

# Quality Payment Program (QPP) and Palliative Care FAQs

*Compiled as of 2/27/2017*

## Introduction

This FAQ document was developed by compiling questions that were posed during the MACRA webinars hosted by the National Coalition for Hospice and Palliative Care in June and November 2016. The answers are intended to support clinicians who are preparing to participate in the Quality Payment Program (QPP); however, this document has not been reviewed nor should it be construed as official guidance by the Centers for Medicare and Medicaid Services (CMS). Please consult the CMS QPP website (<https://qpp.cms.gov/>) or contact CMS directly ([QPP@cms.hhs.gov](mailto:QPP@cms.hhs.gov)) if you have any detailed questions.<sup>1</sup>

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<sup>1</sup> Special thanks to Hart Health Strategies for its support in developing these responses.

## Acronyms<sup>2</sup>

- ACO – Accountable Care Organization
- APM – Alternative Payment Model
- CAHPS – Consumer Assessment of Healthcare Providers and Systems
- CMS – Centers for Medicare and Medicaid Services
- CMMI – Center for Medicare and Medicaid Innovation
- EHR – Electronic Health Record
- MACRA – Medicare Access and CHIP Reauthorization Act
- MIPS – Merit-based Incentive Payment System
- NQF – National Quality Forum
- PQRS – Physician Quality Reporting System
- QCDR – Qualified Clinical Data Registry
- QP – Qualifying APM Participant
- QPP – Quality Payment Program

## Quality Payment Program (QPP) and Merit-based Incentive Payment System (MIPS) Eligibility

### Who is considered an eligible clinician in the QPP?

In Years 1 and 2 of the QPP, Physicians (MD/DO and DMS/DDS), Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, and Certified Registered Nurse Anesthetists are considered eligible clinicians. Note that this does not include providers, such as clinical social workers, who have been reporting quality measures under the PQRS for a number of years. CMS will consider expanding the definition of eligible clinician in Year 3 of the program.

### What are the MIPS provider exclusions?

The main QPP exclusions are:

- Medicare Part B clinicians who do not meet the low-volume threshold (i.e., those billing less than \$30,000 a year or providing care for 100 or fewer traditional Medicare patients a year);
- Clinicians who are enrolled in Medicare for the first time during the performance period; or
- Clinicians significantly participating in Advanced APMs (i.e., receiving at least 25 percent of Medicare payments or seeing at least 20 percent of Medicare patients through an Advanced APM).

### Is the low-volume threshold based on individual NPI allowed charges or by the group TIN allowed charges?

Per the MIPS and APMs Final Rule<sup>3</sup>: ". . . the low-volume threshold exclusion is determined at the individual (TIN/NPI) level for individual reporting and at the group (TIN) level for group reporting." (p. 77065) Since the same threshold applies to both groups and individuals, group practices should consider whether allowing their clinicians to participate as individuals would result in any of these individuals qualifying for the low-volume exclusion from MIPS.

### "See 100 or fewer Medicare Part B patients a year" – if the financial risk belongs to the Medicare Advantage Plan, do we still qualify? Or must all 100+ patients be straight Medicare (i.e., with no Medicare Advantage Plan assigned)?

In the case of MIPS, the eligible clinician volume threshold is based only on traditional Medicare Part B billing, and does not consider Medicare Advantage Plan billing at all.

While the low-volume threshold applies only to MIPS, it is worth noting that in the case of Advanced APMs, all payments/patients must be through traditional Medicare Part B in the first two years. The All-Payer Combination Option – in which Medicare Advantage payments/patients are counted as long as the Advanced APM meets a minimum Part B

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<sup>2</sup> For a complete list of value-based payment terminology, refer to CAPC's Payment Glossary of Terms

[https://media.capc.org/filer\\_public/55/07/55072a38-3868-46ca-8bc5-3638e2baa8e8/capc-payer\\_glossary-final\\_110416.pdf](https://media.capc.org/filer_public/55/07/55072a38-3868-46ca-8bc5-3638e2baa8e8/capc-payer_glossary-final_110416.pdf)

<sup>3</sup> <https://www.federalregister.gov/documents/2016/11/04/2016-25240/medicare-program-merit-based-incentive-payment-system-mips-and-alternative-payment-model-apm>

threshold – will become available in 2019 (payment year 2021). Again, this note only applies to clinicians who are interested in achieving Qualified APM Participant (QP) status in order to receive the APM incentive payment and be excluded from MIPS (see APMs section).

**I am a single physician in a small hospice with a palliative care practice of approximately two dozen clients and no team support except fielding calls at night. How does the QPP apply to me?**

Given your patient volume, you will likely fall beneath the low-volume threshold, and will therefore be exempt from MIPS. If you build up your practice to the point where you are billing Medicare Part B more than \$30,000 AND seeing over 100 patients in a year, then MIPS will apply to you.

