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# QPP Y3: Helping Audiologists in a Value-Based World

# Kentucky Regional Extension Center

*UK's Kentucky REC is a trusted advisor and partner to healthcare organizations, supplying expert guidance to maximize quality, outcomes and financial performance.*

## Kentucky REC Description

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To date, the Kentucky REC's activities include:

- Assisting more than 4,000 individual providers including primary care providers and specialists
- Supporting more than half of all Kentucky hospitals and health systems with MU, HIPAA, and other regulatory initiatives
- Providing a Security Risk Analysis for more than 200 organizations with multiple locations
- Supporting practices and health systems across the Commonwealth with practice transformation and preparation for value based payment

## REC Service Lines

*Hospital Services*

1. Promoting Interoperability Program (Meaningful Use)
2. HIPAA Privacy & Security Analysis
3. Project Management
4. Hospital Quality Improvement & Value-Based Purchasing

*Physician Services*

1. Promoting Interoperability (MU) & Mock Audit
2. HIPAA Security Risk Analysis & Project Management
3. Patient Centered Medical Home (PCMH) Consulting
4. Patient Centered Specialty Practice (PCSP) Consulting
5. Value Based Payment & MACRA Support
6. Alternative Payment Model (APM) Support

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# Kentucky REC Team




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# Objectives

- Impetus for Healthcare Reform: Creation of MACRA
- QPP: 2019 Program Overview
- 2019 MIPS Performance Category Updates
- Audiologists' Next Steps

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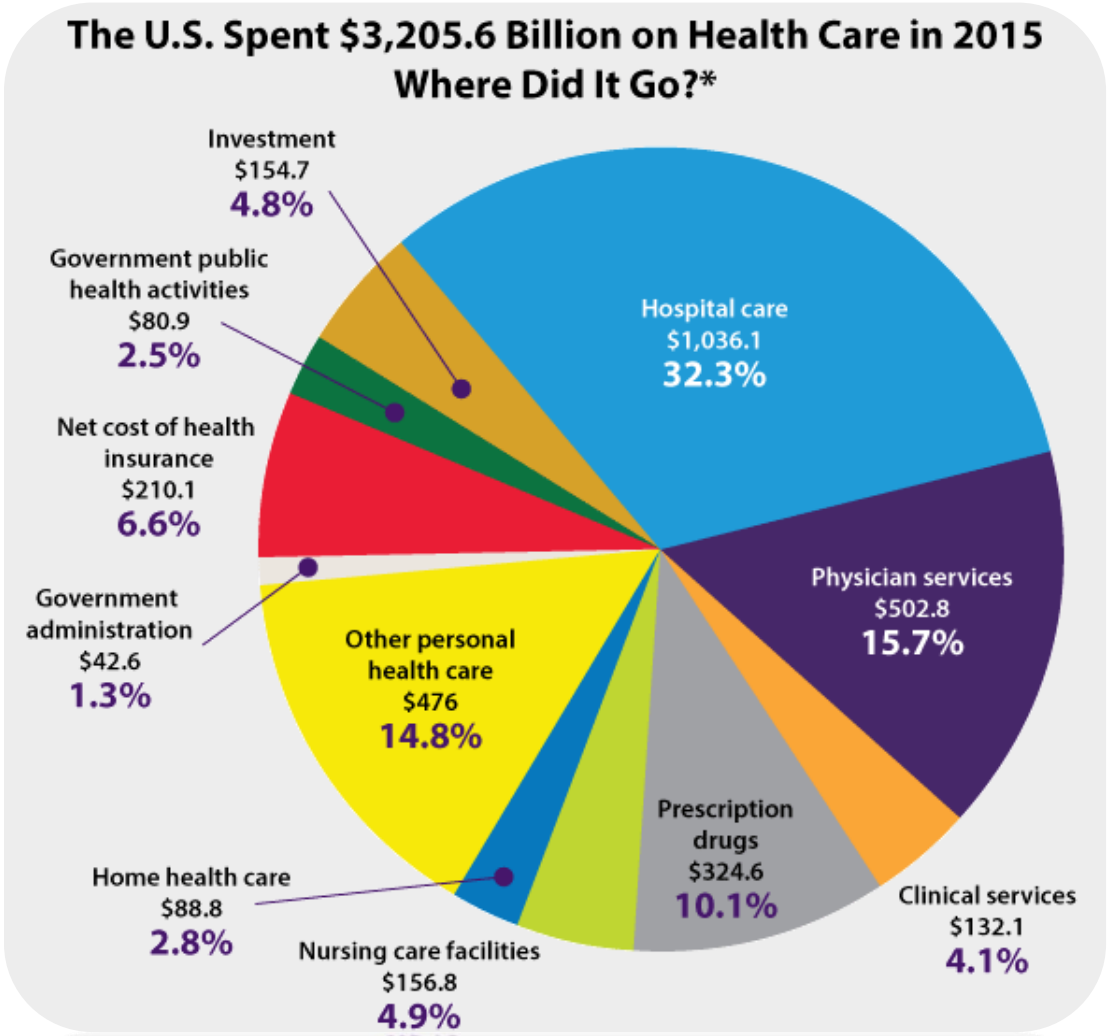
# The Impetus for Healthcare Reform: Creation of MACRA

# What Problems Are We Solving?

- U.S. health care system is the most expensive in the world
- In 2015, U.S. health care spending reached $3.2 trillion, or $9,990 per person.
- By 2025, health care will consume 20% percent of the GDP
- Federal, state and local governments finance 47 percent of national health spending
- Widespread quality issues & unnecessary spending
- 28.5 million still uninsured in 2015

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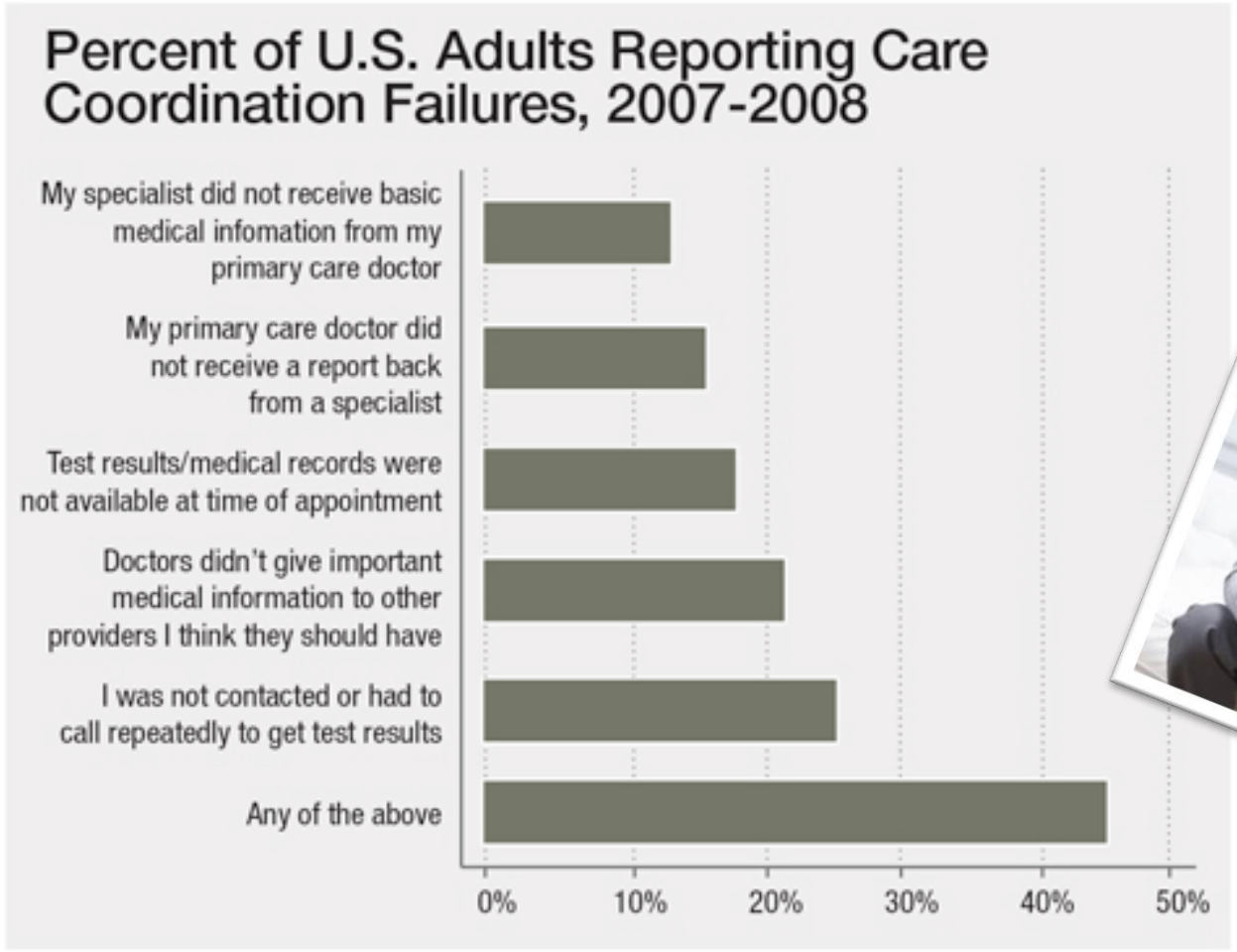
# Problems from a Patient's Perspective

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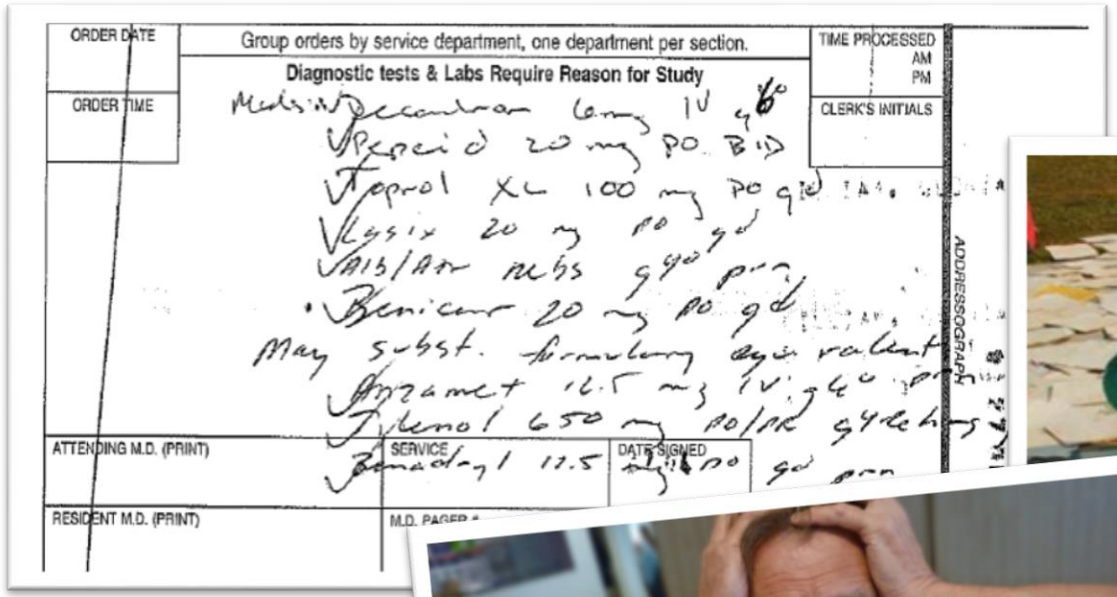
# Problems from a Clinician's Perspective

***Can you read this?***




***Can you organize this?***

***Can you understand this?***

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# Changes Impacting Healthcare

