

AAO-HNS/F MIPS Reporting



AMERICAN ACADEMY OF
OTOLARYNGOLOGY-
HEAD AND NECK SURGERY

FOUNDATION



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WHAT IS THE QUALITY PAYMENT PROGRAM (QPP)?

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 created the **Quality Payment Program (QPP)**, containing two pathways for participation: the Merit-based Incentive Payment System (MIPS) and the Advanced Alternative Payment Model (APM) program. Both payment programs began January 1, 2017.

In 2017, CMS will base an eligible clinician's (ECs) composite performance score (CPS) based on reporting from three categories: quality, advancing care information (ACI), and improvement activities.

All physicians, physician assistants, nurse practitioners, clinical nurse specialists, or certified registered nurse anesthetists who bill Medicare must participate in MIPS, unless they qualify for an exemption, do not meet

Important Information to Keep in Mind

Qualifying APM Participants (QPs) who are part of Advanced APMs may be exempted from MIPS reporting and receive a 5 percent lump sum bonus.

ADVANCED APMs MUST:

- Use certified EHR technology
- Provide payment for covered professional services
- Be a Medical Home Model or bear more than a nominal financial risk.

CMS will publish a list of all qualifying Advanced APMs annually.

the minimum reporting threshold, or are part of an Advanced APM.

CMS will use a CPS to determine if an EC will receive a bonus payment or be subject to a payment reduction.

2019 payment adjustments will be based on 2017 reporting.

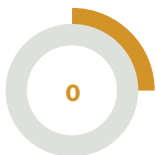
2017 Reporting Options

Don't Participate



Do not submit **any** data after January 1, 2017
-4% payment adjustment

Test Pace



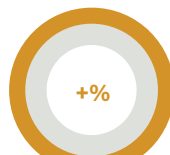
Submit **some** data after January 1, 2017
Avoid negative payment adjustment

Partial



Report one or more measures for a 90-day period after January 1, 2017
Small positive payment adjustment

Full



Report on all categories for at least any 90 consecutive days in 2017
Modest positive payment adjustment

Participate in an Advanced APM



Some practices may choose to participate in an Advanced Payment Model in 2017

- Partial and full participation may result in higher payments in 2019.
- ECs who do not submit data will receive a score of zero and be subject to payment reduction

WHAT IS THE MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) PROGRAM?

The MACRA of 2015 replaced the Sustainable Growth Rate (SGR) and created the QPP. One component of the QPP is the **Merit-based Incentive Payment System (MIPS)**. ECs will report in MIPS in 2017 and have three reporting options: a test pace, partial year, or full year reporting.

Important Information to Keep in Mind

ECs and groups are given a composite performance score on a scale of 1 - 100 based on reporting and scores from each performance category.

ECs with a final score of 4 - 69 will receive a positive adjustment, and ECs who receive a final score of 70 or higher are eligible for additional bonuses determined on a linear sliding scale, starting at 0.5 percent.

IMPORTANT DATES MOVING FORWARD:

2017

January 1, 2017
First performance period opens

October 2, 2017
To be eligible for the maximum positive payment adjustment, begin submitting data before this date

December 31, 2017
First performance period closes

2018

March 31, 2018
Final date to submit 2017 performance data




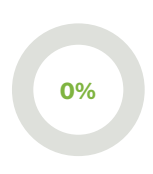
2019

January 1, 2019
First payment adjustments based on 2017 performance data go into effect

Reg-entSM and MIPS Reporting:

Reg-ent, the AAO-HNSF's clinical data registry, will allow participants to report the required 2017 MIPS performance categories below.

MIPS Performance Categories for 2017

| QUALITY | ADVANCING CARE INFORMATION (ACI) | IMPROVEMENT ACTIVITIES | COST* |
|--|--|---|--|
|  <p>60%</p> <p>Replaces Physician Quality Reporting Systems and quality component of the Value-Based Payment Modifier (VM) program</p> <p>ECs select from 300 measures to report on six; these can be specialty measures</p> |  <p>25%</p> <p>Replaces the Medicare Electronic Health Record (EHR) Incentive Program</p> <p>Requires use of EHR technology - 2014, 2015, or combination</p> |  <p>15%</p> <p>This is a new category</p> <p>ECs select from a list of over 90 activities to receive credit</p> |  <p>0%</p> <p>Replaces the cost component of the VM Program</p> <p>Score is based on Medicare claims</p> <p><i>* ECs will still receive feedback on their cost performance in 2018.</i></p> |



WHAT IS THE QUALITY PERFORMANCE CATEGORY?

