GA-HITEC

South Georgia MGMA

February 20, 2019

Are You Ready?

QPP Year 3 - 2019

The future of Health IT is here. **Turn it on.**

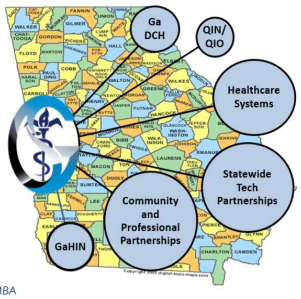
GA-HITEC

Who is GA-HITEC?

GA-HITEC is Georgia's Health IT Center for assisting clinicians in the redesign of healthcare delivery through the successful adoption of EHR technology and interoperable systems.

Goal: Optimize patient information management for the successful transition to value-based clinical models and better health outcomes.

Located at Morehouse School of Medicine, National Center for Primary Care



Carmen L. Hughes
Executive Director

Dominic H. Mack, MD, MBA
Executive Medical Director

GA-HITEC | GaHC Georgia Health Connect

CMS LAN Webinars

The monthly LAN webinar is available "live" at two different days and times.

Next Monthly CMS LAN Webinars

Tuesday, February 19, 2019 11:00:00 AM EST - 12:00:00 PM EST
Thursday, February 21, 2019 3:30:00 PM EST - 4:30:00 PM EST

Submitting Your MIPS Data: Advice for Solo and Small Group Practices


GA-HITEC
GaHC
Georgia Health Connect
ANNOUNCEMENTS
GA-HITEC Interactive Workshop:
HIPAA Privacy & Security Workshop
Wednesday, March 20th, 2019
8:45 AM -3:00 PM
Register here
GA-HITEC


GA-HITEC
GaHC
Georgia Health Connect
@GAHITEC #QPPResources
QPP Office Hours
The format for our Winter QPP Office Hours will be a 1 hour session with a topical presentation followed by an open forum for questions and answers.
Next Office Hours – March 12, 2019, 12:00-1:00


GA-HITEC
Moderators
Liz Hansen, CMUP, CHSP, CHSA, PCMH CCE
Health IT Consultant, GA-HITEC
Phoebe Nelms, CMUP
Program Manager, Technical Outreach
GA-HITEC,
National Center for Primary Care
Morehouse School of Medicine

Agenda

- Quality Payment Program Overview
- Merit-based Incentive Payment System (MIPS) Overview
- Final rule for Year 3 (2019) – MIPS
  - Eligibility
  - Reporting Options and Data Submission
  - Performance Categories
  - Additional Bonuses, Performance Threshold, and Payment Adjustments
- Checklist
- Quality Payment Program – Help & Support

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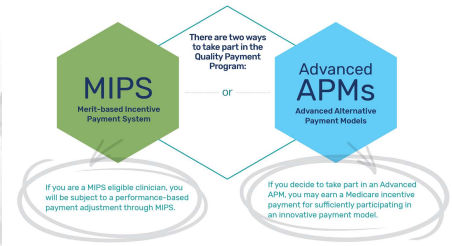
Quality Payment Program

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS by law to implement an incentive program, referred to as the Quality Payment Program:



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Quality Payment Program
Considerations

- Improve beneficiary outcomes
- Reduce burden on clinicians
- Increase adoption of Advanced APMs
- Maximize participation
- Improve data and information sharing
- Ensure operational excellence in program implementation
- Deliver IT systems capabilities that meet the needs of users

Quick Tip: For additional information on the Quality Payment Program, please visit qpp.cms.gov

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Merit-based Incentive Payment System (MIPS)
Quick Overview

Combined legacy programs into a single, improved program.

