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On the topic: All You Need to Know about MIPS
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All You Need to Know About MIPS

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What’s the CMS Quality Payment Program?

• The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA):
  – Ended the Sustainable Growth Rate (SGR) formula, which would have significantly cut payment rates for participating Medicare clinicians.
  – MACRA required CMS to implement an incentive program, the Quality Payment Program (QPP).
  – There are 2 ways clinicians can choose to participate in the Quality Payment Program:
    – The Merit-based Incentive Payment System (MIPS):
      • If you’re a MIPS eligible clinician, you’ll be subject to a performance-based payment adjustment through MIPS.
    – Advanced Alternative Payment Models (APMs):
      • If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for sufficiently participating in an innovative payment model.
WHAT IS THE BENEFIT OF PARTICIPATING IN MIPS IN 2019?

For 2019 Performance Period, CMS predicts that 800,000 Part B providers will be subject to MIPS. Possible consequences for these Providers?

• Can earn a bonus up to 7% of Medicare Part B allowed payments for Performance Year (PY) in 2021.
• Can prevent a penalty of up to 7% of Medicare Part B allowed payments submitted for Performance Year (PY) in 2021.
• In the 2020 PY, the maximum penalty increases to 9% of Part B payments.
  – The maximum incentive is the sum of the maximum base incentive and the maximum exceptional performance bonus, which depend on several respective factors.
  – For each performance year, CMS sets a PT (Performance Threshold) number of points at which a provider earning PT points receives 0% adjustment, no penalty, no incentive.
  – PT is 30 points for the 2019 PY. A maximum penalty is assessed if a clinician scores below ¼ of PT (equal to 7.5 points for 2019).
  – On the other hand, if a clinician scores at or above the exceptional performance bonus threshold (EPBT); set to 75 for 2019, then the exceptional bonus is applied in proportion to the amount by which the MIPS score exceeds the EPBT.

Why MIPS?

• MIPS was designed to:
  1. *Tie payments to quality and cost* efficient care;
  2. *Drive improvement in care processes and health outcomes*;
  3. *Increase the use of healthcare information*; and
  4. *Reduce the cost of care*. 
2019 MIPS PERFORMANCE PERIOD

- Full performance period is January thru December 31, 2019.
  - However, not all performance categories require 12 months of data collection.
  - Payment adjustments based on this performance period will be made in 2021.
- Just a few of the Acronyms used in this presentation are:
  - APM = Alternative Payment Model
  - MIPS = Merit-Based Incentive Payment System
  - NPI = National Provider Identifier
  - QP = Qualifying APM Participant
  - QPP = Quality Payment Program
  - TIN = Taxpayer Identification Number

WHO REPORTS MIPS?

- Under MIPS:
  - Clinicians are included:
    - If they are an eligible clinician type; and
    - Meet the low volume threshold:
      - Which is based on allowed charges for covered professional services under the Medicare Physician Fee Schedule (PFS) and
      - The number of Medicare Part B patients who are furnished covered professional services under the Medicare Physician Fee Schedule.
WHAT TYPES OF CLINICIANS ARE INCLUDED IN MIPS FOR 2019?

• Physicians:
  – Doctors of:
    • Medicine
    • Osteopathy
    • Dental surgery
    • Dental medicine
    • Podiatric medicine
    • Optometry
    • Osteopathic practitioners
    • Chiropractors
  – Nurse Practitioners
  – Clinical Nurse Specialists
  – Certified Registered Nurse Anesthetists

• New for 2019 Eligible Clinicians also include:
  – Clinical Psychologists
  – Physical Therapists
  – Occupational Therapists
  – Qualified Speech-Language Pathologists
  – Qualified Audiologists
  – Registered Dietitians and Nutrition Professionals.

HOW CMS EVALUATES ELIGIBILITY TO PARTICIPATE IN MIPS

• CMS looks at each practice (identified by TIN)
  – Where you have reassigned billing rights in PECOS.
  – This means that you may be required to participate in MIPS at some Practices, but not at others.

• Your eligibility is based on your:
  – National Provider Identifier (NPI)
  – Associated Taxpayer Identification Numbers (TINs)

• TIN can belong to:
  • You, if you are self-employed;
  • A group or practice;
  • A hospital or other organization.
DETERMINING REQUIREMENT TO PARTICIPATE IN MIPS FOR 2019

• If one of the previous listed clinician types on the previous slide, you are required to participate if you:
  
  – Exceed the low-volume threshold; AND
  – Enrolled in Medicare prior to January 1, 2019; AND
  – Don’t become a QP or Partial QP (Qualified APM Participant).

WHAT IS LOW-VOLUME THRESHOLD?

• CMS looks at Medicare claims from two 12-month segments (referred as the MIPS determination period) to assess the volume of care you provide to Medicare beneficiaries:
  – October 1, 2017 – September 30, 2018
  – October 1, 2018 - September 30, 2019

• You must participate in MIPS, if, in both 12-month segments you:
  – Bill more than $ 90,000 for Part B covered professional services; AND
  – See more than 200 Part B patients; AND
  – Provide 200 or more covered professional services to Part B patients (This is a NEW requirement).
EVEN IF NOT REQUIRED TO PARTICIPATE AS AN INDIVIDUAL

• You may still be required to participate (and receive a payment adjustment) if:
  – Your practice chooses to participate as a **Group**;
  – You are a part of a **Virtual Group**;
  – You participate in a type of APM called a **MIPS APM**.
CAN I CHOOSE TO PARTICIPATE IN MIPS IF NOT ELIGIBLE?

Yes. If you exceed one or two of the three thresholds related to volume of charges, beneficiaries and services, you can:

1. Elect to “opt-in”.
   If you do elect to “opt-in”, you will receive a payment adjustment (positive, negative or neutral) in 2021.

