Quality Payment
PROGRAM

2021 APM PERFORMANCE PATHWAY (APP) OVERVIEW

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Presentation

- Overview of Quality Payment Program
- Overview of APM Performance Pathway
- Overview of APP for Shared Savings Program ACOs
- APP Submissions
- APP Scoring
- Resources and Q&A

Quality Payment Program

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula, which would have resulted in a significant cut to Medicare payment rates for clinicians. MACRA advances a forward-looking, coordinated framework for clinicians to successfully participate in the Quality Payment Program (QPP), which is composed of 2 tracks:

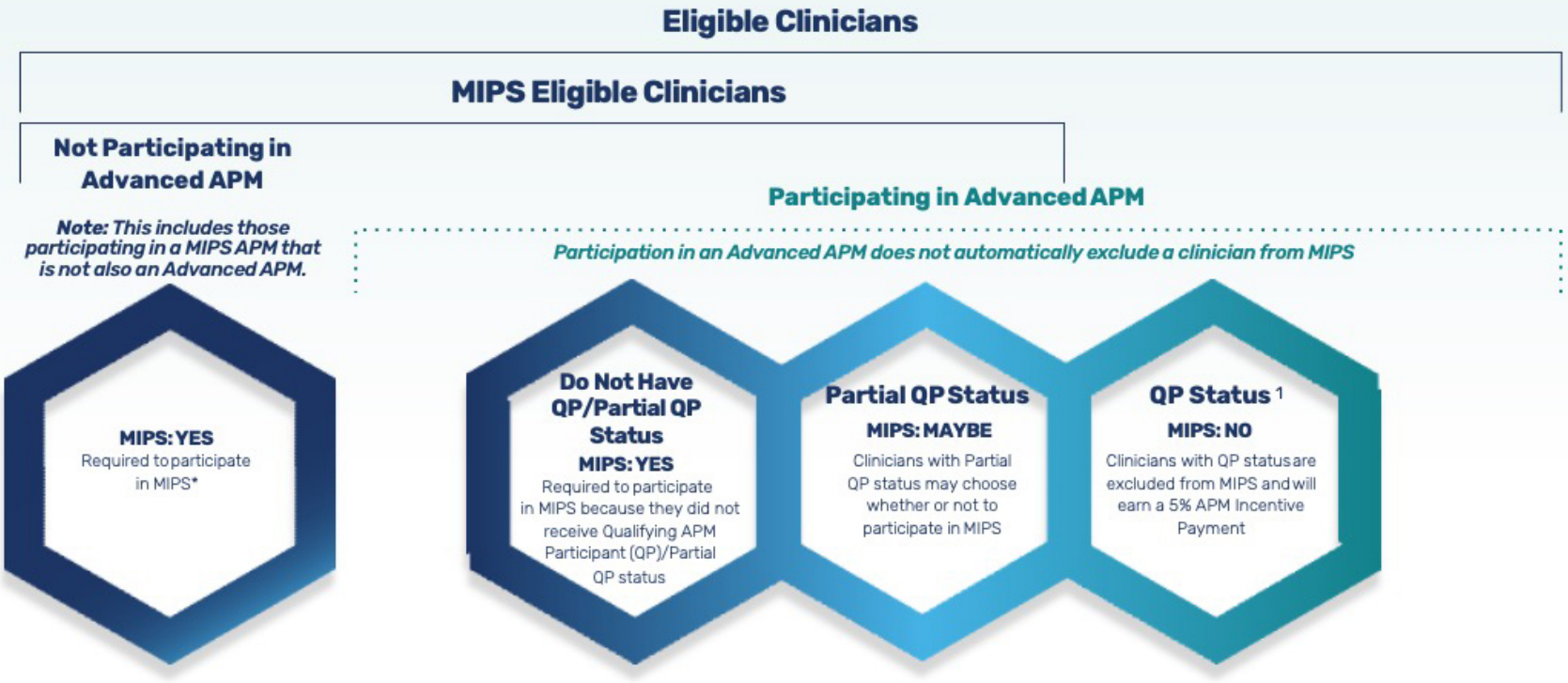
If you are a MIPS eligible clinician, you will be subject to a performance-based payment adjustment through MIPS.