**If our organization is building a palliative care group that will bill Part B services under a new TIN, are we exempted from participation if we have fewer than 15 doctors in the group?**

The threshold is not based on the number of doctors in the group, but on the group's total annual Part B billings and number of beneficiaries cared for. Assuming that these clinicians are not newly enrolled in Medicare, the group is included in MIPS if it bills more than \$30,000 and sees more than 100 traditional Medicare beneficiaries. That being said, you may qualify as a small practice which has certain benefits (see next question).

**Please provide clarification on the designation of small practices and what that entails.**

If you are a small practice (defined as a practice consisting of 15 or fewer eligible clinicians) that does not fall under the low-volume threshold, you are not exempt from MIPS, but CMS has finalized special policies that apply specifically to you. For example, CMS reduces the number of Improvement Activities (IA) that must be reported to only one high-weighted or two medium-weighted activities. In addition, under the Cost Performance Category, **CMS will not apply the administrative claims-based All-Cause Readmission (ACR) measure to solo practices or small groups with 15 or fewer clinicians, or MIPS individual reporters.** As mandated by MACRA, CMS will make \$100 million in technical assistance available to MIPS-eligible clinicians in small practices, rural areas, and practices located in geographic health professional shortage areas over the next five years. Additionally, in future years, there will be an option for solo and small practices to join in "virtual groups" to combine their MIPS reporting.

On February 17, 2017, CMS announced that it awarded \$20 million to the following 11 practices to provide on-the-ground training and education to small practices:

- Altarum
- Georgia Medical Care Foundation (GMCF)
- HealthCentric
- Health Services Advisory Group (HSAG)
- IPRO
- Network for Regional Healthcare Improvement (NRHI)
- QSource
- Qualis
- Quality Insights (West Virginia Medical Institute)
- Telligent
- TMF Health Quality Institute

You can find the full press release at <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-02-17.html>.

**Please confirm that hospice physicians who bill only to Part A on the hospice claim are NOT subject to the QPP. The requirements would apply only to palliative care physicians that may be part of a hospice organization, right?**

Correct; the QPP only applies to clinicians billing Part B (Part A billings are not included in the program). Program eligibility is not based on care setting; it is simply whether you have sufficient Part B billings/patients to be considered an eligible clinician.

**Could hospitals participate with a group of providers (e.g., hospitalists group)? How does that work for acute care hospitals?**

No, the QPP is a clinician payment program; hospitals bill Part A, thus preventing the inclusion of hospital billings. The clinicians in the hospitalists group would participate as a group without the hospital data. However, CMS has the authority under MACRA to consider ways to use facility-level measures as a proxy for clinician-level MIPS performance. We expect to see more details about this potential policy in a future rule.

**Where does care for people younger than age 18 fit into MIPS?**

MIPS applies only to payments and patients under traditional Medicare. If a provider bills Medicare for more than \$30,000 and sees more than 100 beneficiaries, then his/her practice is included in the program regardless of the patient's age. While it is unlikely that practices focusing on pediatrics will see more than 100 Medicare beneficiaries, it is not impossible.

Additionally, while payment adjustments are only applied to future Medicare Part B payments, the payment adjustments themselves are predicated on reporting quality measures that often apply beyond the Medicare population. For example, the registry and EHR reporting mechanisms require that clinicians report on ALL patients, not just Medicare, and there are multiple MIPS measures that target pediatric populations. Furthermore, there is no language in the regulations that limits activities in Improvement Activities Reporting Category to those over the age of 18.

**We are under the impression that if we don't bill any physician charges, only billing nurse practitioner charges, we will not have to participate in the Advancing Care Information category. Is this true?**

This depends on the setting in which you are providing care. Under MIPS, CMS will give a weight of 0 to the ACI category for hospital-based MIPS eligible clinicians, which are defined as a clinician who furnishes *75 percent or more of his or her covered professional services in sites of service identified by the Place of Service (POS) codes used in the HIPAA standard transaction as an inpatient hospital (POS 21), on campus outpatient hospital (POS 22), or emergency room (POS 23) setting*, based on claims for a period prior to the performance period as specified by CMS. Thus, the ACI category is not required for these clinicians; however, they can voluntarily opt to participate in this category and if they do, they will be scored and subject to the full weight of this category. Otherwise, all four categories of MIPS are applicable to all eligible clinicians and will be included in the composite score following the "Pick Your Pace" year. Nurse practitioners are considered eligible clinicians starting in 2017.