- Physician Quality Reporting System (PQRS)
- Value-Based Payment Modifier (VM)
- Medicare EHR Incentive Program (EHR) for Eligible Professionals

MIPS

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Merit-based Incentive Payment System (MIPS)
Quick Overview

MIPS Performance Categories

- Comprised of **four** performance categories
- *The points from each performance category are added together to give you a MIPS Final Score*
- The MIPS Final Score is compared to the MIPS performance threshold to determine if you receive a **positive**, **negative**, or **neutral payment adjustment**

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Merit-based Incentive Payment System (MIPS)
Terms to Know

As a refresher…

- TIN - Taxpayer Identification Number
  - Used by the Internal Revenue Service to identify an entity, such as a group medical practice, that is subject to federal taxes
- NPI – National Provider Identifier
  - 10-digit numeric identifier for individual clinicians
- TIN/NPI
  - Identifies the individual clinician and the entity/group practice through which the clinician bills services to CMS

Performance Period	Also referred to as…	Corresponding Payment Year	Corresponding Adjustment
2017	2017 "Transition" Year	2019	Up to +4%
2018	"Year 2"	2020	Up to +5%
2019	"Year 3"	2021	Up to +7%

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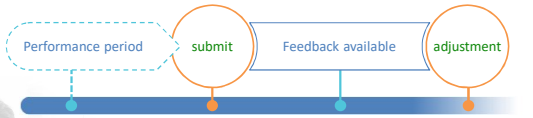
Merit-based Incentive Payment System (MIPS)
Timeline



2019
Performance Year
- Performance period opens January 1, 2019
- Closes December 31, 2019
- Clinicians care for patients and record data during the year

March 31, 2020
Data Submission
- Deadline for submitting data is March 31, 2020
- Clinicians are encouraged to submit data early

Feedback
- CMS provides performance feedback after the data is submitted
- Clinicians will receive feedback before the start of the payment year

January 1, 2021
Payment Adjustment
- MIPS payment adjustments are prospectively applied to each claim beginning January 1, 2021

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MIPS Year 3 (2019)

MIPS Eligible Clinician Types

Year 2 (2018) Final

MIPS eligible clinicians include:

- Physicians
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
- Groups of such clinicians

Year 3 (2019) Final

MIPS eligible clinicians include:

- Same five clinician types from Year 2 (2018)

AND:

- Clinical Psychologists
- Physical Therapists
- Occupational Therapists
- Speech-Language Pathologists*
- Audiologists*
- Registered Dieticians or Nutrition Professionals*

**Modified proposals to add these additional clinician types for Year 3 as a result of the significant support received during the comment period*

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MIPS Year 3 (2019) Final

Low-Volume Threshold Criteria

What do you need to know?

1. Threshold amounts **remain the same** as in Year 2 (2018)
2. Added a third element – Number of Services – to the low-volume threshold determination criteria
   - The finalized criteria now includes:
     - Dollar amount - $90,000 in covered professional services under the Physician Fee Schedule (PFS)
     - Number of beneficiaries – 200 Medicare Part B beneficiaries
     - Number of services* *(New)* – 200 covered professional services under the PFS

*When we say "service", we are equating one professional claim line with positive allowed charges to one covered professional service

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MIPS Year 3 (2019) Final
Low-Volume Threshold Determination

How does CMS determine if you are 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)*

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MIPS Year 3 (2019) Final
Low-Volume Threshold Determination

What else do you need to know?

Clinicians who:

- x **DO NOT** bill more than $90,000 a year in allowed charges for covered professional services under the Medicare Physician Fee Schedule (PFS)

OR

- x **DO NOT** furnish covered professional services to more than 200 Medicare beneficiaries

OR

- x **DO NOT** provide more than 200 covered professional services under the PFS (*New*)

Are excluded from MIPS in Year 3 (2019) and do not need to participate

Remember: To be **required** to participate, clinicians must: BILLING >$90,000 AND Beneficiaries >200 AND SERVICES >200

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MIPS Year 3 (2019) Final
Low-Volume Threshold Determination

What happens if you are excluded, but want to participate in 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.

