ADVANCING PRACTICE TRANSFORMATION

APRIL 16, 2021

DISCLOSURE

- This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of MedChi, The Maryland State Medical Society and the Maryland Health Care Commission (MHCC). MedChi is accredited by the ACCME to provide continuing medical education for physicians
- MedChi designates this virtual online educational activity for a maximum of 1 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity

PRESENTER DISCLOSURES

- The following presenters have reported no relevant relationships to disclose: Anene Onyeabo, Charlotte Gjerloev, and Kasey Fields

- Daniel Mingle, MD has disclosed the following relevant relationship, Shareholder and Executive Chairman of Mingle Health, Inc.

ABOUT MHCC

- Advance innovative value-based care delivery and health information technology statewide by promoting adoption and use, identifying challenges, and raising awareness through outreach activities
- Provide timely and accurate information on availability, cost, and quality of health care services to policy makers, purchasers, health care providers, and the public

AGENDA

- Learning Lessons from Practice Transformation Network (PTN) efforts in Maryland
- Quality Payment Program 2021 Updates
- Tips and Resources for Succeeding in the Merit-based Incentive Payment System (MIPS)
- Questions and Answers

PTN EFFORTS IN MARYLAND

LESSONS LEARNED

BACKGROUND

- Transforming Clinical Practice Initiative (TCPI) aimed to help health care providers be successful under the Quality Payment Program, part of the Medicare Access and CHIP Reauthorization Act of 2015
- TCPI began in September 2015 and concluded in September 2019
- TCPI grantees formed PTNs to support primary care and specialty practices through peer-based learning to achieve health care transformation
- Partnership between Maryland Health Care Commission, MedChi, The Maryland State Medical Society, the University of Maryland School of Medicine Department of Family and Community Medicine and the New Jersey Innovation Institute in 2016

QUALITY IMPROVEMENT

- Continuous data collection and assessment informs rapid-cycle quality improvement[1]
- PTN practices used a practice transformation analytics dashboard to review data and identify areas where improvements could be made to reduce cost and improve performance[2]
  - 23 percent of practices improved on one quality measure, 15 percent on two, 13 percent on three, 19 percent improved on four and 2 percent on five
- Resources to help your practice use data to inform quality improvement include:
  - TCPI Change Package (Drivers 2.2 – 2.4: Quality improvement strategy supporting a culture of quality and safety, Transparent measurement and monitoring, and Optimal use of HIT)
  - AHRQ

Source - [1] bmchealthservres.biomedcentral.com/articles/10.1186/s12913-019-4482-6 .

[2] www.annfammed.org/content/17/Suppl_1/S73 .

ENGAGING PATIENTS AND FAMILIES

- Patient engagement is a cost-effective and patient-centered strategy for advancing care*
- Practices reported patient and family engagement (PFE) measures to track progress towards incorporating PFE into care delivery:
  - Support for patient and family voices
  - Shared decision making
  - Patient activation
  - Active e-tool
  - Health literacy survey
  - Medication management

*Source - www.ncbi.nlm.nih.gov/pmc/articles/PMC7919701/.

ENGAGING PATIENTS AND FAMILIES CONTINUED

- All practices met at least two PFE measures, most practices met four of the six PFE measures, 11 percent met all six
- Resources to support patient and family engagement efforts include:
  - Patient and Family Advisory Council Guide for Ambulatory Practices
  - TCPI PFE Compendium

CARE COORDINATION

- Coordinating care across settings, clinicians, and specialties can lead to improved health outcomes, superior patient experiences, and lower costs*
- PTN practices focused on care transitions and managing chronic care to reduce unnecessary hospitalizations
  - 11 percent of practices showed improvements in care planning
  - 28 percent improved in transitional care management
- Care management resources are available at:
  - Agency for Healthcare Research and Quality
  - Maryland Health Care Commission

*Source - jamanetwork.com/journals/jamanetworkopen/fullarticle/2712173.

ENHANCED ACCESS TO CARE

- Access to care has demonstrable health benefits including improved outcomes[1] and has been linked to reduced health costs[2]
- Strategies recommended to enhance access include:
  - Using alternatives to increase access to care-team and provider, such as evisits, phone visits, group visits, home visits
  - Providing 24/7 access to provider or care team for advice about urgent and emergent care
- Practices improved on providing enhanced access to care from 9 percent to 81 percent of practices providing alternative care visit types
- Resources to support enhanced access to care include:
  - Telehealth Readiness Assessment Tool
  - Telehealth Virtual Resource Center
  - Telehealth Implementation Program for Ambulatory Practices

Source – [1] www.ncbi.nlm.nih.gov/pmc/articles/PMC7170539/

[2] bmjopen.bmj.com/content/9/7/e027869.long

The CMS Quality Payment Program - 2021

April 16, 2021

Dr Dan Mingle

For the

MHCC | MARYLAND HEALTH CARE COMMISSION

Welcome to the Webinar

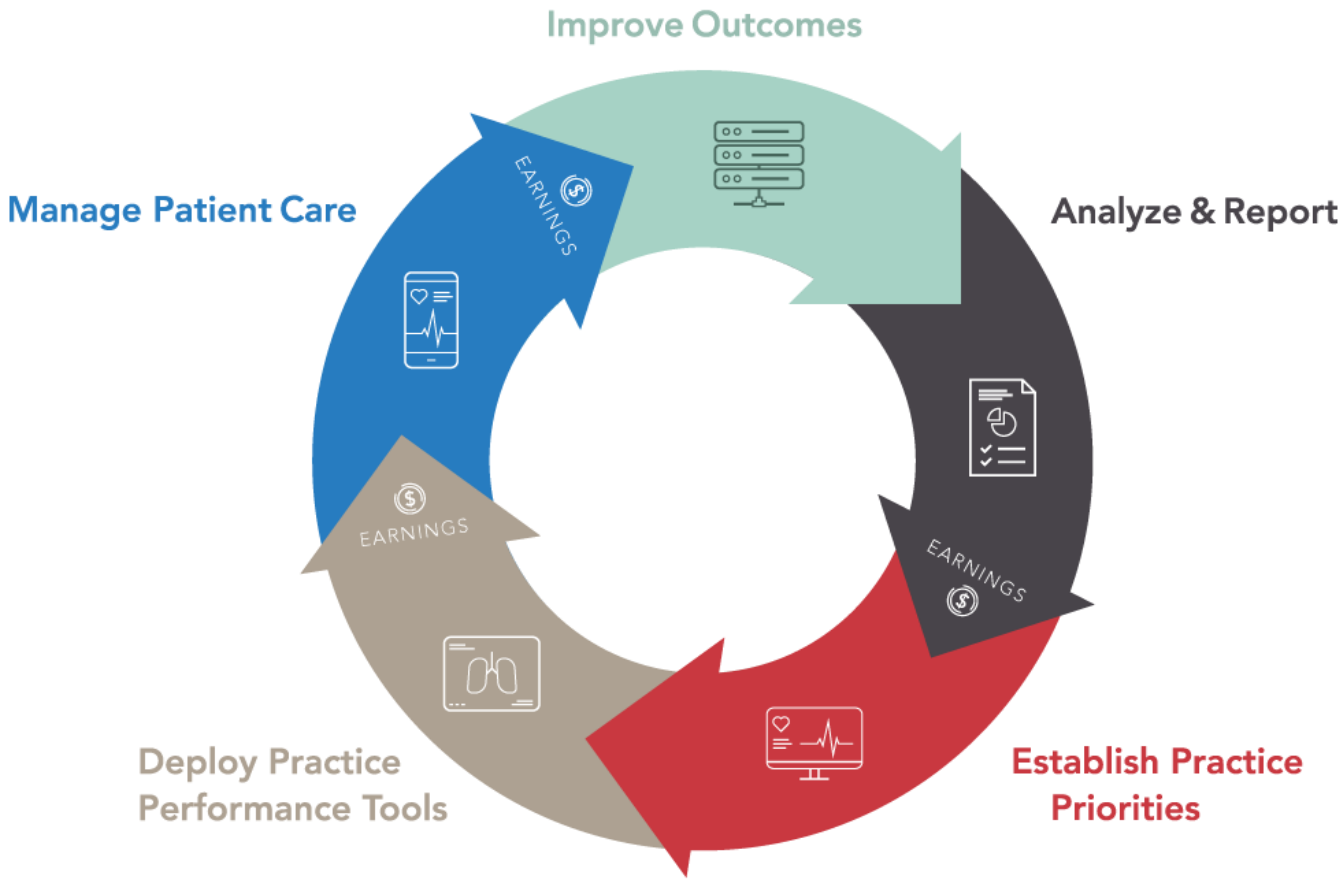
Dan Mingle, MD, MS
Executive Chairman, Mingle Health