2. Voluntarily report.
   If you choose to voluntarily report, you will not receive a payment adjustment in 2021.

Clinicians Exempt From MIPS

- Clinicians who are not one of the clinician types listed as an Eligible Clinician.
- Clinicians who enroll in Medicare for the first time in 2019
- Clinicians who participate in an Advanced APM and are either a Qualifying APM Participant (QP) or Partial QP
- Clinicians who are not in a MIPS eligible specialty
- Clinicians or groups that have billed $90,000 or less in Physician Fee Schedule (PFS) services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries
  - (Including Railroad Retirement Board and Medicare secondary Payer)
- Clinicians or groups that have seen 200 or fewer Medicare Part B FFS beneficiaries
- Clinicians or groups that provide less than 200 professional services in 2019 to Part B Patients.
HOW TO FIND OUT IF REQUIRED TO PARTICIPATE?
https://qpp.cms.gov/mips/overview

HOW TO PARTICIPATE IN MIPS?

• Performance is measured through the data clinicians report in four areas:
  – 1. Quality;
  – 2. Improvement Activities;
  – 3. Promoting Interoperability (formerly Advancing Care Information); and

• CMS designed MIPS to update and consolidate previous programs, including:
  – Medicare Electronic Health Records (EHR) Incentive Program for Eligible Clinicians;
  – Physician Quality Reporting System (PQRS); and
  – The Value-Based Payment Modifier (VBM).
TOTAL PERFORMANCE SCORE RESULTS FOR 2019

- CMS uses a clinician’s total performance score to apply a positive or negative payment adjustment to their Medicare Part B reimbursements.

- For 2019, clinicians and groups must earn at least 30 MIPS points to receive a neutral payment adjustment, as cited in the 2019 QPP Final Rule.
  - Clinicians earning higher than 30 points may receive a payment bonus of up to 7 percent;
  - While MIPS-eligible clinicians who receive lower than 30 points or who fail to participate in MIPS will receive as much as a negative 7 percent payment adjustment.

Choose How You Will Participate

• Clinicians participating in MIPS may participate as individuals or as a member of a group.
  – Beginning in performance year 2018, clinicians also had the option to participate as part of a virtual group.

• Individual:
  – If you report MIPS data in as an individual, your payment adjustment will be based only on your performance.
  – An individual is defined as a single NPI tied to a single TIN.

Choose How You Will Participate

• Group:
  If you report MIPS data with a group, your payment adjustment is based on the group’s performance.
  A group is defined as a set of clinicians - identified by their National Provider Identifier (NPI) - sharing a common Taxpayer Identification Number (TIN), no matter the specialty or practice site.

• Virtual Group:
  – A Virtual Group is a combination of two or more Taxpayer Identification Numbers (TINs) made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together “virtually” (no matter specialty or location) to participate in MIPS for a performance period of a year.
How MIPS Works

• As stated, there are four performance categories that make up your final score.
• Your final score determines what your payment adjustment will be.
• These categories are:
  – 1. Quality – 45% of MIPS final score for 2019 (down from 50% in 2018(+)
    • This performance category replaces PQRS.
    • Covers the quality of the care you deliver, based on performance measures created by CMS, as well as medical professional and stakeholder groups.
    • You pick the six measures of performance that best fit your practice

Specialty Measure Sets

• Clinicians and groups can choose to submit:
  – A specialty or subspecialty measure set.
  – In doing so, they must submit data on at least 6 measures within that set.
  – If the set contains fewer than 6 measures, the clinician or group should submit each measure in the set.
CHANGES IN THE QUALITY CATEGORY IN 2019

• **One of the most significant changes** to the Quality performance category for 2019 is:
  – Addition of **eight new Quality measures** and
  – Removal of 26 old Quality measures that CMS deemed duplicative or too easy.

• Among the new MIPS quality performance measures:
  – One that may be applicable for some health clinicians is the **Continuity of Pharmacotherapy for Opioid Use Disorder (OUD)** measure.
  – This measure is also a **High Priority measure**, as all opioid-related Quality measures are now counted as High Priority measures for the 2019 performance year.

• Also “**Practices that submit two or more High Priority Quality measures can earn bonus points in the Quality performance category to improve their overall MIPS score**”.


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What **Quality** Data Should I Submit for MIPS 2019?

• An individual or group can:
  – Submit any combination of measures across these collection types (eCQMs, MIPS CQMs, QCDR Measures, and for small practices, Medicare Part B claims measures)
  – To fulfill the requirement to submit 6 measures.
  – The CAHPS for MIPS Survey measure can also count as one of the 6 measures submitted.

• In addition:
  – **For groups of 16 or more clinicians who meet the case minimum of 200, the administrative claims-based all-cause readmission measure will be automatically scored as a seventh measure**
CMS Web Interface

• Groups and virtual groups:
  – With 25 or more clinicians,
  – Who are registered and choose to submit data using the CMS Web Interface,
  – Must report all 10 required quality measures for the full year (January 1 - December 31, 2019).

