



Qualis Health Toolkit: How to Succeed with MIPS Under the Quality Payment Program



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Introduction

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is a milestone in efforts to improve and reform health care with increased focus on the quality and value of care delivered. MACRA repealed the Medicare Sustainable Growth Rate (SGR) methodology for updates to the Medicare Physician Fee Schedule (PFS) and replaced the SGR with a new approach to payment called the Quality Payment Program (QPP).

The QPP rewards high quality patient care through two interrelated pathways: **Advanced Alternative Payment Models** and the **Merit-based Incentive Payment System (MIPS)**. The QPP establishes incentives for participation in Advanced APMs, supporting the goal of transitioning from fee-for-service (FFS) payment to payment for quality and value, including approaches that focus on better care, smarter spending and healthier people.

To be an Advanced APM, an APM must meet the following three criteria:

1. Require participants to use certified EHR technology;
2. Provide payment for covered professional services based on quality measures comparable to those used in the quality performance category of the Merit-based Incentive Payment System (MIPS); and
3. Bear a certain amount of greater than nominal financial risk (as outlined below) OR qualify as a Medical Home Model
 - o Meet revenue-based standard (average of at least 8% of revenues at-risk for participating APMs) or
 - o Meet benchmark-based standard (maximum possible loss must be at least 3% of spending target)

The APM entity must also meet requirements for the minimum percentage of payments OR patients tied to an Advanced APM. CMS will choose to use whichever threshold is more favorable for the APM entity in determining eligibility for the APM track. Over time, the payment and patient count percentages will gradually increase.

MIPS is a new program that will make payment adjustments based on quality, cost and other measures for certain Medicare-participating eligible clinicians. MIPS consolidates components of three existing programs; Physician Quality Reporting System (PQRS), the Physician Value-based Payment Modifier (VM), and the Medicare Electronic Health Record (EHR) Incentive Program for Eligible Professionals (EPs), and will continue the focus on quality, cost, and use of certified EHR technology (CEHRT) in a cohesive program that avoids redundancies.

With the arrival of CMS' Quality Payment Program it is critical to understand how this transition will impact your practice. Qualis Health developed this toolkit to help you successfully prepare for and understand the transition to value-based payment. The toolkit provides you with strategies, tools and resources.

- [Section 1 – Understand the Quality Payment Program and its Requirements](#)
- [Section 2 – Analyze Current State](#)
- [Section 3 – Develop Data and Reporting Plan](#)
- [Section 4 – Implement Improvement Strategies](#)

Qualis Health is the Quality Innovation Network QIO (QIN - QIO) for Idaho and Washington. We engage providers at all levels of performance in rapid-cycle projects for collaborative learning and action that accelerate healthcare quality improvement. We bring the voices of beneficiaries and families into healthcare quality improvement initiatives so providers can understand and improve the experience of care.

This material was prepared by Qualis Health, the Medicare Quality Innovation Network - Quality Improvement Organization (QIN-QIO) for Idaho and Washington, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. ID/WA-HITC-QH-2762-01-17.

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Section 1: Understand the Program Requirements

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Section 1: Understand the Program Requirements

Section one serves as an introduction to the Quality Payment Program. It includes key strategies, resources and tools. Our goal is to put you on the road to success with the Quality Payment Program.

Learning Objectives

At the end of section one, we hope you will:

- Develop a familiarity with key terms and acronyms
- Utilize key resources to gain program knowledge
- Be aware of the 2017 MIPS timeline and important dates
- Determine which pace works for your practice

Key Resources

We assembled a list of key resources and links for you to review that will help you understand the Quality Payment Program. We will link to the Qualis Health MIPS Minute video series throughout this toolkit. We recommend reviewing the series and referring to key episodes as needed. The series is designed to help you get clarity around individual topics such as eligibility or the timeline, without having to spend too much time digging for information. Each episode is brief and focuses on an important aspect of the Quality Payment Program in a short, easy to digest format.

- Review Qualis Health's MIPS Minute Series Episode: [MACRA The Medicare Access & CHIP Reauthorization Act](#)
- Get more in-depth information on the Quality Payment Program by reviewing the [CMS Quality Payment Program website](#).
- Subscribe to [email updates](#)
- Attend CMS [webinars](#)
- Read the CMS [QPP Executive Summary](#)
- Read the CMS [Final Rule at the Federal Register](#)
- Listen to the AMA ReachMD Podcast [Implementing MACRA: The AMA's Keys to Advancing Opportunities, Avoiding Pitfalls](#)

Need help? The Quality Payment Program Service Center is available to help.