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MIPS Year 3 (2019) Final
Opt-in Policy

- MIPS eligible clinicians who meet or exceed at least one, but not all, of the low-volume threshold criteria may choose to participate in MIPS

MIPS Opt-in Scenarios

Dollars	Beneficiaries	Professional Services (*New*)	Eligible for Opt-in?
≤ 90K	≤ 200	≤ 200	No – excluded
≤ 90K	≤ 200	> 200	Yes (may also voluntarily report or not participate)
> 90K	≤ 200	≤ 200	Yes (may also voluntarily report or not participate)
> 90K	≤ 200	>200	Yes (may also voluntarily report or not participate)
≤ 90K	> 200	> 200	Yes (may also voluntarily report or not participate)
> 90K	> 200	> 200	No – required to participate

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MIPS Year 3 (2019) Final
Opt-in Policy – Example

Physical Therapist (Individual)

- ✓ Billed $100,000
- x Saw 100 patients
- ✓ Provided 201 covered professional services

- Did not exceed **all** three elements of the low-volume threshold determination criteria, therefore exempt from MIPS in Year 3

However…

- This clinician could **opt-in** to MIPS and participate in Year 3 (2019) since the clinician met or exceeded at least **one** (in this case, two) of the low-volume threshold criteria and is also a MIPS eligible clinician type

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MIPS Year 3 (2019) Final
Opt-in Policy

What else do you need to know?

- Once an election has been made, the decision to opt-in to MIPS would be **irrevocable** and **could not be changed for that year**
- Clinicians or groups who opt-in are subject to all of the MIPS rules, special status, and MIPS payment adjustment
- Please note that APM Entities interested in opting-in to participate in MIPS under the APM Scoring Standard would do so at the APM Entity level

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MIPS Year 3 (2019) Final
MIPS Determination Period

Year 2 (2018) Final	Year 3 (2019) Final
Low Volume Threshold Determination Period: • First 12-month segment: Sept. 1, 2016-Aug. 31, 2017 (including 30-day claims run out) • Second 12-month segment: Sept. 1, 2017 to Aug. 31, 2018 (including a 30-day claims run out) **Special Status** • Use various determination periods to identify MIPS eligible clinicians with a special status and apply the designation. • Special status includes: – Non-Patient Facing – Small Practice – Rural Practice – Health Professional Shortage Area (HPSA) – Hospital-based – Ambulatory Surgical Center-based (ASC-based)	**Change to the MIPS Determination Period:** • First 12-month segment: Oct. 1, 2017-Sept. 30, 2018 (including a 30-day claims run out) • Second 12-month segment: Oct. 1, 2018-Sept. 30, 2019 (does not include a 30-day claims run out) • Goal: consolidate the multiple timeframes and align the determination period with the fiscal year • Goal: streamlined period will also identify MIPS eligible clinicians with the following special status: – Non-Patient Facing – Small Practice – Hospital-based – ASC-based *Note: Rural and HPSA status continue to apply in 2019*

Quick Tip: MIPS eligible clinicians with a special status **are included in MIPS** and qualify for special rules. Having a special status **does not exempt** a clinician from MIPS.

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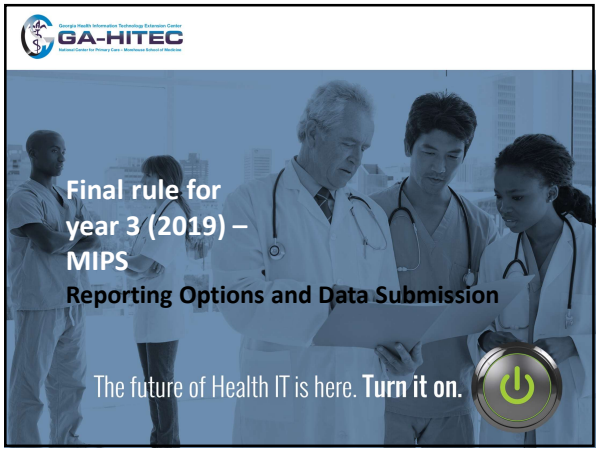

MIPS Year 3 (2019) Final
Reporting Options

What are your reporting options if you are required to participate in MIPS?

Same reporting options as Year 2. Clinicians can report as an/part of a:

Individual	Group	Virtual Group
1. As an Individual—under an National Provider Identifier (NPI) number and Taxpayer Identification Number (TIN) where they reassign benefits	2. As a Group a) 2 or more clinicians (NPIs) who have reassigned their billing rights to a single TIN* b) As an APM Entity	3. As a Virtual Group – made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together "virtually" (no matter what specialty or location) to participate in MIPS for a performance period for a year

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MIPS Year 3 (2019) Final

Submitting Data - Collection, Submission, and Submitter Types

What do you need to know about submitting performance data?