Dr. Dan Mingle, executive chairman and nationally recognized Medicare quality reporting expert. He is a family physician with private, group, and academic practice experience. His insights into the many problems that plague our healthcare system led him on a quest to help practices of all sizes master their data for value-based care success.

Mingle Health: Facilitating Your Virtuous Cycle

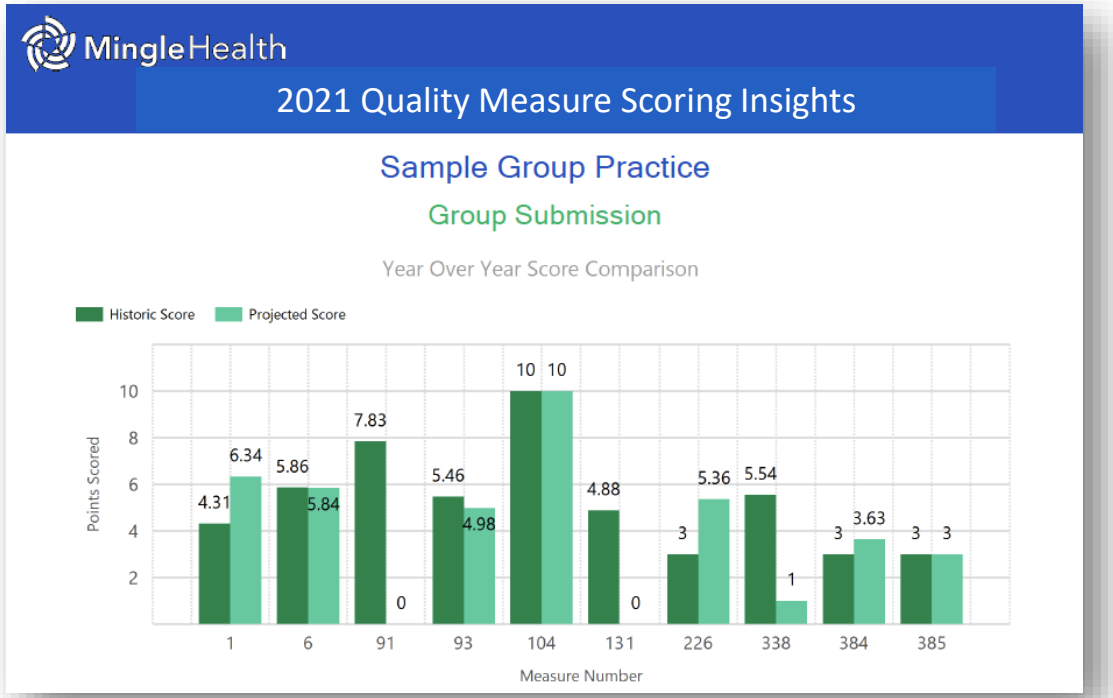
Here to Help

- Engage patients
- Improve Outcomes
- Measure Results
- Look ahead
- Next steps
- Repeat



Agenda

- The Quality Payment Program v2021
- Eligibility
- Performance Categories
- MIPS Value Pathway
- Web Interface and the APM Value Pathway



Quality Payment Program(QPP)

First Pathway

Second Pathway

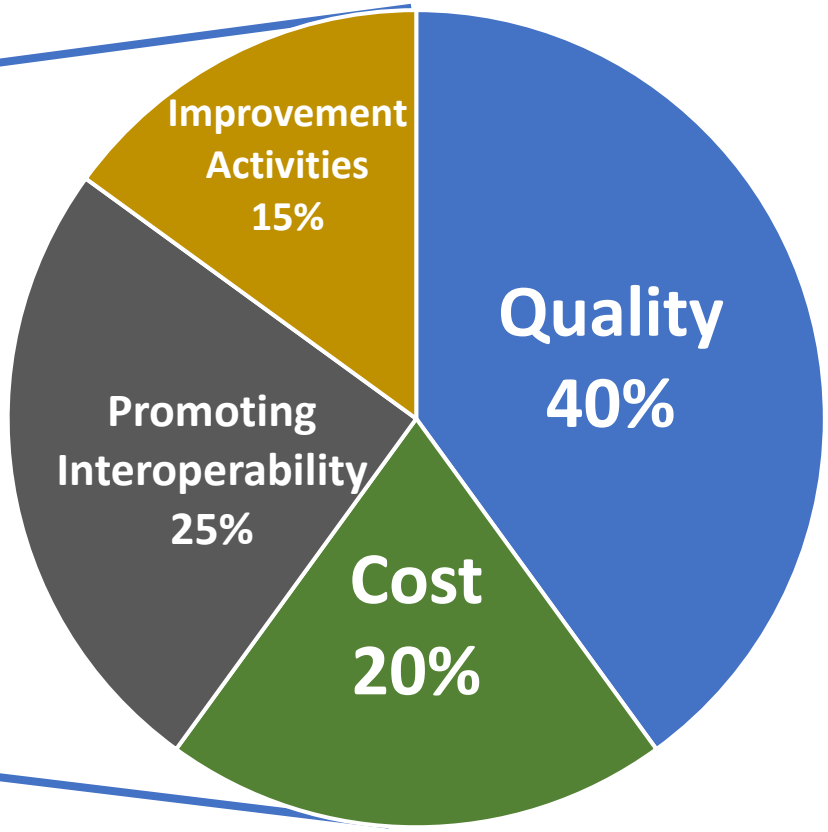
(APM) Alternative Payment Models

(MIPS) Merit-Based Incentive Payment System

(advanced) APM

MIPS APM

Performance Categories 2021



MIPS Eligible Clinicians - v2021

MIPS Eligible by Credentials aka “Provider Type”

Physicians

Doctors of:

- Chiropracty
- Dental Medicine
- Dental Surgery
- Medicine
- Optometry
- Osteopathy
- Podiatric Medicine

Non-Physicians

- Audiologist
- Certified Registered Nurse Anesthetist (CRNA)
- Clinical Nurse Specialist (CNS)
- Clinical Psychologist
- Nurse Practitioner (NP)
- Occupational Therapist
- Physical Therapist
- Physician Assistant (PA)
- Registered Dietician or Nutrition Professional
- Speech-Language Pathologist

Still Ineligible

- Certified Nurse Midwife
- Clinical Social Worker

Low Volume Exclusion and Opting In - Unchanged

Included	Excluded	May Opt In
> $90k Allowable Charges	≤ $90k Allowable Charges	> $90k Allowable Charges
AND > 200 Medicare Patients	OR ≤ 200 Medicare Patients	OR > 200 Medicare Patients
AND > 200 Charge Line Items	OR ≤ 200 Charge Line Items	OR > 200 Charge Line Items

Individual or group may opt in if:

1. MIPS Eligible
2. Qualifies for Low Volume Threshold by < 3 criteria
3. Make irrevocable election in QPP Portal

MIPS Special Rules Apply

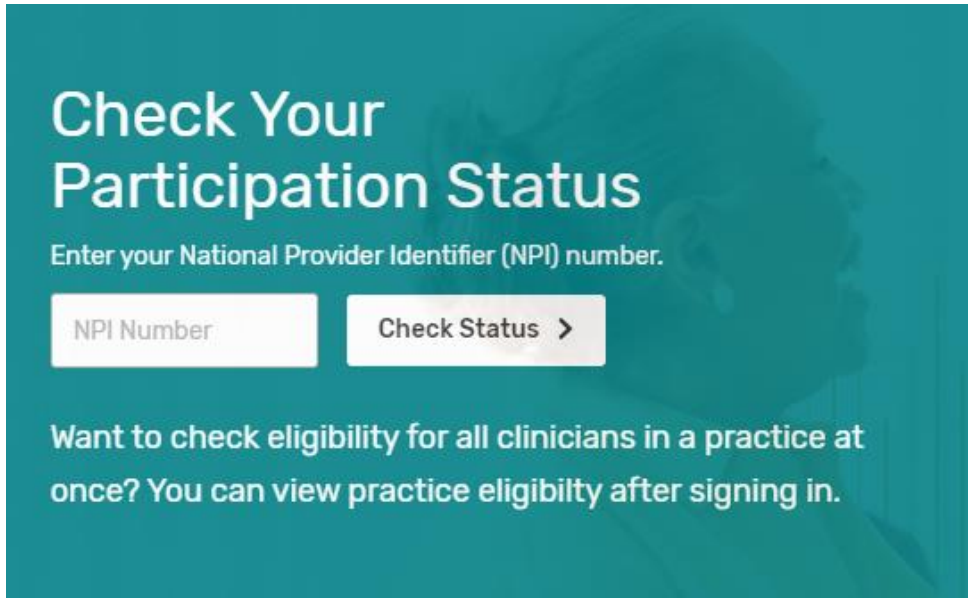
For Provider/Practices that are:

- Low-volume
- Small practice
- Non-patient facing
- Hospital-based
- Ambulatory Surgical Center-based

Rules relating to:

- MIPS-eligibility
- Eligibility for opt-in
- Promoting Interoperability not required
- Small practice bonus
- Special scoring consideration

