GUIDEPOINT Reimbursement Resources

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Medicare Quality Programs Question and Answers

1. *Do physicians choose the mechanisms for all patients for all clinical conditions? or can they elect it for a particular condition but not others? I understand the differing levels of risk, but how does reward vary?*

   Answer: Measure selection should be decided based on the practice and ease of collection. When determining quality measures, the practice will need to evaluate the level of performance and effort required to earn points toward the quality score. The individual physician or group must report all chosen measures in the same manner. For example, if a practice chooses two quality measures that require registry reporting, the practice could not select additional measures that require another manner of reporting, such as EHR or Part B claims submission.

   Source: https://qpp.cms.gov/mips/quality-measures

2. *How do you define a "quality improvement activity"?*

   Answer: Scoring includes Quality, Resource Use (cost), Improvement Activities, and Advancing Care Information. Quality Measures

   Improvement Activities are specified activities intended to advance practices in areas such as care coordination, safety checklists and expanded access for patients. Participation in Improvement Activities is expected to improve the patient care experience. Improvement activities include the activities such as the use of evidence-based decision aids to support decision making; improved practices for patient engagement, and collection and follow-up on patient experience and satisfaction data of beneficiary engagement. It is recommended that each practice review the Improvement Activities for applicability to its organization.

   Quality Measures as defined by CMS are “Tools that help us measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care. These goals include: effective, safe, efficient, patient-centered, equitable, and timely care.”
   The Quality Performance Category is closely related to the previous quality reporting system< PQRS. Measures are chosen by the practice based on applicability. Like Improvement Activities, each practice should review Quality Measures for optimum performance and scoring.

3. *Does a practice choose the quality measures? Do they have to be across each patient population? What if they choose to focus on just one clinical care condition?*

   Answer: Yes, the practice chooses the quality measures specific and appropriate to their patient population. A practice can choose based on specialty or select outside of the specialty specific sets. Quality measures have a specific patient population, for example, Childhood Immunization Status, CMS Measure ID CMS 117V5's initial patient population is defined as: Children who turn 2 years of age during the measurement period and have a visit during the measurement period.

   Source: https://qpp.cms.gov/mips/quality-measures

4. *On slide 23 under the partial/full year participation, you state 6 quality measures must be reported for a full year. Does that mean if you choose a 90-day period, you still use a full year of reporting or a 90-day period of reporting? Thanks*

   Answer: To clarify, Partial Participation requires the reporting of 6 quality measures for a 90-day period.

   Source: https://qpp.cms.gov/docs/QPP_MIPS_Participation_Fact_Sheet.pdf

5. *For Test pace only: 1 Quality measure or 1 Improvement measure or ? what was the advancing care requirement?*

   For Test Pace Participation: It is 1 Quality Measure, OR 1 Improvement Measure OR 4or 5 Advancing Care Information Measures.

   Sources: CMS Merit-based Incentive Program, November 29, 2016

6. *Do I understand correctly that the requirement is either one quality measure or one improvement measure or whatever the advancing care requirement is, not all three?*

   Answer: Yes, your understanding is correct. It is 1 Quality Measure, OR 1 Improvement Measure OR 4 or 5 Advancing Care Information Measures.

   Sources: CMS Merit-based Incentive Program, November 29, 2016

7. *Please explain in detail how we report these measures, please*

   Answer: The quality measure can be reported through multiple mechanisms: Electronic Healthcare Record, Qualified Clinical Data Registry/registries, claims, CMS Web, Interface, administrative claim, measures, and Consumer Assessment of Healthcare Providers and Systems (CAHPS)for MIPS.
   Sources: CMS Merit-based Incentive Program, November 29, 2016

8. *What if there are no existing models for erectile dysfunction or other urology conditions? is there a benefit to starting a model?*

   Answer: Although, not specifically an erectile dysfunction model, it is my understanding that Large Urology Group Practice Association (LUGPA) has begun an initiative to develop a Urology-Centric APM. LUGPA will develop, in connection with another partner, two APM projects: Prostate Cancer Biopsy Taking Risk on Sepsis; and Positive Biopsy/Localized Prostate Cancer. Additional information can be obtained through LUGPA.

9. *Would implementation of a care pathway for ONE clinical patient population allow the practice to be certified for APMs for ALL clinical conditions?*

   Answer: The provider's eligibility status is not an option on the part of the clinician. The eligibility is determined by CMS each year. With the onset of each performance year, CMS will post a list of eligible APMs and Advanced APMs. At the end of the same performance year, the CMS determines whether eligible professionals were assigned to one or more APMs based on the participation list submitted by the APM.

   Source: https://qpp.cms.gov/apms/overview