**Does CMS decide if your patient and billing volumes qualifies you for MIPS? If so, when do you get notified?**

You should be able to determine whether you are eligible for MIPS based on your own billing/patient records; however, CMS is the ultimate arbiter. Per the MIPS and APMs Final Rule:

- "For eligibility determinations pertaining to the low-volume threshold exclusion, we [CMS] will be conducting our analysis for each TIN/NPI and TIN identified in the claims data and make a determination based on the Medicare Part B allowed charges billed" (p. 77065) and
- CMS will ". . . make eligibility determinations regarding low-volume status using historical data. This . . . will allow us to inform individual MIPS eligible clinicians and groups of their low-volume status prior to the performance period." (p. 77069)

CMS recently stated that it will soon distribute letters to groups and individuals who qualify for the low-volume threshold. CMS has also signaled intent to create an online "look-up tool."

**Will eligible clinicians be assigned to MIPS or an Advanced APM?**

If you are participating in an Advanced APM, CMS will conduct three data "Snapshots" in 2017: March 31, June 30, and August 31. If you meet pre-specified criteria at any one of these snapshot points, you will be considered a Qualifying Participant (QP) in an Advanced APM. If you do not meet these thresholds, but participate in what CMS considers an "Advanced APM," you might still qualify as a "Partial" Qualifying APM Participant (Partial QP) and have the *option* of participating in MIPS. There is no volunteering or assignment involved – CMS determinations are based on the claims you submitted and whether you are listed as a formal participating provider with the APM entity.

If you are an eligible clinician not participating in an APM, you will automatically participate in MIPS. If you are unsure of whether you are participating in an APM, make sure to check with your administrator.

### **What is a MIPS APM clinician?**

CMS also defines special scoring and data submission rules for a subclass of clinicians who are called “MIPS APM clinicians.” Take, for example, clinicians who participate in a one-sided risk Track 1 Medicare Shared Savings Program ACO. This ACO is not considered an Advanced APM that would normally qualify for a MIPS exemption, but does qualify for special rules that ease MIPS reporting burdens and grant MIPS points for APM participation; for instance, all clinicians identified on the Participation List of a MIPS APM will receive at least one-half of the highest score for the Improvement Activities (IA) category. The MIPS APM policy is intended to provide some relief to those APM clinicians who otherwise would be subject to the full range of MIPS requirements in addition to their APM obligations.

To understand individual clinician eligibility as a MIPS APM clinician, it is necessary to understand the terms alternative payment model (APM) and MIPS APM, as defined under the QPP. First, an “APM,” as defined under MACRA, includes only these payment models run by CMS (not by commercial payers):

- CMS Innovation Center Model (other than a Health Care Innovation Award)
- Medicare Shared Savings Program (MSSP ACOs)
- Demonstration under the Health Care Quality Demonstration Program
- Demonstration required by federal law

Second, CMS defines “MIPS APMs” as a subclass of APMs which meet all of the following criteria:

- APM entities participate under an agreement with CMS
- APM entities include one or more MIPS eligible clinicians on an APM participation list
- APM bases payment incentives on performance on cost/utilization and quality measures

It is important to note that the criteria for determining whether an APM is a MIPS APM are separate from the criteria for identifying an APM as an Advanced APM. Therefore, it is possible for an APM to be a MIPS APM, an Advanced APM, both, or neither. For instance, an Advanced APM may not include MIPS eligible clinicians on its participation list and, thereby, would not be deemed a MIPS APM. For more information, see the section below on “APMs.”

### **Our organization is a part of Pioneer and now Next Generation ACO, but only a portion of patients in the health system are in the ACO. Where does that leave us with MIPS vs. Advanced APMs?**

This will depend on if the patients or the billings are sufficient to meet the thresholds to become a QP (i.e., if 25 percent of your Medicare Part B payments are through an Advanced APM or if you see 20 percent of your Medicare patients through an Advanced APM). There are also thresholds to be considered a partial APM, which would provide the option of choosing whether to report under MIPS.

### **We are a startup palliative care program in a large health system. Our program is community-based in our home health and hospice agency, with NPs and doctors. We are part of our system's "Next Generation ACO" as a preferred provider for home health and hospital. Would enrollment of provider in Next Gen automatically place us in the APM, provided we have certified EHR? Quality measures are collected and reported.**

Yes, if your program's TIN (or the group's TIN) is officially included in the NextGen ACO participating providers, then you should be automatically in that Advanced APM. It is important to remember that CMS will defer to the official list of participating or affiliated providers in an APM, so you must ensure that you are listed as a participant. However, keep in mind that participation in an Advanced APM by itself does not guarantee that you will receive the APM incentive payment or be exempt from the MIPS reporting requirements. The Advanced APM entities' participants must collectively meet the QP thresholds described above; only then will you not have to separately report under MIPS on the CEHRT because you would not be on the MIPS track.