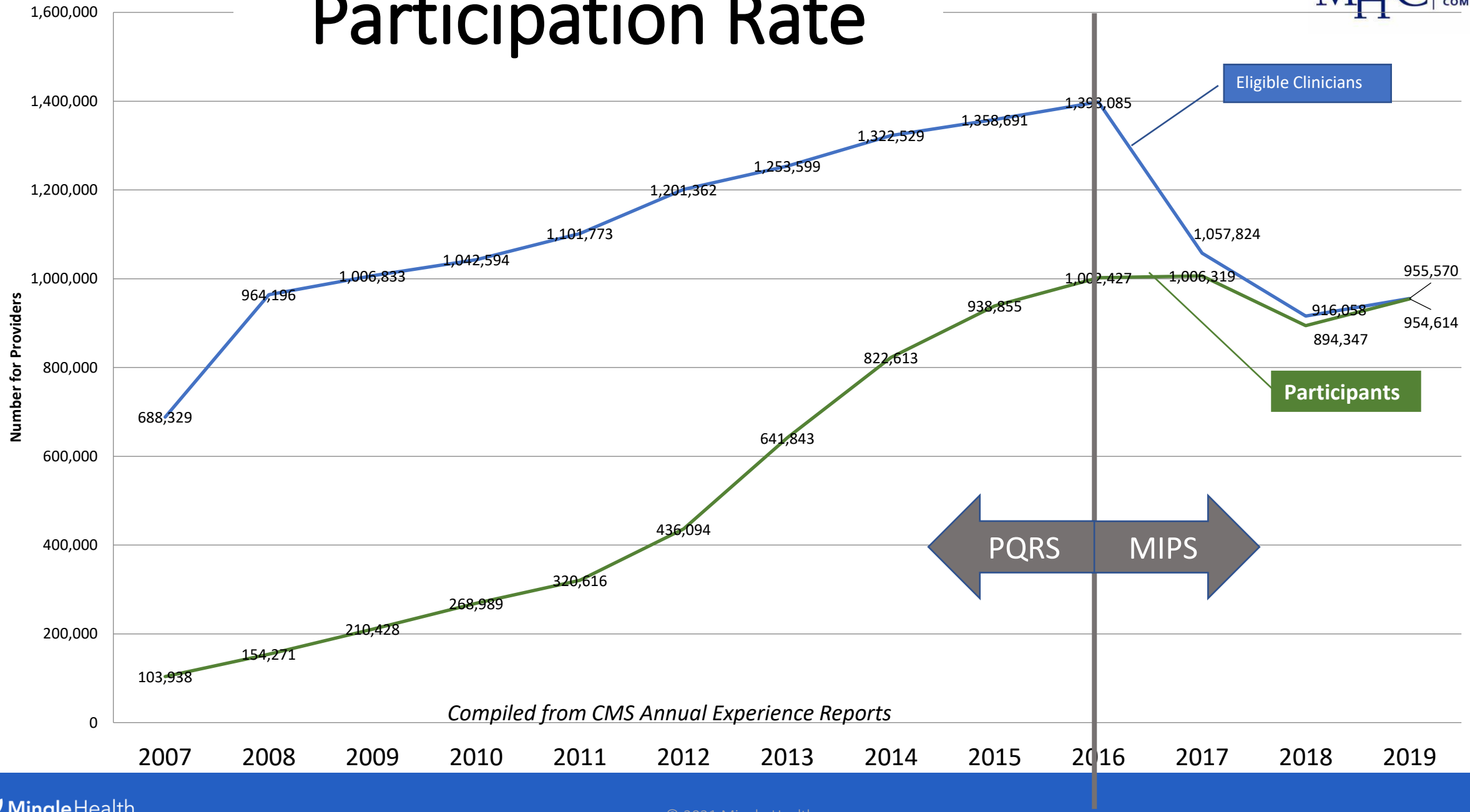
QPP.CMS.GOV



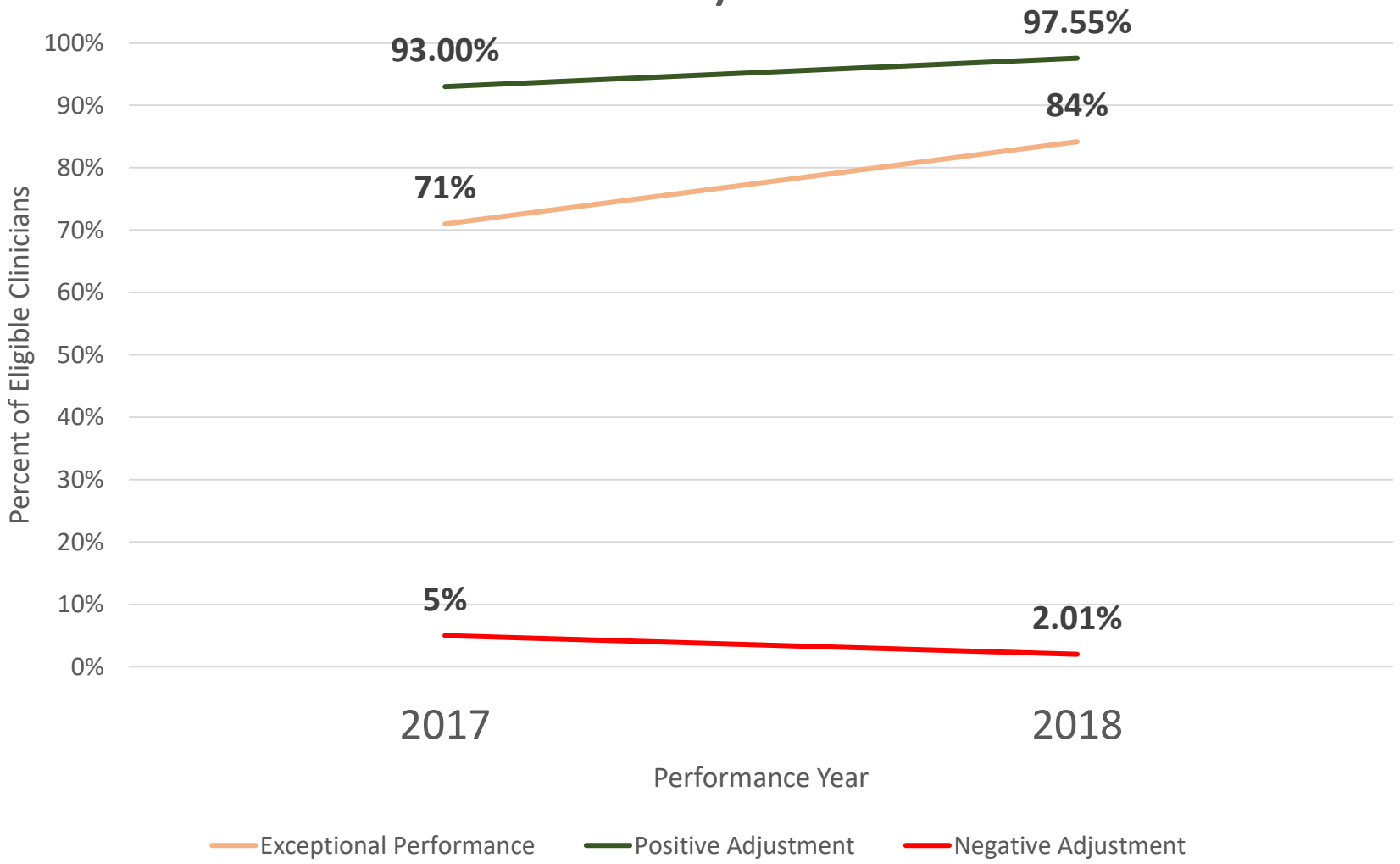
MIPS Special Status Determination Periods

First Determination Year	Second Determination Year
10/1/19 – 9/30/20	10/1/20 – 9/30/21