- 1-866-228-8292. TTY: 1-877-715-6222
- Available M-F 8:00am to 8:00pm ET
- QPP@CMS.hhs.gov

Section 1: Understand the Program Requirements

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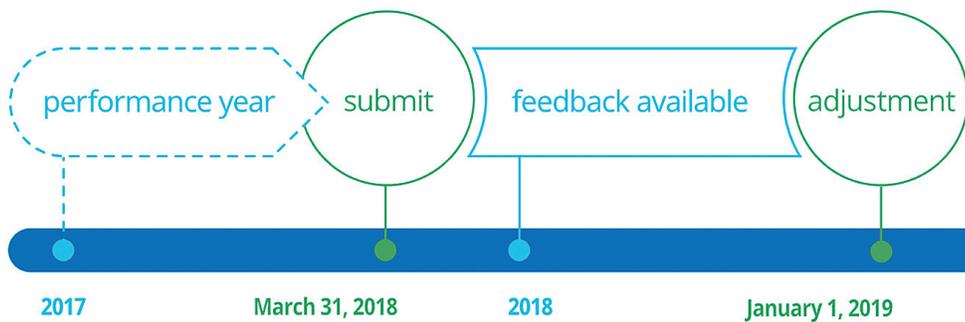
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Review the 2017 MIPS Timeline and Learn about Important Dates

Understanding the MIPS timeline is an important step in your success with the Quality Payment Program. We've outlined a few critical dates below.

2017 MIPS Timeline:

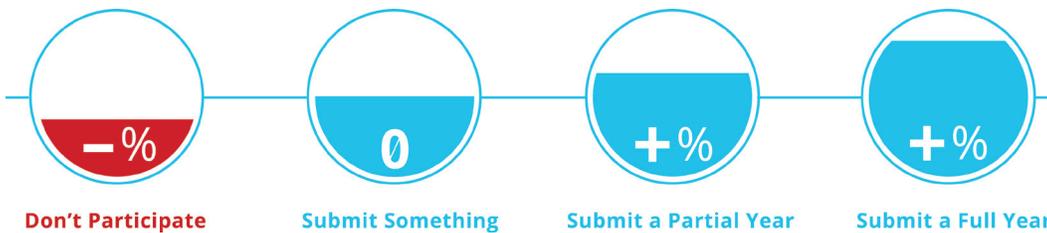
- Performance period – 1/1/2017 to 12/31/2017
- Submit data by March 31, 2018
- Access feedback reports in 2018
- Payment adjustments begin January 1, 2019



Pick Your Pace

Flexible participation options are available in 2017. MIPS eligible clinicians (EC) can pick a pace of participation that best suits their practice.

- Those that choose to not participate will receive an automatic 4% penalty.
- Those that submit “one thing,” such as a quality measure, improvement activity or the measures and objectives for Advancing Care Information that are required for the base score, will not receive a payment penalty in 2019.
- Those that choose to partially participate will not only avoid a penalty, but may be eligible for an incentive in 2019.
- Those that choose to participate in the full program will avoid penalties and be eligible for an incentive.
- Those that choose to submit 90 days of 2017 data could earn a neutral or positive adjustment, and may even earn the max adjustment.



Resources

Listen to Qualis Health's MIPS Minute Series Episode 2: Pick your Pace

Section 2: Analyze Current State

One key component of the Quality Payment Program is gaining MIPS points. They are earned by meeting certain program requirements and exceeding benchmarks. Section two provides guidance on how to prepare for reporting.

A key strategy for MIPS success is to understand how it applies to your practice, and which clinicians are eligible for the program. Before diving into developing a strategic reporting plan, take some time to use your past experience to drive future success. Utilizing past reports such as previous Quality Resource Use Report and PQRS Feedback reports, is a great way to maximize your MIPS score.

Learning Objectives

At the end of section two, we hope you will:

- Leverage past reports, such as the 2015 Quality Resource Use Report (QRUR) and the PQRS Feedback Report to identify strengths and areas for improvement.
- Identify eligible clinicians

Leverage past reports

Utilizing past reports such as the 2015 Quality Resource Use Report (QRUR) and the PQRS Feedback Report to identify strengths and areas for improvement, is a great way to improve your MIPS score. Leveraging existing data from your QRUR to position you for MIPS can benefit you.