If you participate in an Advanced APM* and achieve Qualifying APM Participant (QP) status, you may be eligible for a 5% incentive payment and you will be excluded from MIPS.

*Note: If you participate in an Advanced APM and don't achieve QP or Partial QP status, you will be subject to a performance-based payment adjustment through MIPS unless you are otherwise excluded.

QPP Eligibility

While the Quality Payment Program consists of 2 tracks—MIPS and Advanced APMs—the tracks can overlap. For instance, MIPS eligible clinicians participating in Advanced APMs will be required to participate in MIPS unless they earn Qualifying APM Participant (QP) or Partial QP status or are otherwise exempt.



*Assumes clinician(s) not exempt from MIPS for other reasons

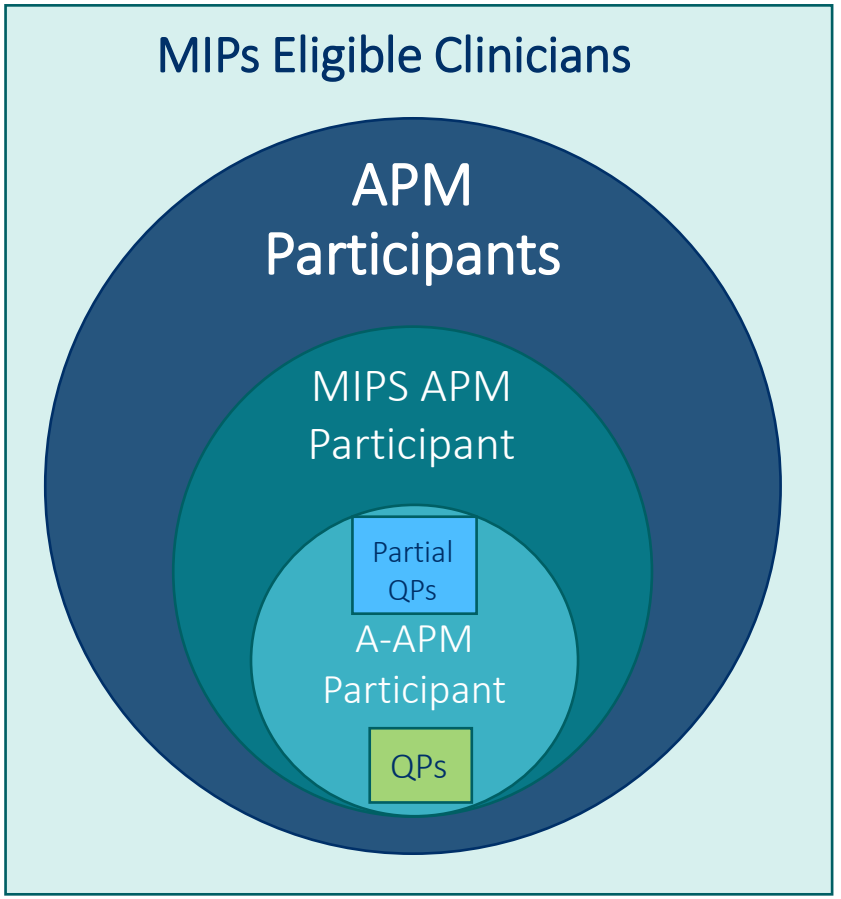
[1] Certified Midwives and Clinical Social Workers can be Qualifying APM Participants (QPs), but are not MIPS Eligible Clinicians

Alternative Payment Models (APMs)

Overview

- **Qualifying APM Participants (QPs)** are eligible clinicians who have met or exceeded the payment amount or patient count thresholds based on participation in an Advanced APM
  - They are exempt from reporting in MIPS and may earn a 5% payment on Part B claims for performance year 2021

- **Partial QPs** can choose whether or not to participate in MIPS
  - Clinicians who meet Partial QP status and elect to participate in MIPS may earn a payment adjustment



Please note: The designation of the APM does not affect a clinician's eligibility for MIPS. APM participants will still need to participate in MIPS unless they receive QP status or are otherwise exempt.