EXAMPLES OF 2019 MEASURES TO CHOOSE FROM CMS WEBSITE DOWNLOAD

<table>
<thead>
<tr>
<th>Measure Title</th>
<th>Measure Number</th>
<th>Overall Performance Rate</th>
<th>Number of Performance Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ankylosing Spondylitis (AS) w/ Biologic Therapy - Prior Inflammatory Arthritis</td>
<td>C5012R-7</td>
<td>6/7</td>
<td>2</td>
</tr>
<tr>
<td>Anti-Hypertensive Medication Management</td>
<td>C61119-7</td>
<td>6/2</td>
<td>2</td>
</tr>
<tr>
<td>Hypertensive Medication Post-Discharge</td>
<td>P/A</td>
<td>6/6</td>
<td>2</td>
</tr>
<tr>
<td>HIV/AIDS: Preventive Prav大发防/Prav大发防 (PEP) Treatment</td>
<td>C5803R-7</td>
<td>6/6</td>
<td>2</td>
</tr>
<tr>
<td>Preventive Care and Screening: Tobacco Use Screening and Reduction Treatment</td>
<td>C5803R-7</td>
<td>6/6</td>
<td>2</td>
</tr>
<tr>
<td>High-Intensity Medications to the Elderly</td>
<td>C5803R-7</td>
<td>6/6</td>
<td>2</td>
</tr>
<tr>
<td>Weight Management and Counseling for Nutrition and Physical Activity for Children and Adolescents</td>
<td>C5803R-7</td>
<td>6/6</td>
<td>2</td>
</tr>
<tr>
<td>Antipsychotic Medication Use in Therapy</td>
<td>C61119-7</td>
<td>6/6</td>
<td>2</td>
</tr>
<tr>
<td>HERL &amp; Implementable Cardiovascular Stenosis (ICR) Complications Rate</td>
<td>P/A</td>
<td>6/6</td>
<td>2</td>
</tr>
<tr>
<td>Follow-Up Care for Children Prevented ANG1 Medications (ADH)</td>
<td>C5803R-7</td>
<td>6/6</td>
<td>2</td>
</tr>
<tr>
<td>Depression Treatment at Primary Visits</td>
<td>C5803R-7</td>
<td>6/6</td>
<td>2</td>
</tr>
</tbody>
</table>
MIPS: How Are Measures Scored?

- Measure achievement points are determined by CMS by comparing performance on a measure to a measure benchmark.
  - If a measure can be reliably scored against a benchmark, it means:
    - A benchmark is available; and
    - Has at least 20 cases; and
    - Meets the data completeness requirement standard, which is generally 60 percent.

MAXIMIZING QUALITY POINTS IN 2019

- Clinicians can maximize their possible Quality points by:
  - **Submitting more than the required six measures.**
    - If additional Quality measures are submitted, only the six highest-scoring measures will count towards the clinician’s Quality score.
- **Other ways to earn bonus points in 2019:**
  - **“Submit data using End-to-End Electronic Reporting:**
    - Clinicians that report their Quality data directly from certified electronic health record technology (CEHRT) using End-to-End Electronic Reporting can earn bonus points in the Quality category.
  - **“Earn a bonus for being a small practice:**
    - Practices with 15 or fewer providers in their Associated Taxpayer Identification Number (TIN) earn six bonus points in the Quality category if they submit on at least one Quality measure.
    - This small practice bonus is increased from the five-point bonus offered in 2018.
    - Additionally, if a small practice can meet the completeness requirements for a Quality measure, they will still earn at least three points for that measure.
  - **“Display improvement from the previous year:**
    - Practices and clinicians that show improvement in their Quality score from the previous MIPS performance year can earn up to 10 additional percentage points.”

How to Earn Quality Bonus Points

- Quality measure bonus points can be earned in the following ways:
  - Submission of 2 or more outcome or high priority quality measures (bonus will not be awarded for the first outcome or high priority quality measure and will not be awarded for measures submitted via CMS Web Interface)
    - Opioid-related measures are now included in high priority quality measures
  - Submission using End-to-End Electronic Reporting, with quality data directly reported from a certified EHR technology (CEHRT)
  - 6 bonus points are added to the Quality performance category score for clinicians in small practices who submit at least one measure, either individually or as a group or virtual group.
  - Clinicians can also earn up to 10 additional percentage points based on their improvement in the Quality performance category from the previous year.

MIPS: How Should I Submit Data?

- Individual clinicians in a small practice and small practices participating as a group or virtual group:
  - Can submit their quality measures through Medicare Part B Claims.

- Registered groups and virtual groups, with 25 or more clinicians:
  - Can submit their quality measures through the CMS Web Interface.

- Individual clinicians, groups, virtual groups, and third-party intermediaries:
  - Can log in and upload their quality measure data in an approved file format on qpp.cms.gov.

- Authorized third-party intermediaries can:
  - Perform a direct submission, transmitting data through a computer-to-computer interaction, such as an API.
Third-Party Intermediaries

- Third-party intermediary collects and submits data on behalf of MIPS eligible clinicians
  - Such intermediaries can be a qualified registry, a qualified clinical data registry (QCDR),
  - A health IT vendor that obtains data from a MIPS eligible clinician's CEHRT, or
  - A CMS-approved survey vendor.
- Certain CMS-approved third-party intermediaries also provide feedback to clinicians throughout the year to support and drive improvement.
  - Qualified Clinical Data Registries
  - Qualified Registries

2. Promoting Interoperability (PI) – 25% of MIPS Final Score- 2019

- Same % of total score as 2018.
- CMS has re-named the Advancing Care Information performance category to Promoting Interoperability (PI) to focus on:
  - 1. Patient engagement; and
  - 3. Again, this performance category replaced the Medicare EHR Incentive Program for EPs, commonly known as Meaningful Use.
- This is done by proactively sharing information with other clinicians or the patient in a comprehensive manner.
- This may include:
  - Sharing test results;
  - Visit summaries; and
  - Therapeutic plans with the patient and other facilities to coordinate care.
• **Promoting Interoperability (PI) performance category** saw some major changes for MIPS 2019 including:
  – New scoring methodology,
  – Stricter reporting requirements and
  – Changes to the PI measures.

