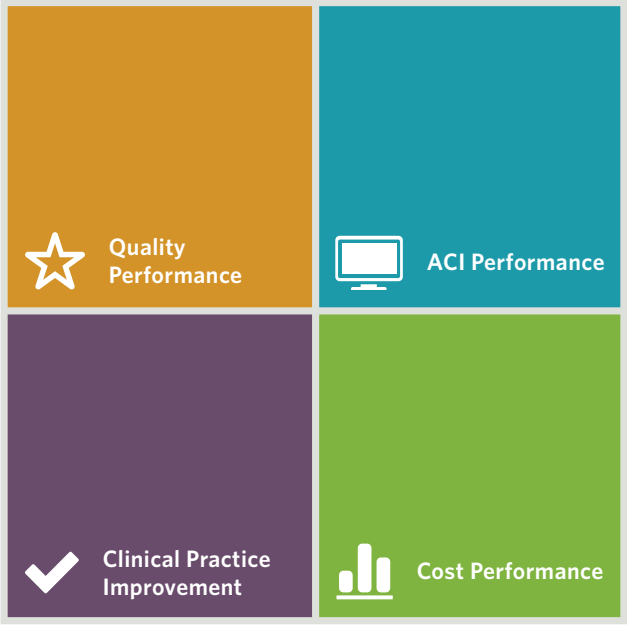
2018

Quality Payment Program



AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY FOUNDATION

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 replaced the Sustainable Growth Rate methodology and created the **Quality Payment Program (QPP)**, which began in 2017. This represents a major change to the way physicians receive payment for providing Medicare services, with the goal of rewarding value over volume.

The QPP contains two pathways for participation: the Merit-based Incentive Payment System (MIPS) and the Advanced Alternative Payment Model (APM) program.

Most AAO-HNS members will participate in QPP via MIPS. The AAO-HNS has developed this summary of the QPP to provide members with high-level information, primarily on MIPS, and the changes to the program in year two.

MIPS

Components: MIPS combines and replaces the previous Medicare quality programs into one comprehensive initiative. The MIPS program includes four performance categories:

- Quality (formerly Physician Quality Reporting System, PQRS);
- Advancing Care Information (ACI) (formerly the Medicare EHR Incentive or Meaningful Use);
- Improvement Activities (IA); and
- Cost (formerly Value-based Payment Modifier program).

Scoring: In year two, CMS will use a composite score of all four categories to calculate a final MIPS score. By participating, physicians can receive a bonus payment or a payment reduction.

- A MIPS score of 15 avoids the negative adjustment; a score of 70+ earns the exceptional performance bonus.
- The penalty for not participating for the 2018 reporting period has increased to five percent, and over time, the maximum penalty will continue to increase. (See timeline below)
- 2020 payment adjustments will be based on 2018 reporting.

APMs

Qualifying APM Participants (QPs) who are part of Advanced APMs may be exempted from MIPS reporting and receive a five percent lump sum bonus.

2018 Performance Year	**March 31, 2019** Data Submission	**Feedback**	**January 1, 2020** Payment Adjustment
Performance period opens January 1, 2018 Closes December 31, 2018 Clinicians care for patients and record data during the year	Deadline for submitting data is March 31, 2019 Clinicians are encouraged to submit data early	CMS provides performance feedback after the data is submitted Clinicians will receive feedback before the start of the payment year	MIPS payment adjustments are prospectively applied to each claim beginning January 1, 2020

Does MIPS apply to me?

Certain Medicare participating providers are **exempt** from MIPS reporting including:

1	Providers meeting the low-volume threshold *(Exemption identified by entering NPI number at* **qpp.cms.gov/participation-lookup***)*
2	Participants in an Advanced APM
3	First-year Medicare providers
4	Clinicians in areas affected by Hurricanes Harvey, Irma, and Maria

MIPS Changes in 2018

Change to the Low Volume Threshold	Excludes providers who have less than or equal to $90,000 in Medicare allowed charges or 200 beneficiaries.
Includes Virtual Group Reporting	Defines virtual groups as solo practitioners and groups of 10 or fewer Eligible Clinicians (ECs) who come together "virtually" to participate in MIPS for a performance year.
Adds Accommodations for Small Practices	Adds five bonus points for ECs in small practices, 15 or fewer clinicians, assuming data is submitted in at least one performance category.
Increases Bonus Points for Care of Complex Patients	Adds five bonus points for clinicians who treat complex patients *(previously three points)*.
Adjusts the Performance Threshold	Threshold is set at 15 points, instead of three points in 2017, in order to avoid penalty and receive a neutral score.

The Quality performance category counts toward 50 percent of the final MIPS score. It replaces the previous Medicare quality reporting program, PQRS.

The performance period for the Quality category is a full calendar year.

Clinicians receive three to 10 points on each measure based on performance against benchmarks. There is a possibility to earn bonus points.

MAXIMUM POSITIVE PAYMENT ADJUSTMENT

270+ measures are available for reporting.