Past PQRS Feedback Reports show reporting details by eligible practitioner, including:

- Method(s) of reporting
- Total # of measures satisfactorily reported
- Indicator for whether a practitioner is receiving a PQRS payment adjustment, as well as the rationale for that.
- Total Estimated Allowed Medicare Part B FFS Charges during the reporting period.
- PQRS Total Earned Incentive Amount for each Eligible Provider
- With 60% of the final MIPS score coming from Quality data, you can find out which measures are already positioned for high performance, and which measures you may want to improve throughout the year.

MIPS TIP

The Quality Payment Program is flexible instead of one-size fits all. Clinicians can choose to participate in a way that is best for them, their practice and their patients.

Identify Eligible Clinicians

2017 MIPS eligible clinicians include the following categories of clinicians who bill more than \$30,000 in Medicare Part B allowed charges, **AND** provide care to more than 100 Medicare patients per year:

- Physicians: Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatric Medicine, Doctor of Optometry, Doctor of Oral Surgery, Doctor of Dental Medicine and Doctor of Chiropractic.
- Physician assistants
- Nurse practitioners
- Clinical nurse specialists
- Certified registered nurse anesthetists

Additional considerations to be aware of:

- Non-patient facing MIPS eligible clinicians are not exempt from any performance category under MIPS unless the eligible clinician bills 100 or fewer patient-facing encounters including Medicare telehealth services.
- A group of eligible clinicians providing non-patient facing encounters are not exempt from MIPS unless 75% of the NPIs billing under the group's TIN meet the definition of a non-patient facing individual MIPS eligible clinician.
- Hospital-based clinicians are eligible clinicians if they meet the eligibility criteria. A hospital-based MIPS eligible clinician is defined as a MIPS eligible clinician who furnishes 75% or more of his or her covered professional services in sites of service identified by the Place of Service (POS) codes used in the HIPAA standard transaction as an inpatient hospital (POS 21), on campus outpatient hospital (POS 22) or emergency room (POS 23) setting.

Exclusions to be aware of in determining if you are a MIPS eligible clinician in 2017 are:

- If you have a low-volume threshold and bill \$30,000 or less in Medicare Part B allowed charges, **OR** if you provide care for 100 or fewer Medicare patients.
- If 2017 is your first year participating in Medicare.
- If you have significant participation in an Advanced Alternative Payment Model (APM).

Resources

To gain a thorough understanding of eligibility, listen to the Qualis Health:

- [MIPS Minute video: What You Need to Know About MIPS Eligibility](#)
- The [Qualis Health MIPS Tracking Tool](#) is used to identify and track your eligible clinicians. You can calculate the potential financial impact on 2019 Medicare Part B allowed charges.

Links to 2015 QRUR:

- [2015 Quality and Resource Use Report](#)
- [QRUR Guide link](#)
- [2015 PQRS Feedback Report](#)

Section 3: Develop Data and Reporting Plan

Establishing and formalizing a reporting plan early on is a key strategy that ensures program success. There are many important decisions to consider during this process. Section three is designed to provide you with critical information to help make informed decisions to create a strategic plan.

Learning Objectives

At the end of section three, we hope you will:

- Decide whether to report as an individual or a group
- Select a reporting mechanism
- Understand and estimate your MIPS final score
- Develop a strategic reporting plan for each category of MIPS
- Track your progress throughout the year

Determine whether to report as an individual or group

MIPS eligible clinicians can either participate in MIPS as an individual (by NPI) or as a group by Tax Identification Number (TIN). Determining how your organization will report is a critical step in developing a reporting plan.

Reporting MIPS as an individual:

- If you submit MIPS data as an individual, your payment adjustment will be based on your performance.
- An individual is defined as a single National Provider Identifier (NPI)
- You will send your individual data (NPI level) for each of the MIPS categories

If you report MIPS as a group:

- If you submit your MIPS data as a group, the group will get one payment adjustment based on the group's performance.
- A group is defined as a set of clinicians (identified by the NPIs) who share a common Tax Identification Number (TIN), regardless of locations, group size or specialties.
- The group, as a whole, will send in group level data for each of the MIPS categories.