Alternative Payment Models (APMs)

QP Thresholds

QP thresholds are frozen for the next 2 years. They will be the same as they were in 2020.

Performance Year	2020	2021	2022
Payment Year	2022	2023	2024
QP Payment Amount Threshold	50%	50%	50%
QP Patient Count Threshold	35%	35%	35%

- For Partial QP, you must receive at least 40% of your Medicare Part B payments or see at least 25% of Medicare patients through an Advanced APM entity during the QP performance period (January 1 - August 31)

If you are not determined to be a QP or a Partial QP, you will be required to participate in MIPS and will be subject to a MIPS Final Score and payment adjustment, unless you are otherwise excluded. Visit qpp.cms.gov to learn more about MIPS.

APM Participants in MIPS

APM participants who are MIPS eligible (i.e., not QPs) may report to MIPS however they choose:

- Individual
- Group
- Virtual Group*
- MIPS APM Entity
  - APM Entities will have the cost performance category reweighted to 0% of their final MIPS score in traditional MIPS

All participants in MIPS APMs also have the option to report to MIPS via the new APM Performance Pathway (APP).

APM Performance Pathway (APP)

We finalized the **APM Performance Pathway (APP)** as a new reporting framework beginning with the 2021 performance year.

The APP is:

- Only available to **MIPS APMs participants**
- **Required** for all Medicare Shared Savings Program ACOs
  - Please note: ACOs report quality measures on behalf of their MIPS eligible clinicians
- Available for reporting by the individual eligible clinician, group (TIN), or APM Entity
  - CMS will award the highest available score
- Complementary to MVPs
- Composed of a fix set of measures for each performance category

APM Performance Pathway (APP)

We modified the quality measures set for the APP to add the CMS Web Interface as an additional collection type for ACO Entities to use to report on behalf of their clinicians for the 2021 performance period.

The APP's quality measure set is finalized as:

- The CAHPS for MIPS survey measure
- 2 administrative claims measures
- 3 eCQMs/MIPS CQMs quality measures
  - For the 2021 performance period, **Medicare Shared Savings Program ACOs** have the option to report the 10 CMS Web Interface measures in lieu of these 3 measures

2022 APP Proposals

2021 Final

MIPS APM participants can report the APP as an individual, a group, or APM Entity.

Shared Savings Program ACOs can report the CMS Web Interface measures for the 2021 performance year only.

Beginning with the 2022 performance year, the CMS Web Interface would be removed as a collection type.

2022 Proposed

We are proposing to make the CMS Web Interface option available for:

- **2022 performance year** for Shared Savings Program ACOs and MIPS groups.
- **2023 performance year** for Shared Savings Program ACOs only.

For the 2023 performance year, we are proposing to score the CMS Web Interface measures for Shared Savings Program ACOs that also report at least 1 eCQM/MIPS CQM.

APP FOR SHARED SAVINGS PROGRAM ACOS

Shared Savings Program Final Policies

Quality Reporting Requirements

2020 Performance Year	2021 Performance Year
23 measures reported via CMS Web Interface, CAHPS for ACOs, and administrative claims spanning four domains (For PY 2020, CMS finalized the proposal to waive the requirement for ACOs to field a Consumer Assessment of Healthcare Providers and Systems (CAHPS) for ACOs survey patient experience of care surveys and ACOs received automatic full credit for the patient experience of care measures.)	An ACO is required to report under the APP on either: • the 10 measures under the CMS Web Interface, **or** • the 3 eCQM/MIPS CQMs*. An ACO is required to field the CAHPS for MIPS survey. CMS will calculate 2 measures using administrative claims data. Based on the ACO's chosen reporting option, either 6 or 10 measures will be included in calculating the ACO's quality performance score. *ACOs reporting the 3 eCQMs/MIPS CQMs are required to meet data completeness for all 3 measures. To meet data completeness criteria for each measure, ACOs must report performance data (performance met, not met, or denominator exceptions) for at least 70% of the eligible population (denominator) as provided at 414.1340. This includes reporting 100% of patients in the denominator that meet the eligibility criteria.

