QPP in the Real Word: How Your Peers Are Achieving Success

Monday, September 25, 2017
3:00 – 4:30 PM ET
Meet Your Speakers

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QPP in the Real World:
How Your Peers are Achieving Success

Monday, September 25, 2017
Disclaimer

This material was prepared by the New England Quality Innovation Network-Quality Improvement Organization (QIN-QIO), the Medicare Quality Improvement Organization for New England, 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.
Overview

- QPP Overview
- Eligibility
- Pick Your Pace
- Guided Conversation
  - Coastal Medical Inc.
  - Nielsen Eye Care Center
- Resources
- Questions
Acronyms

- **APM** – Alternative Payment Models
- **CMS** – Centers of Medicare & Medicaid Services
- **EHR** – Electronic Health Record
- **MACRA** – Medicare Access & CHIP Reauthorization Act
- **MIPS** - Merit-Based Incentive Payment System
- **IA** – Improvement Activities
- **QPP** – Quality Payment Program
- **MU** – Meaningful Use
- **EC** – Eligible Clinician
- **PQRS** – Physician Quality Reporting System
- **QRUR** – Quality Resource & Use Reports
- **TIN** – Tax Identification Number
- **VBM** – Value Based Modifier
- **ACI** – Advancing Care Information
- **ONC** – Office of the National Coordinator
CMS’s QIO Program Approach to Clinical Quality – Triple Aim:

- QIN-QIOs are regional, multistate entities providing services within 2 to 6 states for 5 year contracts.
Quality Payment Program (QPP)

MIPS

- Physician Quality Reporting System (PQRS)
- Meaningful Use (MU)
- Value-based Modifier (VBM)

Merit-Based Incentive Payment System (MIPS)

APMs

MIPS APMs*

- Medicare Shared Savings Track 1

Advanced APMs

- Medicare Shared Savings Tracks 2 & 3
- Next Generation ACO
- Comprehensive Primary Care Plus
- Comprehensive End-Stage Renal Disease Model
- Oncology Care Model
Check Your Eligibility

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

MIPS Participation Status

To check if you need to submit data to MIPS, enter your 10-digit National Provider Identifier (NPI) number.

If you’re exempt from MIPS with the first review, you won’t need to do anything else for MIPS this year. If you are included in MIPS, you may be exempt with the second review of eligibility determinations at the end of 2017. Learn more about MIPS eligibility.

NATIONAL PROVIDER IDENTIFIER (NPI)  

Check Now

Below is a list of the clinician(s) associated with your TIN, their National Provider Identifier(s) (NPI), and whether they are subject to the Merit-Based Incentive Payment System (MIPS).

Inclusion in MIPS is based on a number of factors, including whether the group or the individual clinician exceeds the low volume threshold criteria. Under this criteria, you will be exempt from MIPS if you bill Medicare less than $30,000 a year or provide care for less than 100 Medicare patients a year.

Note, however, that if your group chooses to report as a group, MIPS assessment will be based on all individuals in the group, and the payment adjustment will include those clinicians who do not exceed the low-volume threshold as individuals.

If you are currently subject to MIPS, please prepare to participate in the program; we will notify you of any changes in your participation status.

This information should be shared with the clinicians associated with your TIN. If you have questions, please call the Quality Payment Program at 1-866-288-8292 (Monday-Friday 8AM-8PM ET). TTY users can call 1-877-775-6222.

TIN  | NPI  | MIPS Participation
---  |------|---------------------
987654321 |  | Included in MIPS; OR
123456789 |  | Included in MIPS
234567891 |  | Exempt from MIPS. Below threshold for Medicare Part B payments or patients
345678912 |  | Exempt from MIPS. Not an eligible provider type.

Please note, clinicians who practice under multiple TINs will be notified at the TIN level of their eligibility and therefore may have different eligibilities for each of their TIN/practice combinations.
## MIPS ‘Pick Your Pace’ Reporting Table

<table>
<thead>
<tr>
<th>Pace Option</th>
<th>Performance Points</th>
<th>Reporting Period</th>
<th>Performance Requirements</th>
<th>Payment Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DO NOTHING</strong></td>
<td>0 Points</td>
<td>Forego reporting entirely</td>
<td>Choose not to report on any measures or activities</td>
<td>Negative 4% payment adjustment</td>
</tr>
<tr>
<td><strong>CRAWL</strong></td>
<td>3 points</td>
<td>Less than 90-day period for quality</td>
<td>Any</td>
<td>One Quality Measure OR One Improvement Activity OR Required Advancing Care Information “Base” Measures</td>
</tr>
</tbody>
</table>
### MIPS ‘Pick Your Pace’ Reporting Table, cont.