**What Promoting Interoperability Data Should I Submit?**

• **Beginning in 2019,** you will submit a single set of Promoting Interoperability Objectives and Measures to align with **2015 Edition CEHRT** which is required.
  – This single measure set includes new and existing Promoting Interoperability performance category measures organized under **4 objectives.**
  – Measures are no longer classified as base score or performance score measures.

• **Requirements:**
  – Participants must submit collected data for **certain measures from each of the 4 objectives measures** (unless an exclusion is claimed) **for 90 continuous days or more during 2019.**
  – **In addition to submitting measures,** clinicians must:
    • Submit a “yes” to the Prevention of Information Blocking Attestation,
    • Submit a “yes” to the ONC Direct Review Attestation; and
    • Submit a “yes” for the security risk analysis measure
ONC Direct Review Attestation

Attestation Statement:

- I attest that I –
  - (1) Acknowledge the requirement to cooperate in good faith with ONC direct review of his or her health information technology certified under the ONC Health IT Certification Program if a request to assist in ONC direct review is received; and
  - (2) If requested, cooperated in good faith with ONC direct review of his or her health information technology certified under the ONC Health IT Certification Program as authorized by 45 CFR part 170, subpart E, to the extent that such technology meets (or can be used to meet) the definition of CEHRT, including by permitting timely access to such technology and demonstrating its capabilities as implemented and used by the MIPS eligible clinician in the field.

- Score Weight 0

ONC (Office of the National Coordinator for Health Information Technology) –

- The purpose of ONC is to promote a national health information technology (HIT) infrastructure and oversee its development.
- For healthcare providers, ONC is associated with nationwide efforts to provide electronic health records (EHR) to patients as a way to better curb medical errors and eliminate paper records.

Source: [https://searchhealthit.techtarget.com/definition/ONC](https://searchhealthit.techtarget.com/definition/ONC)

SCORING PI MEASURE IN 2019

- Each PI measure score will be added together for:
  - Total PI performance score out of 100 possible points.
- The 2019 MIPS PI measures fall under four objectives:
  - 1. e-Prescribing
  - 2. Health Information Exchange
  - 3. Provider to Patient Exchange
  - 4. Public Health and Clinical Data Exchange
- Clinicians must report measures from each of the four objectives to complete their PI requirements.
- Failure to submit for a required PI measure without claiming an exclusion for that measure will result in a score of zero for the entire PI performance category score.
  - If a clinician does claim an exclusion for one of the PI measures, those percentage points will be reallocated to the Quality performance category.
PROMOTING INTERAOPERABILITY

• “In 2019 clinicians must submit:
  – A single set of measures that are all scored based on performance.
  – Clinicians will submit a numerator and denominator for each measure that
    will then be used to calculate a total score for that measure.”

• “Example:
  – To complete the Support Electronic Referral Loops by Sending Health
    Information measure, clinicians who are referring or transitioning a patient
    must:
    • Create a summary of care record using CEHRT and
    • Electronically exchange that record to the new provider.
    – The denominator for this measure is: The number of transitions of
      care and referrals performed during the performance period and
    – The numerator is the number of transitions of care and referrals
      during the performance period where a summary of care record
      was created and exchanged using CEHRT.”


e-PRESCRIBING MEASURE IN 2019

• For the e-Prescribing objective in 2019:
  – Clinicians will have the opportunity to earn five bonus points for each of two
    additional measures:
    • Verify Opioid Treatment Agreement and
    • Query of Prescription Drug Monitoring Program (PDMP).
3. Improvement Activities – 15% of MIPS Final Score - 2019

• Same % of total score as in 2018.
• Performance category that includes an inventory of activities that assess how you:
  – 1. Improve your care processes;
  – 2. Enhance patient engagement in care; and
  – 3. Increase access to care.
  – The inventory allows you choose the activities appropriate to your practice from categories such as:
    • Enhancing care coordination;
    • Patient and clinician shared decision-making; and
    • Expansion of practice access.

What Improvement Activities Data Should I Submit?

• To earn full credit in this performance category, participants must submit one of the following combinations of activities (each activity must be performed for 90 continuous days or more during 2019):
  – 2 high-weighted activities
  – 1 high-weighted activity and 2 medium-weighted activities
  – 4 medium-weighted activities

• UPDATED: How Are Activities Scored?
  – High-weighted activities receive 20 points and
  – Medium-weighted activities receive 10 points.
Special Status for IA for 2019

• You will receive double points for each high- or medium-weighted activity you submit if you are an individual clinician, group, or virtual group who holds any of these special statuses:
  – Small practice
  – Non-patient facing
  – Rural
  – Health Professional Shortage Area (HPSA)
  – Patient-centered Medical Homes
    • If you are a participant in a recognized or certified patient-centered medical home or comparable specialty practice, you will earn the maximum Improvement Activity performance category score by attesting to this during the submission period.
    • (For organizations with multiple practice sites, at least 50 percent of these locations must be recognized or certified patient-centered medical homes or comparable specialty practices to attest to this.)

How Should I Submit Data on IA?