Shared Savings Program Final Policies

Quality Performance Standard

2020 Performance Year	2021 Performance Year
ACOs in first PY of their first agreement period: complete and accurate reporting. **All other ACOs:** completely and accurately report all quality measure data and achieve ≥ 30th percentile of the quality performance benchmark on at least one measure in each domain.	If the ACO achieves a quality performance score that is equivalent to or higher than the **30th percentile across all MIPS Quality performance category scores**, excluding entities/providers eligible for facility-based scoring, then the ACO will meet the quality performance standard.

Quality Performance Standard

Failure to Report via the APP and Quality Performance Standard

Shared Savings Program ACOs must meet these additional requirements in order to meet the quality performance standard under the Shared Savings Program.

1. **Performance year 2021** – For performance year 2021, if an ACO does not report any of the ten CMS Web Interface measures or any of the three eCQM/MIPS CQM measures it is actively required to report and does not field a CAHPS for MIPS survey via the APP, the ACO would not meet the quality performance standard for purposes of the Shared Savings Program.

2. **Performance year 2022 and subsequent performance years** – For performance year 2022 and subsequent performance years, if an ACO does not report any of the three eCQM/MIPS CQM measures it is actively required to report and does not field a CAHPS for MIPS survey via the APP, the ACO would not meet the quality performance standard for purposes of the Shared Savings Program.

Shared Savings Program Proposals

Proposed Quality Performance Standard for PY 2022 and Subsequent PYs

2022 Performance Year	2023 Performance Year	2024 and Subsequent Performance Years
For an ACO that reports the 10 CMS Web Interface measures: the ACO must report on the first 248 consecutively ranked beneficiaries in the sample for each measure or module. If the sample of eligible assigned beneficiaries is less than 248, then the ACO must report on 100 percent of assigned beneficiaries to meet data completeness. If the ACO achieves a quality performance score that is equivalent to or higher than the **30th percentile across all MIPS Quality performance category scores**, excluding entities/providers eligible for facility-based scoring, then the ACO would meet the quality performance standard. For an ACO that reports all 3 eCQM/MIPS CQMs: If the ACO meets the data completeness and case minimum requirements for all 3 eCQM/MIPS CQMs and achieves a quality performance score equivalent to or higher than the **30th percentile of the performance benchmark on at least one measure** in the APP measure set, then the ACO would meet the quality performance standard.	For an ACO that reports the 10 CMS Web Interface measures: the ACO must also report at least 1 eCQM/MIPS CQM. However, if an ACO does not report at least 1 eCQM/MIPS CQM, then the ACO would not meet the quality performance standard. Same as PY 2022	For an ACO that reports all 3 eCQM/MIPS CQMs: If the ACO achieves a quality performance score that is equivalent to or higher than the **40th** percentile across all MIPS Quality performance category scores, excluding entities/providers eligible for facility-based scoring, then the ACO would meet the quality performance standard.

APP SUBMISSIONS

APP Submissions

The following submitters can report on behalf of MIPS APM participants:

- Third Party Intermediaries (TPIs)
- Qualified registries/Qualified Clinical Data Registries (QCDRs)
- APM participants reporting their own data

QPP allows for the following file submissions

- QPP Java Script Object Notation (JSON)
- Quality Reporting Data Architecture (QRDA) III

Data for APP reporting is submitted using

- QPP Portal User Interface (UI)
- Direct submission via Application Programming Interface (API)
- Part B Claims (when applicable)
- Web Interface submissions for SSP ACOs

APP Submissions

Aggregating and submitting your data

- APM Entity level reporting means that you are reporting on behalf of all clinicians in the APM Entity
  - Your submission should include aggregated all payer data for all clinicians in the APM Entity as determined by the measure specifications

- For MIPS CQMs/eCQMs quality data must be aggregated prior to submitting files to CMS. CMS will not aggregate data submitted by TINS in an APM Entity to create an APM Entity level submission

- Submissions may include data for clinicians and groups with MIPS exclusions, exemptions and exceptions.