<table>
<thead>
<tr>
<th>Pace Option</th>
<th>Performance Points</th>
<th>Reporting Period</th>
<th>Performance Requirements</th>
<th>Payment Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>WALK</td>
<td>4 - 69 Points</td>
<td>Minimum of consecutive 90-day period, Start no later than October 2, 2017</td>
<td>Six Quality Measures (at least one outcome or high priority measure), One to Four Improvement Activities (depending on practice size), Required Advancing Care Information “Base” Measures</td>
<td>Small positive payment adjustment</td>
</tr>
<tr>
<td>RUN</td>
<td>≥ 70 Points</td>
<td>Report for 90-days up to a full calendar year</td>
<td>Six Quality Measures (at least one outcome or high priority measure), One to Four Improvement Activities (depending on practice size), Required Advancing Care Information “Base” Measures</td>
<td>Moderate positive payment adjustment, Opportunity to receive an exceptional performance bonus</td>
</tr>
</tbody>
</table>
Polling Question

Question #1

What is the size of your practice?

a) Solo practice

b) 2-5 clinicians

c) 6-15 clinicians

d) More than 15 clinicians
Polling Question

Question #2

What is your practice type?

a) Internal Medicine/Family Practice

b) Specialty

c) Multi-specialty

d) Hospital-based
Polling Question

Question #3

What reporting pace has your practice chosen?

a) Crawl/Test Pace

b) Walk/Partial Year

c) Run/Full Year

d) I am part of an APM

e) Unsure
Preparing for the Quality Payment Program

Ed McGookin, MD, FAAP
Chief Medical Officer
• 20 locations
• 145 providers
• ~110,000 patients
  • 10,800 Medicare beneficiaries
• 1 EHR
COASTAL MEDICAL TIMELINE

- EHR: 2006
- Pay for Performance: 2007
- PCMH: 2009
- Meaningful Use: 2011
- Shared Savings: 2012
- Accountable Care: 2014
Why Coastal Chose to Become an ACO in 2011

- Two ACO opportunities (MSSP, BCBSRI) on horizon
- The Triple Aim resonated deeply with shared values
- We already had PCMH as a foundation
- All providers were already on a single EHR
- Already doing P4P on quality since 2007
- MSSP included chance for Advanced Payment Model
- We postulated value was being redefined
Looking Ahead

- CPC+
  - 13 practices
  - 123 clinicians
  - PCMH and MSSP ACO work foundational to CPC+

- MSSP Track 1.5
  - Downside risk as a percentage of revenue
Advancing Care Information

• Replacement for Meaningful Use program

• Goals:
  • Simplify reporting requirements
  • Support patient care
  • Create multiple paths to success - flexibility

• Emphasis on interoperability, information exchange and security
Strategies

- Utilize Data-Driven Population Health Management
- Create Systems of Care
- Reduce Variability
Systematize Quality

- Early experience taught us that measuring performance improves quality
- Too many quality measures to track
- Single EHR but multiple methods of documentation
- Data collection disrupted offices at year end
- Gaps in care identified too late to address
- Success required use of structured data fields and a single workflow for each measure
Coastal Medical ($8,455, 94.6%)
MSSP ACO Cost vs. CMS Quality Score for 2015 Performance Year

Coastal Medical
(100%, $8,481)

*ACOs with pay for reporting quality scores have been removed (n=89)

Average Quality Score = 91.44%

Average Cost = $10,360.73
## Population Health Management Metrics

<table>
<thead>
<tr>
<th>Year</th>
<th>Colonoscopy</th>
<th>Mammography</th>
<th>HgbA1c Control (&lt;8%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>67%</td>
<td>86%</td>
<td>57%</td>
</tr>
<tr>
<td>2013</td>
<td>80%</td>
<td>85%</td>
<td>79%</td>
</tr>
<tr>
<td>2014</td>
<td>82%</td>
<td>87%</td>
<td>80%</td>
</tr>
<tr>
<td>2015</td>
<td>87%</td>
<td>87%</td>
<td>81%</td>
</tr>
<tr>
<td>2016</td>
<td>89%</td>
<td>91%</td>
<td>87%</td>
</tr>
</tbody>
</table>
Patient Satisfaction

Coastal met or exceeded the National CAHPS Benchmark Database’s (NCBD) average in 6 out of 7 measures.
Does It Work?

- In 2015:
  - Quality score of 100%
  - $9.7 million reduction in cost of care
- From July 2012 to December 2015:
  - 18% reduction in Emergency Department visits
  - 28% reduction in ED visits resulting in admission
  - 34% reduction in inpatient admissions
  - 17% reduction in readmission rate
  - $24 million aggregate savings over 3 years of MSSP participation
MIPS SUCCESS

Min Cheng, COMT

Director of Clinical & Surgical Services
Nielsen Eye Center

- 3 locations in MA:
  - Quincy, Norwell & Weymouth

- Services provided:
  - General Ophthalmology - Cataract and Refractive (Lasik), and Retina

- 5 MDs, 3 ODs, and 32 ancillary staff
Patient Demographics

- 26,000 total active patients
- 19% yearly revenue from Medicare claims
Previous Reporting Experience

- **PQRS since 2015**
  - Manual attestation through claims
  - No penalty - met criteria

- **Meaningful Use (Stage 2 Modified) 2016**
  - Attested via EHR (MDIntelleSys)
  - Submission accepted
Preparation for MIPS

- 90 day reporting (or more based on reports)
- Considering Group vs Individual Reporting.
  - Want to ensure performance is adequate across the board to achieve high performance
  - Full time and part time doctors are performing similarly well
  - With larger denominator, well-performing doctor’s result diluted by non-performing doctors
- Using Iris Registry for reporting
Quality Measure Selection

- Worked with QIN-QIO to map out current practice to best match with quality measures.