Participation Rate

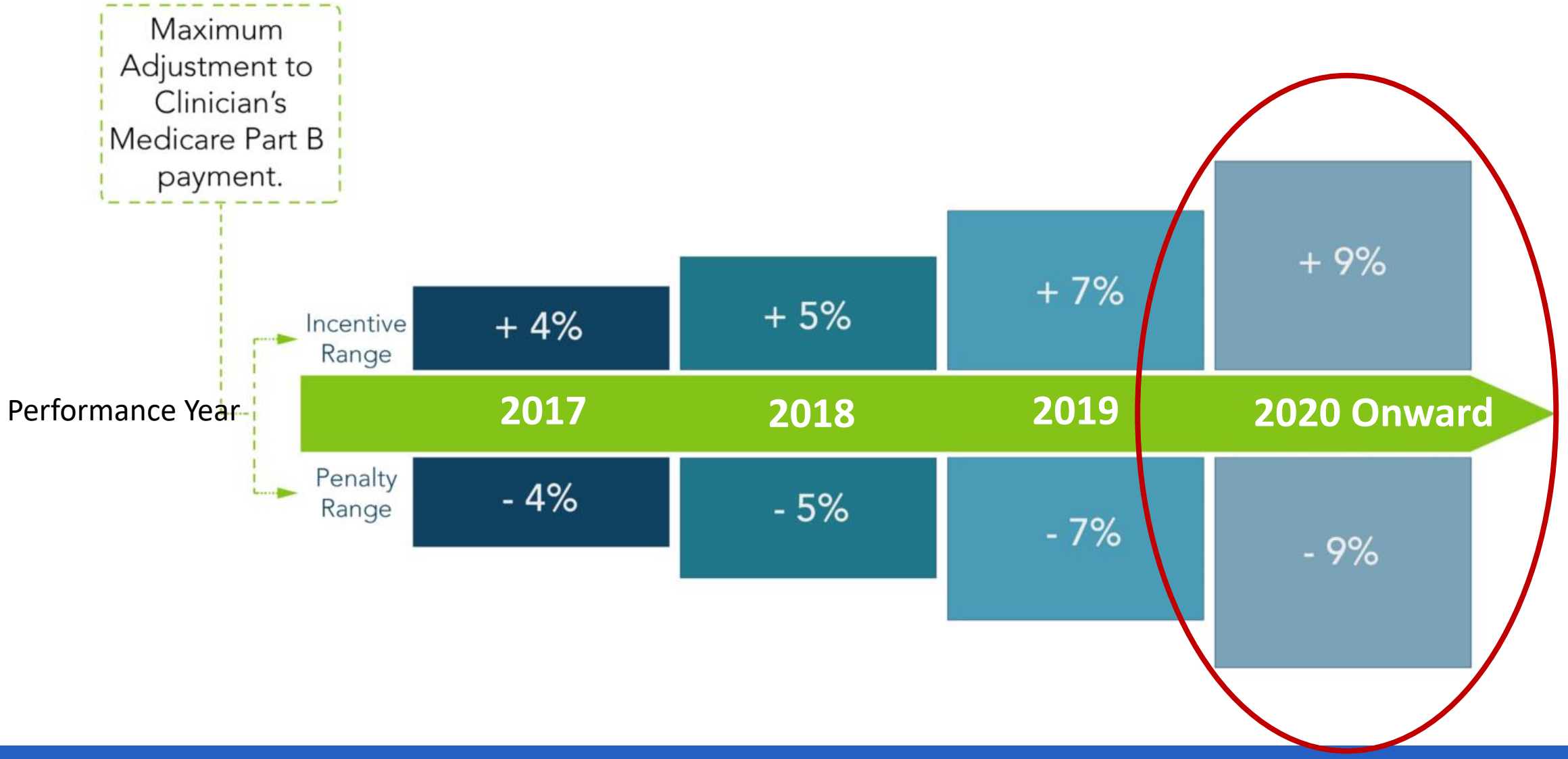


MIPS Performance by Performance Year



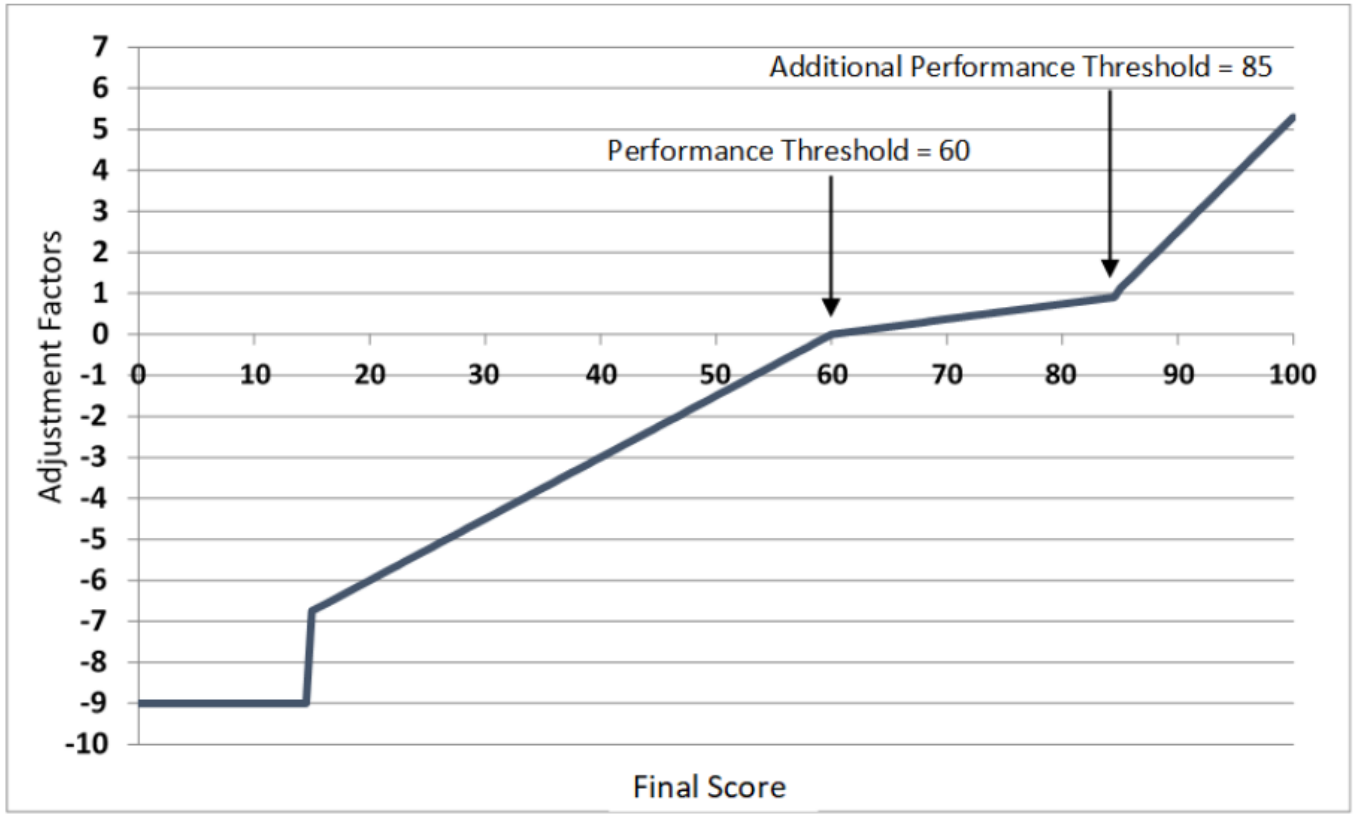
Compiled from CMS Annual Experience Reports

What is at Stake (Theoretical)

