

QPP Quickinar – Getting Prepared for MIPS 2019



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Introductions



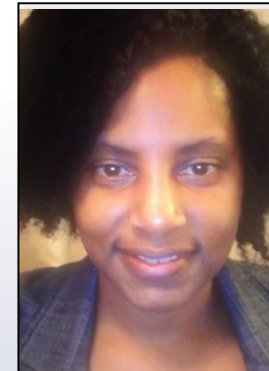
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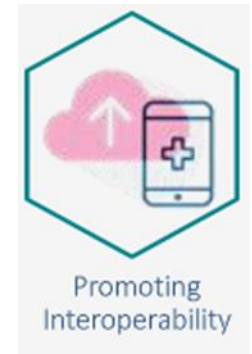
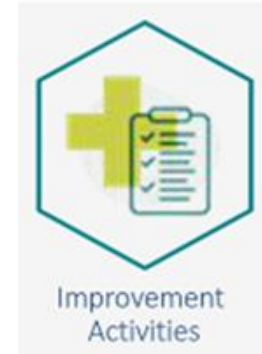
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Housekeeping

- We want to hear from you! Chat Line is open for questions/comments. Please place your questions in chat and they will be addressed at the end of the presentation.
- All phones will be placed on mute during the presentation. At the end of the presentation, we will open up all phone lines so that you can ask questions
- If you receive a call during the webinar, please hang up and dial back in to the phone line. Do not place your phone on hold.
- Please participate in the polling questions, even if your answer is that it is not applicable to your position/practice.
- The slides of this webinar are available to download on the first webpage as you connect to the webinar. Log into <https://qualitynet.webex.com/ec>. Find the listing for today's QPP Quickinar. Click Join. The event page will display. On the left side of the screen, you will see Event Materials. Enter the password "QPP" and the documents will be available to download.
- At the end of the webinar, a survey will display before you leave the Webinar. Please fill it out to help us improve our support



Objectives



- ▶ Key dates for 2018 reporting
- ▶ MIPS 2019 Checklist
 - MIPS Eligible vs AAPM Reporting
 - Quality
 - Promoting Interoperability
 - Facility-based Scoring
 - Improvement Activities
 - Cost
 - HARP
 - Bonus Points
- ▶ Questions
- ▶ Next QPP Quickinar March 19 – Newly Eligible Clinicians for 2019

MIPS Year 2 (2018) Data Submission Period



Overview

Key Dates

- **January 2 – April 2, 2019:** The data submission period for MIPS-eligible clinicians submitting data through the QPP website or through Qualified Clinical Data Registries (QCDRs) and Qualified Registries
- **January 22 – March 22, 2019:** Clinicians choosing to submit their 2018 data via the **CMS Web Interface** must do so within this time period.

MIPS Eligible vs AAPM Reporting

- ▶ Check MIPS Eligibility for clinicians
 - [Participation Status Lookup Tool](#)

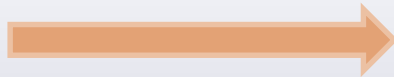
Clinician Level



Clinician Level Information

Exceeds low volume threshold	Yes
Medicare patients for this clinician	Exceeds 200
Allowed charges for this clinician	Exceeds \$90,000
MIPS eligible clinician type	Yes
Enrolled in Medicare before January 1, 2018	Yes

Practice Level



Practice Level Information

Exceeds low volume threshold	Yes
Medicare patients at this practice	Exceeds 200
Allowed charges at this practice	Exceeds \$90,000

MIPS Eligible vs AAPM Reporting

▶ APM Eligibility for clinicians

APM Participation (1)

🕒 CHECK APM REQUIREMENTS

is a participant in 1 APM Entity, and may need to submit data in this system as part of APM specific reporting requirements.

Name of the APM

Classification	MIPS APM
Model	Medicare Shared Savings Program Accountable Care Organizations / MSSP ACO - Track 1
Exceeds APM low volume threshold	Yes
Medicare patients at the APM entity level	Exceeds 200
Allowed charges at the APM entity level	Exceeds \$90,000

LOW VOLUME THRESHOLD

How does CMS determine if I am included in MIPS in Year 3 (2019)?