- For Year 3 (2019), revised existing terms and defined additional terminology to help clarify the process of submitting data:
  - Collection Types
  - Submission Types
  - Submitter Types

Why make this change?

- In Year 2 (2018), used the term "submission mechanism" all-inclusively when talking about:
  - The method by which data is submitted (e.g., registry, EHR, attestation, etc.)
  - Certain types of measures and activities on which data are submitted
  - Entities submitting such data (i.e., third party intermediaries submitting on behalf of a group)
- Found that this caused confusion for clinicians and those submitting on behalf of clinicians

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MIPS Year 3 (2019) Final

Submitting Data - Collection, Submission, and Submitter Types

Definitions for Newly Finalized Terms:

- **Collection type**- a set of quality measures with comparable specifications and data completeness criteria, as applicable, including, but not limited to: electronic clinical quality measures (eCQMs); MIPS Clinical Quality Measures* (MIPS CQMs); Qualified Clinical Data Registry (QCDR) measures; Medicare Part B claims measures; CMS Web Interface measures; the CAHPS for MIPS survey; and administrative claims measures
- **Submission type**- the mechanism by which a submitter type submits data to CMS, including, but not limited to: direct, log in and upload, log in and attest, Medicare Part B claims, and the CMS Web Interface.
  - The Medicare Part B claims submission type is for clinicians or groups in small practices only to continue providing reporting flexibility
- **Submitter type**- the MIPS eligible clinician, group, virtual group, or third party intermediary acting on behalf of a MIPS eligible clinician, group, or virtual group, as applicable, that submits data on measures and activities.

*The term MIPS CQMs would replace what was formerly referred to as "registry measures" since clinicians that don't use a registry may submit data on these measures.

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MIPS Year 3 (2019) Final

Collection, Submission, and Submitter Types - Example

Data Submission for MIPS Eligible Clinicians Reporting as Individuals

Performance Category	Submission Type	SubmitterType	Collection Type
Quality	• Direct • Log-in and Upload • Medicare Part B Claims (small practices only)	• Individual • Third Party Intermediary	• eCQMs • MIPS CQMs • QCDR Measures • Medicare Part B Claims Measures (small practices only) ***Can mix multiple collection types***
Cost	• No data submission required	• Individual	-
Improvement Activities	• Direct • Log-in and Upload • Log-in and Attest	• Individual • Third Party Intermediary	-
Promoting Interoperability	• Direct • Log-in and Upload • Log-in and Attest	• Individual • Third Party Intermediary	-

MIPS Year 3 (2019) Final

Collection, Submission, and Submitter Types - Example

Data Submission for MIPS Eligible Clinicians Reporting as Groups

Performance Category	Submission Type	Submitter Type	Collection Type
Quality	• Direct • Log-in and Upload • CMS Web Interface (groups of 25 or more eligible clinicians) • **Medicare Part B Claims** (small practices only)	• Group • Third Party Intermediary	• eCQMs • MIPS CQMs • QCDR Measures • CMS Web Interface Measures • CMS Approved Survey Vendor Measure • Administrative Claims Measures • Medicare Part B Claims (small practices only)
Cost	• No data submission required	• Group	-
Improvement Activities	• Direct • Log-in and Upload • Log-in and Attest	• Group • Third Party Intermediary	-
Promoting Interoperability	• Direct • Log-in and Upload • Log-in and Attest	• Group • Third Party Intermediary	-

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MIPS Year 3 (2019) Final

Performance Periods

Year 2 (2018) Final

Performance Category	Performance Period
Quality	12-months
Cost	12-months
Improvement Activities	90-days
Promoting Interoperability	90-days

Year 3 (2019) Final - *No Change*

Performance Category	Performance Period
Quality	12-months
Cost	12-months
Improvement Activities	90-days
Promoting Interoperability	90-days

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MIPS Year 3 (2019) Final
EHR Certification

Year 2 (2018) Final

Performance Category	EHR Certification
Quality	2014 or 2015
Cost	-
Improvement Activities	2014 or 2015
Promoting Interoperability	2014 or 2015

