership/Measure_Applications_Partnership.aspx)
- Pre-Rulemaking
- Quality Payment Program
  - [https://qpp.cms.gov/](https://qpp.cms.gov/)
- NQF Submitting Standards
Clinical Quality Measure Collection in CMS Quality Payment Programs
Reminder:

• If you are currently developing quality measures that you would like to present to CMS, contact the MMS Support Desk at MMSsupport@Battelle.org

Planned Upcoming Webinars:

• Suggestions for future topics?
• Email: MMSsupport@battelle.org
Contact Information

• **Battelle**
  – Measures Management System Contract Holder
  – Contact: MMSsupport@Battelle.org

• **CMS**
  – PIMMS email box
  – QPP help desk at qpp@cms.hhs.gov or 1-866-288-8292.
Questions?