1. Be a MIPS eligible clinician type (*as listed on slide 12*)
2. Exceed all three elements of the low-volume threshold criteria:
 - ✓ Bill more than \$90,000 a year in allowed charges for covered professional services under the Medicare Physician Fee Schedule (PFS)
AND
 - ✓ Furnish covered professional services to more than 200 Medicare Part B beneficiaries
AND
 - ✓ Provide more than 200 covered professional services under the PFS (*New*)

Remember: To be required to participate, clinicians must:



LOW VOLUME THRESHOLD OPT-IN TO MIPS

You have two options:

1. Voluntarily participate

- You'll submit data to CMS and receive performance feedback
- You will not receive a MIPS payment adjustment

2. Opt-in (*Newly added for Year 3*)

- Opt-in is available for MIPS eligible clinicians who are excluded from MIPS based on the low-volume threshold determination
- If you are a MIPS eligible clinician and meet or exceed at least one, but not all, of the low-volume threshold criteria, you may opt-in to MIPS
- If you opt-in, you'll be subject to the MIPS performance requirements, MIPS payment adjustment, etc.

As of this time, the method for opting-in has not been released by CMS.



Quality

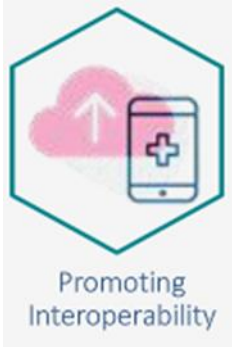
QUALITY

Bonus Points

Basics:

- 45% of Final Score in 2019
- You select 6 individual measures
 - 1 must be an outcome measure
- OR
- High-priority measure
- If less than 6 measures apply, then report on each applicable measure
- You may also select a specialty-specific set of measures

Year 2 (2018) Final	Year 3 (2019) Final
<ul style="list-style-type: none">• 2 points for outcome or patient experience• 1 point for other high-priority measures• 1 point for each measure submitted using electronic end-to-end reporting• Cap bonus points at 10% of category denominator	<p>Same requirements as Year 2, with the following changes:</p> <ul style="list-style-type: none">• Add <u>small practice bonus of 6 points</u> for MIPS eligible clinicians in small practices who submit data on at least 1 quality measure• Updated the definition of high-priority to include the opioid-related measures



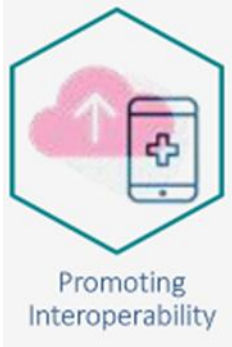
Promoting Interoperability

Objectives and Measures

Basics:

- 25% of Final Score in 2019
- Must use 2015 Edition Certified EHR Technology (CEHRT) in 2019
- New performance-based scoring
- 100 total category points

Year 2 (2018) Final	Year 3 (2019) Final
<ul style="list-style-type: none">• Two measure set options for reporting based on the MIPS eligible clinician's edition of CEHRT (either 2014 or 2015)	<ul style="list-style-type: none">• <u>One</u> set of Objectives and Measures based on 2015 Edition CEHRT• Four Objectives: e-Prescribing, Health Information Exchange, Provider to Patient Exchange, and Public Health and Clinical Data Exchange• Added two new measures to the e-Prescribing Objective: Query of Prescription Drug Monitoring Program (PDMP) and Verify Opioid Treatment Agreement



