

MIPS Reporting and the Opioid Epidemic

Congratulations to all of those that participated in Transition year for MIPS!

Opioid overdose deaths in the U.S. increased 28% from 2016 to 2017 across every demographic group.¹ Deaths from prescription pain medications overall are four times higher than they were 20 years ago, and an estimated 44 individuals die from prescription opioid overdoses each day.² Beyond the significant social and emotional costs, the opioid epidemic has cost the U.S. more than \$1 trillion since 2001 – especially in lost productivity, increased healthcare costs, and lost tax revenue – with another \$500 billion expected by 2020 if conditions continue (see figure).³

Moving the Needle with MIPS

If you're working to improve opioid prescription safety in your practice, you can monitor your progress and be rewarded for your efforts by reporting on relevant MIPS measures (listed in the table below). One resource that could help you improve your performance on these measures is the National Quality Partners' Playbook on safer opioid prescribing: http://www.qualityforum.org/News_And_Resources/Press_Releases/2018/NQF_Issues_Critical_Guidance_to_Support_Safer_Opioid_Prescribing.aspx.

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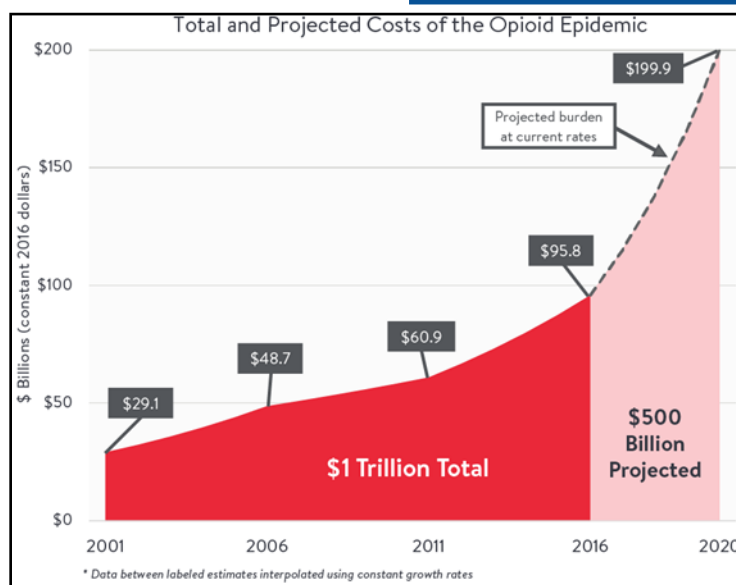
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This newsletter is produced by IMPAQ International who is functioning as the QPP SURS Central Support contractor. Questions or suggestions about the newsletter can be sent to QPPSURS@IMPAQINT.COM.



¹<https://www.cdc.gov/mmwr/volumes/67/wr/mm6709e1.htm>

²<https://www.healthit.gov/opioids>

³<https://altarum.org/about/news-and-events/economic-toll-of-opioid-crisis-in-u-s-exceeded-1-trillion-since-2001>

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Opioid-Related Measures for MIPS Clinicians	
Quality Measure 412	<p>MIPS Measure Name: Documentation of Signed Opioid Treatment Agreement</p> <p>Description: All patients 18 and older prescribed opiates for longer than six weeks duration who signed an opioid treatment agreement at least once during Opioid Therapy documented in the medical record.</p>
Quality Measure 414	<p>MIPS Measure Name: Evaluation or Interview for Risk of Opioid Misuse</p> <p>Description: All patients 18 and older prescribed opiates for longer than six weeks duration evaluated for risk of opioid misuse using a brief validated instrument (e.g. Opioid Risk Tool, SOAPP-R) or patient interview documented at least once during Opioid Therapy in the medical record.</p>
Quality Measure 408	<p>MIPS Measure Name: Opioid Therapy Follow-up Evaluation</p> <p>Description: All patients 18 and older prescribed opiates for longer than six weeks duration who had a follow-up evaluation conducted at least every three months during Opioid Therapy documented in the medical record.</p>
Improvement Activity IA_PSPA_10	<p>MIPS Measure Name: Completion of training and receipt of approved waiver for provision opioid medication-assisted treatments</p> <p>Description: Completion of training and obtaining an approved waiver for provision of medication-assisted treatment of opioid use disorders using buprenorphine.</p>
Improvement Activity IA_PSPA_6	<p>MIPS Measure Name: Consultation of the Prescription Drug Monitoring Program</p> <p>Description: Clinicians would attest that, 60 percent for first year, or 75 percent for the second year, of consultation of prescription drug monitoring program prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription that lasts for longer than 3 days.</p>

Tools and Resources

A number of additional tools and resources may also help you figure out how to participate in improvement efforts related to the opioid epidemic:

1. Make the most of **Prescription Drug Monitoring Programs:** Prescription drug monitoring programs (PDMPs) are state-operated electronic databases that can provide information about an individual's use of prescriptions for controlled substances. In addition, registering for and using a PDMP can qualify as a MIPS Improvement Activity. Check with your EHR vendor or the PDMPConnect website (<https://www.healthit.gov/pdmp/PDMPConnect>) to learn what kind of PDMP access is available in your state. Read more about PDMPs here: <https://www.healthit.gov/PDMP>.

