First Base: What’s New in QPP for Year 3!

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Health Informatics Specialists
Health Services Advisory Group (HSAG)
March 8, 2019
Poll Time

Please participate in a poll!

Select your response(s) and click [Submit].
To View the Chat Box:

1. Click the [Chat] icon at the bottom of the Webex® screen.
2. The Chat panel will open in the upper right corner.

**Please Note:** The [Chat] box is only viewable and comments cannot be added.
To Submit Questions Via Q&A:

1. Click the [More] option icon (three dots) at the bottom of the presentation and select Q&A.

2. The Q&A panel will open.

3. Indicate that you want to send a question to the **HSAG QPP Service Center**.

4. Type your question in the box at the bottom of the panel.

5. Click [Send].
Objectives

At the completion of this training, the attendee will be able to:

- Identify key 2019 QPP Final Rule highlights.
- Recognize strategies to meet the 2019 QPP requirements.
# Acronyms Used In Today’s Presentation

<table>
<thead>
<tr>
<th>Acronym</th>
<th>DEFINITION</th>
<th>Acronym</th>
<th>DEFINITION</th>
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<tbody>
<tr>
<td>ACO</td>
<td>Accountable Care Organization</td>
<td>CQMs</td>
<td>Clinical Quality Measures/Registry</td>
</tr>
<tr>
<td>APM</td>
<td>Alternative Payment Model</td>
<td>eCQM</td>
<td>Electronic Clinical Quality Measure</td>
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<td>ASC</td>
<td>Ambulatory Surgery Center</td>
<td>E&amp;M</td>
<td>Evaluation and Management</td>
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<tr>
<td>CAHPS</td>
<td>Consumer Assessment of Healthcare Providers and Systems</td>
<td>EOB</td>
<td>Explanation of Benefits</td>
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<tr>
<td>CEHRT</td>
<td>Certified Electronic Health Record Technology</td>
<td>HARP (formerly EIDM)</td>
<td>Health Care Quality Information Systems (HCQIS) Access Roles and Profile</td>
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<td>CHIP</td>
<td>Children's Health Insurance Program</td>
<td>HPSA</td>
<td>Health Professional Shortage Area</td>
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<tr>
<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
<td>IA</td>
<td>Improvement Activities</td>
</tr>
</tbody>
</table>
## Acronyms Used In Today’s Presentation (cont.)

<table>
<thead>
<tr>
<th>Acronym</th>
<th>DEFINITION</th>
<th>Acronym</th>
<th>DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>LVT</td>
<td>Low Volume Threshold</td>
<td>PFS</td>
<td>Physician Fee Schedule</td>
</tr>
<tr>
<td>MACRA</td>
<td>Medicare Access and CHIP Reauthorization Act</td>
<td>PI</td>
<td>Promoting Interoperability</td>
</tr>
<tr>
<td>MIPS</td>
<td>Merit-based Incentive Payment System</td>
<td>QCDR</td>
<td>Qualified Clinical Data Registry</td>
</tr>
<tr>
<td>NPI</td>
<td>National Provider Identifier</td>
<td>QPP</td>
<td>Quality Payment Program</td>
</tr>
<tr>
<td>PCMH</td>
<td>Patient Centered Medical Home</td>
<td>SURS</td>
<td>Small Underserved Rural Support</td>
</tr>
<tr>
<td>PECOS</td>
<td>Provider Enrollment, Chain, and Ownership System</td>
<td>TIN</td>
<td>Tax Identification Number</td>
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</tbody>
</table>
Learning Forum Friday Updates
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No-Cost QPP Technical Assistance

Large Practices
Large practices have more than 15 clinicians. We have selected external assistance providers (Quality Innovation Network QIN-QIOs) throughout the country that can help large practices participate in the Quality Payment Program.

Small Practices
Small practices that have 15 or fewer clinicians, including those in rural locations, health professional shortage areas, and medically underserved areas, can find customized technical assistance on the Support for Small, Underserved, and Rural Practices page.

Transforming Clinical Practice Initiative (TCPI)
The CMS supported Transforming Clinical Practice Initiative (TCPI) helps you and more than 140,000 other clinicians to share, adapt, and develop comprehensive quality improvement strategies. If you participate in the program, you’ll be able to successfully participate in MIPS or learn how to successfully move toward participating in APMs and Advanced APMs.

