IMPLEMENTING CQMS THAT IMPROVE CARE DELIVERY, BENEFIT PATIENTS, AND IMPROVE THE PRACTICE BOTTOM LINE

Physicians and small medical practices may have difficulty keeping up with all the changes being implemented by the Centers for Medicare and Medicaid Services, or CMS. In an ongoing effort to modify care management programs and improve patient outcomes, CMS is slowly pushing the transition towards a value-based healthcare system.

Clinical Quality Measures are used for various initiatives that seek to improve care quality, provide medical practices with reimbursement for reporting, and increase the amount of public information available.

The Promoting Interoperability (PI) Programs hope to improve the patient's access to health information and reduce the time required from physicians to comply with program requirements. This was recently refined to introduce a performance-based methodology which focuses around a smaller set of objectives.

Clinical Quality Measures, or CQMs, are the tools that CMS utilizes to measure and track the quality of health care services provided by eligible professionals (EP) in order to ensure that the system is delivering efficient, patient-centered care. These measures assess the provider's ability to deliver high-quality care including:

- Health outcomes
- Clinical processes
- Patient safety
- Efficient use of health care resources
- Care coordination
- Patient engagement
- Public health and population health
- Adherence to clinical guidelines

CMS has implemented a quality payment incentive program, referred to as the Quality Payment Program, which rewards value and outcomes. The Merit-based Incentive Payment System (MIPS) which is divided into four parts (Cost, Quality, Promoting Interoperability and Improvement Activities).

Click here to watch a webinar on tracking and reporting CQMs.

CLINICAL QUALITY MEASURES

MIPS is the Medicare value-based care payment program. Beginning in 2018, CMS will begin publishing MIPS scores from 2017 for over 500,000 clinicians to provide patients with more information about their medical care providers. Each calendar/performance year eligible providers will receive a score based on a 100 point scale. Practices must meet a certain minimum threshold, with incentives provided for going beyond that minimum. A MIPS performance score is measured through the data clinicians report in four areas, plus additional bonus point opportunities:

Quality — 45% weight, or 45 MIPS points maximum: This category covers the quality of care delivered by a practice, based on certain performance measures created by CMS, as well as medical professional and stakeholder groups. Each provider will pick the six measures of performance that best fit their practice.

Promoting Interoperability — 25% weight, or 25 MIPS points maximum: This measurement focuses on patient engagement and the electronic exchange of health information using certified electronic health record technology. Practices are encouraged to proactively share information such as visit summaries, test results and treatment plans with other clinicians, facilities or the patient in a comprehensive manner.

Improvement Activities — 15% weight, or 15 MIPS points maximum: This area is focused on motivating providers to constantly assess how they can improve care processes, enhance patient engagement, and improve population health. Practices can choose activities from such categories as enhancing care coordination, expansion of practice access, and increasing shared decision-making.

Cost — 15% weight, or 15 MIPS points maximum: Beginning in 2018, CMS will review Medicare claims submitted, in order to calculate the total cost of care provided during the year.

Using these scores, adjustments are applied to every Medicare Part B item and service billed by the clinician two years after the rating year. For example, 2019 will be the payment adjustment year based on performance ratings from 2017. In 2019, the maximum MIPS incentive is 4%, with a maximum exceptional performance bonus of 10% and a maximum MPS penalty of 4%. Incentives and penalties will increase through payment year 2022 to a maximum of 9% each. Penalties applied to poor performers will help create a pool to pay incentives earned by the higher-rated performers.

Practices must earn a minimum number of points to avoid receiving an MIPS penalty. This can be accomplished through a combination of meeting base scores and submitting quality measures that meet data completeness thresholds or specifically-weighted improvement activities. There are more than 270 quality measures that are final for reporting for the 2018 performance period in the Quality Payment Program. These cover process measures, outcome measures and high priority measures.

Chronic conditions generally require a high level of in-office care and follow-up, but there are certainly many steps which can be taken to increase preventative patient care and more fully involve patients in their own care regimens. Keeping appointments, monitoring glucose levels, having regular blood tests, following medication guidelines and increasing patient education can all lead to an improved doctor-patient relationship without having to increase the actual number of patient visits. In addition to the patient health benefits, eligible practitioners will be able to bill for at least 20 minutes or more of care coordination services per month.