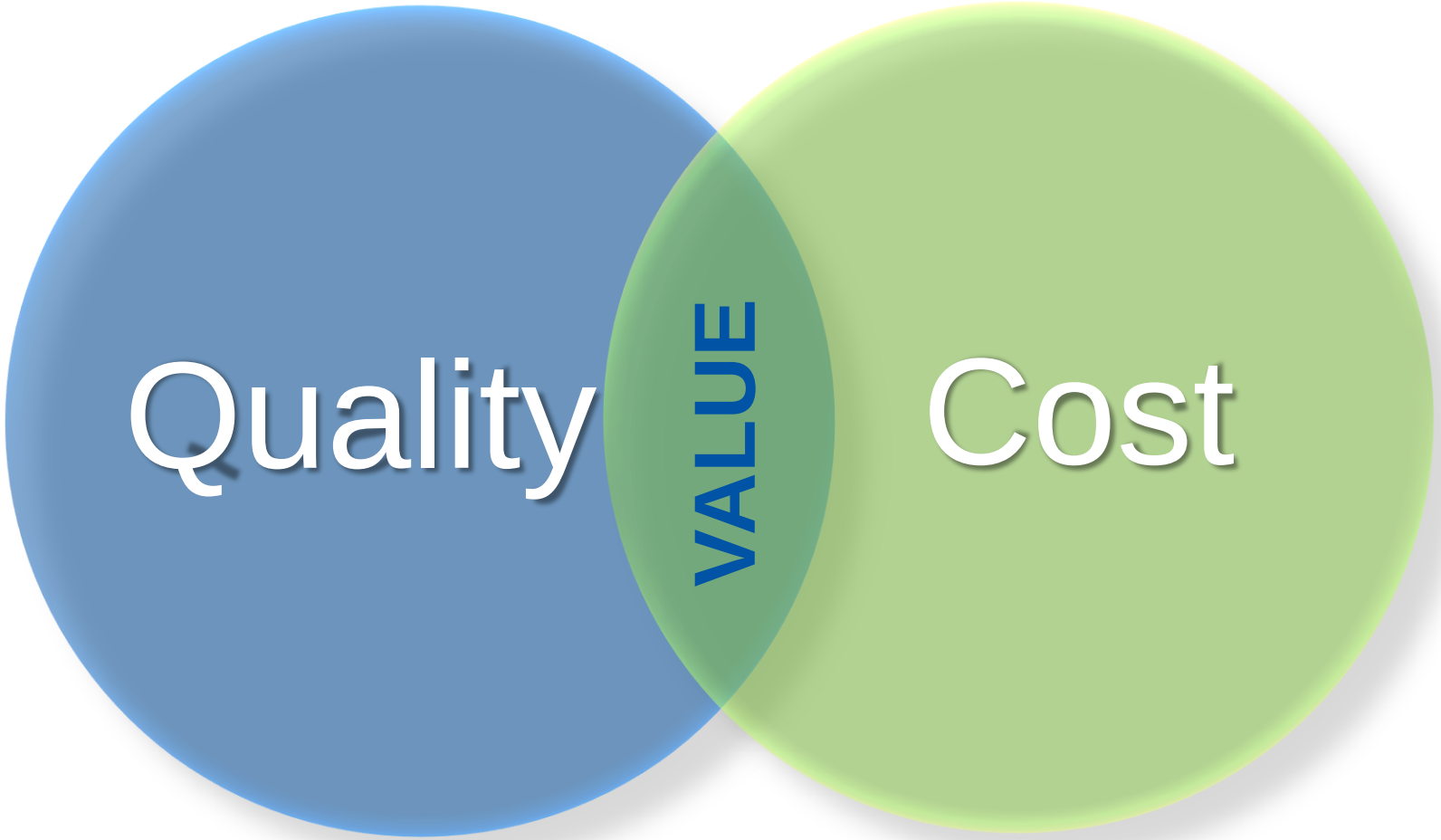
## Industry Stressors

- Increasing consumer choice and transparency
- High deductible plans
- Technology: Mobile phones and tablets resulting in 24/7 Information Access
- Aging population challenging capacity and driving cost
- Retail Health competition
- Market consolidation
- KY Health Trends
  - Obesity
  - Drug use

## Industry Responses

- Population health and consumer focused/patient centered medicine, shared-decision making
- Increased price/cost transparency
- Technology – EHRs, telehealth, remote monitoring, big data
- Integrated delivery networks, ACOs, Clinically integrated networks
- Care coordination, linkages with behavioral health, community resources, social determinants of health

# What is Value-Based Care?



# Essential Elements of Value-Based Care

## Reducing Costs

- Productivity
- Sustainability
- Cost Efficacy

## Population Health Management

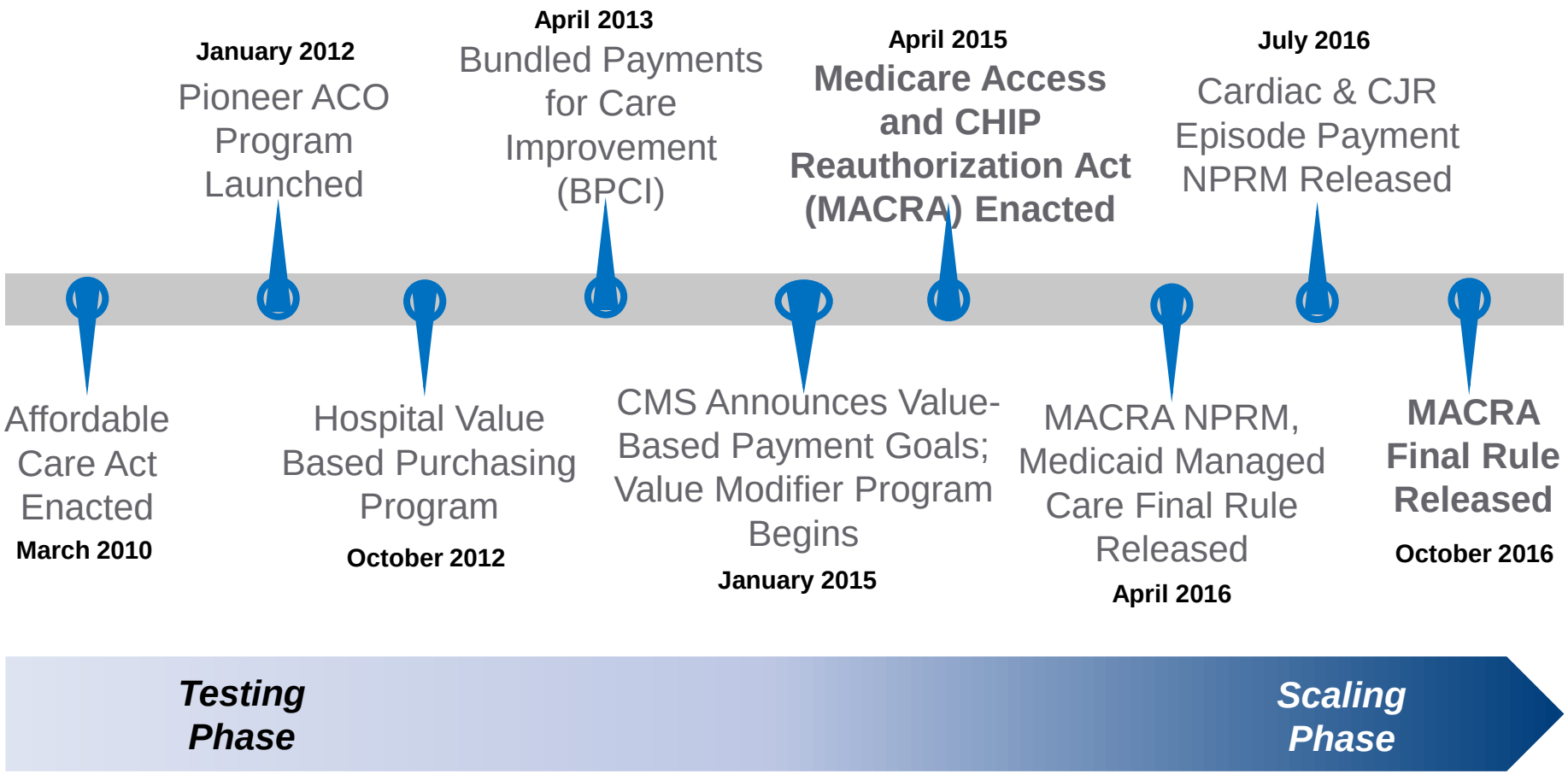
- Risk Management via Pooling
- Preventative Care
- Socio-economically Impactful

## Patient Experience

- Patient Satisfaction
- Outcomes
- Quality
- Safety

# Volume to Value-Based Shift

**Recent legislative, regulatory and marketplace developments suggest that the transition from volume to value-based payment is accelerating from a "testing" phase to a "scaling" phase**

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# Commercial Insurers Accelerate VBP

"Our industry is in the midst of a profound shift from fee-for-service, or volume-based care, to value-based care. Aetna has successfully built more than 72 ACO relationships with providers, growing from very small numbers in 2011 to more than 2 billion dollars in revenue today. …**We plan to maintain 75 percent of our medical spending in value-based contracts by 2020."**

- *Charles Kennedy, MD, chief population officer for Healthagen, Aetna*

Health Learning & Action Network

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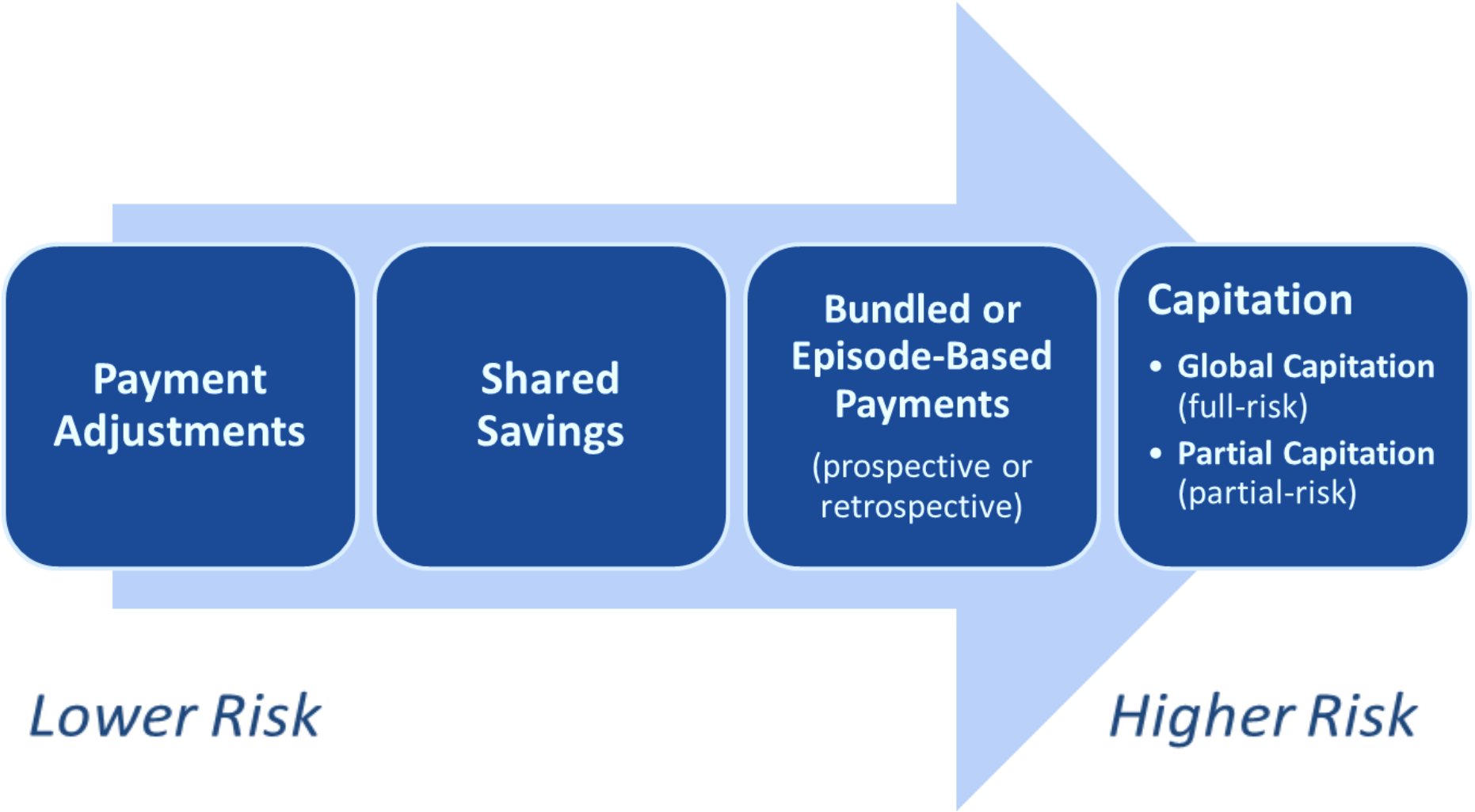
# New Payment Models



# Impact of MACRA on Medicare Providers

## Financial & Strategy Implications

- MACRA moves Medicare payment from one size fits all to a meritocracy
- Market share will shift from low performers to high performers over time
- Delay means disaster; exponential leaps in value will be needed to catch up with those that perform better as thresholds increase over time

## Reputational Status

Publicly available scores on quality and value that compare organizations/professionals will affect:

- Health plan negotiations
- Talent recruitment
- Consumer choice

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# 2019 Quality Payment Program (QPP) Overview

# QPP Glossary of Terms

## MACRA (Medicare Access & CHIP Reauthorization Act)

- Legislation that replaced Sustainable Growth Rate, with a goal for CMS to pay for quality and value, rather than volume (fee for service).

## QPP (Quality Payment Program)

- Created by the MACRA legislation which pays for quality and value rather than volume. Providers will choose between MIPS and APM.

## MIPS (Merit-Based Incentive Payment System)

- Medicare pay-for-performance system created by MACRA that consolidates several existing Medicare pay-for-performance programs.

## APM (Alternative Payment Model)

- CMS Model that pays providers for services based on quality, outcomes, and cost-containment; 5% annual bonus payment to Qualified Physicians who are participating in APMs, and exempts them from participating in MIPS.