In 2017, the quality performance category counts toward 60 percent of an EC final MIPS composite performance score (CPS). Failure to submit performance data for a quality measure results in zero points for quality.

Clinicians may refer to the Otolaryngology measure set to identify applicable measures. Clinicians receive 3 – 10 points on each measure based on performance against benchmarks. There is a possibility to earn bonus points. Groups in APMs qualifying for special scoring under MIPS report quality through the APM.

Important Information to Keep in Mind

If a clinician is unable to report and the quality performance category is reweighted to zero, the improvement activities and advancing care information (ACI) categories will **both be increased to 50 percent** of the final MIPS CPS.

If the ACI performance category is reweighted to zero percent due to a significant hardship, CMS will redistribute the percentage to the quality performance category, **increasing the quality performance category from 60 percent to 85 percent** of the final MIPS CPS.

The quality performance category weight **decreases to 50 percent** for 2018 reporting.

CMS will publish the list of quality measures available for reporting by November 1 of each year.

| | | |
|---|--|---|
| <p>TEST PACE REPORTING PERIOD</p> | <p>Report a single measure at any point to avoid a negative payment adjustment.</p> | <p>Clinicians and groups can report the quality performance category via:</p> <ul style="list-style-type: none"> ■ Administrative Claims ■ Claims ■ Comma Separated Value (CSV) ■ CMS Web Interface ■ Electronic Health Record (EHR) ■ Registry ■ Qualified Clinical Data Registry (QCDR) |
| <p>MAXIMUM POSITIVE PAYMENT ADJUSTMENT</p> | <p>Clinicians must report on six quality measures for a minimum of 90 days. Of those six measures, one must be either an outcome measure or a high-priority measure if an outcome measure is not applicable.</p> | |
| <p>GROUPS USING THE WEB INTERFACE</p> | <p>Must report 15 quality measures for a full year.</p> | |





WHAT IS THE ADVANCING CARE INFORMATION (ACI) PERFORMANCE CATEGORY?

In 2017, ACI counts toward 25 percent of an EC final MIPS composite performance score (CPS).

Clinicians must use certified EHR technology (CEHRT) to report ACI.

Important Information to Keep in Mind

Hospital-based MIPS ECs may report under the ACI performance category.

ECs who are unable to report ACI measures due to a significant hardship can apply to have their ACI score weighted to zero. If the ACI score is reweighted to zero, CMS **will increase quality from 60 percent to 85 percent** of the final score to offset the difference.

If the quality category is reweighted to zero, the **ACI category will each be increased to 50 percent**.

1

ECs 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 → Electronic Prescribing

Patient Electronic Access → Patient Access Measure

Health Information Exchange → Send a Summary of Care Measure

→ Request/Accept Patient Care Record Measure

2

ECs 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

- 2017 Advancing Care Information Transition Objectives and Measures
- Combination of the measure sets

For those using EHR Certified to the 2015 Edition

- Advancing Care Information Objectives and Measures
- Combination of the measure sets

3

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





WHAT IS THE IMPROVEMENT ACTIVITIES PERFORMANCE CATEGORY?

In 2017, the improvement activities category counts toward 15 percent of an EC and group's final MIPS composite performance score (CPS).

For 2017, clinicians choosing the test pace reporting period can report one performance improvement activity to avoid a negative payment adjustment.

ECs and groups attest to completing up to four improvement activities, which are selected from a list of over 90 activities.

Participants in different settings may have different reporting requirements, as seen below.

Important Information to Keep in Mind

The maximum number of points is 40.

Medium weighted activities are 10 points per activity and high weighted activities are 20 points.

For small, rural, or underserved practices, or for practices with non-patient facing clinicians or groups, medium weighted activities are 20 points per activity and high weighted activities are 40 points per activity.