The data completeness threshold for each quality measure is 70% of all eligible instances. Best practice is to be over 70%. To determine included instances the practice will:

1. Determine a reporting period of a full year.
2. Count all patients seen during the reporting period, not just the Medicare population.
3. Break down the patient population by factors such as age group and diagnosis code (depends on the measure ifbroken down).
4. Review the specific instructions for the quality being measured to determine the Eligible Instances.
5. Divide the Eligible Instances by two to determine the minimum number of included instances.
6. Report from 60-100 percent of the Eligible Instances

CMS plans to gradually increase competition for practices to provide higher levels of care by increasing financial and reputation impacts through 2022.

STEPS OF QUALITY PAYMENT PROGRAM PARTICIPATION

Step One

Beginning in 2018, MIPS eligible clinicians may participate in MIPS individually, as a group, or as a virtual group.

- ***Participate as an individual:*** MIPS eligible clinicians participating as individuals will have their payment adjustment based on their individual performance. An individual is a single clinician, tied to a specific Taxpayer Identification Number.
- ***Participate as a group:*** MIPS eligible clinicians participating in a MIPS group will receive a payment adjustment based on the group's performance. Under MIPS, a group is a single Taxpayer Identification Number with 2 or more MIPS eligible clinicians, as identified by their National Provider Identifiers (NPI).
- ***Participate as a virtual group:*** MIPS eligible clinicians participating in a MIPS Virtual Group will receive a payment adjustment based on the Virtual Group's performance. A Virtual Group can be made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together "virtually" (no matter what specialty or location) to participate in MIPS for a performance period for a year.

Step Two

Determine ***Quality*** measures related to your specialty. These factors have been categorized into efficiency, intermediate outcome, outcome, patient engagement/experience, process and structure measures, with some tagged as high priority or bonus eligible. Most providers will be required to report on six quality measures of which many choose to use the specialty-specific measures defined by CMS.

Step Three

Review ***Improvement Activities*** measures. For 2018 your practice will have to attest to the fact that you completed two to four out of the 112 available activities. A minimum of 90 continuous days will need to be reported for this category for 2018, but there may be special considerations available for certain practices.

Step Four

Report on efforts at ***Promoting Interoperability.*** This area examines the meaningful use of certified Electronic Health Record technology. Certain exclusions and exceptions are available for 2018 for clinicians limited by certain circumstances.

Step Five

There is no data submission required for the Cost category as CPS utilizes available Medicare claim information.

Step Six

Collect data related to each of the applicable categories. Possible data submission methods include Qualified Clinical Data Registry, Qualified Registry, Electronic Health Record, Claims and CMS Web Interface. Each reporting method requires a minimum amount of all-payer patient visits or Medicare patient data to meet data completeness requirements.

Step Seven

Receive feedback from CMS, and assess your level of performance as compared to your available historical benchmarks from any previous year submissions.

Step Eight

CMS will make an MIPS payment adjustment if practice data is submitted by the official deadline of March 31.

PRACTICE BENEFITS OF MIPS PROGRAM PARTICIPATION

Although the end result will be a vast change from the reporting and reimbursement approach most practices have become accustomed to, the result of the phased-in approach should lead to improved outcomes for the practice and the patients. Since there are currently over 55 million Medicare patients in the United States, practices of every size and specialty will be impacted by these changes. Those that implement the care policies and data collection systems to meet the program requirements will see health care delivery that is better and smarter.

Benefits to the individual practice of including Clinical Quality Measures into everyday patient care include:

Enhanced Preventative Patient Care

With the data collection and public reporting mechanisms instituted by CMS, practices are incentivized to improve the support for providing a culture of safety and reducing the levels of unnecessary care. Reducing reimbursement rates based solely on the quantity of care provided may eventually lead to making care more affordable for everyone. Patients will become more involved in their care, have better access to their records, and receive more motivation to take steps necessary to live a healthier life.

Improved Care Delivery

By using incentives to improve levels of care provided to patients, CMS is pushing forward with the objective of achieving the patient-focused era of medical care. They are working to encourage providers to change how care is given by building better teams, increasing coordination across providers and health care facilities, and directing more attention to population health.

Increased Bottom Line

Although there may be some initial costs involved in setting up the data reporting system and training staff on its use, the practice benefits financially in the long run when it achieves the ability to receive payment adjustments. Other benefits come from having patients who stay with the practice longer, provide higher ratings, and recommend it to their family and friends because of the outstanding level of service they receive. Practices that are reported to the public as being high performing may also notice an increase in the level of new patients as they become aware that helpful rating information is now available for their review.

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