**As a Hospice Medical Director, overseeing collaborative agreements with my APN's and NP's who see Medicare patients and will be billing for services in 2017, do I need to participate in MIPS or APMs given the indirect payments provided to the Agency?**

If your APNs and NPs are billing Medicare and do not meet any of the QPP exclusions listed above, they will be considered eligible clinicians and must participate in MIPS or APMs or risk receiving a negative payment adjustment. Your hospice's participation (and potential impact on your Medicare income) will depend on whether you decide to bill at the individual or group level. If your clinicians bill individually and your personal billings fall under the low-volume threshold, then the fact that you are the collaborator will not obligate you to participate in the QPP. If you bill as a group, however, the fate of your Medicare income will be based on your group's performance.

## Quality Measures

**How will PQRS (now MIPS) be applied to a home and/or community based palliative care program?**

Leading with quality measures (since this category is the most heavily weighted), if you are working in an outpatient setting or a home-based setting, you will need to look at the entire list of MIPS measures (<https://qpp.cms.gov/measures/quality>) to identify and select those that are the most meaningful for you. The encouraging part of the transition from PQRS to MIPS is that after the "Pick Your Pace" year, CMS reduced the minimum number of measures eligible clinicians must report on from 9 measures to 6 (if they are reporting individually).

**PQRS oncology-related measures did not allow for home-based visits. Has anyone made a recommendation to CMS to expand the location of visits to include the home and/or community based programs?**

Several member organizations of the National Coalition for Hospice and Palliative Care have made recommendations to CMS on multiple occasions to increase the availability of measures that span not just across care settings, but patient populations as well. A limiting factor to the number of available measures is that CMS maintains high standards around testing and validating measures; this is to ensure that measures are directly linked to things that clinicians can control, and that there are no unintended consequences. We continue to advocate for more cross-cutting measures and support the work of palliative care measure developers to create more measures that reflect the needs of our patient population and the care our clinicians provide.

**As a palliative care clinician, which MIPS measures should I submit?**

Unfortunately, we are unable to provide a detailed breakdown of which MIPS individual measures palliative care clinicians submit based on their setting. While there are a number of measures that could pertain to palliative care (please refer to slide 21 in the November webinar deck: [https://central.capc.org/le-media/content/media/documents/4505\\_2092\\_macra\\_final\\_rule\\_webinar\\_v4.pdf](https://central.capc.org/le-media/content/media/documents/4505_2092_macra_final_rule_webinar_v4.pdf)), many of these are limited by diagnosis or place of care. That being said, as you proceed with reviewing and identifying measures for your program, we encourage you to keep the following considerations in mind:

- Perform due diligence to determine if it makes more sense to report as an individual or as part of a group.
- Review the CPT and ICD codes contained in the denominator to ensure that these apply to your patients, settings, and in some instances, providers.
- Understand what reporting on the measure entails; for instance, some measures can be completed with a single visit, while others require follow-up.
- When possible, select measures that can be used for true quality improvement purposes; however, be aware that if you submit fewer than 6 measures and CMS determines that you could have submitted additional measures, you risk receiving a lower score and a possible negative payment adjustment.

For general guidance, we encourage you to review "Top 10 Tips About the Physician Quality Reporting System for Palliative Care Professionals" (<https://www.ncbi.nlm.nih.gov/pubmed/27139259>), which includes several measures that have been carried over from PQRS to MIPS. Meanwhile, we strongly recommend that you contact your organization's billing and coding specialist or an external consultant as soon as possible to determine which measures apply to you.

**Do you know when the measures will be posted with the appropriate CPT codes?**

The preliminary MIPS measures specifications were posted on the CMS QPP website in November 2016, and have been updated since: <https://qpp.cms.gov/education>. Please see the "Measures Specifications Fact Sheet", "Measures Specifications Download", and "Measures Specifications Implementation Guide" for more details.

**Can different MIPS measures be used for various cohorts within a provider group's population (e.g., oncology vs. pulmonology vs. internal medicine, etc.) for different embedded clinics or home-based efforts? Or, must all selected MIPS measures be identical for all patients served?**

Assuming that this question refers to full participation for a clinician who is reporting individually, it is possible to select different measures for different populations as long as you meet the required case minimum for each measure ("20 cases for all quality measures, with the exception of the all-cause hospital readmissions measure", which only applies to groups with 10 or more clinicians, p. 77287). For the measures that you do select, you must report on a minimum of 50 percent of patients eligible in the denominator (Medicare-only for claims; all-payer data for other registry, QCDR, and EHR). This threshold is expected to increase in future years.