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WEBSITES

Centers for Medicare and Medicaid Services
cms.gov

Quality Payment Program
qpp.cms.gov

Healthcare Communities
healthcarecommunities.org

For FREE assistance funded by CMS, clinicians in small practices can contact their Direct Support Organization
qpp.cms.gov/about/small-underserved-rural-practices

CONTACT US

QPP SURS Central Support Team
(202) 774-1060
qppsurs@impagint.com

CMS QPP Service Desk
1 (866) 288-8292
1 (877) 715-6222 (TTY)
qpp@cms.hhs.gov

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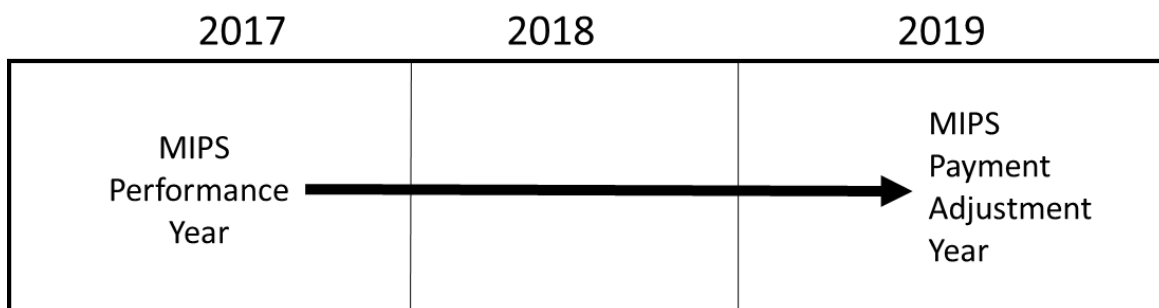
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2. If you have access to a statewide **Health Information Exchange (HIE)**, you can use it to support coordinated care or request information on a patient in an emergency. Electronically creating a summary of care record or transmitting it to another clinician was an Advancing Care Improvement measure for the 2017 transition year.
 - A. Learn more about HIEs: <https://www.healthit.gov/provider-professionals/health-information-exchange/what-hie>
 - B. Access a state-by-state list of HIE contact information: <https://www.healthit.gov/policy-researchers-implementers/state-health-information-exchange-cooperative-agreement-program-key>
3. Take the **Medication Management and Opioid (MMO) Initiative pledge**. Join a community of like-minded clinicians who commit to learning about best practices, treating persons with opioid use disorder in a respectful and person-centered way, aligning with existing programs to combat opioid misuse, and share successes and best practices. Clinicians who sign the pledge receive a certificate of recognition, which you can display in your waiting room: <https://www.healthcarecommunities.org/Home/MMOPledge.aspx>
4. Check out the CDC's **Guidelines for Prescribing Opioids for Chronic Pain**. This two-page fact sheet is designed for primary care providers who treat adults with chronic pain: https://www.cdc.gov/drugoverdose/pdf/Guidelines_Factsheet-a.pdf
5. Review two recent webinars on maintaining a good therapeutic relationship to help patients manage their pain and their medications. The Quality Improvement Organizations (QIO) program recently recorded two events that may inform your thinking in this area:
 - A. Psychologically integrated approaches to pain management: <http://qioprogram.org/medication-safety-lan-event-january-2018>
 - B. Perspectives from rural communities on the opioid crisis: <http://qioprogram.org/national-disparities-lan-event-march-2018>

MIPS Payment Adjustments

Payment adjustments based on your 2017 final MIPS score will go into effect on January 1, 2019. Here is how your final score will affect the rate Medicare pays you for Medicare part B services:

- A percent increase (up to 4%) based on funds available from all MIPS scores, or MIPS scores of 4 points or above;
- A percent decrease (-4%) for MIPS clinicians who did not report enough to achieve a neutral adjustment, or had total MIPS scores of less than 3 points; or
- No change (0%) for exempt clinicians or those who reported enough data for a neutral adjustment, or had total MIPS scores of 3 points.