APP Submissions

Data completeness requirements

- Data completeness refers to the volume of performance data reported for the measure's eligible population. When reporting a quality measure, you must identify the eligible population (or denominator) as outlined in the measure's specification.

- To meet data completeness criteria, you must report performance data (performance met or not met, or denominator exceptions) for at least 70% of the eligible population denominator. This includes reporting 100% of patients in the denominator that meet the eligibility criteria.

- For MIPS APM participants reporting at the APM Entity level, the data completeness calculation applies to the APM Entity. This means that an aggregated APM Entity level submission should account for 100% capture of the eligible population across all participants in the APM Entity.

APP SCENARIOS

Scenario 1

APP Measure not Applicable to Clinician

Q: I am a neurosurgeon who is part of a MIPS APM and would like to report the APP as an individual. I do not treat any diabetes as part of my practice. For measure 001, I would not be able to report this measure. What will happen to my APP MIPS score?

A: If you do not submit a claim using any of the Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) codes included in the measure specifications for a measure in the APP quality measure set, you will not be scored on this measure. You or your third-party intermediary (TPI) will need to report the measure using the following format:


```
{
"measureId": "001",
"value": {
  "isEndToEndReported": false,
  "performanceMet": 0,
  "performanceNotMet": 0,
  "eligiblePopulation": 0,
  "eligiblePopulationExclusion": 0,
  "eligiblePopulationException": 0
  }
}
```


- By reporting the measure in this fashion, the system will acknowledge a lack an eligible patient population and reduce the denominator for required reportable measures by 10 points.

Scenario 1

APP Measure not Applicable to Clinician

Scoring:

Measure	Score	Quality Denominator	Applicable
001	–	–	No
134	8	10	Yes
236	7	10	Yes
CAHPS	–	–	No
HWR	–	–	No
MCC	–	–	No
Quality Score	15	20	15 / 20 * 50 = 37.5 Points

Scenario 2

Reporting Aggregated Data for your APM Entity

The following example describes an acceptable method for aggregating data for APM Entity level submissions for MIPS reporting

In this example, the APM Entity is composed of 4 Tax Identification Numbers (TINs) and the measure being reported is Measure 236 via the APP. In addition, there is one clinician that is a non-APM participant.

Measure # and Title	Quality ID: 236 Controlling High Blood Pressure
Collection Type	• Electronic Clinical Quality Measure (eCQM)/ MIPS Clinical Quality Measure (CQM)
Submitter Type	• MIPS Eligible Clinician • Representative of a Practice • **APM Entity** • Third Party Intermediary