Year 3 (2019) Final

Performance Category	EHR Certification
Quality	2015
Cost	-
Improvement Activities	2015
Promoting Interoperability	2015

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MIPS Year 3 (2019) Final
EHR Certification

- Must have 2015 edition CEHRT to report in 2019
- Must have 2015 edition prior to the 90-day performance period you will use to report for PI
- EHR must be certified by Dec. 31, 2019

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MIPS Year 3 (2019) Final
Performance Category Weights

Year 2 (2018) Final

Performance Category	Performance Category Weight
Quality	50%
Cost	10%
Improvement Activities	15%
Promoting Interoperability	25%

Year 3 (2019) Final

Performance Category	Performance Category Weight
Quality	45%
Cost	15%
Improvement Activities	15%
Promoting Interoperability	25%

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MIPS Year 3 (2019) Final
Quality Performance Category

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

Meaningful Measures

- Goal: The Meaningful Measures Initiative is aimed at identifying the highest priority areas for quality measurement and quality improvement to assess the core quality of care issues that are most vital to advancing our work to improve patient outcomes
- For 2019:
  - Removing 26 quality measures, including those that are process, duplicative, and/or topped-out
  - Adding 8 measures (4 Patient-Reported Outcome Measures), 6 of which are high-priority
- Total of 257 quality measures for 2019

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MIPS Year 3 (2019) Final
Quality Performance Category

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

Bonus Points

Year 2 (2018) Final	Year 3 (2019) Final
• 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	**Same requirements** as Year 2, with the following changes: • Add **small practice bonus** of **6 points** 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

Quick Tip: A small practice is defined as 15 or fewer eligible clinicians

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MIPS Year 3 (2019) Final
Quality Performance Category

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

Data Completeness

Year 2 (2018) Final	Year 3 (2019) Final
• 60% for submission mechanisms except for Web Interface and CAHPS • Measures that do not meet the data completeness criteria earn 1 point • Small practices continue to receive 3 points	**Same requirements** as Year 2

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MIPS Year 3 (2019) Final
Quality Performance Category

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

Special Scoring Considerations

Measures Impacted by Clinical Guideline Changes
- CMS will identify measures for which following the guidelines in the existing measure specification could result in patient harm or otherwise provide misleading results as to good quality care
- Clinicians who are following the revised clinical guidelines will still need to submit the impacted measure
- The total available measure achievement points in the denominator will be reduced by 10 points and the numerator of the impacted measure will result in zero points

Groups Registered to Report the CAHPS for MIPS Survey
- If the sample size was not sufficient and if the group doesn't select another measure, the total available measure achievement points will be reduced by 10 and the measures will receive zero points

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MIPS Year 3 (2019) Final
Quality Performance Category

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

Improvement Scoring

Year 2 (2018) Final	Year 3 (2019) Final
• Eligible clinicians must fully participate (i.e. submit all required measures and have met data completeness criteria) for the performance period • If the eligible clinician has a previous year Quality performance category score less than or equal to 30%, we would compare 2018 performance to an assumed 2017 Quality performance category score of 30%	• **Same requirements** as Year 2

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MIPS Year 3 (2019) Final
Quality Performance Category

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

Topped-out Measures

Year 2 (2018) Final	Year 3 (2019) Final
• A topped out measure is when performance is so high and unwavering that meaningful distinctions and improvement in performance can no longer be made • 4-year lifecycle to identify and remove topped out measures • Scoring cap of 7 points for topped out measures	**Same requirements** as Year 2, with the following changes: • Extremely Topped-Out Measures: – A measure attains extremely topped-out status when the average mean performance is within the 98th to 100th percentile range – CMS may propose removing the measure in the next rulemaking cycle • QCDR measures are excluded from the topped out measure lifecycle and special scoring policies

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MIPS Year 3 (2019) Final

Cost Performance Category

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
• Case minimum of 20 for Total per Capita Cost measure and 35 for MSPB	**Same requirements** as Year 2, with the following additions: • Case minimum of 10 for procedural episodes • Case minimum of 20 for acute inpatient medical condition episodes

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MIPS Year 3 (2019) Final

Cost Performance Category

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 Attribution

Year 2 (2018) Final	Year 3 (2019) Final
• 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	**Same requirements** as Year 2, with the following additions: • 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

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MIPS Year 3 (2019) Final

Facility-based Quality and Cost Performance Measures

What is it?