# Quality Payment Program (QPP) Overview


**MIPS**

Merit-based Incentive Payment System

**APM**

Alternative Payment Models

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# MACRA Creates Medicare Payment Program

**Value-Based Care**


**Fee For Service/Volume**

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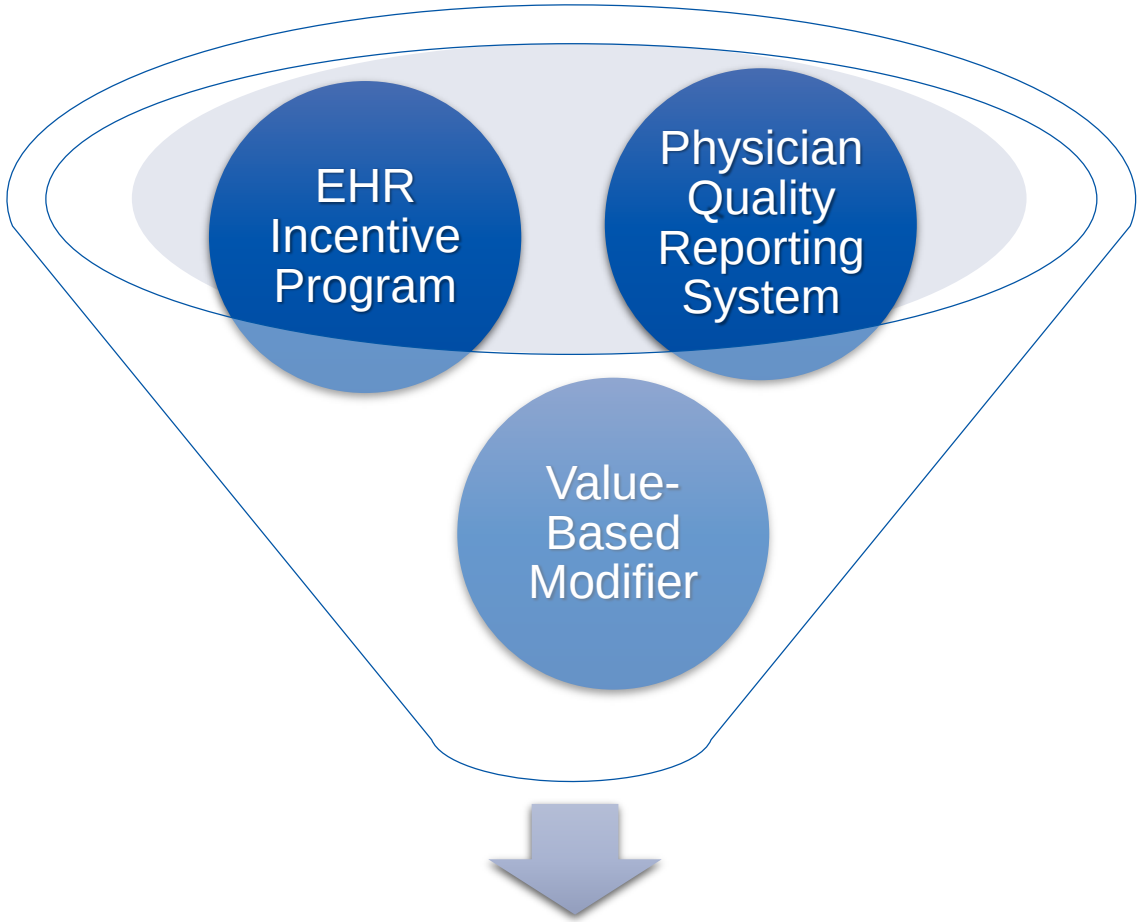
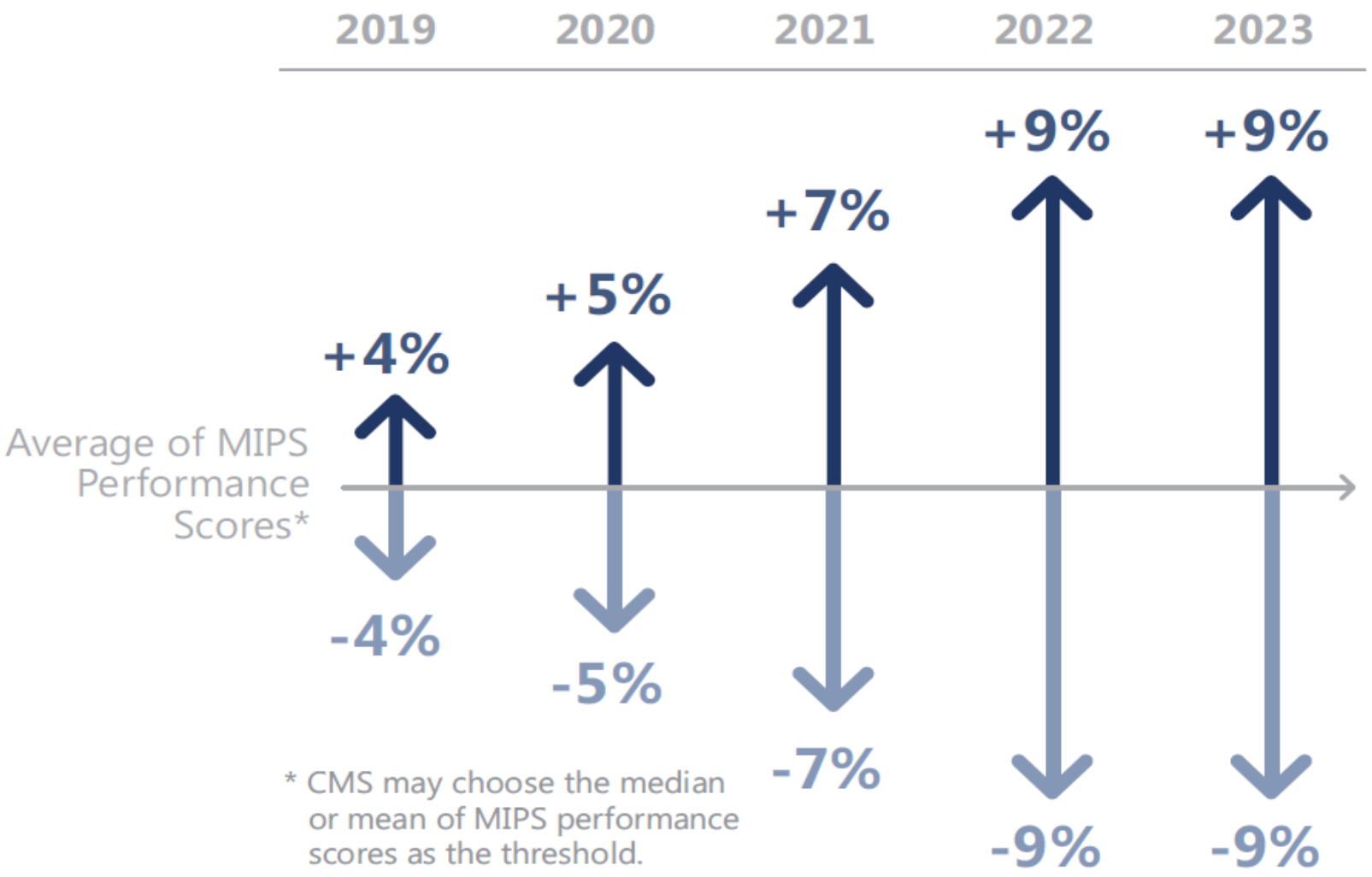
# MIPS: A Consolidation of 3 Programs



# Maximum MIPS Payment Adjustments




*Source: Leavitt Partners - MACRA: Quality Incentives, Provider Considerations, and the Path Forward*

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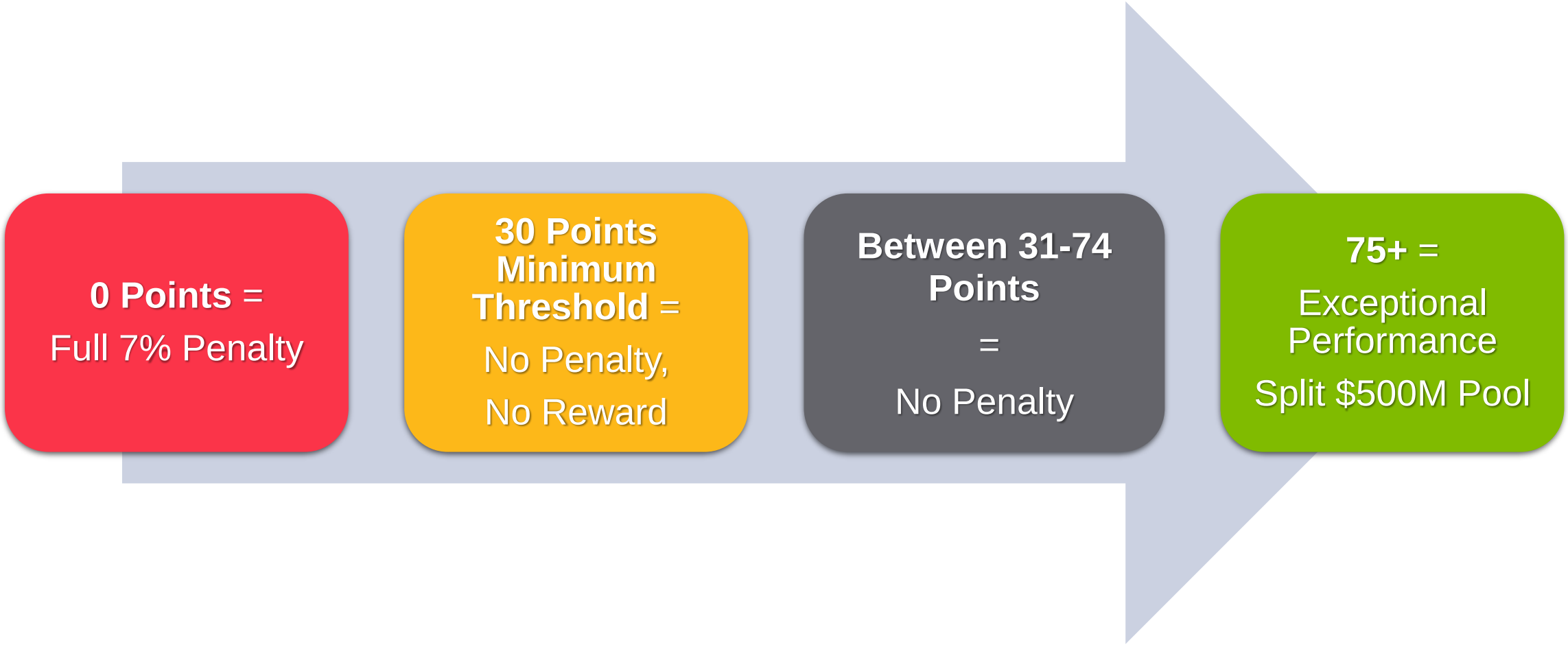
# MIPS Thresholds



# Low-Volume Threshold

**$90,000** in Part B Charges + **200** Medicare Patients + **200** Covered PFS = *2019 MIPS EC Required Participation*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# MIPS Eligible Clinicians (ECs)

## 11 Types of Eligible Clinicians (ECs):

Physician, PA, NP, CNS, CRNA, **PT, OT, Qualified Speech-Language Pathologist, Qualified Audiologist, Clinical Psychologist, Registered Dietitian or Nutrition Professional**

## Exclusions:

- 1st year ECs
- Less than $90K and/or 200 Medicare patients and 200 PFS
- Advanced APM Qualifying Provider

## Opt-In Options:

- ≥ 90K Part B
- ≥ 200 Medicare Patients
- ≥ 200 Professional Covered Services

# Determining Your QPP Eligibility

## Determining Eligibility

QPP.CMS.GOV

QPP Submission Portal

## Factors Impacting Submission

Group vs. Individual Eligibility

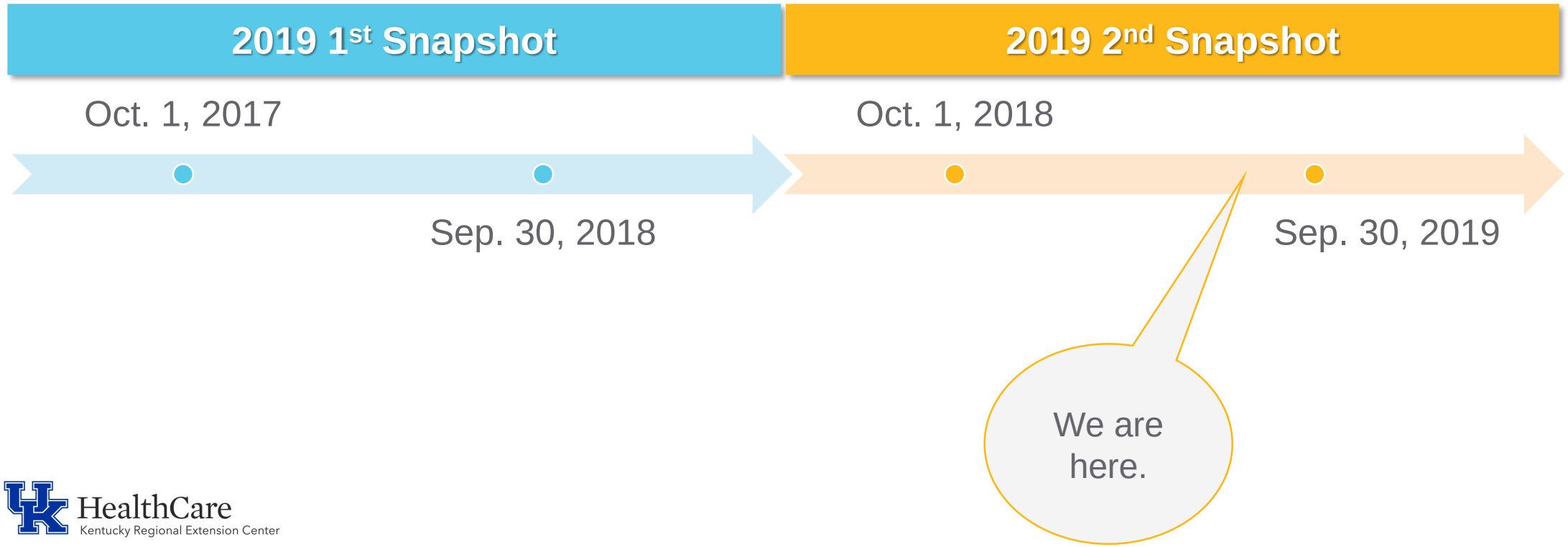
## New Provider Types

How are you billing?