Promoting Interoperability

Objectives	Measures	Maximum Points
e-Prescribing	<ul style="list-style-type: none"> e-Prescribing 	<ul style="list-style-type: none"> 10 points
	<ul style="list-style-type: none"> Query of Prescription Drug Monitoring Program (PDMP) (new) 	<ul style="list-style-type: none"> 5 bonus points
	<ul style="list-style-type: none"> Verify Opioid Treatment Agreement (new) 	<ul style="list-style-type: none"> 5 bonus points
Health Information Exchange	<ul style="list-style-type: none"> Support Electronic Referral Loops by Sending Health Information (formerly Send a Summary of Care) 	<ul style="list-style-type: none"> 20 points
	<ul style="list-style-type: none"> Support Electronic Referral Loops by Receiving and Incorporating Health Information (new) 	<ul style="list-style-type: none"> 20 points
Provider to Patient Exchange	<ul style="list-style-type: none"> Provide Patients Electronic Access to their Health Information (formerly Provide Patient Access) 	<ul style="list-style-type: none"> 40 points
Public Health and Clinical Data Exchange	<ul style="list-style-type: none"> Immunization Registry Reporting Electronic Case Reporting Public Health Registry Reporting Clinical Data Registry Reporting Syndromic Surveillance Reporting 	<ul style="list-style-type: none"> 10 points

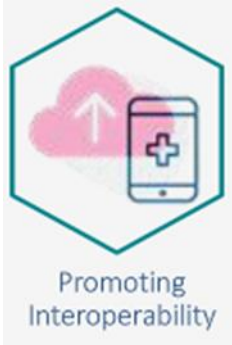


Promoting Interoperability

Scoring

To earn a score for the Promoting Interoperability Performance Category, a MIPS eligible clinician must:

1. User CEHRT for the performance period (90-days or greater)
2. Submit a “yes” to the Prevention of Information Blocking Attestation
3. Submit a “yes” to the ONC Direct Review Attestation
4. Submit a “yes” for the security risk analysis measure
5. Report the required measures under each Objective, or claim the exclusions if applicable



Promoting Interoperability

Scoring

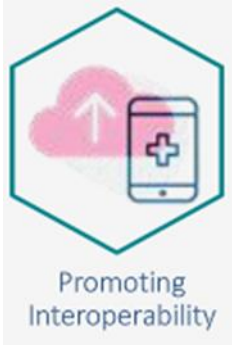
Year 2 (2018) Final	Year 3 (2019) Final
<ul style="list-style-type: none">• Fulfill the base score (worth 50%) by submitting at least a 1 in the numerator of certain measures AND submit “yes” for the Security Risk Analysis measure• Performance score (worth 90%) is determined by a performance rate for each submitted measure• Bonus score (worth 25%) is available• Maximum score is 165%, but is capped at 100%	<ul style="list-style-type: none">• Performance-based scoring at the individual measure level• Each measure will be scored on performance for that measure based on the submission of a numerator and denominator, or a “yes or no”<ul style="list-style-type: none">– Must submit a numerator of at least one or a “yes” to fulfill the required measures• The scores for each of the individual measures will be added together to calculate a final score• If exclusions are claimed, the points will be allocated to other measures



Promoting Interoperability

Scoring Example

Objectives	Measures	Maximum Points	Numerator/Denominator	Performance Rate	Score
e-Prescribing	<ul style="list-style-type: none"> e-Prescribing 	<ul style="list-style-type: none"> 10 points 	200/250	80%	10 x 0.8 = 8 points
Health Information Exchange	<ul style="list-style-type: none"> Support Electronic Referral Loops by Sending Health Information 	<ul style="list-style-type: none"> 20 points 	135/185	73%	20 x 0.73 = 15 points
	<ul style="list-style-type: none"> Support Electronic Referral Loops by Receiving and Incorporating Health Information 	<ul style="list-style-type: none"> 20 points 	145/175	83%	20 x 0.83 = 17 points
Provider to Patient Exchange	<ul style="list-style-type: none"> Provide Patients Electronic Access to their Health Information 	<ul style="list-style-type: none"> 40 points 	350/500	70%	40 x 0.70 = 28 points
Public Health and Clinical Data Exchange	<ul style="list-style-type: none"> Immunization Registry Reporting Public Health Registry Reporting 	<ul style="list-style-type: none"> 10 points 	<ul style="list-style-type: none"> Yes Yes 	N/A	10 points
				Total	78 Points