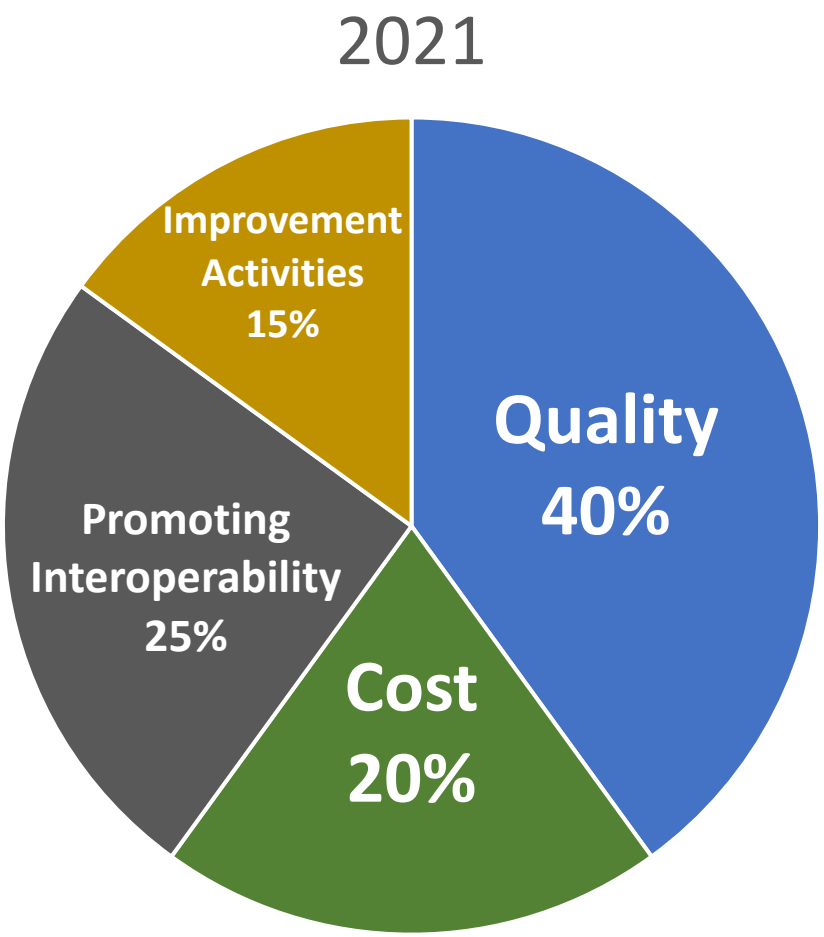


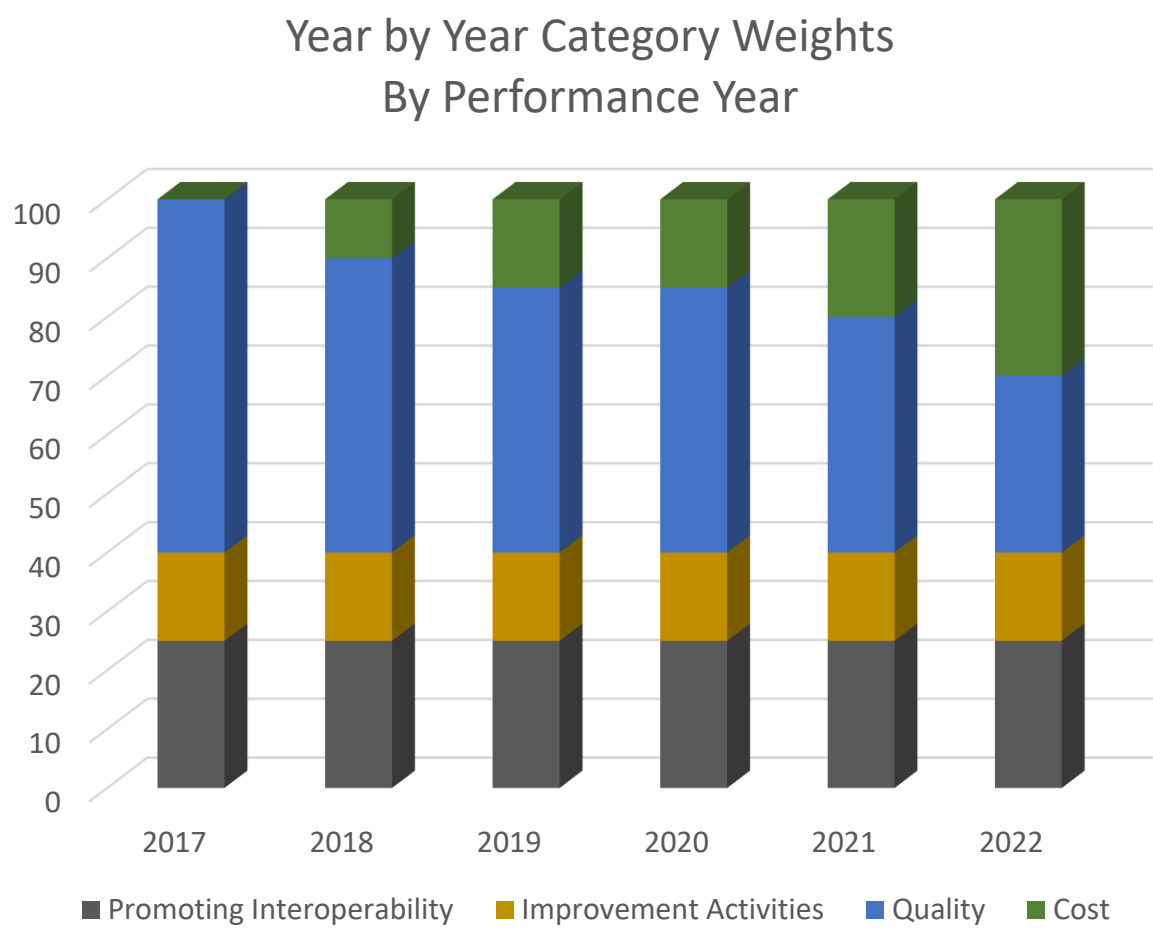
Payment Adjustments v2021

Performance Year	2017	2018	2019	2020	2021	2022
Payment Year	2019	2020	2021	2022	2023	2024
Design	±4%	±5%	±7%	±9%	±9%	±9%
Maximum Gain	1.8%	1.7%	1.79%	~1.8%	~5.3%	~3%
Exceptional Performance Threshold	70	70	75	85	85	**NA**
Performance Threshold	3	15	30	45	60	74
Maximum Loss	4%	5%	7%	9%	9%	9%



Performance Category Weights





Data Completeness Criteria

Quality

40 Points

Full Year of Data

All Payers

≥ 70% of Eligible Patients

+

Cost

20 Points

Full Year of Data

+

Improvement Activities

15 Points

≥ 90 Days

50% of Eligible Clinicians Participate

+

Promoting Interoperability

25 Points

≥ 90 Days

=

100 Possible Final Points

Quality Measures 2021

- 209 measures
- 11 measures have been removed
- 2 new measures (administrative claims)
  - Hospital-Wide Readmissions (200 case minimum, groups >15 only)
  - Complications of Total Hips/Knees (25 case minimum, 3-year sample period)
- 113 measures with substantial changes
  - HbA1c now has strata
  - Depression Screening with tighter specifications for appropriate action
- Specialty Measure Sets changed

Improvement Activities

- Removal of 1 activity re Patients Hospital Engagement Network
- Clarifications to new COVID-19 IA
- Extended Call-For-Activities timeframe to Feb 1 – June 30 annually
- Open Season for HHS IA nominations
- New criterion for nominations: “can be linked to existing and related MIPS quality and cost measures”

Promoting Interoperability

Objective	Measure	Maximum Points
Electronic Prescribing	e-Prescribing	10 points
	Bonus: Query of PDMP	10 points (*bonus*)
Health Information Exchange OR	Support Electronic Referral Loops by Sending Health Information	20 points
	Support Electronic Referral Loops by Receiving and Reconciling Health Information	20 points
Health Information Exchange (alternative)	HIE Bi-Directional Exchange	40 points
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	40 points
Public Health and Clinical Data Exchange	Report to two different public health agencies or clinical data registries for any of the following: • Syndromic Surveillance Reporting • Immunization Registry Reporting • Electronic Case Reporting • Public Health Registry Reporting • Clinical Data Registry Reporting	10 Points

Security Risk Analysis required but not scored

CEHRT compliant to 21st Century Cures Act required by the end of 2022

Cost

- No new episode or other cost measures
- Adding/Clarifying Telehealth and other related codes are in the specifications

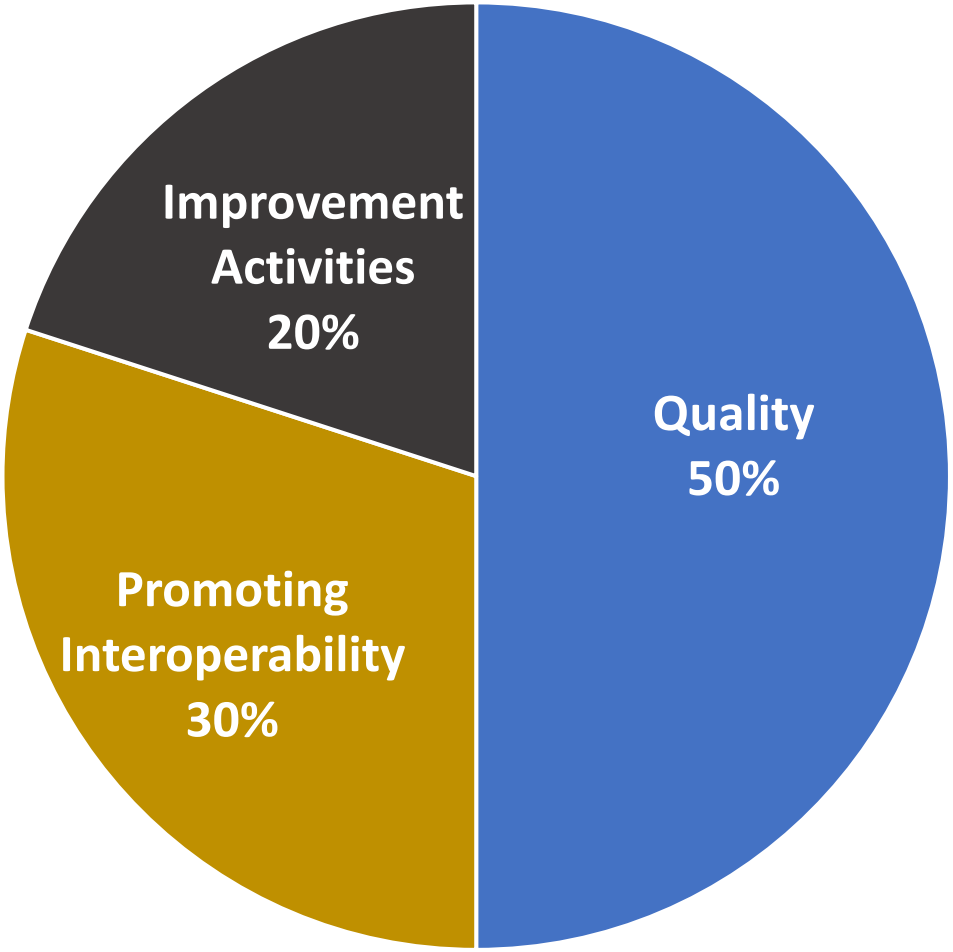
New Specifications in Audit Rules

- There must be a Data Validation Audit representing
  - ≥ 3% of Client TIN-NPIs (min 10, max 50)
  - ≥ 25% of measure-eligible patients of each TIN-NPI (min 5, max 50)
- Targeted Audits when there are any anomalies on Data Validation
  - Duplicate validation audit sample with no patient overlap
- Requirement to complete audits, root cause analysis, and data corrections before submission
- New Specifications of what must be in the audit report to CMS
- All Performance Categories must be audited

MIPS Value Pathways (MVP)

- Postpone until 2022 (or later)
- More details about MVP build dynamics
- An MVP nomination form available on QPP.CMS.Gov
- Intent to allow subgroup level reporting
- Intent to include QCDR measures in MVPs

Category Weights for MIPS APM



- Automatic reweighting of Cost Category
- All APMs have minimum 50% credit for IA
- Additional IA credit depending on plan-design
  - All existing APMs come with 100% IA
- Quality Threshold = 30% for 2021, 2022
- Quality Threshold = 40% after 2022

APMs considered advanced for 2020 (2021)

- Bundled Payments for Care Improvement Advanced Model
- Comprehensive Care for Joint Replacement Payment Model (CEHRT Track)
- Comprehensive Primary Care Plus Model
- Comprehensive ESRD Care Model (LDO arrangement and Non LDO Two Sided Risk Arrangement)
- Maryland Total Cost of Care Model (Care Redesign Program; Maryland Primary Care Program)
- Medicare Shared Savings Program (Track 2, Track 3, Basic Track Level E, and the ENHANCED Track)
- Medicare Accountable Care Organization (ACO) Track 1+ Model
- Next Generation ACO Model
- Oncology Care Model (Two-Sided Risk Arrangements)
- Vermont All-Payer ACO Model (Vermont Medicare ACO Initiative)