# Eligibility Snapshot Cycle

## Assigning Eligibility

CMS uses a 2-Segment Determination Period to identify eligibility for the MIPS program based on “snapshot” periods of clinician’s submitted claims.

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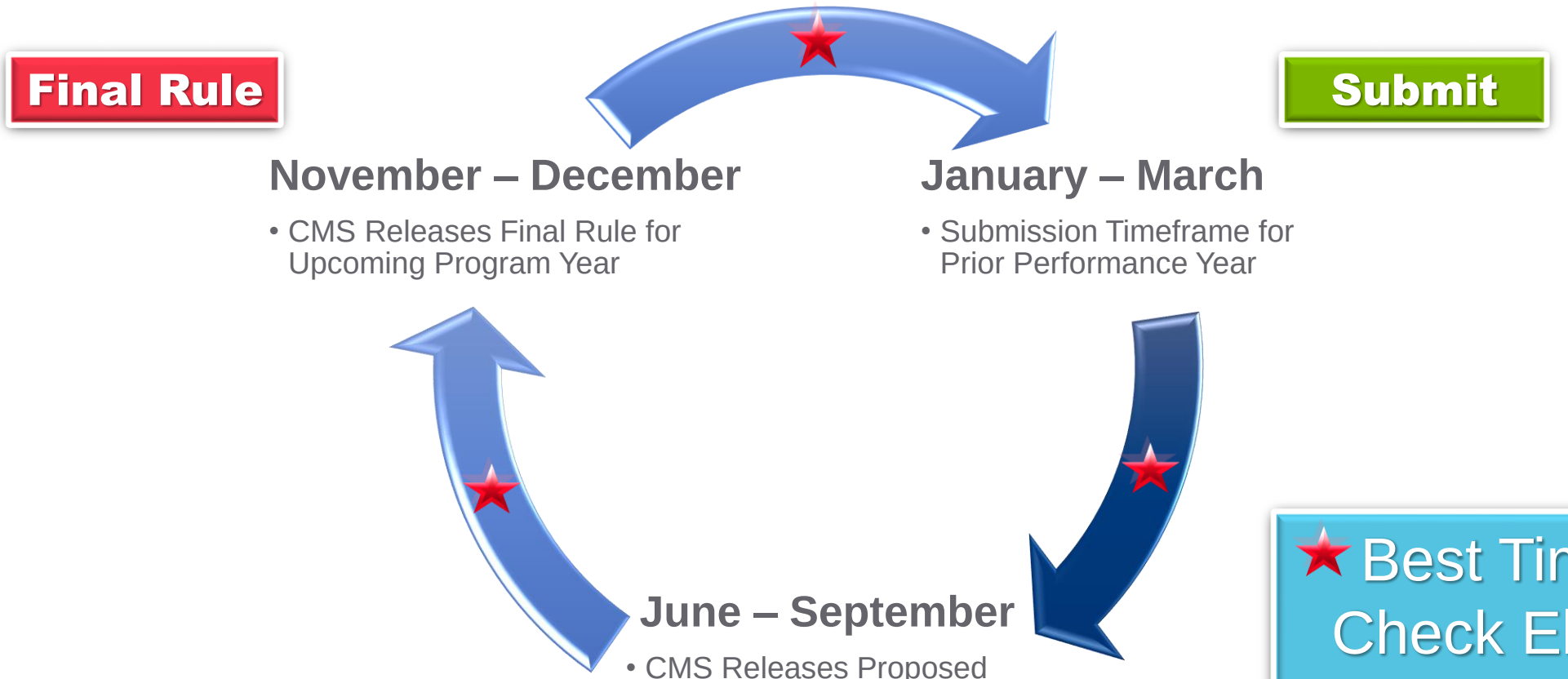
# QPP Program Lifecycle




★ Best Times to Check Eligibility for the QPP

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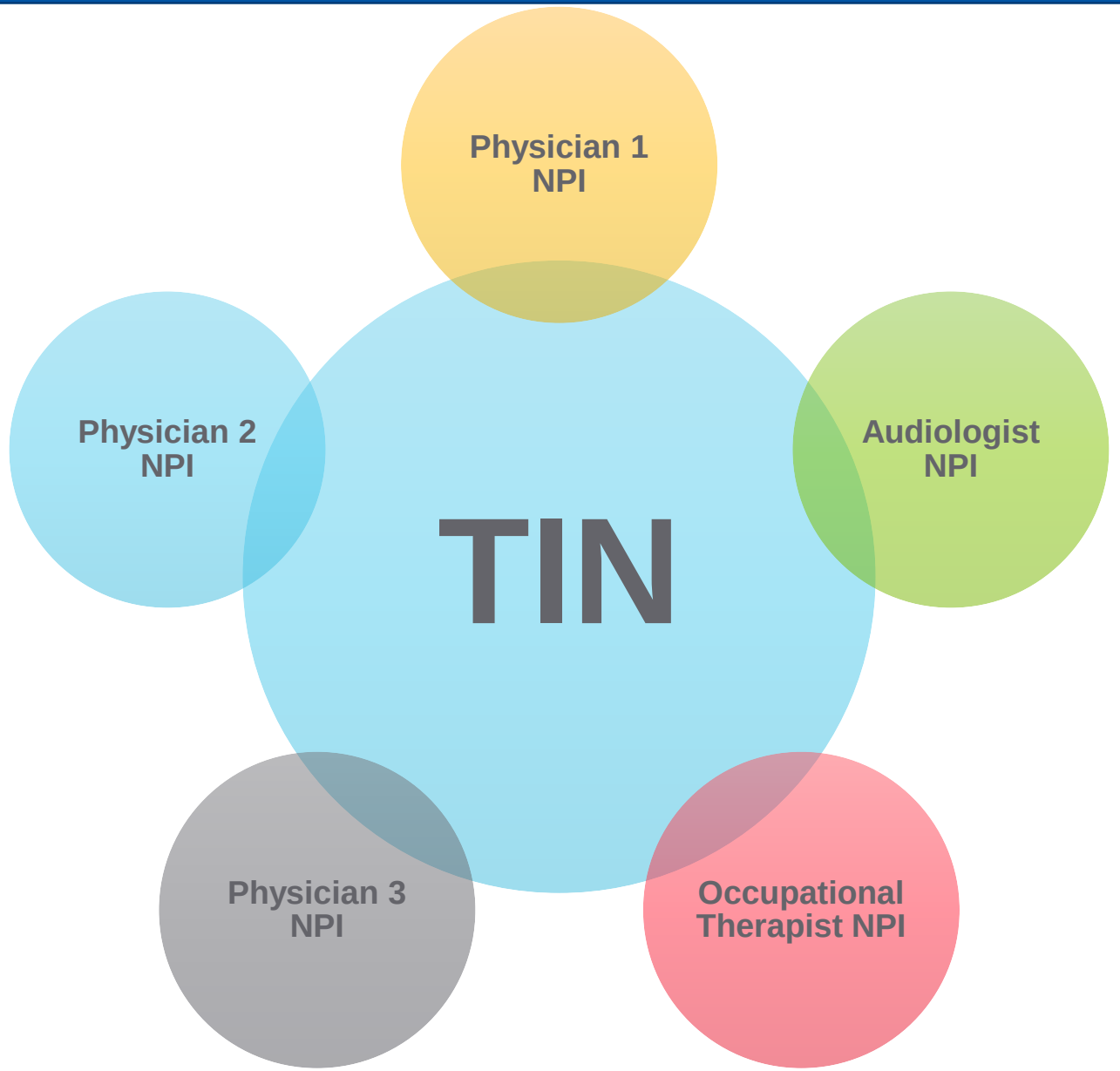
# Group Eligibility

## Group Level Eligibility

- TIN has exceeded low volume thresholds
- Group receives 1 score, applied to all ECs under TIN
- Group's score associated with 1 payment adjustment

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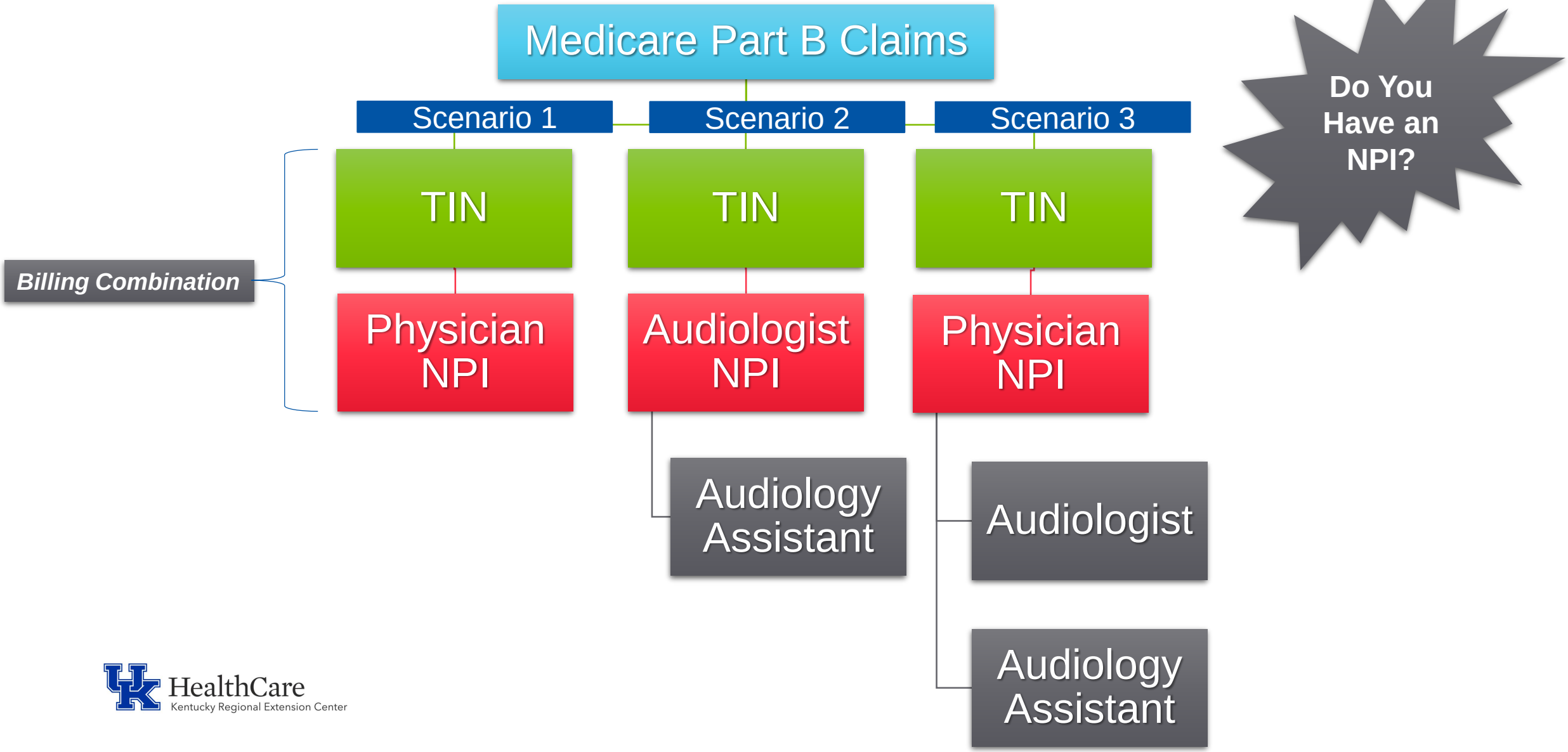
# Individual Eligibility