- Will ensure Iris Registry can support selected measures and that workflows are in place to support them.
Quality Measure Selection

Have 7 selected:

- Age-Related Macular Degeneration: Dilated Macular Examination
- Cataracts: Improvement in Visual Function within 90 days post surgery**
- Cataracts: Patient Satisfaction within 90 days post surgery**
- Diabetes Eye Exam
- Diabetic Retinopathy: Communication with Physician Managing Diabetes Care *
- Documentation of Current Medications in the Medical Record *
- Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

*4 Bonus points for 1 additional outcome and 2 additional high priority measures
Advancing Care Information

- Using MDIntelleSys EHR (MDI)
  - ONC 2014 Certified

- ACI Measures:
  - Security Risk Analysis
  - E-Prescribing
  - Provide Patient Access
  - Health Information Exchange
ACI- ePrescribing

Chart Summary
- GENERAL NOTES: None.
- TREATMENT NOTES: 1. Dr.纸质版 OD refer. 2. last HFV 10/12/2016.
- ALLERGIES: None.
- OCULAR MEDS: Artificial Tears 1 gtt pm OU (Chinese Brand), Baby Shampoo Lid Scrubs OU, Contact 1 gtt bid OU.
- PROCEDURE NOTES:
- PACHYMETER: (2/7/2016) OD: 2.
- IOL Master FINDINGS OD: FINDINGS OS:
- MIR DRY (8/16/2017): OD: -1.25Sph = +0.75 x 001 = +0.75.
- WEARS DIST. (11/16/2016): OD: -0.25Sph. OS: -1.75 x 125 x 007.

Encounter Summary
- REASONS FOR VISIT: Follow up - Astigmatism, Regular, Myopia, New Uncomplicated Myopia OD.
- PRIMARY: Astigmatism, Regular, Myopia, New Uncomplicated Myopia OD.
- SECONDARY: Hyperopia OS.
- FOLLOW UP:
- DISCUSSION: All questions answered and patient understands. Patient understands condition, prognosis and need for follow-up care. Advised against heavy lifting, bending, or straining. Advised on how to decrease risk of spread. Advised to increase Omega 3 fatty acids in diet or take supplements. 2.4 grams a day. Advised regular use of...
ACI- ePrescribing (2)
ACI- ePrescribing (3)
ACI- Provide Patient Access (Portal)

- **New Workflow**
  - Front desk prints portal codes & hands to patients at check-in
  - If patient says no, leave it in the sleeve, technician takes patient into room and explain the importance again.
  - Technician will assist with sign up if they can using a default password (last name + birth year)
  - Entire practice uses one email address for doctor’s business cards, Surgical Coordinator's business cards. Any email we receive we respond by directing them to sign up on Portal with code(email in Draft folder, c/p individual code)

- **Portal allows for:**
  - Summary of visit
  - Request for refills and appointments
  - Communication with provider
Improvement Activities

- **Goal**: better engage 2 key departments
- **Fully implementing for at least 90 days**
- **Implemented Focus Group**
  - Supervisors part of decision making process, the action plan, and the goal for better implementation. They are invested in day-to-day monitoring of the process.
  - Document meeting agenda, meeting minutes and attendees
- **Running weekly reports**
Improvement Activities

- Measure and improve quality at the practice and panel level
  - IA_PSPA_18

- Adopt a formal model for quality improvement and create a culture in which all staff actively participates in improvement activities.....
  - IA_PSPA_19
Patient Satisfaction Survey

- IA_PSPA_18
- Targeting specific aspect of visit
- Start with technicians
- Roughly 30 random patients per week
- Trying to get at least 15 responses back
Weekly Staff Meeting/Bi-Weekly Presentations

- IA_PSPA_19

- Building on what we have been doing

- Implemented quiz after each weekly staff educational presentation session

- Staff must get 4 out of 5 correct to pass

**Billing quiz**

Name ________________________________ Date __________________

1. Does Medicare cover refractions?  
   - Yes  
   - No

2. We accept VSP insurance.  
   - True  
   - False

3. Who is our HIPAA officer?  
   - Min  
   - Frank  
   - Samantha

4. What does HIPAA stand for?  
   (A) Health Insurance Privacy and Accountability Act  
   (B) Health Insurance Portability and accountability Act

5. A reason that would indicate a patient should be scheduled for a routine exam is  
   (pick 2)  
   (A) My eyes are dry and itchy  
   (B) I need a new prescription  
   (C) My vision has changed/ blurry  
   (D) I was referred because I am diabetic and need an eye exam.
Thank You

Min Cheng, COMT
Director of Clinical and Surgical Services
mcheng@golasik.net
(617)680-0278
Questions?
Resources

• **New England QIN-QIO MACRA website:**
  – **Ask A Question:**

• **CMS Quality Payment Program website:**
  [https://qpp.cms.gov/](https://qpp.cms.gov/)
Contact Information

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Thank you for participating!