- 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

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MIPS Year 3 (2019) Final

Improvement Activities Performance Category

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

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MIPS Year 3 (2019) Final

Promoting Interoperability Performance Category

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

Reporting Requirements

Year 2 (2018) Final	Year 3 (2019) Final
• Comprised of a base, performance, and bonus score • Must fulfill the base score requirements to earn a Promoting Interoperability score	• Eliminated the base, performance, and bonus scores • **New performance-based scoring** at the individual measure level • Must report the required measures under each Objective, or claim the exclusions if applicable

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MIPS Year 3 (2019) Final

Promoting Interoperability Performance Category

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

Objectives and Measures

Year 2 (2018) Final	Year 3 (2019) Final
• Two measure set options for reporting based on the MIPS eligible clinician's edition of CEHRT (either 2014 or 2015)	• One 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

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MIPS Year 3 (2019) Final

Promoting Interoperability Performance Category – Point Value

Objectives	Measures	Maximum 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

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MIPS Year 3 (2019) Final

Promoting Interoperability Performance Category

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

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

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MIPS Year 3 (2019) Final

Promoting Interoperability Performance Category

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

Scoring

Year 2 (2018) Final	Year 3 (2019) Final
• 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-based scoring at the individual measure level
• Performance score (worth 90%) is determined by a performance rate for each submitted measure	• Each measure will be scored on performance for that measure based on the submission of a numerator and denominator, or a "yes or no" – **Must submit a numerator of at least one or a "yes" to fulfill the required measures**
• Bonus score (worth 25%) is available	• The scores for each of the individual measures will be added together to calculate a final score
• Maximum score is 165%, but is capped at 100%	• If exclusions are claimed, the points will be allocated to other measures

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MIPS Year 3 (2019) Final

Promoting Interoperability Performance Category – Scoring Example

Objectives	Measures	Maximum Points	Numerator/ Denominator	Performance Rate	Score
e-Prescribing	• e-Prescribing	• 10 points	200/250	80%	10 x 0.8 = 8 points
Health Information Exchange	• Support Electronic Referral Loops by Sending Health Information	• 20 points	135/185	73%	20 x 0.73 = 15 points
	• Support Electronic Referral Loops by Receiving and Incorporating Health Information	• 20 points	145/175	83%	20 x 0.83 = 17 points
Provider to Patient Exchange	• Provide Patients Electronic Access to their Health Information	• 40 points	350/500	70%	40 x 0.70 = 28 points
Public Health and Clinical Data Exchange	• Immunization Registry Reporting • Public Health Registry Reporting	• 10 points	• Yes • Yes	N/A	10 points
				Total	78 Points

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Promoting Interoperability Performance Category – Scoring Example

Total Score (from previous slide)	78 points
Calculate the contribution to MIPS Final Score	78 x .25 (the category value) = 19.5 performance category points
Final Performance Category Score	**19.5 points out of the 25 performance category points**

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MIPS Year 3 (2019) Final

Promoting Interoperability Performance Category

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

Reweighting

Year 2 (2018) Final	Year 3 (2019) Final

• 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
  ◦ Example: clinicians who are in small practices
	Same requirements as Year 2, with the following additions:
	• Extended the automatic reweighting for:
	  ◦ Physical Therapists
	  ◦ Occupational Therapists
	  ◦ Clinical Psychologists
	  ◦ Speech-Language Pathologists
	  ◦ Audiologists
	  ◦ Registered Dieticians or Nutrition Professionals