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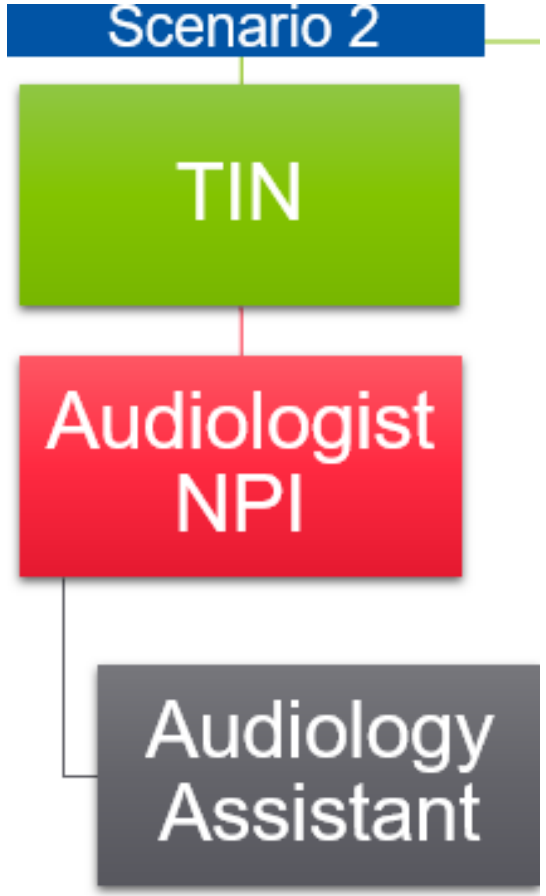
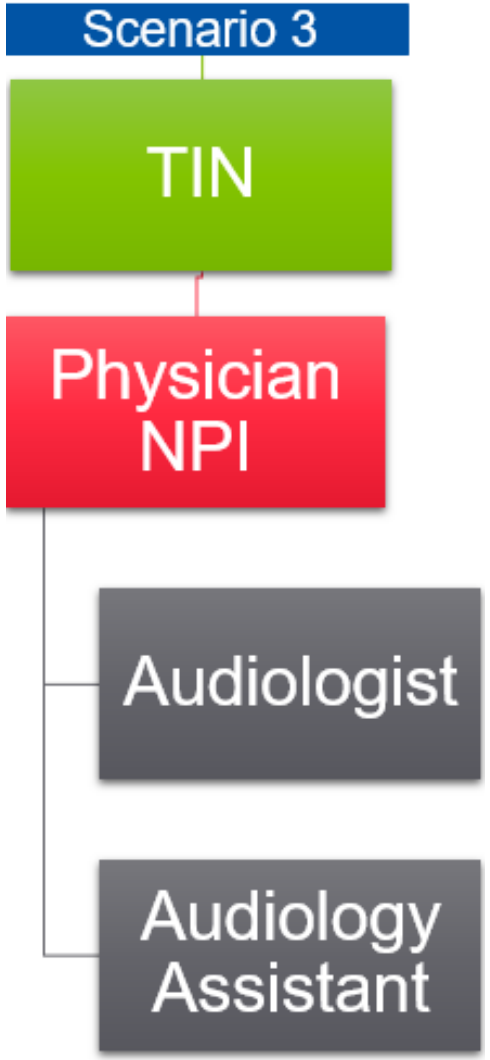
# Billing Using Your Own NPI

- Organization Expectations
- Actions to Avoid NPI Penalties
- Communication with Assistants
- Documentation Requirements



# Billing Through a Physician's NPI

- Organization Expectations
- Actions to Avoid NPI Penalties
- Communicate with Physician & Assistant
- Documentation Requirements



# Moving from Eligibility to Performance

Determining Eligibility

Understanding Performance Categories

Optimizing Performance

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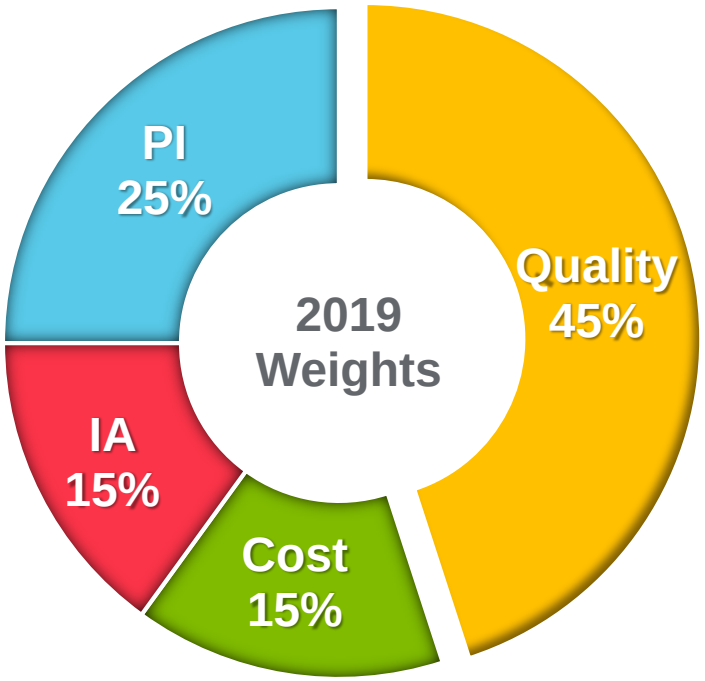
# MIPS Performance Category Overview

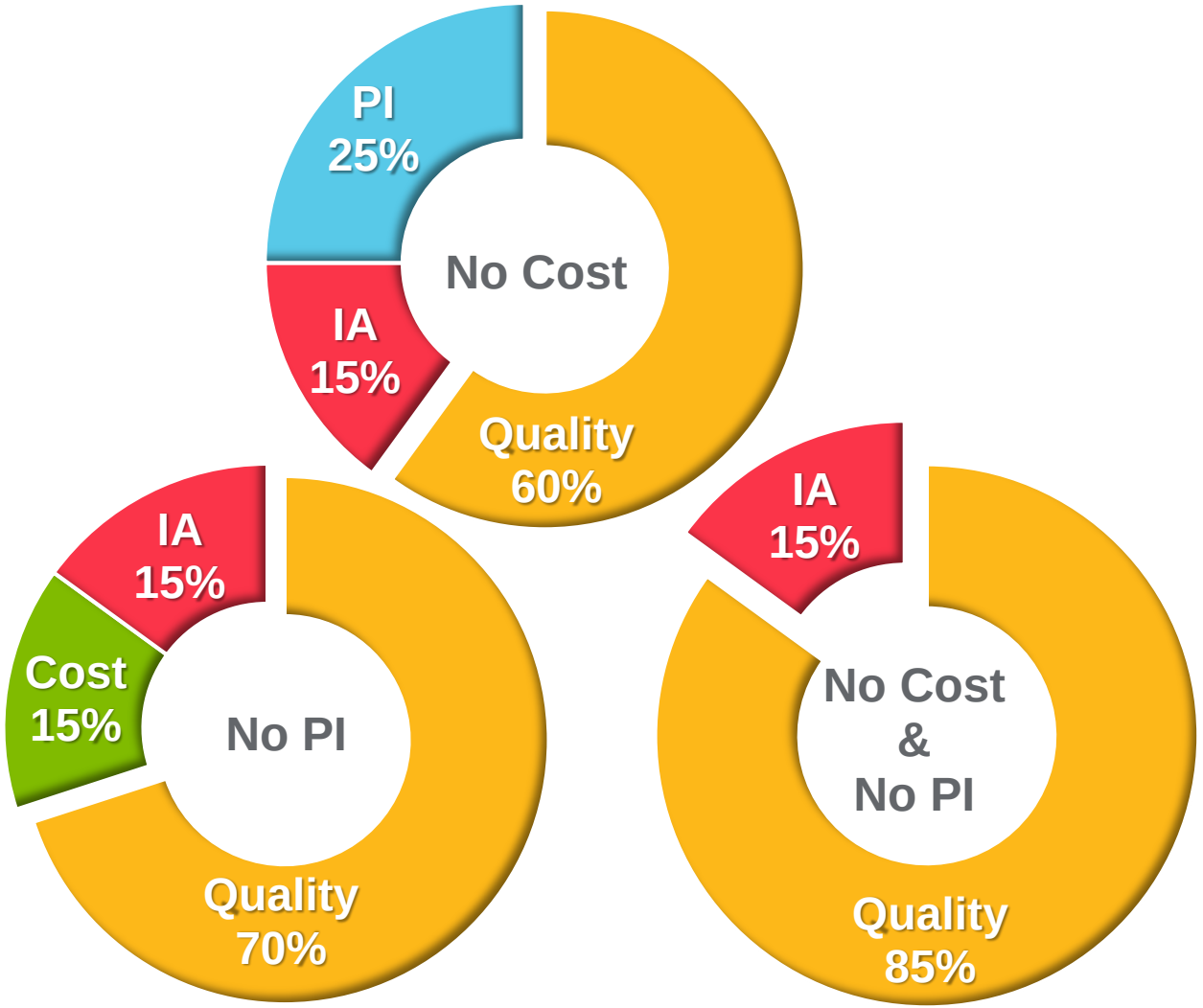
| Program Year | Payment Year | Quality  | Improvement Activities  | Promoting Interoperability  | Cost  | Adjustment Factor + / - |
|---|---|---|---|---|---|---|
| 2017 (Y1) | 2019 | 60% | 15% | 25% | 0% | 4% |
| 2018 (Y2) | 2020 | 50% | 15% | 25% | 10% | 5% |
| 2019 (Y3) | 2021 | 45% | 15% | 25% | 15% | 7% |

# Reweighting Opportunities

## 2019 MIPS Category Weights w/o Any Reweighting




## 3 Most Common Reweighting Scenarios

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# MIPS 2019 Reporting Timeframes

| Quality: | IA: | PI: | Cost: |
| --- | --- | --- | --- |
| Reporting Requirement: 365 days | Reporting Requirement: At least 90 days in program year | Reporting Requirement: At least 90 days in program year | *Reporting Requirement: 365 days *no reporting required |

**Must Submit by March 31st, 2020**

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# QPP Y3: Group vs. Individual

## Group

- **Quality:** Must include all clinicians under TIN
- **Promoting Interoperability:** Must include all clinicians on certified EHR
- **Improvement Activities:** Only one EC has to perform activity, covers group
- **Payment Adjustment:** Same across TIN

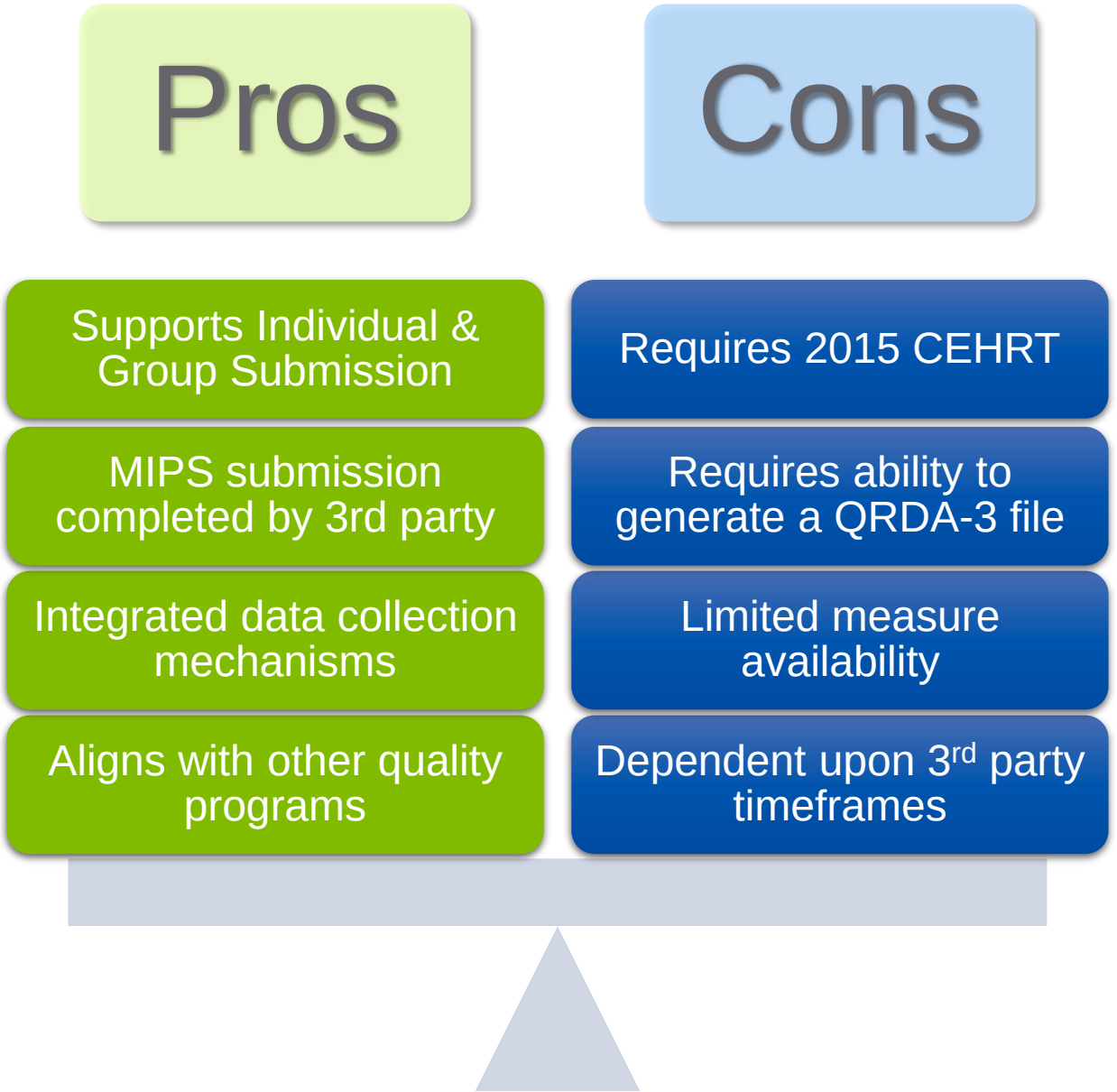
## Individual

- **Quality:** Submission for each EC
- **Promoting Interoperability:** Submission for each EC
- **Improvement Activities:** Submission for each EC
- **Payment Adjustment:** Different for each NPI based on performance