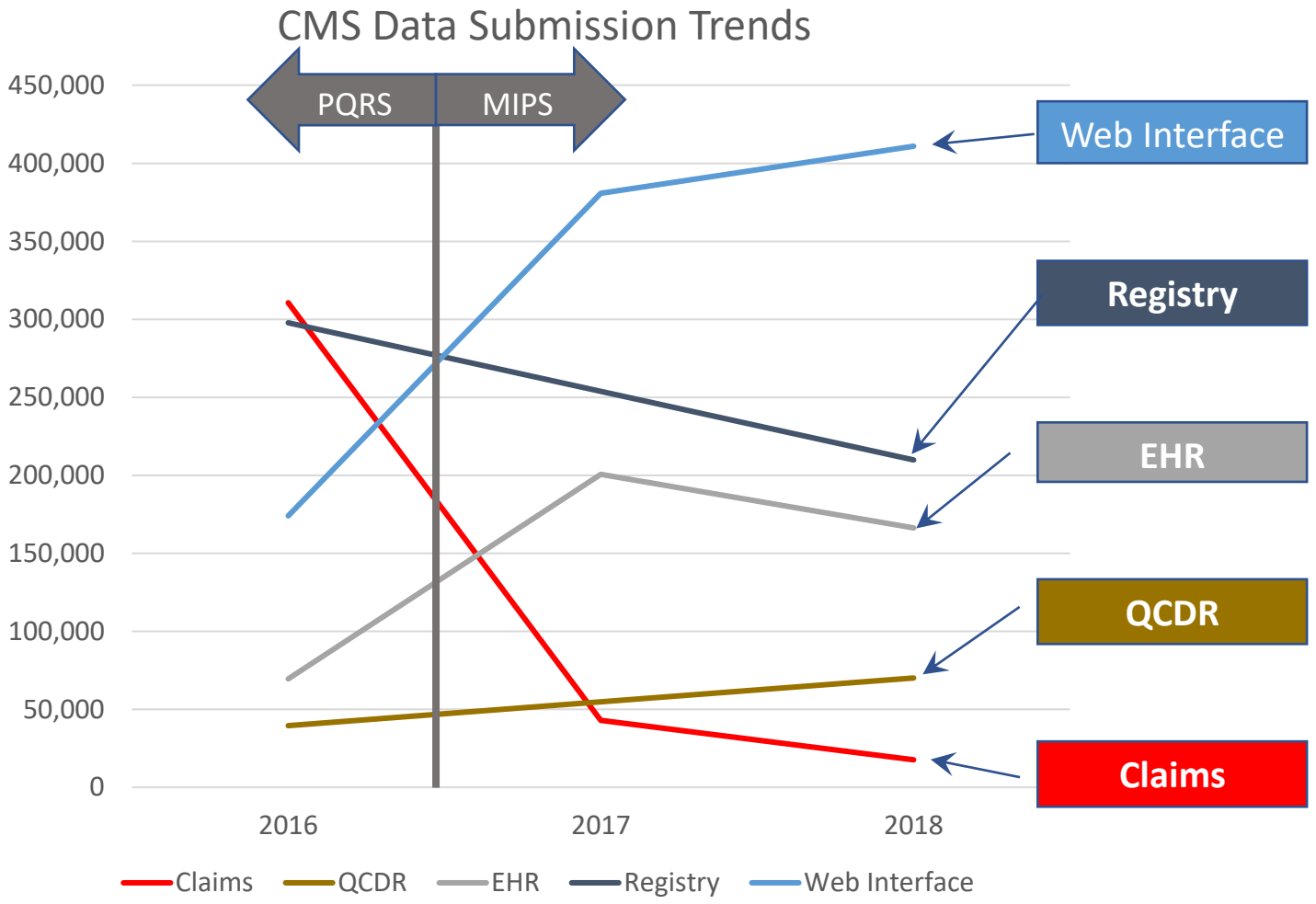
- Primary Care First (2021)

Web Interface to End after 2021 Reporting Year

- 80% of Web Interface utilization by MIPS APMs
- MIPS utilization dropping
- For MIPS Groups

  2017 – 2019:

  - 45% reduction in eligibility
  - 40% reduction utilization



Sunset the CMS Web Interface submission method

Implement the Alternative Payment Model (APM) Performance Pathway (APP)

- APM Performance Pathway (APP) replaces Web Interface for APM participants
- Styled after MVP
- APP Operational for 2021 Performance Year
- Web Interface for Quality Measures a valid option for 2021
- No Web Interface for 2022 and beyond
- Terminate the APM Scoring Standard

APP Quality Measure Choices 2021

Qlty ID	Measure	APP	Web	Submitter Type
#321	CAHPS for MIPS	Yes	Yes	Survey Vendor
#479	HWR Readmission Rate	Yes	Yes	CMS Administrative Claims
#TBD	MCC Unplanned Admissions	Yes	Yes	CMS Administrative Claims
#001	HbA1c Poor Control	Yes	Yes	EHR, Qual Reg, QCDR
#134	Screen for Depression and Follow up	Yes	Yes	EHR, Qual Reg, QCDR
#236	Control of High BP	Yes	Yes	EHR, Qual Reg, QCDR
#318	Screen for Falls Risk		Yes	
#110	Flu Immunization		Yes	
#226	Tobacco Use Screening and Follow up		Yes	
#113	Colorectal Cancer Screening		Yes	
#112	Breast Cancer Screening		Yes	
#438	Statin Therapy		Yes	
#370	Depression Remission at 12 m		Yes	

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Up next:
Kasey Fields from Qlarant

MIPS 2021 – THE ROAD AHEAD

Presenters from Qlarant:

Kasey Fields, Quality Improvement Consultant

Charlotte Gjerloev, MACRA Project Manager

Maryland Health Care Commission

April 16, 2021

Quality Improvement Organizations
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IPRO
QIN-QIO

Healthcentric Advisors
Qlarant

Kasey Fields

Kasey has been with Qlarant for 4 years. She is a Quality Coordinator for the MACRA/SURS contract for Maryland and the District of Columbia. She is responsible for providing technical assistance to eligible clinicians. Previously, she worked with the Quality Improvement Organization (QIO) team in the 11th SOW and assisted the larger groups of clinicians and hospitals with the Quality Payment Program. Prior to working at Qlarant, she was a Quality Data Analyst for New Wave technologies.

Charlotte Gjerloev

Charlotte has been with Qlarant for almost 10 years. She is currently the Project Manager for the MACRA/SURS contract for Maryland and the District of Columbia (DC). She is also the Project Lead for the Nursing Home Quality Initiative for Maryland, Delaware and DC as part of the IPRO Quality Innovation Network-Quality Improvement Organization (QIN-QIO)12th SOW. Previously, she worked with the Utilization Management contract for Maryland Medicaid for over 10 years. She graduated with a Bachelor degree in Science in Nursing (BSN, RN) from the University of Copenhagen, Denmark in 1994.

OUR ROLE

Qlarant (as a subcontractor to IPRO) was awarded the contract for the Quality Payment Program (QPP)/MIPS in 2017 for eligible clinicians in Maryland and the District of Columbia. We are working closely with our colleagues at IPRO and other stakeholders to develop strategies that will help the eligible clinicians be successful in the MIPS program. This is a five year contract and expires in 2022.

Learning Objectives

 # 1 - Maryland clinicians will be able to locate and determine their eligibility status, participation options and goals for MIPS 2021.