Please note that selected measures and reporting mechanisms will vary based on whether you are reporting as an individual or as part of a group.

**Under MIPS, how can we account for the large volume of people who may be happy with the services provided but do not take the time to complete quality services?**

Currently, the only satisfaction measure in MIPS is the CAHPS, and by virtue of being a survey, it can only measure the results received. The "good" news is that your score is compared to other practices, which also only tend to see a small fraction of their surveys completed. So in this regard, clinicians are on relatively equal footing under MIPS.

Also note that under the IA category, clinicians can receive credit for the following activities related to patient experience:

- Collection of patient experience and satisfaction data on access to care and development of an improvement plan, such as outlining steps for improving communications with patients to help understanding of urgent access needs [MEDIUM WEIGHT]
- Collection and follow-up on patient experience and satisfaction data on beneficiary engagement, including development of improvement plan [HIGH WEIGHT]
- Use of qualified clinical data registry (QCDR) patient experience data to inform and advance improvements in beneficiary engagement [MEDIUM WEIGHT]
- Regularly assess the patient experience of care through surveys, advisory councils, and/or other mechanisms [MEDIUM WEIGHT]

**Is there a CAHPS survey that palliative care providers in the community can use?**

There are a variety of CAHPS surveys available based on setting, including the CAHPS for PCMH, HHCAHPS (home health), Hospice CAHPS, etc. The latter two are distinctive in that they allow for proxy completion, unlike CAHPS surveys in other settings. However, the CAHPS survey for MIPS is specific and may or may not be applicable to community-based providers.

## Qualified Clinical Data Registry (QCDR)

### What is a QCDR?

Per CMS: "A QCDR is a CMS-approved entity that collects clinical data on behalf of clinicians for data submission. Examples include, but aren't limited to, regional collaboratives and specialty societies. QCDRs can't be owned or managed by an individual, locally-owned specialty group." The benefit of using a QCDR for quality reporting is that it allows specialties to report on measures they deem more clinically relevant to the patients they see. It can also allow for a fairer comparison across clinicians in the same specialty.

You can find the current listing of approved QCDRs at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2016QCDRPosting.pdf> (this should be updated in the near future), and more information on QCDRs generally at [https://qpp.cms.gov/docs/QPP\\_QCDR\\_Self-Nomination\\_Fact\\_Sheet.pdf](https://qpp.cms.gov/docs/QPP_QCDR_Self-Nomination_Fact_Sheet.pdf).

### **What is the registry devoted to palliative care?**

To help ease the reporting burden for palliative care clinicians, there are efforts among HPM professional organizations to develop palliative care-specific QCDRs. The goal of these QCDRs is to ensure that the measures clinicians are using to report are also meaningful to their patients and practice. The American Academy of Home Care Medicine has already developed The National Home-Based Primary Care & Palliative Care Registry (<https://www.medconcert.com/NHBCPCR>) which is relevant to home-based palliative care clinicians, and the QDACT (developed by the Global Palliative Care Quality Alliance <http://www.gpcqa.org/qdact/>) collects 12 palliative care QCDR questions created specifically for specialty palliative care delivered across various settings, including hospital-based practice and outpatient clinic.

### **How do the QCDR and the new NQF measures coming out this summer relate to each other?**

This depends greatly on the entity that is developing and/or maintaining the QCDR. The benefit of the QCDR is that it allows specialties to go beyond the MIPS list of quality measures and identify other quality measures that are relevant to their services and patient population. There are benefits to considering the use of measures that were endorsed by the NQF Palliative and End-of-Life Care Standing Committee (<http://www.qualityforum.org/ProjectDescription.aspx?projectID=80663>) in palliative care QCDRs, as these measures have been vetted by some of the foremost experts in our field. However, there are other palliative care measures that exist outside the NQF process that meet reasonable standards for validity, reliability, feasibility, etc., that can be included in the QCDR.

### **Where does the National Palliative Care Registry™ fall in relation to a QCDR?**

The National Palliative Care Registry™ (<https://registry.capc.org/>) collects aggregate program data, and therefore is not eligible to serve as a QCDR (which requires individual patient clinical data). However, participation in the Registry can help palliative care programs identify areas for quality improvement, which can in turn help performance on the Quality and Improvement Activity categories in MIPS.