We have included a few frequently asked questions below related to payment adjustments that may be helpful. If you have other or more specific questions, you can contact your Technical Assistance Contractor for **free** support: <https://qpp.cms.gov/about/small-underserved-rural-practices>

Q: If I only have 1 "eligible" physician in my practice, am I only held responsible to report the 1 physician?

A: Yes, if the practice is reporting as individual clinicians, only those clinicians that CMS designates as MIPS- eligible based on the QPP NPI Lookup Tool would be subject to the MIPS payment adjustment. To verify 2017 eligibility you can check each NPI using the QPP NPI Lookup Tool here: <https://qpp.cms.gov/participation-lookup>

Q: If I report as an individual for each MD for a full year, they each get the bonus? If we report as a group, is the bonus less for the full year because they are reporting as group? What is the difference in reporting individual vs. group?

A: If each MD reports individually, each MD's adjustment is based on their own TIN/NPI MIPS score. If you report as a group, the scoring and payment adjustment are calculated at the TIN level based on the group's performance – including the performance of both eligible and non-eligible clinicians. The group's MIPS score may be higher or lower than an individual MD's score, so bonuses received through group reporting may be higher or lower than individual bonuses.

Q: What if a provider changes practices in the middle of a performance year? Do you count patients/ performance across practices or only look at one?

A: You would need to use the CMS NPI lookup tool to check MIPS reporting requirements for each TIN-NPI combination associated with the clinician. If the clinician joined a new practice after August 31, 2017, he or she would not be subject to the 2017 MIPS payment adjustment under that new TIN-NPI combination. However, the clinician may still be eligible under prior TIN-NPI combination(s) billed. We recommend using the NPI lookup tool to be sure of eligibility requirements at a given TIN-NPI.

How to Participate in MIPS through an ACO

Clinicians have the option to join an Alternative Payment Model (APM) for a different MIPS reporting experience. While there are several kinds of APMs, Accountable Care Organizations (ACOs) are the most familiar APM for many clinicians.

What’s an ACO?


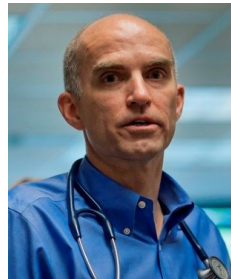
ACOs are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients. ⁴

Why Join an ACO?

Better care. Clinicians who are part of an ACO work together to help make sure patients get the right care at the right time, avoid unnecessary duplication of services, and prevent medical errors.

Financial rewards. When an ACO helps Medicare save money, it can keep a portion of the savings, as long as it’s performing well on quality measures that are similar to MIPS measures. This benefit is in addition to any positive payment adjustment you may qualify for under MIPS or on the advanced APM track.

Help with MIPS reporting. Many ACOs help clinicians with MIPS reporting, and if you are in an ACO that qualifies as an advanced APM, you may be exempt from MIPS entirely.

	<p>“I can’t say enough about our ACO. We are independent, not a part of a hospital or system, but it honestly has helped so much. Especially if you’re new and going in blind, they have people who do this all day every day who can help you through the process.”</p> <p>Crystal Bond, Practice Manager, FL</p>
	<p>“Being part of an ACO has definitely changed how we participate in MIPS. A lot of the reporting is done for us by the ACO, but just because you are part of an ACO doesn’t mean you don’t have to do anything. ACI measures will be reported by each practice. The score will be calculated together for a score for the ACO, but at the end of the day, the individual practice is responsible.”</p> <p>Dr. John Berneike, family medicine physician, UT</p>

Things to Consider before Joining an ACO

ACOs can be divided into two types: one-sided models and two-sided models.

One-sided models get to keep some of the savings generated (distributing savings among members), and don’t lose money if care costs more than expected. If you are in this kind of ACO, you’ll still need to report MIPS measures. Your ACO may report MIPS quality measures and improvement activities on your behalf, but you’ll need to report your own advancing care information (ACI) measures.

⁴<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/>

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Two-sided models get to keep a bigger share of the savings generated, but if costs are higher than expected, the ACO (including you) may lose money. Two-sided models qualify as advanced APMs. If you participate in an advanced APM and meet the threshold for being a qualified participant (QP) (i.e., seeing 20% of your patients or obtaining 25% of your Medicare part B revenues through your advanced APM), then:

- You are exempt from MIPS; and
- Beginning in 2019, you will be eligible for a lump sum incentive payment equal to 5% of your estimated aggregate payment amounts from 2018 for covered services.