 # 2 - Maryland clinicians will be able to identify a workflow for their practice, including data collection and submission options.

 # 3 - Maryland clinicians will be able to access and navigate resources that are available to lessen provider burden.

MIPS Eligible Clinicians

- MIPS Eligible as an Individual
- MIPS Eligible as Part of a Group
- MIPS Eligible in a MIPS APM
- MIPS Eligible in a Virtual Group

What Happens if I Elect to Opt-in to MIPS?

- Be considered a MIPS eligible clinician and be required to report data to MIPS
- Receive performance feedback report
- Receive a MIPS payment adjustment (positive, negative, or neutral),
- Be assessed in the same way as MIPS eligible clinicians who are required to participate in MIPS.

Practice goals

- Which reporting method works best for your practice? (*Financial budget)*
- Create accounts that will allow security holders to access information. (*Document passwords, and security questions)*
- Establish relationship with EHR vendor personnel
- Create a consistent workflow for collecting data
- Choose measures that are applicable to your practice.
- Choose a goal for payment adjustment!(positive, *negative, or neutral)*

MIPS 2021- THE ROAD AHEAD

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- Start now
- Look at your practice/specialty
- Build on what you are already doing
- Continue with your daily routines
- Develop a good workflow for collecting data
- Involve all your staff
- Communicate/meet on a regular basis
- Check your RA/EOB regularly

MIPS 2021 – THE ROAD AHEAD

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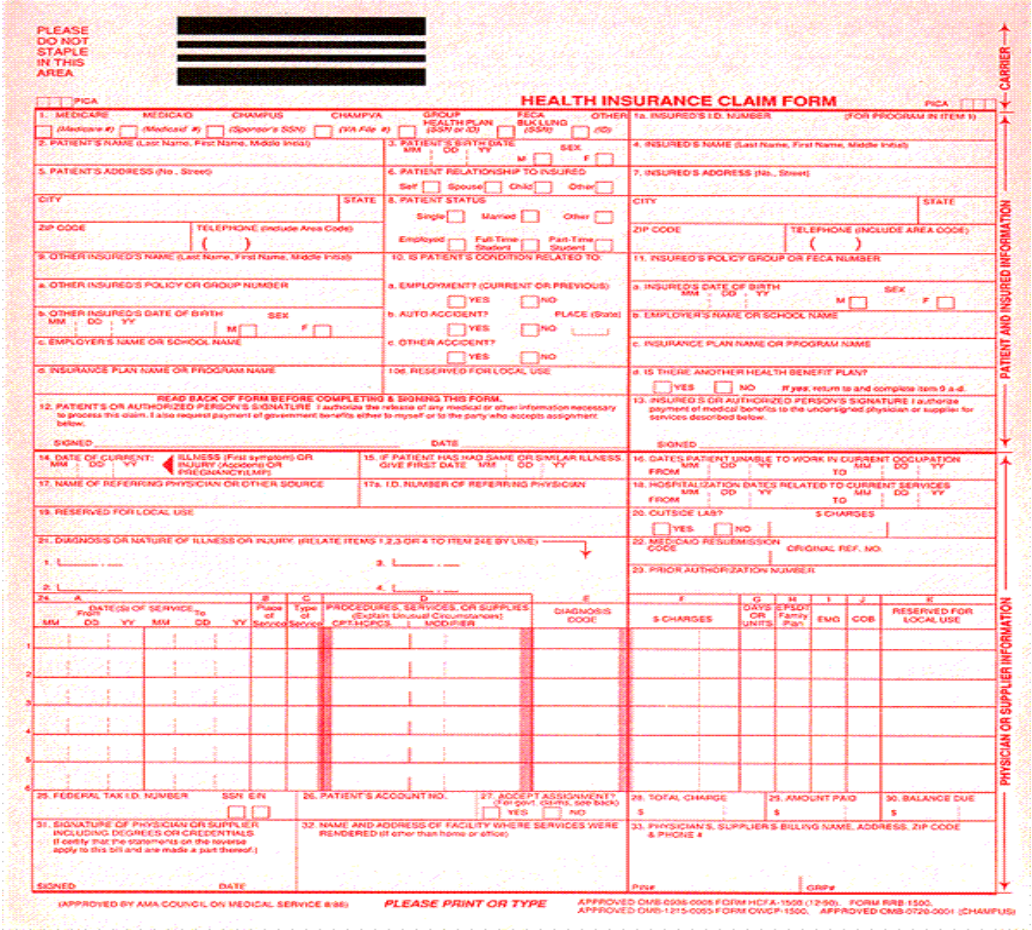
Medicare Part B Claims Form

- Item 21 A – Diagnosis
- Item 24 D – This is were the QDC/G-code is reported for a Quality Measure
- Item 24 E – The Diagnosis Pointer points to the diagnosis code in item 21 A
- Item 24 F – Add a $ 0.01 charge or a $ 0.00 charge



Remittance Advice (RA)/Explanation of Benefits (EOB):

- The RA/EOB lists denial codes that correspond to the information you submitted on the claim form.
- When **N620** is listed as a denial code, it tells you that the QDC(s) are valid for the 2021 MIPS performance period.
- If you bill a $0.00 QDC line item, you'll get the **N620** code.
- If you bill a $0.01 QDC line item, you'll get the CO 246 **N620** code.
- Remember… keep track of all the denominator eligible cases you have reported and compare them to the RA notice you receive from your Medicare Administrative Contractor (MAC).

Case study:

Dr. B has a small family practice. He has one administrative assistant, Ms. R, who is responsible for the billing, amongst many other things.

Dr. B does not have an electronic health record system. All his patient's medical records are paper records. At the beginning of each performance year, he identifies 6 quality measures that align well with his normal day to day work.

Since he does not have an EHR, he will have to report his quality measures via Medicare Part B claims.

Each of the 6 quality measures has a corresponding QDC code/G-code. These codes are added to the Part B claims form by Ms. R.

Best practices for Dr. B and Ms. R:

Dr. B and Ms. R developed a simple, but very efficient workflow for communicating the quality measures for each patient. After each patient visit, Dr. B writes all the applicable quality measures on a sticky note and attaches it to the patient's chart.

When Ms. R does her billing, she compares the quality measures on the sticky note with a cheat-sheet, that has all the corresponding QDC/G-codes. This is an easy way for her to identify which quality measures to report on the Medicare Part B claims form for each of the patients.

Example:

Quality measure # 130 Documentation of Current Medications in the Medical Record

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.

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

Numerator: Eligible professional or eligible clinician attests to documenting, updating or reviewing the patient's current medications.

Current Medications Documented: Performance Met, use G8427

By adding **G8427** to item 24 D on the Part B claims form, the clinician reports on Quality Measure # 130.

Special statuses

- If you've been automatically assigned a special status, it will be added to your eligibility profile in the QPP Participation Status Tool

- Special statuses are assigned if you reach the requirements for at least one of the MIPS determination segments. Special Status Impacts and Circumstances include:

Ambulatory Surgery centers, hospital based clinicians, Non- patient facing, Small and Rural practices, and Health Professional Shortage Areas (HPSA)

Exception applications

- The *Extreme and Uncontrollable Circumstances Exception* application allows you to request reweighting for any or all performance categories if you encounter and extreme and uncontrollable circumstance or public health emergency, such as COVID-19, that is outside of your control.

- The *MIPS Promoting Interoperability Performance Category Hardship Exception* application allows you to request reweighting specifically for the Promoting Interoperability performance category (to 0%) if you meet certain criteria.

AVAILABLE RESOURCES

Quality Payment Program website: https://qpp.cms.gov/

IPRO website: https://ipro.org/for-providers/medicare-qpp

IPRO Office hours: https://ipro.org/for-providers/medicare-qpp/ipro-present

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QUESTIONS?

THANK YOU