Promoting Interoperability

Scoring Example

Total Score
(from previous slide)

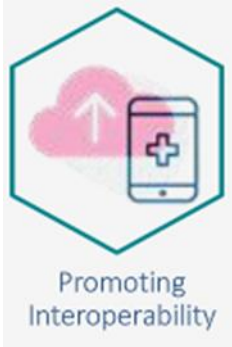
78 points

Calculate the contribution to
MIPS Final Score

$78 \times .25$ (the category value) = 19.5
performance category points

Final Performance Category Score

19.5 points out of the 25 performance
category points



Promoting Interoperability

Scoring Example

Reweighting

Year 2 (2018) Final	Year 3 (2019) Final
<ul style="list-style-type: none">• Automatic reweighting for the following MIPS eligible clinicians: Non-Patient Facing, Hospital-based, Ambulatory Surgical Center-based, PAs, NPs, Clinical Nurse Specialists, and CRNAs• Application based reweighting also available for certain circumstances<ul style="list-style-type: none">• Example: clinicians who are in small practices	<p>Same requirements as Year 2, with the following additions:</p> <ul style="list-style-type: none">• Extended the <u>automatic reweighting</u> for:<ul style="list-style-type: none">• Physical Therapists• Occupational Therapists• Clinical Psychologists• Speech-Language Pathologists• Audiologists• Registered Dietitians or Nutrition Professionals



Facility-based Scoring



- Facility-based scoring is an option for clinicians that meet certain criteria beginning with the 2019 performance period
 - CMS finalized this policy for the 2019 performance period in the 2018 Final Rule
 - Facility-based scoring allows for certain clinicians to have their Quality and Cost performance category scores based on the performance of the hospitals at which they work



Facility-based Scoring



Applicability: Individual

- MIPS eligible clinician furnishes 75% or more of their covered professional services in inpatient hospital (Place of Service code 21), on-campus outpatient hospital (POS 22), or an emergency room (POS 23), based on claims for a period prior to the performance period
- Clinician would be required to have at least a single service billed with POS code used for inpatient hospital or emergency room

Applicability: Group

- Facility-based group would be one in which 75% or more of eligible clinicians billing under the group's TIN are eligible for facility-based measurement as individuals



Improvement
Activities

Improvement Activities



Basics:

- 15% of Final Score in 2019
- Select Improvement Activities and attest “yes” to completing
- Activity weights remain the same:
 - Medium = 10 points
 - High = 20 points
- Small practices, non-patient facing clinicians, and/or clinicians located in rural or HPSAs continue to receive double-weight and report on no more than 2 activities to receive the highest score



Activity Inventory

- Added 6 new Improvement Activities
- Modified 5 existing Improvement Activities
- Removing 1 existing Improvement Activity
- Total of 118 Improvement Activities for 2019

CEHRT Bonus

- Removed the bonus to align with the new Promoting Interoperability scoring requirements, which no longer consists of a bonus score component

COST



Basics:

- 15% of Final Score in 2019
- Measures:
 - Medicare Spending Per Beneficiary (MSPB)
 - Total Per Capita Cost
 - Adding 8 episode-based measures
- No reporting requirement; data pulled from administrative claims
- No improvement scoring in Year 3



Measure Case Minimums

Year 2 (2018) Final	Year 3 (2019) Final
<ul style="list-style-type: none">• Case minimum of 20 for Total per Capita Cost measure and 35 for MSPB	<p>Same requirements as Year 2, with the following additions:</p> <ul style="list-style-type: none">• Case minimum of 10 for procedural episodes• Case minimum of 20 for acute inpatient medical condition episodes

