Quality Payment Program
2019 Performance Checklist

Alliant QPP Support Partners

North Carolina	NC Area Health Education Centers
South Carolina	SC Office of Rural Health
Georgia	GA Health Information Technology Extension Center
Florida	Health Services Advisory Group

Quality Improvement Organizations | ALLIANT QUALITY

2019 Performance Year Reporting Deadline: March 31, 2020

Use this checklist with your team to plan your strategy for successful 2019 MIPS submission

Advanced Alternative Payment Model (AAPM)

1. Are you participating in an Advanced Alternative Payment Model as Qualified Participant? (Full list of 2018 CMS qualifying APMs found here. Clinicians can determine if they are a Qualifying APM Participant (QP) by using CMS' Participation Lookup Tool	☐ Yes ☐ NO
2. Do you receive 25% of your Medicare Payments or see 20% of your Medicare patients through an Advanced APM?	☐ Yes ☐ NO

If you answered YES to either of the 2 questions above, you are exempt from MIPS reporting

Merit Based Incentive Payment System (MIPS)

1. Are you a MIPS Eligible Clinician? (check 2018 eligibility and participating status using an individual NPI on CMS' Participation Status Lookup Tool	☐ Yes ☐ NO
2. Are you participating in a MIPS APM?	☐ Yes ☐ NO
3. Do you meet any MIPS Exclusion Criteria? First year enrollment in Medicare? Low Volume Threshold (bill less than $90,000 in Medicare Part B allowable charge AND see less than 200 Medicare Part B patients a year AND Provide less than 200 covered professional services a year?	☐ Yes ☐ NO ☐ Yes ☐ NO

If you meet only 2 or 3 of the low volume threshold criteria, you are eligible to participate in MIPS by opting in. See page 3 of 2019 Merit-based Incentive Payment System (MIPS) Participation and Eligibility Overview document.

4. Do you meet any MIPS Special Status Requirements?	☐ Yes ☐ NO
Small practice (less than 16 providers)	☐ Yes ☐ NO
Non-Patient Facing (100 or fewer Medicare Part B patient facing encounters per provider, or 75% of clinicians under TIN are non-patient facing)	☐ Yes ☐ NO
Health Professional Shortage Area (HPSA) or Rural Zip Code (as defined by HRSA)Hospital-Based (75% of professional services furnished in hospital setting)	☐ Yes ☐ NO
Ambulatory Surgical Center (75% of professional services furnished at ASC)	☐ Yes ☐ NO

☐ GROUP	2 or more eligible clinicians who have reassigned their Medicare billing rights to the same TIN; Each clinician will have their scores aggregated and will received a payment adjustment based on the group's performance
☐ INDIVIDUAL	Submit data individually and payment adjustment is based on individual performance
☐ VIRTUAL	Virtual group is 2 or more TINs that consist of either solo practitioners or groups (10 or fewer providers per TIN) that elect to participate in MIPS as a group, regardless of location, specialty, etc. Virtual Group elections must be made before December 31, 2018.