Clinicians must report on six quality measures for a full year.

Of those six measures, one must be either an outcome measure or a high-priority measure if an outcome measure is not applicable.

May also select specialty-specific set of measures.

Clinicians and Groups Can Report the Quality Performance Category via:

- Administrative Claims
- Claims
- Comma Separated Value (CSV)
- CMS Web Interface
- Electronic Health Record (EHR)
- Registry
- Qualified Clinical Data Registry (QCDR)

Reg-ent℠
ENT CLINICAL DATA REGISTRY

Reg-ent is the only otolaryngology-specific Qualified Clinical Data Registry (QCDR) focused on quality improvement and patient outcomes.

As a QCDR, Reg-ent can accommodate all required reporting for MIPS 2018 performance categories including Quality, Advancing Care Information (ACI), and Improvement Activities (IA).

Submission to CMS will be completed through the Reg-ent dashboard. The Reg-ent dashboard will provide visual representation to display performance for all three required reporting categories and generate score estimates.

2018 QUALITY **measures**

The measures in Reg-ent include 19 QCDR specialty measures developed by the AAO-HNSF available only in Reg-ent and 44 publicly available Quality Payment Program (QPP) measures.

To learn more about Reg-ent, visit **www.reg-ent.org** and contact **reg-ent@entnet.org**.

Visit **www.entnet.org/2018-measures** to view the full list of quality measures available for MIPS 2018 reporting through Reg-ent.

For any quality or measure specific questions, please contact **qualityimprovement@entnet.org**.

The Advancing Care Information (ACI) performance category counts toward 25 percent of the final MIPS score. This category modifies and replaces the previous Electronic Health Record Incentive program known as Meaningful Use.

The ACI performance period is any continuous 90-day period within the calendar year.

Clinicians must use certified electronic health record technology (CEHRT), either 2014 or 2015 edition, to report ACI.

Scoring is based on key measures of health IT interoperability and information exchange.

NEW for 2018

Expands ACI automatic exception for hospital-based clinicians to include those who furnish 75 percent or more of their covered services in an off-campus outpatient hospital setting.

Creates an additional exemption from the ACI category for Ambulatory Surgery Center (ASC)-based physicians.

Creates an ACI significant hardship exemption to include small practices.

Providers can determine if they are classified as a small practice or are considered hospital- or ASC-based by using the MIPS Participation Status tool: **https://qpp.cms.gov/participation-lookup**.

Clinicians are required to report on base measures or receive a score of zero.

Base measures account for 50 points of the total ACI score.

OBJECTIVE:	REQUIRED (BASE) MEASURE:
Protect Patient Health Information	Security Risk Analysis
Electronic Prescribing	E-Prescribing
Patient Electronic Access	Provide Patient Access
Health Information Exchange	Send a Summary of Care Measure
	Request/Accept Patient Care Record Measure

Clinicians report on additional measures to receive an ACI performance score (up to 90 points).

There are two measure set options for reporting. ECs can report using the 2014 edition, 2015 edition, or a combination of both.

For those using 2014 Certified EHR Technology

- Advancing Care Information Transition Objectives and Mesasures
- Combination of the measure sets

For those using 2015 Certified EHR Technology

- Advancing Care Information Objectives and Mesasures
- Combination of the measure sets
- 10 percent bonus

ECs can choose to report additional measures for up to an additional 15 points.

CLINICAL PRACTICE IMPROVEMENT PERFORMANCE CATEGORY

The Clinical Practice Improvement Activities (CPIA) category counts toward 15 percent of the final MIPS score. CPIA represents a new performance category in MIPS.

Clinicians are required to attest completion to up to four improvement activities that are selected from a list of 112 activities.

Each activity is assigned a point value:		
	High weight activities →	20 points
	Medium weight activities →	10 points

Only two improvement activities need to be reported to obtain a full performance score for small, rural, or underserved practices. Activities must include at least one high weighted activity.

The performance period for 2018 is a minimum of a continuous 90-day period within the calendar year.

CPIA performance data can be reported by simple attestation via a QCDR such as Reg-ent℠, traditional registry, EHR, or the QPP Data Submission System.

COST PERFORMANCE CATEGORY

The Cost performance category counts toward 10 percent of the final MIPS score.

It replaces the previous Value-Based Payment Modifier (VM).

Like the VM, the MIPS Cost category is designed to reward physicians for cost-effective care and efficient use of Medicare resources.

The performance period is the full calendar year.

There are no reporting requirements for the Cost category. CMS will calculate cost measures of a clinician's performance using administrative claims data.

CMS Will Base the Cost Performance Category Score on Two Measures:

1	Total per capita cost for all attributed beneficiaries measure	2	Medicare spending per beneficiary (MSPB) measure

→ If both measures apply, the cost score will be averaged between the two measures.

→ If only one measure applies, it will serve as the performance category score.

For questions, please contact **www.entnet.org/pmi**.