• Individual clinicians, groups, and virtual groups can log in and attest to their improvement activities measure data on qpp.cms.gov.
• Individual clinicians, groups, virtual groups, and third-party intermediaries can log in and upload their improvement activities measure data in an approved file format on qpp.cms.gov.
• Authorized third-party intermediaries can perform a direct submission, transmitting data through a computer-to-computer interaction, such as an API.
EXAMPLE MEASURE: Advance Care Planning

• Implementation of practices/processes to develop advance care planning that includes:
  – Documenting the advance care plan or living will within the medical record,
  – Educating clinicians about advance care planning motivating them to address advance care planning needs of their patients, and
    • How these needs can translate into quality improvement, educating clinicians on approaches and barriers to talking to patients about end-of-life and palliative care needs and ways to manage its documentation, as well as informing clinicians of the healthcare policy side of advance care planning.
• Subcategory Name
  – Population Management
  – Activity Weighting
  – Medium

EXAMPLE: Annual Registration in the Prescription Drug Monitoring Program

• Annual registration by eligible clinician or group in the prescription drug monitoring program of the state where they practice.
• Activities that simply involve registration are not sufficient. MIPS eligible clinicians and groups must participate for a minimum of 6 months.
• Subcategory Name
  – Patient Safety And Practice Assessment
  – Activity Weighting
  – Medium
EXAMPLE: Care coordination agreements that promote improvements in patient tracking across settings

- Establish effective care coordination and active referral management that could include one or more of the following:
  - Establish care coordination agreements with frequently used consultants that set expectations for documented flow of information and MIPS eligible clinician or MIPS eligible clinician group expectations between settings.
  - Provide patients with information that sets their expectations consistently with the care coordination agreements;
  - Track patients referred to specialist through the entire process; and/or
  - Systematically integrate information from referrals into the plan of care.

- Subcategory Name
  - Care Coordination
  - Activity Weighting
  - Medium

EXAMPLE: CDC Training on CDC's Guideline for Prescribing Opioids for Chronic Pain

- Completion of all the modules of the Centers for Disease Control and Prevention (CDC) course:
  - "Applying CDC’s Guideline for Prescribing Opioids" that reviews the 2016 "Guideline for Prescribing Opioids for Chronic Pain."
  - Note: This activity may be selected once every 4 years, to avoid duplicative information given that some of the modules may change on a year by year basis but over 4 years there would be a reasonable expectation for the set of modules to have undergone substantive change, for the improvement activities performance category score.

- Subcategory Name
  - Patient Safety And Practice Assessment
  - Activity Weighting
  - High
What is CAHPS For MIPS Survey?

- The Merit-based Incentive Payment System (MIPS) is one track of the Quality Payment Program, where clinicians earn a performance-based payment adjustment to their Medicare payment.
- Clinicians participating in MIPS have the flexibility to choose the measures and activities that are most meaningful to their practice to demonstrate performance.
  - The CAHPS for MIPS survey is an optional quality measure that groups and virtual groups participating in MIPS can elect to administer.
  - The CAHPS for MIPS survey is also an optional improvement activity that groups and virtual groups can attest to administering.
  - You need to register to participate in PY 2019 between April 1 and July 1, 2019 if a group or virtual group.
  - To register to administer for CAHPS MIPS for PY 2019, you can sign into QPP and go to Manage Access Tab. You will need to be connected to your organization as Security Official.

CMS WEB INTERFACE/CAHPS FOR MIPS SURVEY

- If participating as a group via the CMS Web Interface or CAHPS for MIPS survey, you need to register between April 1 and July 1, 2019.
  - Practices that reported through the CMS Web Interface in PY 2018 do not need to register as they will be automatically registered for PY 2019.
  - Practices in Medicare Shared Savings Program or Next Generation (NextGen) ACO don’t have to register for CMS Web Interface quality reporting as the ACO reports Quality measures on behalf of the participating eligible Clinicians for MIPS.

Source: qpp.cms.gov.
WHAT IS CAHPS For MIPS Survey?

• Consumer Assessment of Healthcare Providers & Systems:
  – Groups and virtual groups that collect measures via various collection types (eCQMs, MIPS CQMs, QCDRs, CMS Web Interface, and for small practices, Medicare Part B claims) may also submit and be scored on the CAHPS for MIPS survey.
  – Groups will have their total available measure achievement points reduced by 10 points if they:
    • Submit 5 or fewer measures; and
    • Register for the CAHPS for MIPS survey but do not meet the minimum beneficiary sampling requirements

CAHPS SURVEY

• The Consumer Assessment of Healthcare Providers & Systems (CAHPS) for MIPS Survey measures ten key domains of beneficiaries’ experiences of care that we refer to as summary survey measures (SSMs).
  – An SSM is a collection of survey items that assess the same patient experience domain of care.
  – The survey contains the core CAHPS Clinician & Group Survey (CG-CAHPS), plus additional items to meet CMS information needs.
  – The survey will be administered through a Mixed-Mode data collection protocol, including:
    • CMS pre-notification letter, two survey mailings, and
    • Up to six follow-up phone calls to beneficiaries who do not return a survey by mail.
    • All final CAHPS for MIPS survey documents and informational materials can be found on the Quality Payment Program resource library.

- Percentage will continue to increase for Cost category in future performance years, as the Bipartisan Budget Act of 2018 stated that the Cost category must be weighted at 30 percent by 2022.
- This performance category replaces the VBM.
- The cost of the care you provide will be calculated by CMS based on your Medicare claims data.
  - MIPS uses cost measures to gauge the total cost of care during the year or during a hospital stay.
  - Beginning in 2018, this performance category began to count towards your MIPS final score.
  - For the cost performance measures:
    - 2019 MIPS will retain the Medicare Spending Per Beneficiary (MSPB) and Total Per Capita Cost (TPCC) measures used in previous years; but
    - Will also add eight new Episode-Based Measures.
    - These episode-based measures are categorized as either procedural or acute inpatient medical condition episodes and include measures such as:
      - Knee Arthroplasty and Simple Pneumonia with Hospitalization.