Resources

- The AMA ReachMD Podcast [Preparing for Quality Reporting: Keys to Keeping Your Practice on Track](#) for reporting options under the Merit-Based Incentive Payment System (MIPS), specifically related to the quality performance category.
- [Qualis Health MIPS Tracking Tool](#)

Section 3: Develop Data and Reporting Plan



Select a reporting mechanism for MIPS data submission

The chart below can assist you in determining which reporting mechanism will work best for you.

Category	Individual	Group
Quality	Qualified Clinical Data Registry (QCDR)	Qualified Clinical Data Registry (QCDR)
	Qualified Registry	Qualified Registry
	EHR	EHR
	Claims - Medicare Part B	CMS Web Interface (groups of 25 or more)
		CMS Survey vendor for CAHPS for MIPS
		For groups of 16 or more EC's Administrative claims (no submission required)
Cost	Administrative claims (no submission required)	Administrative claims (no submission required)
Advancing Care Information	Attestation	Attestation
	Qualified Clinical Data Registry (QCDR)	Qualified Clinical Data Registry (QCDR)
	Qualified Registry	Qualified Registry
	EHR	EHR
		CMS Web Interface (groups of 25 or more)
Improvement Activities	Attestation	Attestation
	Qualified Clinical Data Registry (QCDR)	Qualified Clinical Data Registry (QCDR)
	Qualified Registry	Qualified Registry
	EHR	EHR
		CMS Web Interface (groups of 25 or more)

Understand and estimate your MIPS final score

The MIPS final score factors performance in 4 weighted categories on a 0-100 point scale. In 2017 the performance weights for each category are:

- Quality – 60%
- Advancing Care Information – 25%
- Improvement Activities – 15%
- Cost – 0% (will be evaluated based on claims but not scored in 2017)

MIPS TIP

There is no longer a registration deadline, unless a group plans to use the CMS Web Interface for reporting, or is submitting the CAHPS for MIPS Survey for Quality Measures or Improvement Activities.

June 30, 2017 is the last day to register for CMS Web Interface reporting or for submitting the CAHPS for MIPS Survey.

Resources

- Qualis Health's MIPS Minute Series Episode 6: The MIPS Scoring System

Section 3: Develop Data and Reporting Plan



Develop a strategic reporting plan for each category of MIPS

The Qualis Health MIPS Tracking Tool will help you to track progress throughout the year.

MIPS TIP

Each quality measure accurately submitted is worth at least 3 points. A maximum of 10 points are scored based on how performance compares to the measure benchmark.

Categories

Quality

- 60% of the MIPS final score
- Under MIPS, most clinicians will report 6 quality measures, including an outcome measure.
- Up to 3 bonus points are available for submitting an additional high-priority measure (2 points for each additional outcome and patient experience measure and 1 bonus point for each additional high-priority measure)
- Groups who choose to use the web interface will report 15 quality measures for a full year.
- Groups in APMs qualifying for special scoring under MIPS, such as Shared Savings Track 1 will report quality measures through their APM and will not need to do anything additional for MIPS Quality.
- Individual MIPS eligible clinicians or groups submitting data on quality measures must report on at least 50% of the MIPS eligible clinician or group's patients (all-payer) that meet the measure's denominator criteria.
- The quality measure calculated for 2017 MIPS performance that does not require data submission is All-Cause Hospital Readmission rates for attributed beneficiaries.
- There are separate benchmarks for different reporting mechanisms. For example, there are different benchmarks for EHR, QCDR, registries, claims, CMS web interface, etc.

Resources

- Review Qualis Health's MIPS Minute Series Episode: [What You Need to Know About the Quality Performance Category](#)
- [Pick measures from the QPP website](#)
- Link to [2017 quality measures guide](#)
- [Link to 2015 benchmarks](#)

Section 3: Develop Data and Reporting Plan



Cost

The Cost category will not be factored into the 2017 MIPS final score but is an important part of MIPS and will be evaluated in future years. A two-step attribution process is used to look at medical cost measures for practices “attributed beneficiaries”. *There is no reporting required for this category. CMS will use data from Medicare claims to examine comparative cost and quality measures for attributed patients.*

- Medicare Spending Per Beneficiary (MSPB)
- Total Per-Capita Cost for All Attributed Beneficiaries
- Medicare spending for 10 Episode Groups (i.e. Aortic/Mitral Valve Surgery, Colonoscopy, Mastectomy for Breast Cancer)

Resources

- Review CMS fact sheet on the [two-step attribution process](#) for claims-based quality outcome measures and per capita cost measures
- Review Qualis Health’s MIPS Minute Series Episode: [What You Need to Know About the MIPS Cost Performance Category](#)

MIPS TIP

If you have previously submitted PQRS and participated in the EHR Incentive Program, we highly recommend full participation in the QPP. It’s good practice and could bring big rewards.