Scenario 2

Reporting Aggregated Data for your APM Entity

APM Entity Structure

- APM Entity_1:
- TIN_1 | NPI_1
- TIN_2 | NPI_2
- TIN_3 | NPI_3
- TIN_4 | NPI_4

Non-APM Participant

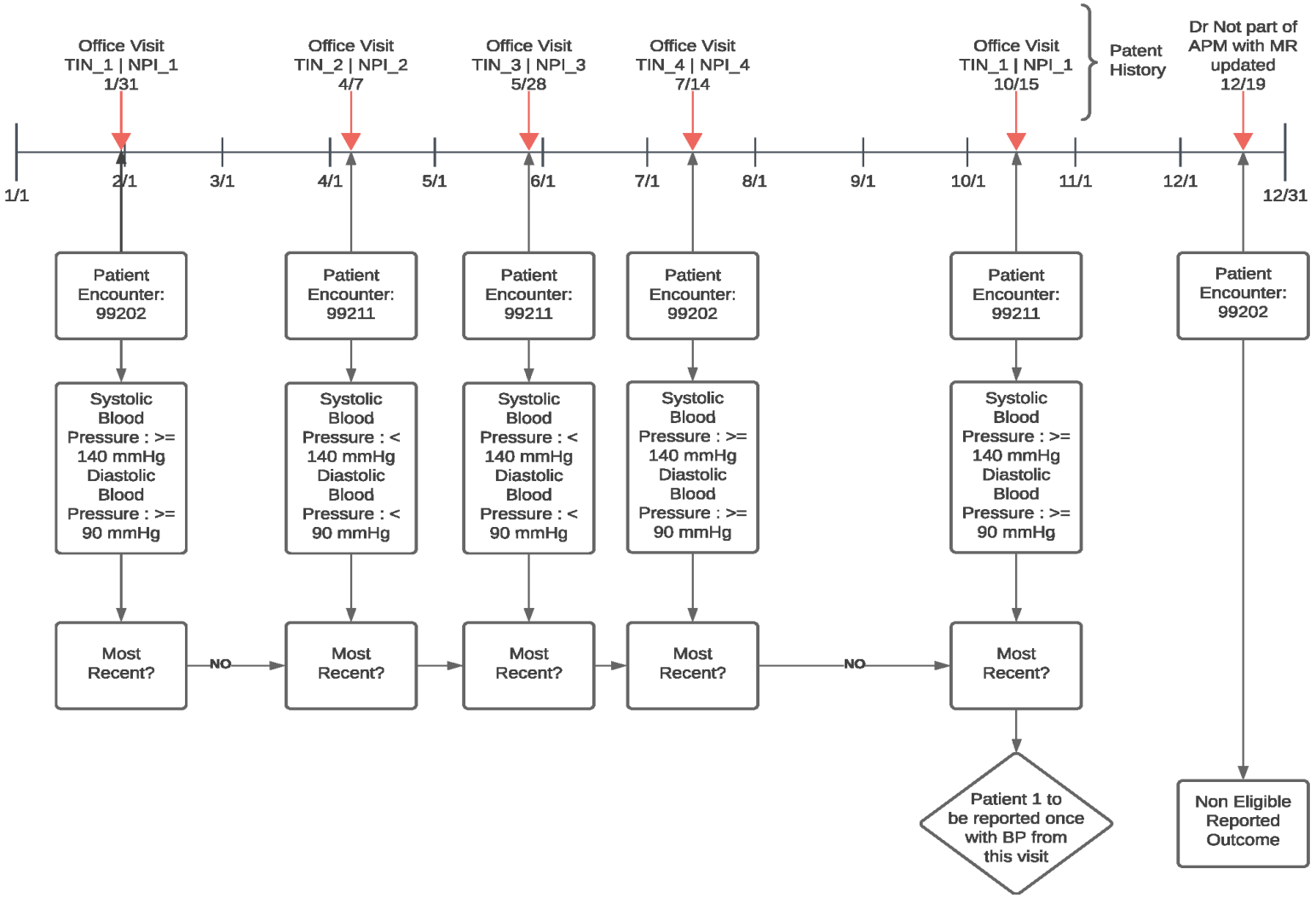
- TIN_X | NPI_X

Scenario:

- Patient X is 65 years of age
- Patient X has a diagnosis of hypertension overlapping the performance period
- Patient X is seen by multiple clinicians that are members of APM Entity_1
- Patient X is eligible for Measure 236

Scenario 2

Reporting Aggregated Data for your APM Entity



Scenario 2

Reporting Aggregated Data for your APM Entity

- Eligible instances of the measure are to be collected by each TIN | National Provider Identifier (TIN/NPI) participating in the APM Entity.
- Performance Met, Not Met, or Exception (if applicable) can only be reported by a clinician in the APM Entity.
- In the instance above, Patient 1 would be reported once being part of the Eligible Population and Performance Not Met, since the Blood Pressure (BP) metrics are above the threshold.
- As the last encounter in the year is not associated with the APM Entity, the visit is not eligible for reporting by the APM Entity.

Scenario 3

QRDA III Scenarios

- I am a Single TIN APM Entity that participates in the Shared Savings Program. As part of my participation in the Shared Savings Program, I must report the APP. I have 2 options for reporting MIPS CQMs or eCQMs:
  - Report directly to Quality Payment Program (QPP) using the QPP Website using either a Quality Reporting Document Architecture Category III (QRDA-III) file or QPP JavaScript Object Notation (JSON) file
  - Use the QRDA-III Convertor to QPP JSON prior to submitting to the QPP Site
    - This tool accepts QRDA-III files and will convert them into a QPP JSON output.