## **Cost**

**In trying to obtain information about costs from claims on our palliative care patients from our hospital system, we have had difficulty identifying patients who receive our services in the CMS database. Is there a way for CMS to require a field that identifies the palliative care provider as well as the primary care physician (similar to the way that skilled nursing facilities (SNFs) have done)?**

It is unlikely that CMS will add a field for palliative care on claims data. At this point for MIPS, the best way for palliative care physicians to be properly assessed under the performance categories is to select palliative care as their specialty – even though it is technically a subspecialty – in PECOS. Otherwise, their costs will be compared to providers in other specialties (e.g., family medicine, internal medicine) that see far less resource-intensive patients. Unfortunately, we are not aware of a similar indicator for nurses, social workers, or other non-physician palliative care providers.

CAPC has submitted comments to CMS on its proposed "Patient Relationship Categories" (<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Patient-Relationship-Categories-and-Codes-Posting-FINAL.pdf>). In future years, these categories could serve as a potential modifier to distinguish clinicians who participate in patient care, but may or may not play a significant role in driving or controlling costs. AAHPM and the AMA have also submitted comments regarding proposed 'episode groupers', which could (if revised) provide another mechanism to identify a discreet time during which an HPM provider is delivering services. Defining a 'palliative care episode' is difficult, but could include a period following initial provider engagement (via claims data and PECOS, as mentioned above) through hospice enrollment or death. Many professional organizations are struggling with these same issues, so we look forward to more dialogue and feedback opportunities through rulemaking and public comment periods.

**Who will palliative care providers be compared to for utilization? Most Hospice and Palliative Medicine doctors listed with CMS are categorized as hospice; however, hospice physicians have a much different utilization than community-based palliative care providers.**

Unfortunately, unless palliative care clinicians are registered as palliative care specialist in PECOS (see previous answer), there is a good likelihood that their performance on MIPS measures will be compared to clinicians in their primary specialty – which can indeed put them at a disadvantage. This underscores the need to appropriately identify palliative care specialists in claims data. We are continuing to advocate to CMS for solutions to address this issue. Comparison groups will also be impacted by the way in which future episodes are defined for purposes of cost measurement.

## **Advancing Care Information (Health IT)**

**What are the mandatory measures in the Advancing Care Information (ACI) category to fulfill the minimum reporting requirements? We currently do not have a certified electronic health record (EHR); however, we do meet some of the other measures.**

A certified EHR is required to participate in the ACI category. No measures in the ACI category are required in the 2017 "Pick Your Pace" year, as long as you submit one quality measure or one improvement activity to avoid a negative payment adjustment (this will change in 2018).

If you do select ACI as your reporting option during the "Pick Your Pace" year, the five required measures are:

- e-Prescribing
- Send Summary of Care (formerly Patient Care Record Exchange)
- Request/Accept Patient Care Record (formerly Patient Care Record)
- Provide Patient Access (formerly Patient Access)
- Security Risk Analysis (p. 77217 in Final Rule)

You can find more information on this, including the full list of ACI measures at <https://qpp.cms.gov/measures/aci>. Note that only 4 measures are required if you are using an earlier version of CEHRT.

**Are there electronic health record (EHR) software solutions available that are more closely aligned with community-based palliative care needs (e.g., patient portals, mobile-cloud based) and can be used in remote areas that lack internet connectivity?**

At this time, we do not know of any existing EHR that is well-aligned with community-based palliative care and includes all the features desired in this question. Telehealth may play a bigger role in palliative care in the future. In some settings, it is difficult to make frequent visits. To meet the ACI requirements under MIPS, clinicians must use ONC-certified health information technology. Among the available certified EHR platforms, you may seek out those that offer some of these other value-added features.

Note that CMS will assign a weight of zero to the ACI performance category for clinicians who face certain significant hardships (previously established as significant hardships under the EHR Incentive Program), including insufficient internet connectivity and extreme/uncontrollable circumstances (e.g., certain issues with EHR vendors). Unlike the hospital-based clinician exclusion discussed earlier, a clinician would have to apply to CMS for reweighting of the ACI category as a result of a hardship.

**How can a freestanding hospice that has a palliative program but NOT a certified EHR meet the requirements for the Advancing Care Information category? All of the information given is geared towards hospital based programs, and ONC certification was never a requirement for hospice (and no incentives were ever made available to programs or vendors).** The "Pick-Your-Pace" option provides a window for those who have not yet begun exploring their EHR options to do so (as long as they report on a quality measure or improvement activity). However, moving forward, there will come a point at which programs employing clinicians billing Medicare Part B will need to invest in certified EHR technology, or risk negative payment adjustments moving forward.

As noted earlier, those that truly cannot afford CEHRT can apply for a hardship exemption, which would have CMS reweight the ACI portion of MIPS composite score, but this is not guaranteed. The broad criteria for a hardship exception are as follows:

- Insufficient Internet Connectivity
- Extreme and Uncontrollable Circumstances
- Lack of Control over the Availability of CEHRT

CMS will provide more detailed information on how to apply for a hardship exemption in the coming months.