COST CATEGORY 2019

- All participating clinicians and practices will be evaluated based on:
  - Same ten Cost performance measures.
  - However, if a clinician does not meet or exceed a specified case minimum for any of these measures, the percentage for the Cost performance category will be added to the Quality category instead.
  - Because some clinicians do not perform the episode-based measures, their Cost percentage will be shifted to the Quality performance category instead —
    - The typical score breakdown for such clinicians will be:
      - 0 percent for Cost,
      - Raising score to 60 percent for Quality,
      - 25 percent for Promoting Interoperability and
      - 15 percent for Improvement Activities.

Source: What You Need to Know About MIPS in 2019 By sandy | March 20, 2019 |
EXAMPLE: Knee Arthroplasty

- The Knee Arthroplasty cost measure is meant to apply to clinicians who perform elective total and partial knee arthroplasties during the performance period for Medicare beneficiaries.
- This surgical procedure is meant to replace a patient's own poorly functional knee with an artificial one, thereby reducing pain and increasing mobility.
- The measure evaluates a clinician's risk-adjusted cost for the episode group by averaging it across all episodes attributed to the clinician.
- The cost of each episode is the sum of the cost to Medicare for services performed by the attributed clinician and other health care providers over the length of the episode, or "episode window."
- The cost measure is calculated by determining the risk-adjusted episode cost, averaged across all of a clinician's episodes during the performance period.
- Collection Type
  - Administrative claims measures
  - Measure ID
  - COST_KA_1

EXAMPLE: Screening/Surveillance Colonoscopy

- The Screening/Surveillance Colonoscopy cost measure is meant to apply to clinicians who perform screening/surveillance colonoscopy procedures for Medicare beneficiaries during the performance period.
- Screening and surveillance colonoscopies are preventative care procedures that are meant to detect the presence of colorectal cancer (CRC) among patients who are at average risk or high risk of CRC, respectively.
- The measure evaluates a clinician's risk-adjusted cost for the episode group by averaging it across all episodes attributed to the clinician.
- The cost of each episode is the sum of the cost to Medicare for services performed by the attributed clinician and other health care providers over the length of the episode, or "episode window."
- The cost measure is calculated by determining the risk-adjusted episode cost, averaged across all of a clinician's episodes during the performance period.
- Collection Type
  - Administrative claims measures
  - Measure ID
  - COST_SSC_1
When for MIPS reporting?

- **The MIPS Performance Year** begins on January 1 and ends on December 31 each year.
  - Program participants must report data collected during one calendar year by March 31 of the following calendar year.
  - For example:
    - Program participants who collected data in 2017 had to report their data by March 31, 2018 to be eligible for a payment increase and to avoid a payment reduction in 2019.
About MIPS Participation

- Your *eligibility for MIPS may change each Performance Year (PY) due to policy changes.*
  - Your eligibility may also change throughout the Performance Year as CMS will review twice starting in 2019.
- As the Quality Payment Program evolves, CMS realizes it can be hard for small practices to participate.
  - To aid small practices, CMS offers tailored flexibility for groups of 15 or fewer clinicians.

About QPP Exceptions for 2019

- CMS understand that there may be circumstances out of your control that make it difficult for you to meet program requirements.
- To reduce this burden, we provide the opportunity to **apply for exceptions** to meeting MIPS program requirements.
- In certain circumstances, these exceptions may be applied automatically.
- QPP exception guidelines may change each Performance Year (PY) due to policy changes.
FACTORS AFFECTING QPP REPORTING REQUIREMENTS IN 2019

• In the Quality Payment Program, there are certain factors including:
  – Special Statuses,
  – QPP Exceptions,
  – Facility-based Determinations,
  – MAQI and the
  – Quality Measures Reporting Study
  – These *can affect your reporting requirements for the different performance categories and can result in fewer or no reporting requirements* for a specific performance category.

Special Statuses

• CMS retrieves and analyzes Medicare Part B claims data to determine who receives a special status.
  – Those with a special status qualify for reduced reporting requirements in certain performance categories.
• Special status applies to those who are:
  – Practicing in a rural area or Health Professional Shortage Area (HPSA);
  – Non-patient facing,
  – Hospital-based, or
  – Ambulatory surgical center (ASC)-based; or
  – A small practice
QPP Exceptions

• CMS understand that there may be circumstances out of your control that make it difficult for you to meet program requirements. Therefore, they provide the opportunity to apply for the:
  1. QPP Extreme and Uncontrollable Circumstances Exceptions for MIPS (for any of the 4 MIPS performance categories) or
  2. The Promoting Interoperability Hardship Exception (for only the Promoting Interoperability performance category) only.

• Exception Applications may change each Performance Year (PY) due to changing policies.

Extreme and Uncontrollable Circumstances Exception

• MIPS eligible clinicians, groups, and virtual groups may submit an application for re-weighting of any or all MIPS performance categories if:
  – They've been impacted by extreme and uncontrollable circumstances that extend beyond the Promoting Interoperability performance category.

• Can I Apply for an Extreme and Uncontrollable Circumstances Exception?
  – Extreme and uncontrollable circumstances are defined as rare events entirely outside of your control and the control of the facility in which you practice.
  – These circumstances would cause you to either be:
    • Unable to collect information necessary to submit for a performance category, or;
    • Unable to submit information that would be used to score a performance category for an extended period of time (for example, if you were unable to collect data for the Quality performance category for 3 months).
**Extreme and Uncontrollable Circumstances Exception**

- **When Does This Exception get Applied Automatically?**
  - The automatic extreme and uncontrollable circumstances policy applies to MIPS eligible clinicians who are located in a Centers for Medicare & Medicaid Services (CMS)-designated region that has been affected by an extreme and uncontrollable event (such as FEMA-designated major disaster) during the 2019 MIPS performance period.
  - The automatic extreme and uncontrollable circumstances policy does not apply to group or virtual group participation.
  - MIPS eligible clinicians identified as affected by the automatic extreme and uncontrollable policy will have all four performance categories re-weighted to 0% of their final score unless they submit data for two or more performance categories.