COST



Measure Attribution

Year 2 (2018) Final	Year 3 (2019) Final
<ul style="list-style-type: none">• Plurality of primary care services rendered by the clinician to determine attribution for the Total per Capita Cost measure• Plurality of Part B services billed during the index admission to determination attribution for the MSPB measure• Added two CPT codes to the list of primary care services used to determine attribution under the Total per Capita Cost measure	<p>Same requirements as Year 2, with the following additions:</p> <ul style="list-style-type: none">• For procedural episodes: CMS will attribute episodes to the clinician that performs the procedure• For acute inpatient medical condition episodes: CMS will attribute episodes to each clinician who bills inpatient evaluation and management (E&M) claim lines during a trigger inpatient hospitalization under a TIN that renders at least 30 percent of the inpatient E&M claim lines in that hospitalization

HARP

HCQIS Access Role and Profile

Beginning in December 2018, **new users** (No current EIDM Account) who want to sign in to qpp.cms.gov will create their account in the HCQIS Access Roles and Profile (HARP) system, and all users will request and manage access to organizations by signing in to qpp.cms.gov.

The HARP account (or your existing/current EIDM) will allow you to:

- Submit measure and activity data for the Quality, Promoting Interoperability, and Improvement Activities performance categories
- Submit quality measure data through the CMS Web Interface for the Shared Savings Program or Next Generation ACO
- Submit eQMs in the QRDA III format for the Comprehensive Primary Care Plus program
- View performance feedback and payment adjustment information
- Request a targeted review
- View in progress performance on claims measures
- View eligibility for all the clinicians in a practice or virtual group
- Register for the CMS Web Interface and/or the CAHPS for MIPS survey
- Access the Physician Compare Preview
- Grant others access to your organization

Go to [Register with HARP](#) to register for a new HCQIS Access Roles and Profiles account. If you have a current EIDM account, you do NOT need to register for a HARP account.

HARP

HCQIS Access Role and Profile

Profile Information	<ul style="list-style-type: none">• Fill out all field mark with an asterisk• Add your “real” home address• Add your SSN
Account Information	<ul style="list-style-type: none">• Create your ID (need a minimum of 5 characters)• Create your password (must be 12 characters and include a capital letter, number and special symbol)• Answer your “Challenge Question”
Remote Proofing	<ul style="list-style-type: none">• Answer 5 credit history questions• If you receive an error message, call 866-288-8292
Confirmation	<ul style="list-style-type: none">• Click on “Login to Complete Setup”• Enter ID and password• Add a device type when prompted [SMS (text message) or Voice]• Add phone number and click “Send Code”• Enter the code you received and hit Submit
Logging Into QPP Portal	<ul style="list-style-type: none">• Login to the QPP Portal – https://qpp.cms.gov/login• Link organization by TIN or by legal business name• Choose Organization Type = “Practice”• Role Type – Choose: “Security Official”• Enter the business contact info (TIN, NPI’s, PTAN’s, etc.)• Click on “Submit”

Bonus Points

Description	MIPS Category	How applied
Small Practice (6 points)	Quality	Applied to Quality Category final score
Additional High Priority (1) or Outcome Measures (2)	Quality	Applied to the Quality Category final score
Electronic End-to-End reporting (1 point for each measure)	Quality	Applied to Quality Category final score
Quality Category Improvement	Quality	Applied to Quality Category final score
Query of PDMP measure (5 points)	Promoting Interoperability	Applied to PI score (total score capped at 100)
Verify Opioid Treatment agreement measure (5 points)	Promoting Interoperability	Applied to PI score (total score capped at 100)
Complex Patient Bonus	Quality/Cost	Applied to Final MIPS Score

Questions?

Next Month's QPP Quickinar March 2019

Join us at 1 p.m. on Tuesday, March 19 for

“New to MIPS in 2019? We Can Help!”

Additional Help for You

If you would like additional help, please contact us:
Practices with >15 eligible clinicians

- ▶ Mary Simpson – Mary.Simpson@Alliantquality.org – GA
678-527-3476
- ▶ Marianne Ferlazzo – Marianne.Ferlazzo@Alliantquality.org – NC
919-695-8329

Practices with <= 15 eligible clinicians
QPPSURS@Alliantquality.org

MAKING HEALTH CARE BETTER