## MIPS Reporting

### How do I report the measures required in the various categories?

Please refer to the QPP website (<https://qpp.cms.gov/>) for independent reporting information. For those overwhelmed with the prospect of reporting, you may consider joining a registry that can submit on your behalf, potentially across multiple MIPS performance categories.

### Will all groups be able to use the QPP web portal to submit measures? Many QCDRs charge for their services.

A QCDR is not required to submit measures. A few clarifying details:

- For the Quality Performance Category, the only reporting mechanism available to groups that could be reporting via a CMS portal is the Web Interface.
- For the ACI and IA Categories, CMS plans to establish a web-based attestation portal for clinicians/groups that are not using a third part vendor (registry, QCDR, EHR) to submit data for these categories.

Please consult the QPP website for instructions on the various reporting mechanisms under MIPS.

### How and where do we submit our hospice data under the QPP?

Hospices are not eligible to participate in the QPP; only clinicians that bill Medicare Part B and meet the eligibility requirements will participate. So, if your clinicians only provide Hospice services (billed under Part A) and do not ALSO bill Part B for other patients, then they are not subject to MIPS. Furthermore, even if they do bill some Part B, only those clinicians with more than \$30,000 in billings and 100 beneficiary patients are eligible.

Hospices participate in the Hospice Quality Reporting Program (HQRP). More information on the HQRP is available at the CMS website link here: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/>

### For the “Pick Your Pace” year, can we submit one quality measure OR one improvement activity for a consecutive period of 90 days and avoid the penalty adjustment?

Yes, and it can be for any point in time and not necessarily for 90 days.

### As a palliative care clinician, is there an advantage to being of a larger clinician group?

Under the QPP, there is likely a benefit to being part of a larger clinician group, as these groups tend to have more resources for administrative support. For large groups, palliative care clinicians also tend to care for a relatively small percentage of the patient population, and therefore performance in the individual areas tends to be absorbed into larger group performance. However, CMS is taking steps to protect smaller practices through the low-volume threshold, reduced reporting requirements for small practices and those in rural and health professional shortage areas.

In larger groups participating in Alternative Payment Models, there is a significant advantage for palliative care providers. Because APMs are held responsible for cost and quality, palliative care providers can play a vital role in their larger group's success by improving care quality (including patient/family experience of care) and reducing cost for some of its sickest, most resource-intensive patients. This is one of the biggest opportunities for palliative care providers in the QPP.

## Alternative Payment Models (APMs)

### What existing models will be considered Advanced APMs?

In 2017, the following models are Advanced APMs:

- Comprehensive ESRD Care (CEC) – Two-Sided Risk
- Comprehensive Primary Care Plus (CPC+)
- Next Generation ACO Model
- Shared Savings Program – Track 2
- Shared Savings Program – Track 3
- Oncology Care Model (OCM) – Two-Sided Risk
- Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1 – CEHRT)<sup>4</sup>
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)

### Models *not* considered Advanced APMs:

- Program of All-Inclusive Care for the Elderly (PACE) is not considered an APM. It is actually a health insurer – if the providers working within PACE are billing the PACE (or are salaried), then MACRA is irrelevant, as it's only for providers that bill more than \$30K per year to traditional Medicare.
- Independence at Home (IAH) is not considered an Advanced APM (although it is an APM) because it does not have any downside risk.
- The Medicare Care Choices Model (MCCM) is not considered an APM. MCCM's fixed monthly payments are made under the hospice benefit, which is Part A, not Part B. If any of your providers are additionally billing Part B (say, for any of the "curative" services), then those may be subject to QPP and participation in the MCCM is irrelevant.

### Where can I find eligible Advanced APMs in my state?

The Center for Medicare and Medicaid Innovation (CMMI) website

(<https://innovation.cms.gov/initiatives/map/index.html#model>) has a listing of each APM and often, the contracted participants, by state. Leavitt Partners (<http://leavittpartners.com/>) keeps data on accountable care organizations (ACO) and the Health Care Payment and Learning Action Network (HCP-LAN) run by Mitre might be another place to look.

### What information is available on the efforts underway to develop APMs that are responsive to palliative care?

The American Academy of Hospice and Palliative Medicine (AAHPM) is in the process of developing an APM and will be making more information available in early 2017. In the meantime, additional stakeholders in the care of patients with serious illness are developing new APMs as well.

### What is the process and timeline for submitting Physician-Focused Payment Models (PFPM)?

The PTAC webpage, which provides information on all aspects of submitting proposals for PFPM, can be found at <https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee>. Letters of Intent are currently being accepted on a rolling basis, and must be submitted at least 30 days prior to the submission of a full proposal.