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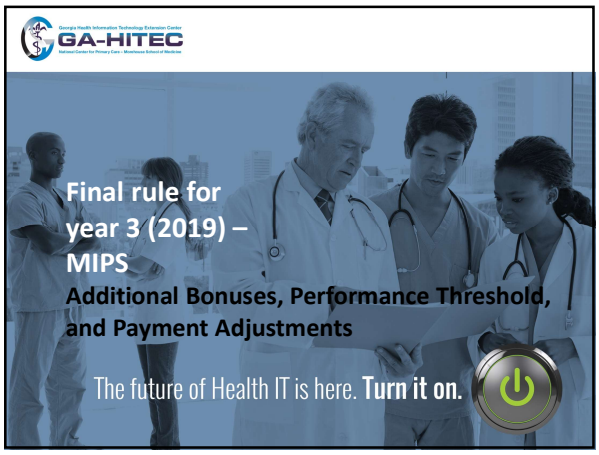

MIPS Year 3 (2019) Final

Complex Patient Bonus

Same requirements as Year 2:

- Up to **5 bonus points** available for treating complex patients based on medical complexity
  - As measured by Hierarchical Condition Category (HCC) risk score and a score based on the percentage of dual eligible beneficiaries
- MIPS eligible clinicians or groups must submit data on at least 1 performance category in an applicable performance period to earn the bonus

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MIPS Year 3 (2019) Final

Performance Threshold and Payment Adjustments

Year 2 (2018) Final	Year 3 (2019) Final
• 15 point performance threshold • Additional performance threshold for exceptional performance bonus set at 70 points • Payment adjustment could be up to +5% or as low as -5%* • Payment adjustment (and additional payment adjustment for exceptional performance) is based on comparing final score to performance threshold and additional performance threshold for exceptional performance	• **30** point performance threshold • Additional performance threshold for exceptional performance bonus set at **75** points • Payment adjustment **could be up to +7%** or as low as -7%* • Payment adjustment (and additional payment adjustment for exceptional performance) is based on comparing final score to performance threshold and additional performance threshold for exceptional performance

**To ensure budget neutrality, positive MIPS payment adjustment factors are likely to be increased or decreased by an amount called a "scaling factor." The amount of the scaling factor depends on the distribution of final scores across all MIPS eligible clinicians.*

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MIPS Year 3 (2019) Final

Performance Threshold and Payment Adjustments

Year 2 (2018) Final

Final Score 2018	Payment Adjustment 2020
≥70 points	• Positive adjustment greater than 0% • Eligible for additional payment for exceptional performance —minimum of additional 0.5%
15.01-69.99 points	• Positive adjustment greater than 0% • Not eligible for additional payment for exceptional performance
15 points	• Neutral payment adjustment
3.76-14.99	• Negative payment adjustment greater than -5% and less than 0%
0-3.75 points	• Negative payment adjustment of -5%

Year 3 (2019) Final

Final Score 2019	Payment Adjustment 2021
≥75 points	• Positive adjustment greater than 0% • Eligible for additional payment for exceptional performance — minimum of additional 0.5%
30.01-74.99 points	• Positive adjustment greater than 0% • Not eligible for additional payment for exceptional performance
30 points	• Neutral payment adjustment
7.51-29.99	• Negative payment adjustment greater than -7% and less than 0%
0-7.5 points	• Negative payment adjustment of -7%

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Use Your Checklist

Working through Your Checklist
Are You on Track in 2019?

- ✓ Eligibility
- ✓ EHR Certification – 2015 CEHRT
- ✓ Reporting Method
  - HARP Access
- ✓ Quality
  - QRDA III
- ✓ Promoting Interoperability
  - HIE
  - Security Risk Assessment
- ✓ Improvement Activities – timelines and documentation
- ✓ Cost – code to highest level of specificity, coordination of care
- ✓ 2018 Audit Book (cloud version, back-up)

Resources

- **General and All Information qpp.cms.gov**
  - **Eligibility look-up tool**
  - **Resource Library**
- **Email: QPP@CMS.HHS.GOV**
- **Phone: Help Desk 1-866-288-8292**
  - **HARP Password reset support**

Questions / Discussion

Thank You!

Liz Hansen
CMUP, CHSP, CHSA, PCMH CCE
GA-HITEC HIT Consultant
lhansen@ga-hitec.org

Phoebe Nelms, CMUP
Program Manger
GA-HITEC
pnelms@ga-hitec.org