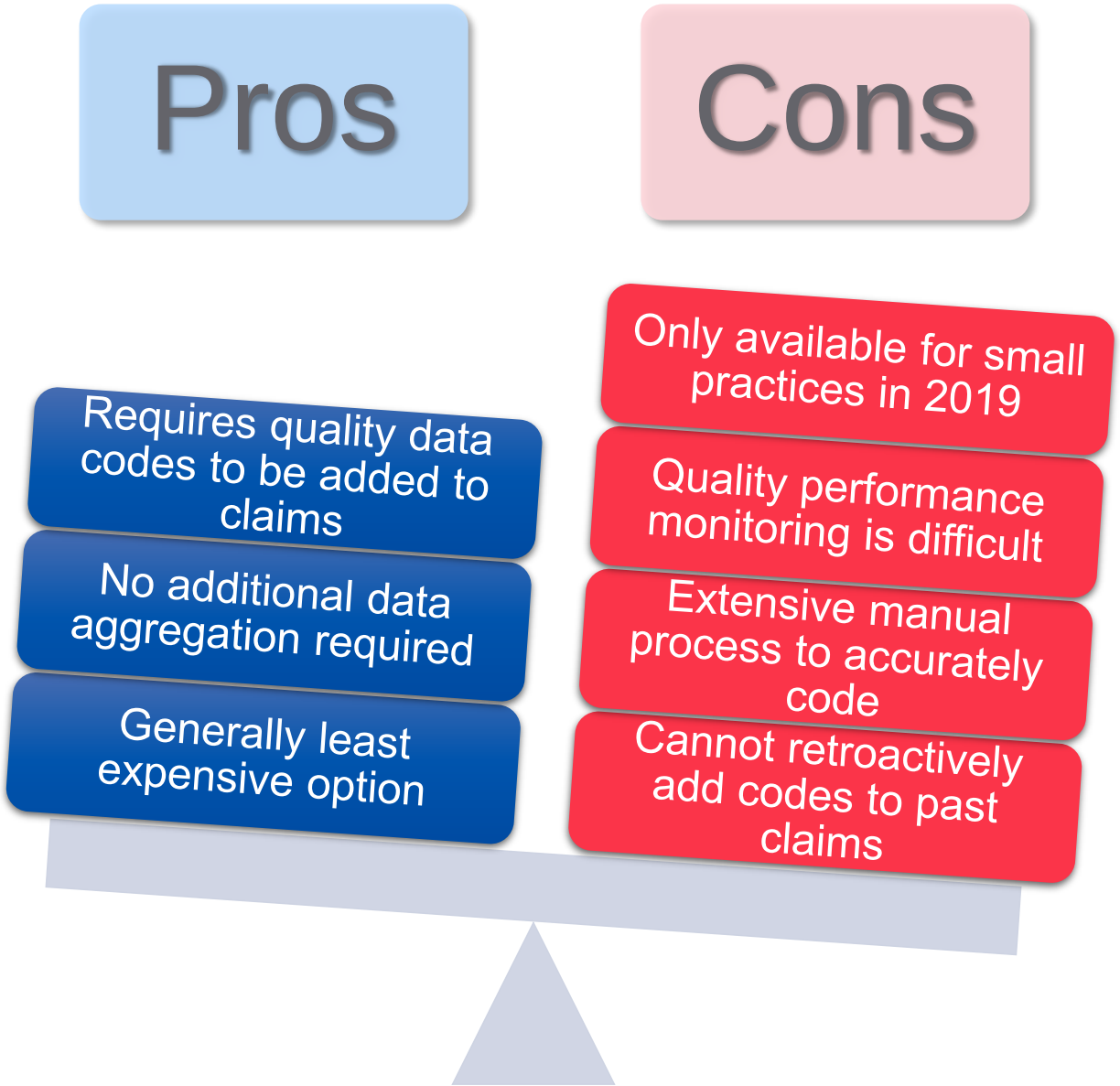
# Data Submission & Collection Types

| Performance Category | Submission Type | Submitter Type | Collection Type |
|---|---|---|---|
| **Quality** | Direct<br>Log-in & Upload<br>CMS Web Interface<br>Medicare Part B Claims (small practice) | Individual/Group<br>3rd Party Intermediary | eCQMs<br>MIPS CQMs<br>QCDR Measures<br>CMS Web Interface Measures<br>CMS Approved Survey Vendor Measure<br>Medicare Part B Claims (small practices)<br>Administrative Claims measures |
| **Cost** | No data submission required | Individual/Group | |
| **Improvement Activities** | Direct<br>Log-in & Upload<br>Log-in & Attest | Individual/Group<br>3rd Party Intermediary | |
| **Promoting Interoperability** | Direct<br>Log-in & Upload<br>Log-in & Attest | Individual/Group<br>3rd Party Intermediary | |

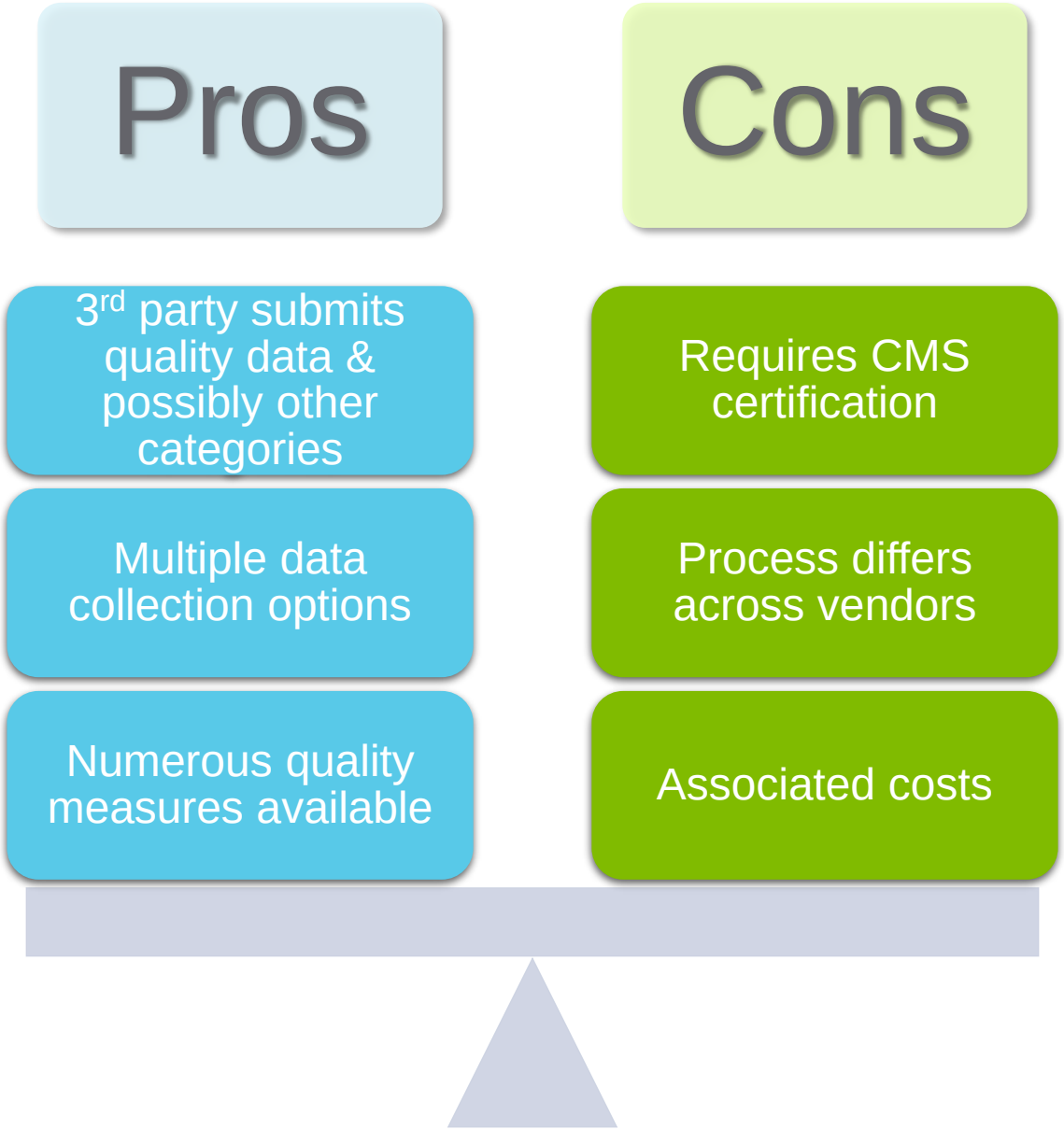
# EHR Collection Type



# Claims Collection Type



# Registry Collection Type

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# 2019 MIPS Performance Category Updates

# QPP Y3: Quality

## % Final Score:

- 45% Weight
- Specialty measure sets
- Flexibility added for Small practices

## Measures:

- Multiple Submission Methods
- Minimum of 6 measures submitted

## Requirements:

- 365-day reporting for PY19 & beyond
- 60% data completeness
- ≥ 1 high priority or outcome measure

## Scoring:

- 6 points – Small Practice Bonus
- Facility-Based Scoring

# QPP Y3: Potential Applicable Measures

**Audiology Recommended Measures**

- **ASHA Recommended Measures:**
  - Documentation of Current Medications in the Medical Record
  - Tobacco Use: Screening and Cessation Intervention
  - Falls: Risk Assessment
  - Falls: Plan of Care
  - Referral for Otologic Evaluation for Patients with Acute or Chronic Dizziness
  - Screening for Depression and Follow-Up Plan

# QPP Y3: Example Quality Measure Specifications

## Documentation of Current Medications in the Medical Record

**Measure Description:** Percentage of visits for patients aged 18 years and older for which the eligible professional or eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter

**Initial Patient Population:** All visits occurring during the 12 month measurement period for patients aged 18 years and older

**Denominator Exclusions:** Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status

| | |
|---|---|
| **Quality ID:** | #130 (eCQM) |
| **Measure Type:** | Process/High Priority |

**Numerator**
Eligible professional or eligible clinician attests to documenting, updating or reviewing the patient's current medications using all immediate resources available on the date of the encounter

**Denominator**
All visits occurring during the 12 month measurement period for patients aged 18 years and older

| Decile 3 | Decile 4 | Decile 5 | Decile 6 | Decile 7 | Decile 8 | Decile 9 | Decile 10 |
|---|---|---|---|---|---|---|---|
| MEASURE TOPPED OUT | | | | | | | |

# QPP Y3: Example Quality Measure Specifications

## Screening for Depression and Follow-Up Plan

**Measure Description:** Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen

**Initial Patient Population:** All patients aged 12 years and older at the beginning of the measurement period with at least one eligible encounter during the measurement period

**Denominator Exclusions:** Patient refuses to participate; Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status; or situations which may impact the accuracy of results

| | |
|---|---|
| **Quality ID:** | #134 (MIPS CQM) |
| **Measure Type:** | Process/High Priority |

**Numerator**

Patients screened for depression on the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen

**Denominator**

All patients aged 12 years and older at the beginning of the measurement period with at least one eligible encounter during the measurement period

| Decile 3 | Decile 4 | Decile 5 | Decile 6 | Decile 7 | Decile 8 | Decile 9 | Decile 10 |
|---|---|---|---|---|---|---|---|
| 4.88 - 10.18 | 10.18 - 17.6 | 17.6 - 28.29 | 28.29 - 42.3 | 42.3 - 56.83 | 56.83 - 73.3 | 73.3 - 87.5 | 87.5+ |

# QPP Y3: Improvement Activities

| % Final Score: | Measures: | Requirements: | Scoring: |
| --- | --- | --- | --- |
| • 15% Weight<br>• Increased Weighting for: Small, Rural, ASC, HPSA & NPF | • Over 114 measures to choose from<br>• All measures are weighted medium unless specified | • At least 90 consecutive days reporting timeframe | • Requires 40 category points for full credit |

# Start-To-Finish IA Implementation Example

Practice XYZ has decided to attest to the activity “Collection & Use of Patient Experience and Satisfaction Data on Access”. This can include formal (CG-CAHPS) or informal patient surveys.

Collection of patient experience and satisfaction data on access to care and development of an improvement plan, such as outlining steps for improving communications with patients to help understanding of urgent access needs.