- **How do I Apply?**
  - The Extreme and Uncontrollable Circumstances Application for Performance Year 2019 will open early summer 2019 and close December 31, 2019.

- **How do I Know if I’m Approved?**
  - You’ll be notified by email if your request was approved or denied. If approved, this will also be added to your eligibility profile in the QPP Participation Status Tool, but may not appear in the lookup tool until the submission window is open in 2020.

- **What Happens if My Application is Approved?**
  - If your application is approved, you do not have to report for the requested performance category or categories, and those categories will be re-weighted.

- **Can I Still Submit Data?**
  - Yes. Whether you qualify for automatic re-weighting or have an approved exception application, you can still choose to report. If you submit data for two or more performance categories, you’ll receive a final score based on your performance in these categories.
Promoting Interoperability Hardship Exception

- **Certified electronic health record technology (CEHRT) is required for participation in the Promoting Interoperability performance category.** Under the Merit-based Incentive Payment System (MIPS), you may qualify for a re-weighting of the Promoting Interoperability performance category (to 0%) if you meet certain criteria.

- **Can I Apply for a PI Hardship Exception?**
  - MIPS eligible clinicians, groups, and virtual groups may submit a Promoting Interoperability Hardship Exception Application citing one of the following specified reasons:
    - You're a small practice
    - You have decertified EHR technology
    - You have insufficient Internet connectivity
    - You face extreme and uncontrollable circumstances such as disaster, practice closure, severe financial distress or vendor issues
    - You lack control over the availability of CEHRT
    - Lacking CEHRT does not qualify you for re-weighting.

- **NOTE:** If you’re already exempt from submitting Promoting Interoperability, you don’t need to apply for this application.

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When Will Facility-Based Measures Scoring Apply?

- **Beginning with the 2019 Performance Period, CMS will identify clinicians and groups eligible for facility-based scoring.**
  - These clinicians and groups **may have the option to use facility-based measurement scores for their Quality and Cost performance category scores.**
  - **Facility-based measurement scoring will be used** for your Quality and Cost performance category scores when:
    - You are identified as facility-based; and
    - You are attributed to a facility with a Hospital Value-Based Purchasing (VBP) Program score for the 2019 performance period; and
    - The Hospital VBP score results in a higher score than the MIPS Quality measure data you submit and MIPS Cost measure data we calculate for you.
Facility-Based Clinicians

• If a clinician is identified as facility-based and is attributed to a facility with a Hospital Value-Based Purchasing (VBP) Program score:
  – Clinician is not required to submit data for the Quality performance category.
  – The Hospital VBP score will be used for both the Quality and Cost performance categories instead.
  – The clinician could also submit individual Quality data via another collection type and CMS will use whichever data set results in a higher combined Quality and Cost score for the clinician.

Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration

• The MAQI demonstration:
  – Is testing waiving MIPS reporting requirements and payment adjustments for clinicians who participate sufficiently in Medicare Advantage (MA) arrangements that are similar to Advanced APMs.
  – The demonstration looks at whether waiving MIPS requirements would increase levels of participation in MA payment arrangements and whether it would change how clinicians deliver care.
Quality Measures Reporting Study

• Each year, CMS conducts a study:
  – (“The CMS Study on Factors Associated with Reporting Quality Measures”) on the workflows and data collection associated with reporting Quality measures.
  – Study participants receive full credit in the Improvement Activities performance category if they submit an application and successfully meet all of the study participation requirements.
  – Upon successful completion, those participants will be identified on the Participation Lookup Tool as receiving the “IA Study Credit.”

What Should I do If I'm an APM Participant?

• MIPS eligible clinicians and Taxpayer Identification Numbers (TINs) participating in a MIPS Alternative Payment Model (APM) do not need to report data for the Promoting Interoperability performance category if they qualify for automatic re-weighting or have an approved hardship exception.
  – However, these clinicians will receive the APM entity score for Promoting Interoperability as determined by the APM scoring standard if the performance category is not reweighted for the entire entity.
• MIPS eligible clinicians who are scored under the APM Scoring Standard receive the APM entity’s Promoting Interoperability score.
  – If these clinicians qualify for re-weighting at the individual or TIN level, they will be assigned a null value when calculating the average score for the APM entity.
IF NOT ALREADY PARTICIPATING, WHAT SHOULD I DO NOW TO PREVENT A REDUCTION IN MEDICARE PAYMENTS IN 2021?

1. Check the QPP Participation Status look-up tool, as previously shown, to verify 2019 eligibility status.
2. If required to participate, start by focusing on the Quality performance category.
   - Why? The Quality Performance category has a 12-month performance period, so you need to start collecting data as soon as possible.
     • Visit the 2019 Quality Requirements page and explore the 2019 measures on the QPP website.
     • Review the 2019 Quality Performance Category Fact Sheet on the QPP Resource Library.
     • Review your participation options, and learn about the Promoting Interoperability and Improvement Activities performance categories.
   - Need additional Help?
     • Email QPP@cms.hhs.gov.
     • Call 1-866-288-8292
     • Contact your local technical assistance organizations for no-cost support.