COLLECTION TYPE (for Quality)	☐ Clinical Quality Measures (CQM- formerly Qualified Registry) ☐ Qualified Clinical Data Registry (QCDR) ☐ Electronic Health Record (EHR) ☐ Claims -small practices (15 or less clinicians only) ☐ Attestation (for PI and improvement activities categories only) ☐ Consumer Assessment for Healthcare Providers and Systems (CAHPS) for MIPS
SUBMISSION TYPE You may have only 1 submission type per category	☐ Direct ☐ Log-in and Upload ☐ Log-in and Attest ☐ Medicare Part B Claims (small practices only)
SUBMITTER TYPE	☐ Individual ☐ Group ☐ Virtual Group ☐ Third Party Intermediary
 QUALITY CATEGORY (45%)	If your practice does not have at least 6 applicable quality measures, CMS will apply the Eligibility Measure Applicability (EMA) process. See page 18 of the 2019 Merit-based Incentive Payment System (MIPS) Quality Performance Category Fact Sheet for additional information. Report a total of six Quality Measures , including at least one Outcome or High Priority measure. * Note: Data completeness threshold be > 60% for each CQM submitted to obtain full benchmark point. **Measures Selected:** **High Priority:** ☐ **Measure #1:**_____ ☐ **YES** ☐ **NO** ☐ **Measure #2:**_____ ☐ **YES** ☐ **NO** ☐ **Measure #3:**_____ ☐ **YES** ☐ **NO** ☐ **Measure #4:**_____ ☐ **YES** ☐ **NO** ☐ **Measure #5:**_____ ☐ **YES** ☐ **NO** ☐ **Measure #6:**_____ ☐ **YES** ☐ **NO** **Bonus Points:** ☐ Submit more than one high priority measure (1 point each for a maximum of 6 points) OR more than one outcome measure (2 points each) ☐ Category Improvement over 2018 Program Year results – the bonus will be added to the Quality total Score. A Maximum of 10 points is available depending on the improvement. ☐ Small Practice Bonus – 6 points will be added to the Quality Score for any small practice. Clinicians must submit data on at least 1 Quality measure. If your practice does not have at least 6 applicable quality measures, CMS will apply the Eligibility Measure Applicability (EMA) process. See page 18 of the 2019 Merit-based Incentive Payment System (MIPS) Quality Performance Category Fact Sheet for additional information.

IMPROVEMENT ACTIVITIES CATEGORY (15%)

FULL 15 points for Improvement Activities for either designation

☐ Recognized Patient Centered Medical Home (if submitting as a group, 50% of practices must have PCMH designation)

☐ APM designated Medical Home Model

2 high-weighted activities or 4 medium-weighted activities OR 1 high-weighted + 2 medium-weighted activities

Special Status – Small, Non-patient Facing, Rural or HPSA

1 high-weighted activity OR 2 medium-weighted activities

☐ Activity #1: _____

☐ Activity #2: _____

☐ Activity #3: _____

☐ Activity #4: _____

PROMOTING INTEROPERABILITY (25%)

Do you qualify for a Hardship Exemption for Promoting Interoperability? Application due December 31, 2019

☐ **YES** ☐ **NO**

2015 Edition CEHRT must be in place by the first day of the performance period for Promoting Interoperability (check the status/edition of your EHR here)

Promoting Interoperability Objectives and Measures

There are 4 Objectives for Promoting Interoperability: ePrescribing, Health Information Exchange, Provider to Patient Exchange and Public Health and Clinical Data Exchange.

Performance Score Measures

Objective	Measure	Points
E-prescribing	• e-prescribing	• 10 points
	• Query of Prescription Drug Monitoring Program (PDMP) (new)	• 5 bonus points
	• Verify Opioid Treatment Agreement (new)	• 5 bonus points
Health Information Exchange	• Support Electronic Referral Loops by Sending Health Information (formerly Send a Summary of Care)	• 20 points
	• Support Electronic Referral Loops by Receiving and Incorporating Health Information (new)	• 20 points
Provider to Patient Exchange	• Provide Patients Electronic Access to their Health Information (formerly Provide Patient Access)	• 40 points
Public Health and Clinical Data Exchange	• Immunization Registry Reporting • Electronic Case Reporting • Public Health Registry Reporting • Clinical Data Registry Reporting • Syndromic Surveillance Reporting	• 10 points

<table>
<tr>
<td>FACILITY-BASED SCORING FOR QUALITY AND COST PERFORMANCE MEASURES</td>
<td>Facility-Based Scoring allows for certain clinicians to have their Quality and Cost Performance category scores based on the performance of the hospitals in which they work.
<table>
<tr><td rowspan="2">Individual</td><td>75% or more of their covered professional services in inpatient hospital (POS 21), on-campus outpatient hospital (POS 22) or an emergency room (POS 23) based on claims for a period prior to the performance period</td></tr>
<tr><td>Must have at least a single service billed with POS code used for Inpatient or emergency room</td></tr>
<tr><td>Group</td><td>75% or more of the eligible clinicians billing under the group’s TIN are eligible for facility-based measurement as individuals.</td></tr>
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COST CATEGORY (15%)</td>
<td>Two Claims measures:

Medicare Spending per Beneficiary
Total Per Capita Cost
Adding 8 episode-based measures

No additional data submission is required for the Cost Category. The category score is calculated based on claims for the full performance year.
Case Minimums: Procedural episodes – 10
Inpatient medical condition episodes – 20
There is no improvement scoring for Year 3 (2019)
2019 Cost Performance Category Fact Sheet
2019 Merit-based Incentive Payment System (MIPS): Summary of Cost Measures
2019 Cost Measure Information Forms
2019 Cost Measure Code Lists</td>
</tr>
<tr>
<td>DOCUMENTATION</td>
<td>☐ Save Quality reports with clinicians names and timeframes

Save on hard paper/cloud based document back-up/external drive and document where you can find it. It is important to save this information to a file that will be backed-up routinely
Save for 7 years (minimum 6 years, 3 months)

☐ Save documentation of Improvement Activities for a minimum of 7 years.
☐ Save Security Risk Analysis documentation. Security Risk Analysis should be performed once during the performance year.
☐ Save Submission receipt

This may be from EHR vendor/registry, saved screens from the QPP attestation, or other
</td>
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HOW TO SUBMIT DATA

The Quality Payment Program uses the HCQIS Access Roles and Profile (HARP) system for credential management

Submit data to CMS before the Reporting deadline of March 31, 2020

If using the CMS QPP Portal to attest: If you have a current EIDM account, you do not need to register for a HARP account. New users can sign up for HARP credentials by clicking on the following link Register for a HARP account or you can go to the QPP website (https://qpp.cms.gov) and click on Sign In at the top of the page. Select the Register tab

Creation of new accounts may take several days. Don't wait until March to do this.

QPP Sign-in for Submission www.qpp.cms.gov

- ☐ Use your EIDM or HARP login and password
  - Test your login and password www.qpp.cms.gov
- ☐ Review practice information for correctness
- ☐ Review provider listing
- ☐ Upload a QRDA III or .JSON file type for the Quality Category
- ☐ Attest for the PI and IA categories using your EHR or manual entry

Resources

2018 QPP User Access Guide

- 2018 QPP User Access Guide – this is a 4 part guide
  - Before You Begin
  - Connect to an Organization
  - Register for a HARP Account
  - Security Officials Manage Access
- Register for a HARP Account

☐ Quality Payment Program Help Desk:

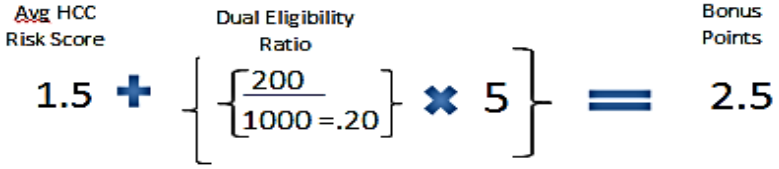
- 1-866-288-8292 TTY: 1-877-715-6222

☐ PECOS Help Desk: 1-888-379-3807

ADDITIONAL BONUS POINTS

☐ Complex Patient Bonus (up to 5 points)

- The bonus will be the sum of the average hierarchical condition category (HCC) risk scores, plus the proportion of dual-eligible beneficiaries (multiplied by five), subject to a five-point cap. CMS will calculate the average HCC risk score by averaging the risk scores, from the calendar year prior to the performance period, for beneficiaries cared for by the MIPS-eligible clinician or clinicians within the group.
- The dual-eligible ratio will be calculated based on the proportion of unique beneficiaries who have dual status (Medicare and Medicaid) seen by the EC, divided by the number of all unique Medicare patients seen by the EC in a 12-month segment. This segment would run from the last four months of a calendar year one year prior to the performance period followed by the first eight months of the performance period.
- MIPS eligible clinicians or groups must submit data in at least one (1) performance category to be eligible for this bonus.



This material was prepared by GMCF, for Alliant Quality, the Medicare Quality Innovation Network – Quality Improvement Organization for Georgia and North Carolina, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication No. 11SOW-AHSQIN-QPP-19-01