IA_EPA_3

Medium Weighted Activity

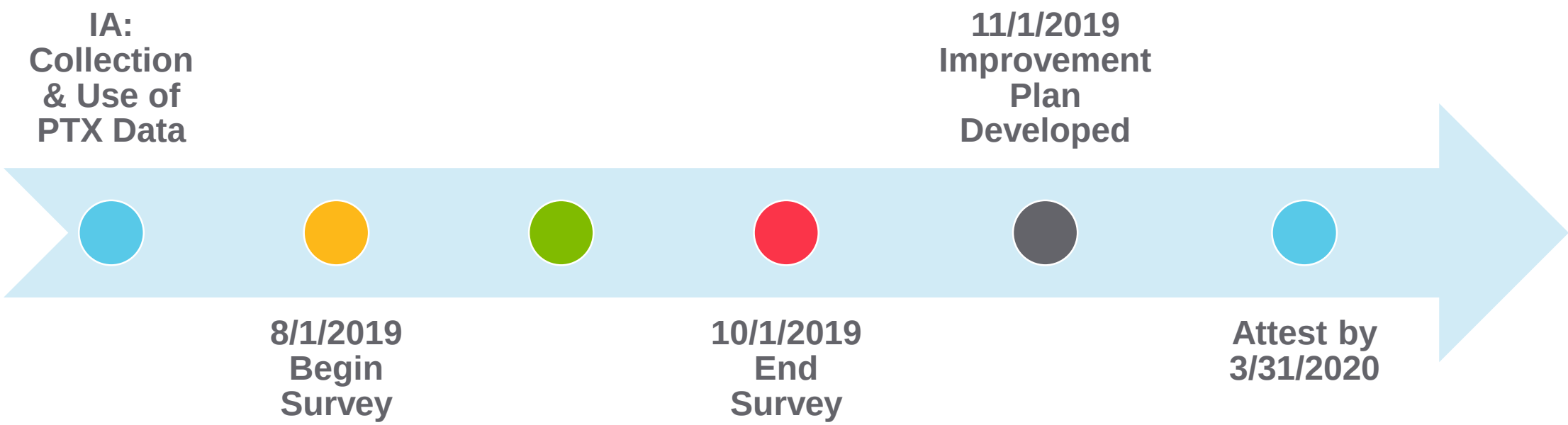
Start: 8/1/2019

End: 11/1/2019

Attestation Due: 3/31/2020

# Start-To-Finish IA Implementation Example

## Chosen Improvement Activity: Collection and Use of Patient Experience and Satisfaction Data on Access (IA_EPA_3)

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# QPP Y3 PI: Overview

## % Final Score:

- 25% Weight
- Automatic reweight for all EC types except Physicians

## Measures:

- Reduced number of objectives
- Exclusions available

## Requirements:

- Use of 2015 CEHRT
- At least 90 consecutive days reporting timeframe

## Scoring:

- Performance-based measurement
- Requires 100 raw category points for full credit

# QPP Y3: PI Objectives & Weight

| Objectives | Measures | Maximum Points |
|---|---|---|
| **e-Prescribing** | e-Prescribing | 10 pts |
| | Bonus: Query of Prescription Drug Monitoring Program | 5 pts bonus |
| | Bonus: Verify Opioid Treatment Agreement | 5 pts bonus |
| **Health Information Exchange** | Support Electronic Referral Loops by Sending Health Information | 20 pts |
| | Support Electronic Referral Loops by Receiving and Incorporating Health Information | 20 pts |
| **Provider to Patient Exchange** | Provide Patients Electronic Access to Their Health Information | 40 pts |
| **Public Health and Clinical Data Exchange** | Choose two of the following:<br>Immunization Registry Reporting<br>Electronic Case Reporting<br>Public Health Registry Reporting<br>Clinical Data Registry Reporting<br>Syndromic Surveillance Reporting | 10 pts |

# QPP Y3: Cost

## % Final Score:

- 15% Weight
- If minimum case threshold not met, reweighted to Quality

## Measures:

- Measure 1: Spending per Beneficiary
- Measure 2: Total per capita costs
- Adding 8 episode-based measures

## Requirements:

- MSPB 35 cases
- TPCC 20 cases
- Procedures 10 cases
- Inpatient 20 cases

## Scoring:

- No improvement scoring
- No submission required

# QPP Y3: Cost Composite Score

| | Type | Cost Measure | Definition/Attribution | Case Minimum |
|---|---|---|---|---|
| Cost Composite Score | MSPB | Medicare Spending Per Beneficiary (MSPB) | All Part A & B costs surrounding a hospital stay up to 3 days prior through 30 days following discharge. | 35 Cases |
| | TPCC | Total Per Capita Cost (TPCC) | Assigned to clinician groups providing primary care services. All Part A & B Costs of all attributed beneficiaries. | 20 Cases |
| | Procedures | Elective Outpatient PCI | Attributed to each MIPS EC who renders a triggering service as identified by HCPCS/CPT codes. The clinician rendering the service(s), or the organization the clinician is billing under for the service(s) provided, is identified on the Part B Physician/Supplier claim. | 10 Cases |
| | | Knee Arthroplasty | | |
| | | Revascularization for Lower Extremity Chronic Critical Limb Ischemia | | |
| | | Routine Cataract Removal with IOL Implantation | | |
| | | Screening/Surveillance Colonoscopy | | |
| | In-Patient | Intracranial Hemorrhage or Cerebral Infarction | Episodes are attributed to each MIPS EC who bills inpatient E&M claim lines during a trigger inpatient hospitalization under a TIN that renders at least 30% of the inpatient E&M claim lines in that hospitalization. | 20 Cases |
| | | Simple Pneumonia with Hospitalization | | |
| | | STEMI with PCI | | |

# Bonus Opportunities

## Complex Patient Bonus

- Up to 5 pts added to final score

## Quality

- Improvement Scoring
- End-to-End Electronic
- Additional High Priority / Outcome

## Small Practice

- Addition of 6 pts to numerator of Quality

## Promoting Interoperability

- 5 pts for Opioid Treatment Agreement
- 5 pts consulting PDMP

# 2019 MIPS: Public Reporting

## Quality

- 1st year Quality measures will not be publicly reported for the first two years in use, starting with Performance Year 2

## Cost

- 1st year Cost measures will not be publicly reported for the first two years in use

## PI

- Includes an indicator of "Successful"
- A "high-performing" indicator will not be reported

## IA

- 1st year IAs will be publicly reported if all other public reporting criteria are satisfied

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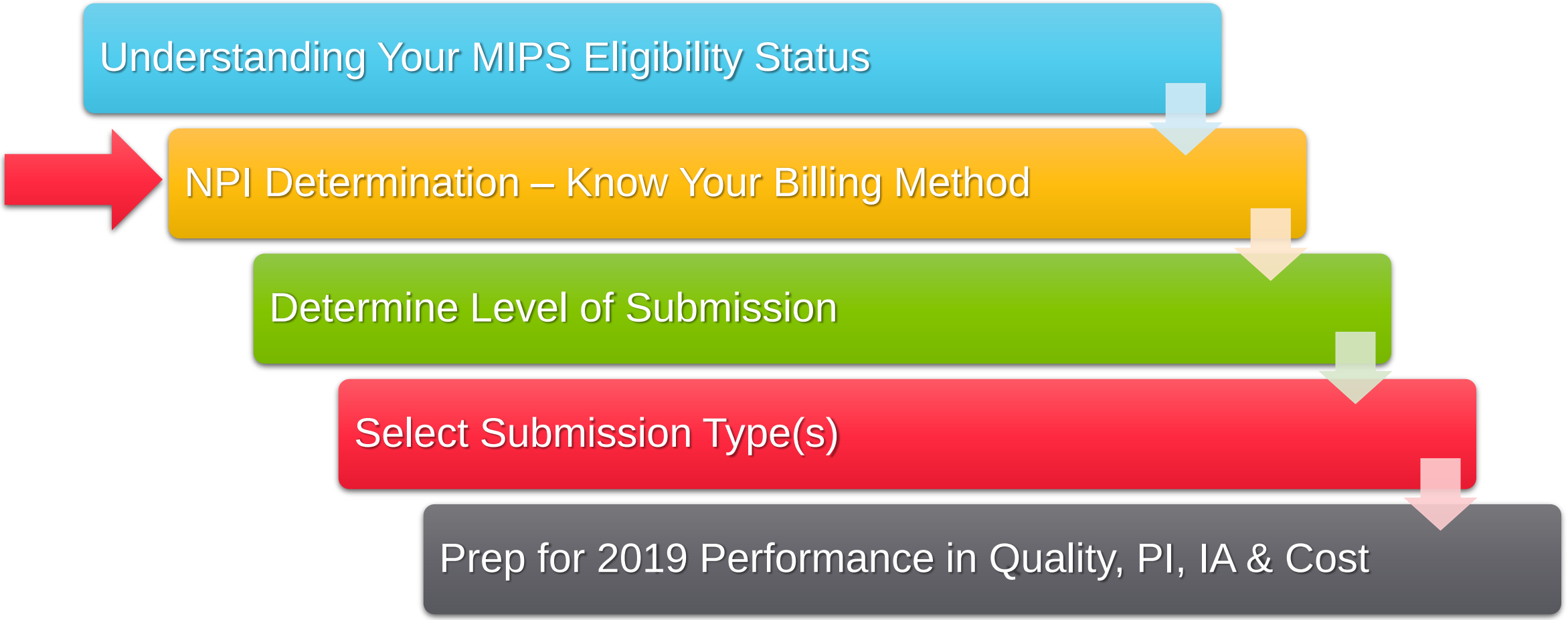
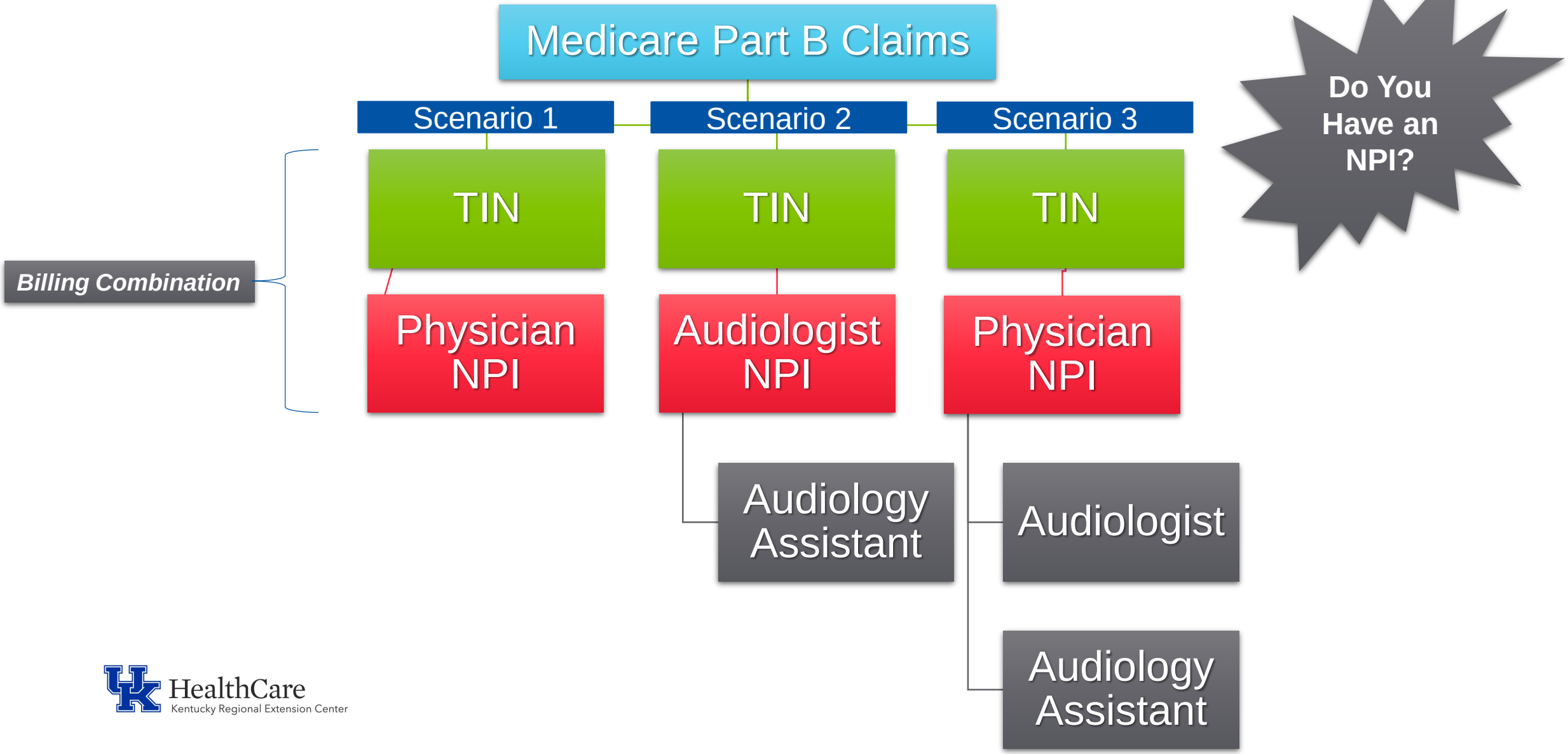
# Audiologists' Next Steps