## Chaplaincy

### How can chaplaincy more clearly articulate our quality service in ways that move us from measures of performance to measures of effectiveness?

While there is certainly a much larger context to this question beyond MACRA, for now it is advisable to scan the literature for studies that show chaplaincy's positive impact on utilization of expensive, potentially unneeded services, such as avoiding emergency department visits or reducing hospital admissions. Literature which speaks to improvement in

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<sup>4</sup> While this model has been proposed, CMS delayed the implementation of the final rule until March 21. The outcome of this delay remains to be seen.

patient and family satisfaction, or any other relevant quality measures, would be helpful as well. Some examples are below:

- "Support of Cancer Patients' Spiritual Needs and Associations with Medical Care Costs At the End of Life (419-C)," *Journal of Pain and Symptom Management* (Balboni et al., 2011)
  - <https://www.ncbi.nlm.nih.gov/pubmed/21563177>
- "The Association of Spiritual Care Providers' Activities With Family Members' Satisfaction With Care After a Death in the ICU," *Critical Care Med* (Johnson et al., 2014)
  - <https://www.ncbi.nlm.nih.gov/pubmed/24797373>
- "Relationship Between Chaplain Visits and Patient Satisfaction," *Journal of Health Care Chaplaincy* (Marin et al., 2015)
  - <https://www.ncbi.nlm.nih.gov/pubmed/25569779>
- "Attention to inpatients' religious and spiritual concerns: predictors and association with patient satisfaction," *Journal of General Internal Medicine* (Williams et al., 2011)
  - <https://www.ncbi.nlm.nih.gov/pubmed/21720904>

**What surveys are in place to begin the task of moving from a qualitative to quantitative standardization of religious/spiritual care? Are there any tools or resources to begin establishing standards of care for chaplains working in a hospice unit?**

Resources for establishing standards of care in hospice include:

- The Association of Professional Chaplains has published standards of practice which are vetted for hospice
  - <http://www.professionalchaplains.org/content.asp?pl=198&sl=200&contentid=200#sop>
- The Health Care Chaplaincy Network has convened international, multidisciplinary panels which developed and published a scope of practice document and a quality indicators document
  - [https://www.healthcarechaplaincy.org/docs/research/scope\\_of\\_practice\\_final\\_2016\\_03\\_16.pdf](https://www.healthcarechaplaincy.org/docs/research/scope_of_practice_final_2016_03_16.pdf)
  - [https://www.healthcarechaplaincy.org/docs/research/quality\\_indicators\\_document\\_2\\_17\\_16.pdf](https://www.healthcarechaplaincy.org/docs/research/quality_indicators_document_2_17_16.pdf)
- The National Consensus Project for Quality Palliative Care *Clinical Practice Guidelines for Quality Palliative Care 3<sup>rd</sup> Edition, 2013*
  - <http://www.nationalconsensusproject.org/>

**Since the focus will be on quality care, will there be any guidelines written that will require healthcare organizations and hospices to use chaplains/spiritual care providers to have Masters Degrees, and Clinical Pastoral Education training?**

At the present time, the QPP does not have any written guidelines, particularly not at a program level. The QPP collects information on patient clinical and financial "performance", rather than program performance. Therefore, there is no way for QPP to collect or compare things like staff qualifications.

Training requirements will likely come, not through MACRA, but from research that demonstrates that this training contributes to the value required by MACRA.

**What should a spiritual care department in a hospital do first to help our institution achieve quality improvement (QI) goals? Should we identify a specific patient population to focus advance care planning on?**

Neither spiritual care providers nor hospitals are directly included in the QPP; therefore, while hospital QI is important and spiritual care can play a vital role, a project that focuses on a hospital will not help achieve any QPP payment improvements. That being said, spiritual care can indirectly help in improving MIPS performance, and there is the potential for a much greater role for spiritual providers under advanced APMs. Therefore, it is critical for spiritual providers to be proactive about learning what their institution's plans are, assert their position at the leadership table, and make clear the instances in which chaplains can help leadership meet its goals.

## Other

**We have had trouble receiving detailed information about how our providers performed under PQRS, making it difficult to "course correct" in preparation for MIPS implementation. How can we get that information?**

- Research appeals process
- Call CMS
- We recognize that this is a real challenge for many clinicians, not just palliative care. We are continuing to advocate that clinicians need real time, detailed information on how they are performing, as well as a meaningful process for appealing incorrect determinations. Please send any stories on your experiences so that we may communicate them as well.

**When will Hospice Compare be made available for public viewing?**

Hospice Compare is not a feature of MACRA, please consult CMS's website for information about this program

(<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/>).