If the quality category is reweighted to zero, the improvement activities and advancing care information (ACI) categories **will both be increased from 25 percent to 50 percent** of the final MIPS CPS.

MOST PARTICIPANTS

Attest completion of **up to 4 improvement activities** for a minimum of 90 days

Practices with 15 or fewer participants or practices located in a rural or health professional shortage area

Attest completion of **up to 2 activities** for a minimum of 90 days

Participants in certain APMs under the APM scoring standard, such as Shared Savings Program Track 1 or the Oncology Care Model

Automatically receive points based on the requirements of participating in the APM. This assigned score will be full credit for all current APMs under the APM scoring standard.

Participants in certain APMs under the APM scoring standard, such as Shared Savings Program Track 1 or the Oncology Care Model

Automatically earn full credit

Participants in any other APM

Automatically earn half credit and may report additional activities to increase score





WHAT IS THE COST PERFORMANCE CATEGORY?

In 2017, cost does not count toward an EC's final MIPS score and will not affect 2019 payments.

However, CMS will still provide feedback on an EC's performance in this category in 2018, which will be similar to current Quality and Resource Use Reports (QRURs).

The cost performance category will not count toward the MIPS composite performance score in 2017; ECs are not required to report cost for 2017.

CMS will use claims data to determine a score for cost.

In 2018, CMS will start using the cost category to determine EC payment adjustment.

Important Information to Keep in Mind

CMS will provide ECs with reports on their 2017 cost performance, which will be similar to the Quality and Resource Use Reports (QRURs).

CMS will use existing Value-based Payment Modifier formulas in addition to newly developed episode-based measures and patient relationship categories to calculate the cost performance score in future years.



Cost Performance
Category Score

=

POINTS ASSIGNED FOR SCORED MEASURES

10 X NUMBER OF SCORED MEASURES

Cost Performance Category's Impact on Final MIPS Score

2017

ECs are not required to report cost for 2017.



2018



2019



WHAT IS THE ADVANCED ALTERNATIVE PAYMENT MODEL (APM) PROGRAM?

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 replaced the Sustainable Growth Rate (SGR) and created the Quality Payment Program (QPP). One component of the QPP is the **Advanced Alternative Payment Model (APM) program.**

Model (APM) program.

In 2017, Eligible Clinicians (ECs) can participate in a CMS defined Advanced APM and seek Qualifying APM Participants (QPs) status or participate in a MIPS APM and receive favorable MIPS scoring.

Qualifying APM Participants (QPs) are clinicians who meet or exceed the minimum Advanced APM payment or patient participation thresholds.

Important Information to Keep in Mind

THRESHOLD SCORE: Advanced APM participants will earn the 5 percent incentive payment in 2019 for participation in 2017 if they:

- Receive 25 percent of Medicare Part B payments through an Advanced APM, or
- See 20 percent of Medicare patients through an Advanced APM



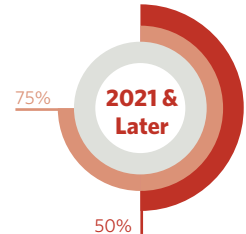
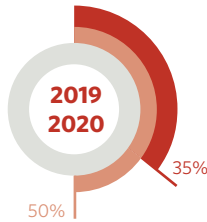
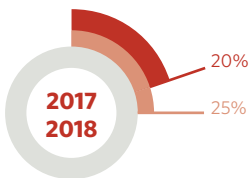
Advanced APM participation requirements increase annually

PERFORMANCE PERIOD: During QP Performance Period, CMS assesses EC Advanced APM participation to determine if they reach QP status for the payment year. The performance period for 2019 will take place from January 1, 2017, through August 31, 2017.

- During the performance period, CMS will take three "snapshots" (March 31, June 30, and August 31) to determine which ECs have met the QP thresholds.
- Meeting the QP threshold **at any one of the three** snapshots results in QP status. ECs will be notified of their QP status after each snapshot.

Requirements for Incentive Payments for Significant Participation in Advanced APMs

(Clinicians must meet patient or payment requirements.)



- Percentage of **PATIENTS** required through an Advanced APM
- Percentage of **PAYMENTS** required through an Advanced APM