Scenario 4

QRDA III Scenarios

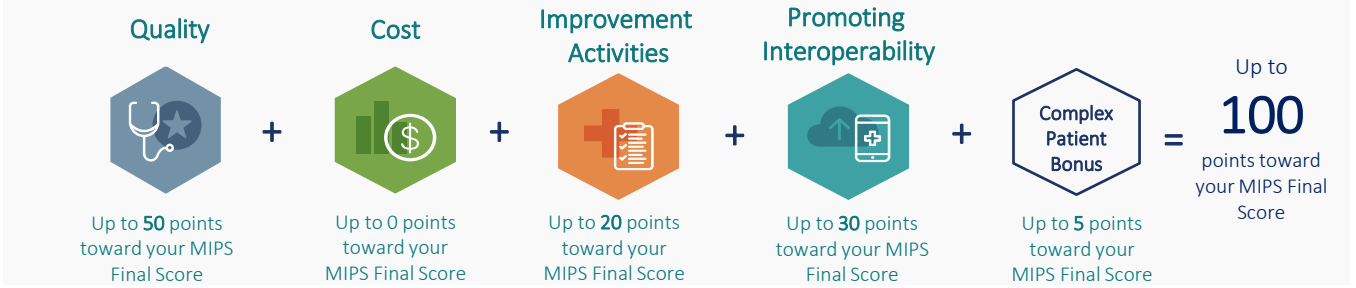
- I am a Multi TIN APM Entity that participates in the Shared Savings Program. As part of my participation in the Shared Savings Program, I must report the APP. Overlapping patients are not identifiable using QRDA III files. Therefore, if you are aggregating data to report at the APM Entity level, the QRDA III file is not an appropriate starting point for doing so. As a result, you will need to de-duplicate the data prior to submitting the file to CMS.

APP SCORING

APP: MIPS Final Score

We multiply your performance category score by the category's weight, and then multiply that figure by 100, to determine the number of points that contribute to your final score for each performance category. To calculate your final score, we add the points for each performance category to any complex patient bonus you may have received.

APP Performance Category Weights in 2021:

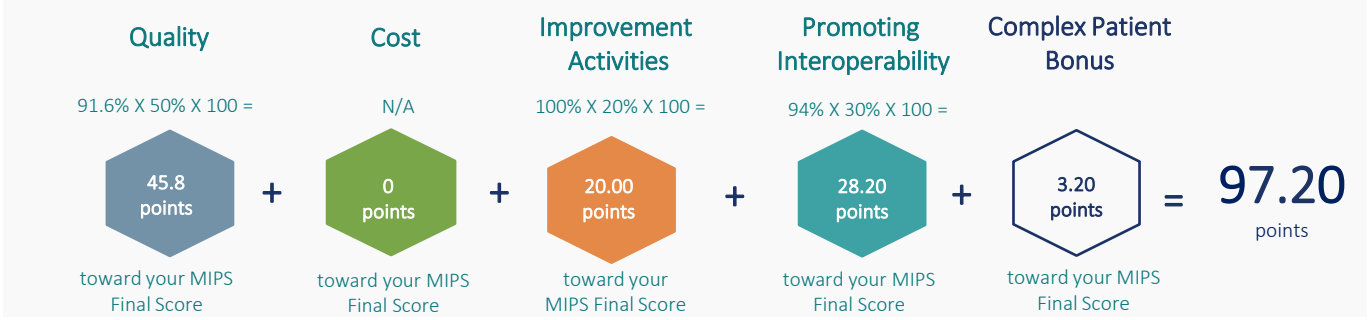


NOTE: The cost performance category is weighted at 0% of the MIPS Final Score for MIPS APM participants reporting through the APP, because all MIPS APM participants are already responsible for costs under their APMs.