Merit-Based Incentive Payment System (MIPS) Quality Measure Data

• Participants collect measure data for the 12-month performance period (January 1 - December 31, 2019).
• The amount of data that must be submitted depends on the collection (measure) type.
  - For electronic Clinical Quality Measures (eCQMs),
  - MIPS CQMs (formerly "Registry measures"),
  - Qualified Clinical Data Registry (QCDR) Measures, and
  - Medicare Part B claims measures (only available to small practices), participants should:
    • Submit collected data for at least 6 measures, or a complete specialty measure set; and
    • One of these measures should be an outcome measure; if you have no applicable outcome measure, you can submit another high priority measure instead.
Merit-Based Incentive Payment System (MIPS) Quality Measure Data

- In addition, for groups of 16 or more clinicians who meet the case minimum of 200:
  - The administrative claims-based all-cause readmission measure will be automatically scored as a seventh measure
- An individual or group can submit any combination of measures across these collection types:
  - eCQMs,
  - MIPS CQMs,
  - QCDR Measures, and
  - For small practices, Medicare Part B claims measures) to fulfill the requirement to submit 6 measures.
  - The CAHPS for MIPS Survey measure can also count as one of the 6 measures submitted.

2019 MIPS Measure #458: All-cause Hospital Readmission

- Measure Description
  - The 30-day All-Cause Hospital Readmission measure is a risk-standardized readmission rate for beneficiaries age 65 or older who were hospitalized at a short-stay acute care hospital and experienced an unplanned readmission for any cause to an acute care hospital within 30 days of discharge
Specialty Measure Sets

• Clinicians and groups can choose to submit a specialty or subspecialty measure set.
• In doing so, they must submit data on at least 6 measures within that set.
• If the set contains fewer than 6 measures, the clinician or group should submit each measure in the set.

CMS Web Interface

• Groups and virtual groups with 25 or more clinicians, who are registered and choose to submit data using the CMS Web Interface:
  – Must report all 10 required quality measures for the full year (January 1 - December 31, 2019).
### APMs AND ADVANCED APMs

**APM:**
- An Alternative Payment Model (APM) is a payment approach that gives added incentive payments to:
  - Provide high-quality and cost-efficient care.
  - APMs can apply to a specific clinical condition, a care episode, or a population.

**Types of APMs:**
- APMs - Meet the statutory definition of an APM.
  - MIPS eligible clinicians participating in an APM are also subject to MIPS.
- **MIPS APMs:** MIPS APMs have MIPS eligible clinicians participating in the APM on their CMS-approved participation list.
  - Certain Alternative Payment Models (APMs) include Merit-Based Incentive Payment System (MIPS) eligible clinicians as participants and hold their participants accountable for the cost and quality of care provided to Medicare beneficiaries.
  - These types of APMs are called MIPS APMs, and participants receive special MIPS scoring under the APM scoring standard.
  - All eligible clinicians should check their participation status to understand their MIPS participation.
- **MIPS APMs are APMs that meet these 3 criteria:**
  - APM entities that participate in the APM under an agreement with CMS;
  - APM entities that include 1 or more MIPS eligible clinicians on a Participation List
  - APM bases payment incentives on performance (either at the APM entity or eligible clinician level), on cost/utilization, and quality measures.

### Advanced Alternative Payment Models (APMS) 2019

**Advanced Alternative Payment Models (APMs) are:**
- A track of the Quality Payment Program that offer a 5 percent incentive for achieving threshold levels of payments or patients through Advanced APMs.
- If you achieve these thresholds, you become a Qualifying APM Participant (QP) and you are excluded from the MIPS reporting requirements and payment adjustment.

**Advanced APMs are APMs that meet these 3 criteria:**
- Requires participants to use certified EHR technology;
- Provides payment for covered professional services based on quality measures comparable to those used in the MIPS quality performance category; and
- Either:
  - (1) is a Medical Home Model expanded under CMS Innovation Center authority OR
  - (2) requires participants to bear a significant financial risk.
ADVANCED APMs

• Advanced APM Potential Benefits:
  – 5 percent bonus
  – APM-specific rewards
  – Exclusion from MIPS

• To become a QP, you must:
  – Receive at least 50 percent of your Medicare Part B payments or
  – See at least 35 percent of Medicare patients through an Advanced APM entity at
    one of the
    – determination periods (snapshots).

• UPDATED: In addition, 75 percent of practices need to be using certified EHR
  Technology within the Advanced APM entity.

• An APM entity is an group (TIN) that has billing rights of a participant or participants
  (NPIs) that participates in an APM or payment arrangement with a non-Medicare
  payer through a direct agreement or through Federal or State law or regulation.

• In some APMs, the APM entity is an Accountable Care Organization (ACO).
  – ACOs are groups of doctors, hospitals, and other health care providers, who
    come together voluntarily to give coordinated high-quality care to the Medicare
    patients they serve.

Partial Qualifying APM Participant (Partial QP)

• All clinicians who participate in Advanced APMs
  and become Partial QPs may choose whether or
  not they want to participate in MIPS.
  – If these clinicians choose to participate, they must
    meet all MIPS reporting and scoring requirements.
  – If these clinicians choose not to participate, they will
    not be required to report to MIPS and will not receive
    a MIPS payment adjustment.

• If the Advanced APM also happens to be a MIPS
  APM, and the Partial QP chooses to participate in
  MIPS, then the Partial QP will be scored under the
  APM Scoring Standards.
OTHER IMPACT OF MIPS SCORING

• “The MIPS Score Follows the Clinician” - even if the he/she moves to another organization.
  - Example: If a MIPS score is earned for 2018, any new organization into which the clinician moves will inherit the MIPS payment adjustment applied in 2020 based on the 2018 score earned.
  - This impacts how organizations should credential and contract with clinicians and may impact an organization’s ability to attract the best if scores are not competitive. (Source: saignite.com, “10 FAQs About the Merit-Based Incentive Payment System (MIPS), Updated for 2019.”)

REFERENCES

• Note: All sources except the ones indicated on the pertinent slides were taken from https://qpp.cms.gov/mips/overview
QUESTIONS?

• THANK YOU!

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