# Audiologists' Next Steps



# Individual Eligibility

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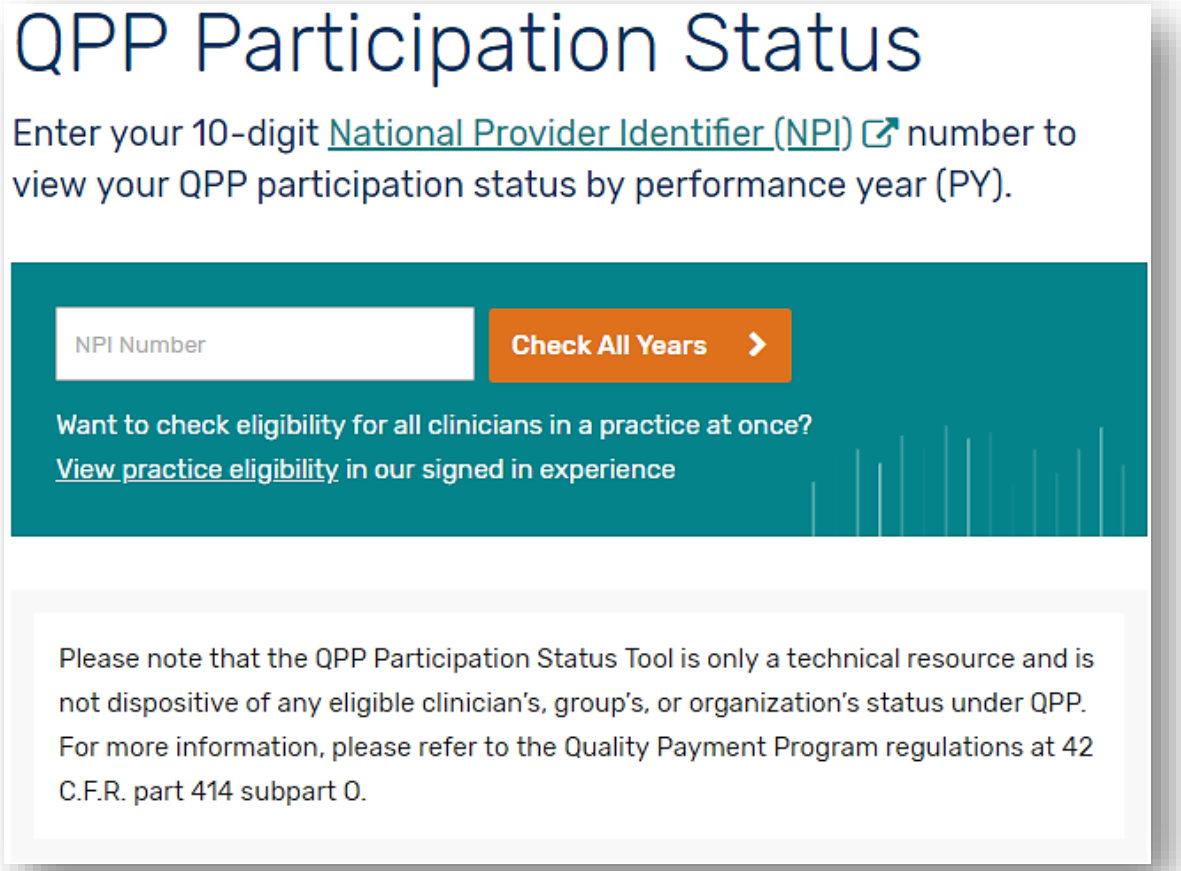
# QPP Participation Status Lookup

https://qpp.cms.gov/participation-lookup




## Requirements

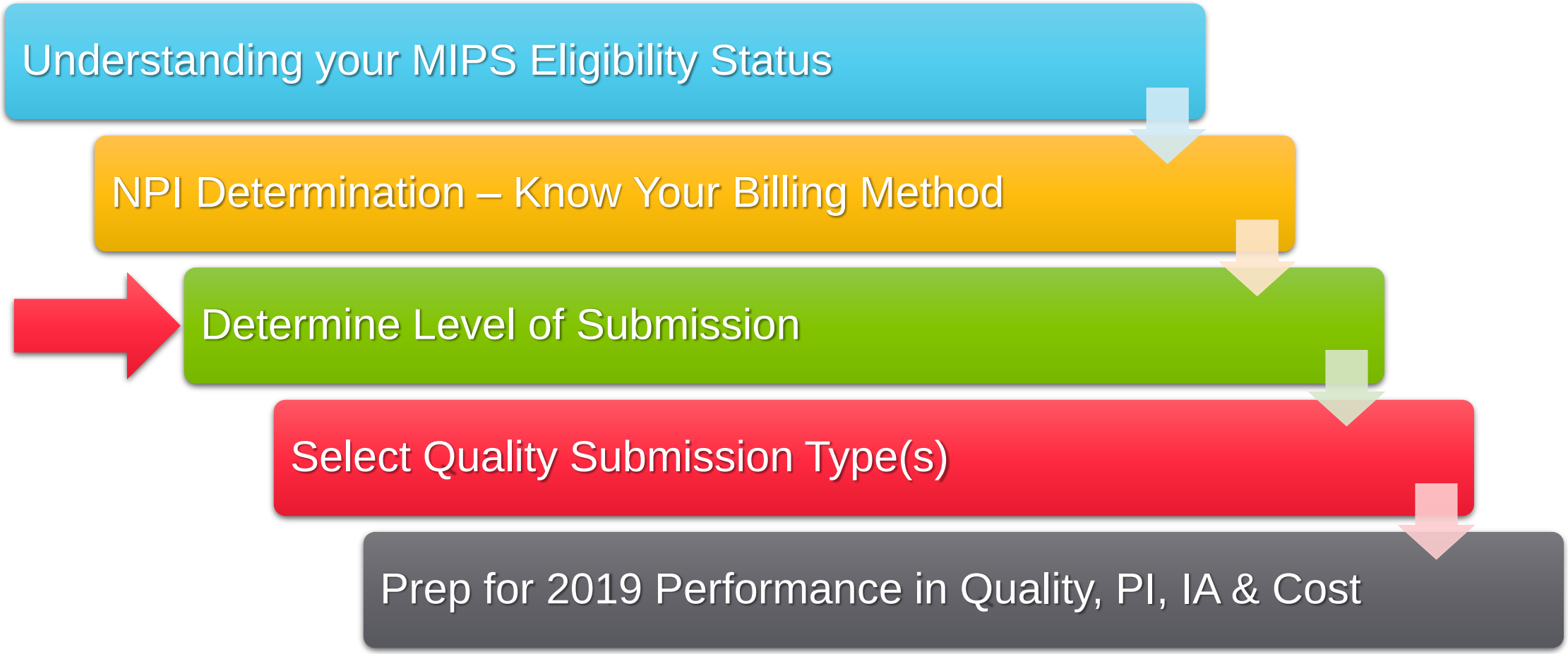
Active NPI tied to a TIN

## User/Role

Allows anyone to look up a Medicare NPI to determine eligibility status

Database updated 2x-3x per year

# Audiologists' Next Steps



# QPP Y3: Group vs. Individual

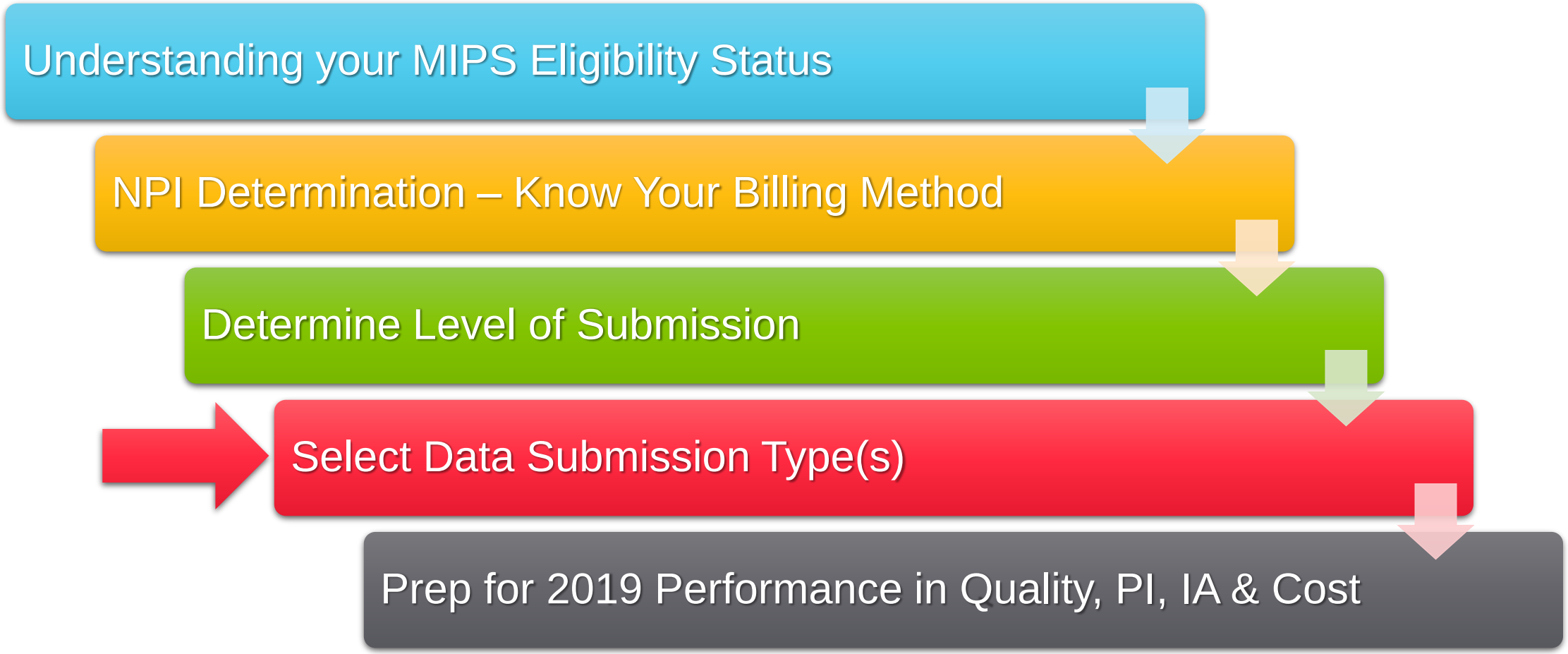
## Group

- **Quality:** Must include all clinicians under TIN
- **Promoting Interoperability:** Must include all clinicians on certified EHR
- **Improvement Activities:** Only one EC has to perform activity, covers group
- **Payment Adjustment:** Same across TIN

## Individual

- **Quality:** Submission for each EC
- **Promoting Interoperability:** Submission for each EC
- **Improvement Activities:** Submission for each EC
- **Payment Adjustment:** Different for each NPI based on performance

# Audiologists' Next Steps



# Data Submission Types

| Performance Category | Submission Type | Submitter Type | Collection Type |
|---|---|---|---|
| **Quality** | Direct<br>Log-in & Upload<br>CMS Web Interface<br>Medicare Part B Claims (small practice) | Individual/Group<br>3rd Party Intermediary | eCQMs<br>MIPS CQMs<br>QCDR Measures<br>CMS Web Interface Measures<br>CMS Approved Survey Vendor Measure<br>Medicare Part B Claims (small practices)<br>Administrative Claims measures |
| **Cost** | No data submission required | Individual/Group | |
| **Improvement Activities** | Direct<br>Log-in & Upload<br>Log-in & Attest | Individual/Group<br>3rd Party Intermediary | |
| **Promoting Interoperability** | Direct<br>Log-in & Upload<br>Log-in & Attest | Individual/Group<br>3rd Party Intermediary | |

# Audiologists' Next Steps

- Understanding your MIPS Eligibility Status
- NPI Determination – Know Your Billing Method
- Determine Level of Submission
- Select Data Submission Type(s)
- Prep for 2019 Performance in Quality, PI, IA & Cost

# Things To Consider

- Quality is a performance-heavy category
- Submission options for Quality are based on system/process capabilities
- Cost will also play a role, but is not a category for which you are required to send data
- The minimum threshold to avoid penalty will rise each year and is eventually expected to be based on the mean or median of all scores by Program Year 2020
- Use your HARP account to gain access to the QPP Submission Portal, where you will be able to connect to a practice or provider using their TIN and associated PTAN information

# Additional Takeaways

## Know Your Eligibility

- Verify Eligibility Status
- Multiple “Snapshots” = Opportunity for Status Change
- Know EC Special Statuses

## Select Your Measures & Track Them Early

- Choose Quality Measures & Improvement Activities Relevant to Practice
- Cross-cutting Measures are Available
- Monitor PI & Quality to Ensure Data Accuracy

# Value-Based Payment Support Services

- **QPP SURS Technical Assistance:**
  Free, high-level resources for organizations with 15 or fewer eligible clinicians as they navigate the Quality Payment Program. The Resource Center include: straightforward, self-directed resources and tools, up-to-date materials, and access to expert Quality Improvement Advisors.
  Sign up: www.qppresourcecenter.com

- **VBP Individualized Assistance:**
  12 months of planning and transformation support tailored to meet specific client needs and support success in value-based payment. This includes current state analysis, recommendations for action, collaborative goal setting and project planning, education, strategic decision support and ongoing advisory services.

- **Advanced APM Support:**
  Ongoing support, research, work plan development and application support for transition to advanced alternative payment models (APM).

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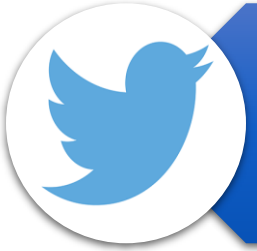

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# QPP Y3: Questions

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