Scoring Example

Below is an example of an APM Entity reporting via the APP. Let's review how the final score is calculated:

APP Performance Category Weights in 2021:



The MIPS Final Score can't exceed 100 points

APP: MIPS Final Score

Quality Performance Category

Maximum Points by Reporting Level	
Individuals	• 30 POINTS –For the 3 required quality measures: - The CAHPS for MIPS Survey can't be administered for individual clinicians. - The Hospital-wide, All-Cause Unplanned Readmission (HWR) measure doesn't apply to individual clinicians. - The Risk-Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions (MCCs) for Shared Savings Program ACOs measure measures doesn't apply to individual clinicians.
Groups and APM Entities	• 50 POINTS –For the 3 required quality measures + CAHPS for MIPS Survey measure + HWR measure - The MCC measure doesn't apply to groups or non-ACO APM entities.
ACOs Reporting eCQMs/MIPS CQMs	• 60 POINTS –For the 3 required quality measures or the 10 CMS Web Interface + CAHPS for MIPS Survey measure + HWR measure + MCC measure

APP: MIPS Final Score

Improvement Activities Performance Category

- All MIPS APM participants who report through the APP will receive a full score for the Improvement Activities performance category in performance period 2021, and therefore will not need to submit additional improvement activity information.

APP: MIPS Final Score

Promoting Interoperability Activities Performance Category

- Promoting Interoperability data is only submitted at the individual or group level, not through the APM Entity. Third-Party Intermediaries can submit data on behalf of Individuals and Groups they support.

APM Entity Participation

- When reporting the APP as an APM Entity, the MIPS eligible clinicians in the Entity still report their Promoting Interoperability measures as individuals or as a group. We score the required measures just as we do for all other individuals and groups, and then we use those scores to calculate a score for the Entity.

- The APM Entity's Promoting Interoperability performance category score is an average of the highest score attributed to each MIPS eligible clinician in the APM Entity based on the required measures from their individual or group reporting.

APP: MIPS Final Score and Payment Adjustment

How Does My MIPS Final Score Determine My Payment Adjustment?

- Your MIPS final score will be between 0 and 100 points. Each final score will correlate to a payment adjustment(s), but in most cases we can't project what this correlation will be. Why? MIPS is required by law to be a budget-neutral program.

- The table below illustrates how 2021 MIPS final scores will correlate to 2023 MIPS payment adjustments for MIPS eligible clinicians:

Final Score	Payment Adjustment
85.00 – 100.00 points (Additional performance threshold = 85.00 points)	• Positive MIPS payment adjustment (subject to a scaling factor to preserve budget neutrality) • Eligible for additional adjustment for exceptional performance (subject to a scaling factor to account for available funds)
60.01 – 84.99 points	• Positive MIPS payment adjustment (subject to a scaling factor to preserve budget neutrality) • Not eligible for additional adjustment for exceptional performance
60.00 points (Performance threshold = 60.00 points)	• Neutral MIPS payment adjustment (0%)
15.01 – 59.99 points	• Negative MIPS payment adjustment (between -9% and 0%)
0 – 15.00 points	• Negative MIPS payment adjustment of -9%

RESOURCES

APP Resources

- Website: https://qpp.cms.gov/mips/apm-performance-pathway
- Zip file of APP resources: PY2021 APM Performance Pathway Toolkit
- MIPS CQM and eCQM Measure Specifications
  - 001 MIPS CQM - Diabetes: Hemoglobin A1c (HbA1c) Poor Control
  - 001 eCQM - Diabetes: Hemoglobin A1c (HbA1c) Poor Control
  - 134 MIPS CQM - Preventive Care and Screening: Screening for Depression and Follow-up Plan
  - 134 eCQM - Preventive Care and Screening: Screening for Depression and Follow-up Plan
  - 236 MIPS CQM - Controlling High Blood Pressure
  - 236 eCQM - Controlling High Blood Pressure

Questions?

To ask a question, please dial:

If prompted, use passcode:

Press ***1** to be added to the question queue.

You may also submit questions via the chat box. Speakers will answer as many questions as time allows.

THANK YOU