Advancing Care Information

2017 Advancing Care Information is 25% of the MIPS Score. MIPS eligible clinicians have the ability to earn up to 155 percentage points for the Advancing Care Information performance category, which will be capped at 100%.

- Base Score – 50%
- Performance Score – Up to 90%
- Bonus Score – Up to 15%

There are two measure set options, based on your certified EHR technology edition:

- Advancing Care Information Objectives and Measures
- 2017 Advancing Care Information Transition Objectives and Measures

Section 3: Develop Data and Reporting Plan



A MIPS eligible clinician's performance score may be reweighted for the following reasons:

- Insufficient Internet Connectivity
- Extreme and Uncontrollable Circumstances
- Lack of Control over the Availability of CEHRT

These MIPS eligible clinicians must submit an application for CMS to reweight the Advancing Care Information performance category to 0%.

Resources

- Review Qualis Health's MIPS Minute Series Episode: [What You Need to Know About Advancing Care Information](#)
- Check that your electronic health record is [certified by the Office of the National Coordinator](#) for Health Information Technology. If it is, it should be ready to capture information for the MIPS advancing care information category and certain measures for the quality category.
- [Read the QPP Advancing Care Information Performance Category Fact Sheet](#)
- Listen to the AMA ReachMD Podcast [How an EHR Can Help You Participate in MACRA](#) to hear Information for

MIPS TIP

Use the Qualis Health MIPS Tracking Tool to track your progress with Advancing Care Information throughout the year.

physicians about the importance of electronic health records (EHRs) to participation in MACRA (6:30)

Improvement Activities

- 15% of the final score
- For full participation, most clinicians will attest to up to four activities to earn the highest possible score of 40 (medium-weighted activities score 10 points, high-weighted activities score 20 points).
- Groups with fewer than 15 ECs and groups in rural or health professional shortage areas will attest to up to 2 Improvement Activities.
- Participants with a patient-centered medical home designation, comparable specialty practices or APMs designated as a Medical Home Model will receive full credit.
- Bonus points in the Advancing Care Information category can be achieved by attesting to certain Improvement Activities that are completed using CEHRT.

Section 3: Develop Data and Reporting Plan



Reporting for the Improvement Activities Category

In order to plan strategically to report Improvement Activities, we recommend you:

- Understand how the Improvement Activities impacts your MIPS final score
- Select from 90+ Improvement Activities
- Perform activities for at least 90 days

Resources

- Qualis Health's MIPS Minute Series Episode: [What You Need to Know About Improvement Activities](#)
- The AMA ReachMD Podcast [Why Participating in Clinical Practice Improvement Activities \(CPIA\) Matters](#) for an overview of the Improvement Activities, or CPIA, category, including how the activities may be reported and scored by CMS (5:29)

Section 3: Develop Data and Reporting Plan



Advanced Alternative Payment Model (APM)

An APM is a payment model that provides incentive payment to provide high-quality and cost-efficient care. In 2017, you are in an Advanced APM if you participate in one of these APMs:

- [Comprehensive ESRD Care \(CEC\) - Two-Sided Risk](#)
- [Comprehensive Primary Care Plus \(CPC+\)](#)
- [Next Generation ACO Model](#)
- [Shared Savings Program - Track 2](#)
- [Shared Savings Program - Track 3](#)
- [Oncology Care Model \(OCM\) - Two-Sided Risk](#)
- [Comprehensive Care for Joint Replacement \(CJR\) Payment Model \(Track 1- CEHRT\)](#)

Resources

- [Quality Payment Program Alternative Payment Models](#)
- Qualis Health's MIPS Minute Series Episode: [What You Need to Know about Alternative Payment Models](#)
- [The Rise of Specialist-Driven Alternative Payment Models in American Medicine](#)