If you participate in an advanced APM and don't meet the threshold for being a full QP, then you may be a partial QP. A partial QP is an eligible provider who meets slightly reduced participation thresholds (i.e., seeing 10% of your patients or obtaining 20% of your Medicare part B revenues through your advanced APM). Partial QPs do not receive the 5 percent APM incentive payment, but can choose whether or not to participate in MIPS. If you are a partial QP and choose not to report to MIPS, you will have no payment adjustment for that year.

Do you feel confident enough to join a two-sided ACO model?

Typically, ACOs start out as one-sided models, and as they gain confidence in their ability to generate savings while delivering high-quality care, they may evolve into two-sided models. It may be helpful to ask about the ACO's past history of generating cost savings for and earning bonuses from Medicare.

What would be the terms of your agreement with the ACO?

Each ACO has its own agreement with Medicare, and sets its own terms for agreements with participating clinicians. You may want to consider how cost savings generated by the ACO will be shared with you, how patients will be attributed to you, and what support the ACO will provide for MIPS reporting and care coordination. In addition, you can consider what data you would need to report to the ACO, and how to report the data.

Interested in joining an ACO?

Check out this list of QPP Alternative Payment Models (APMs), which includes – but is not limited to – ACOs. This list is for 2018, but may be updated in the future: <https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Comprehensive-List-of-APMs.pdf>

Monthly Observance: National Minority Health Month

Each April the country observes National Minority Health Month to draw attention to two things:

1. The health disparities that persist among racial and ethnic minority groups
2. The ways in which policy, legislation, and programs can promote health equity

“Partnerships at the national, state, tribal and local levels are vital to the work of reducing health disparities and advancing health equity.”⁵

Clinicians like you can play a part in reducing health disparities and promoting health equity! One of the purposes of MIPS is to look at health needs among different patient populations. If you have an EHR that can show data by race, ethnicity, language, gender, and other patient characteristics, you can look at how your different patient populations are doing along different MIPS indicators. Do any groups need extra attention? Are there community organizations you can partner with to help those groups?

See more at the U.S. Department of Health and Human Services Office of Minority Health website: <https://minorityhealth.hhs.gov>

Targeted Resource: Cost Performance Category

CMS continues to create resources to help clinicians with reporting MIPS data. This article highlights a recent addition: the **Cost Performance Category Fact Sheet for 2018**.

This fact sheet shows what percentage of your final MIPS score in 2018 will be attributable to the Cost category, and presents further information to help you calculate your Cost score as a first step to understanding how you can improve it.

The Transition year (2017) used a 0% weight for the Cost category, but Year 2 (2018) assigns 10% of your total MIPS score to the Cost category. In future years, the Cost category will grow in importance as a percentage of MIPS scores, reaching 30% by 2022.

For Year 2, there are only two cost measures:

- **Total Per Capita Cost (TPCC)** – measures all of Medicare Part A and Part B costs during the MIPS reporting period, i.e. January 1, 2018 through December 31, 2018.
- **Medicare Spending Per Beneficiary (MSPB)** – measures the Medicare costs for services performed by a clinician during a MSPB episode, i.e. three days before a hospital admission through 30 days after hospital discharge.

For cost to count in your score, you must meet a case minimum of attributed beneficiaries, which is 20 cases (i.e., beneficiaries) for the TPCC measure, or 35 cases for the MSPB measure. If the case minimums aren't met for either of the two measures, CMS will reallocate the Cost performance category weight (10%) to Quality (50%), making the Quality performance category worth 60% of your 2018 MIPS total score.

A March 2018 webinar provided additional information on the cost category for small practices including those in rural and underserved areas. Slides and a recording will be posted here: <https://qppsurs.wordpress.com/resources/>

View the 2018 Cost Performance Category Fact Sheet: <https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Cost-Performance-Category-Fact-Sheet.pdf>

For the full list of 2018 resources, please visit: <https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Resources.html>

⁵<https://www.minorityhealth.hhs.gov/omh/content.aspx?lvl=2&lvlid=12&ID=10234>

Upcoming Events

Information regarding upcoming events, along with registration information, can be found below:



May 2018 LAN Webinar: Succeeding in MIPS: Advice from Peers in Solo & Small Group Practices

Tuesday, May 15, 2018 at 11:00 am ET, Register here:

https://qppsurs.adobeconnect.com/efuupbzc4n2y/event/event_info.html

Thursday, May 17, 2018 at 3:30 pm ET, Register here:

https://qppsurs.adobeconnect.com/ediebwk6xbbu/event/event_info.html

Past Events

Past QPP SURS events are listed here: <https://qppsurs.wordpress.com/resources/>

Upcoming and past CMS events related to MACRA, MIPS, and APMS are listed here: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-Events.html>