Some physicians across the country have taken it upon themselves to design APMs that work within their specialties. In this podcast, Lawrence Kosinski, MD, a gastroenterologist in Illinois, describes SonarMD, a web-based platform that pings patients to keep track of their symptoms outside the office visit to get ahead of issues before they become emergencies. (27:00)

NOTE: *If you leave the Advanced APM during 2017, you should make sure you've seen enough patients or received enough payments through an Advanced APM to qualify for the 5% bonus. If you haven't met these thresholds, you may need to submit MIPS data to avoid a downward payment adjustment.*

MIPS TIP

Requirements for APM incentive payments are you must receive 25% of Medicare payments or see 20% of your Medicare patients through an Advanced APM in 2017. You will then earn a 5% incentive payment in 2019.

Section 4: Implement Improvement Strategies



Learning Objectives

At the end of section four, we hope you will:

- Identify opportunities for improvement and apply improvement methodology
- Identify tools to initiate or continue quality improvement for MIPS

Improvement Process

The Plan-Do-Study-Act (PDSA) cycle is a simple tool for quality improvement in the real work setting — by planning it, trying it, observing the results, and acting on what is learned. The model is not meant to replace change models that practices and organizations may already be using, but rather to accelerate improvement. This model has been used very successfully by hundreds of healthcare organizations to improve many different healthcare processes and outcomes.

The model has two parts:

- Three fundamental questions, which can be addressed in any order:
 - 1) What are we trying to accomplish?
 - 2) How will we know that a change is an improvement?
 - 3) What changes can we make that will result in an improvement?

Source: *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*.
G. Langley, K. Nolan, T. Nolan, C. Norman, L. Provost.

- The Plan-Do-Study-Act (PDSA) cycle to test changes in real work settings.

Resources

- Qualis Health Team-Based Healing Relationships website (link)
- Qualis Health Quality Improvement website (link)
- National priorities and programs that apply best practices

For More Information

The Quality Payment Program Service Center is available to help.

- 1-866-288-8292
- TTY: 1-877-715-6222
- Available Monday – Friday, 8:00AM – 8:00PM Eastern Time
- Send your questions about the Quality Payment Program to QPP@cms.hhs.gov.

Qualis Health Quality Payment Program Resource Center

- QPP-SURS@qualishealth.org
- 877-560-2618

Appendix

Key Terms and Acronyms List

Understanding key terms is critical to gaining deeper knowledge of the Quality Payment Program. We assembled a list of important acronyms and terms for you to review.

ABC™	Achievable Benchmark of Care
ACO	Accountable Care Organization
APM	Alternative Payment Model
APRN	Advanced Practice Registered Nurse
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CEHRT	Certified EHR technology
CMMI	Center for Medicare & Medicaid Innovation (CMS Innovation Center)
CPIA	Clinical Practice Improvement Activity
CPOE	Computerized Provider Order Entry
CPS	Composite Performance Score (final score)
CQM	Clinical Quality Measure
eCQM	Electronic Clinical Quality Measure
EHR	Electronic Health Record
EC	Eligible Clinician
FFS	Fee-for-Service
FQHC	Federally Qualified Health Center
HIE	Health Information Exchange
HPSA	Health Professional Shortage Area
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MIPS	Merit-based Incentive Payment System
MSPB	Medicare Spending per Beneficiary
NPI	National Provider Identifier
PECOS	Medicare Provider Enrollment, Chain, and Ownership System
PFPMS	Physician-Focused Payment Models
PFS	Physician Fee Schedule
PTAC	Physician-Focused Payment Model Technical Advisory Committee
PQRS	Physician Quality Reporting System
QCDR	Qualified Clinical Data Registry
QPP	Quality Payment Program
QRDA	Quality Reporting Document Architecture
QRUR	Quality and Cost Reports
RHC	Rural Health Clinic
SGR	Sustainable Growth Rate
TCPI	Transforming Clinical Practice Initiative
TIN	Tax Identification Number
RBRVS	Resource-Based Relative Value Scale
RFI	Request for Information
RIA	Regulatory Impact Analysis
RVU	Relative Value Unit
VM	Value-Based Payment Modifier
VPS	Volume Performance Standard
Not currently a definition	Hospital Based MIPS Clinicians