You have to enroll with a Practice Transformation Network (PTN) to get this help. A PTN is a peer-based learning network that will coach, mentor, and help you develop core competencies specific to practice improvement. Please understand you’ll have to commit time and data to the PTN.

Email Truven Health to find out how to join a PTN.

To learn more visit https://qpp.cms.gov/about/help-and-support#technical-assistance

Source: The Centers for Medicare & Medicaid Services
Next Learning Forum Friday Event: April 12, 2019

Second Base:

Pitch Your Best Improvement Activities for Maximum Score

For additional event topics and registration information, please visit: https://www.hsag.com/LFF.

Topics and dates are subject to change, so please check the webpage for up-to-date information.
Resources

- CMS Quality Payment Program Website
- Guide for Obtaining an HARP Account [https://goo.gl/oy3JRo](https://goo.gl/oy3JRo)
- Medicare Learning Network (MLN) Learning Management System Booklet (LMS) FAQs
- Associations offering credit for MLN events and training
Opening Poll Results
Today’s QPP Coaches

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Health Informatics Specialist
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HSAG
QPP Overview
What is the QPP?

- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula, which would have resulted in a significant cut to Medicare payment rates for clinicians.
- The MACRA advances a forward-looking, coordinated framework for clinicians to successfully participate in the QPP, which rewards value and outcomes in one of two ways:
  - MIPS
  - Advanced APMs
What is the QPP? (cont.)

The Merit-Based Incentive Payment System
If you are a MIPS-eligible clinician, you will earn a performance-based payment adjustment through MIPS.

MIPS

or

Advanced Alternative Payment Models
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.

Advanced APMs
MIPS Overview
Legacy Programs

MACRA combined three legacy programs into a single, improved program:

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

Source: CMS QPP Year 3 Final Rule.
MIPS Year 3 (2019): Performance Category Weights

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.

Source: CMS. Quality Payment Program Year 3 Final Rule.
MIPS Year 3 (2019): Timeline

Performance Period: January 1, 2019

Performance period begins January 1 and closes 12/31/2019

Submit: March 31, 2020

Data Submission Deadline

Feedback Available: Summer 2020

CMS performance feedback reports

Adjustment: January 1, 2021

MIPS payment adjustments

Source: CMS QPP Year 3 Final Rule.
Year 3 (2019)—MIPS Eligibility
New Eligible Clinician (EC) Types for 2019

Year 2 (2018)
• Physicians
• Physician assistants
• Nurse practitioners
• Clinical nurse specialists
• Certified registered nurse anesthetists

Year 3 (2019)
• Year 2 clinician types AND
• Physical therapists
• Occupational therapists
• Qualified speech-language pathologists
• Qualified audiologists
• Clinical psychologists
• Registered dietitians/nutrition professionals

Source: CMS. Quality Payment Program Year 3 Final Rule.
Low-Volume Threshold (LVT) (2019) Criteria Addition

A clinician must **meet all three** of the following **criteria:**

He/she **must be:**

- A MIPS-eligible clinician billing $>90,000 a year in allowed charges for covered professional services under the Medicare PFS.
- Furnishing covered professional services to $>200 Medicare beneficiaries a year.
- Providing $>200 covered professional services under the PFS.

**Note:** For MIPS APM participants, the LVT determination will continue to be calculated at the APM Entity level.

Source: CMS QPP Year 3 Final Rule.
Who is Exempt?

Newly-Enrolled in Medicare
Enrolled in Medicare for the first time during the performance period (exempt until the following performance year)

Below the Low-Volume Threshold*
Medicare Part B allowed charges ≤ $90,000 a year
OR
Sees ≤ 200 Medicare Part B patients a year
OR
Has < 200 covered professional services*

Significantly Participating in Advanced APMs
Receive 25% of Medicare payments
OR
See 20% of their Medicare patients through an Advanced APM

* New Low Volume Threshold Criteria for Year 3 2019
Opt-In or Voluntary Participation

• **Opt-In** (New for Year 3 [2019]) participation is available:
  – If you meet or exceed at least *one*, but not all three, of the LVT criteria.
  – Will submit data to CMS and receive feedback and any applicable payment adjustments.

• **Voluntary** participation is available if clinicians *cannot meet any* of the three LVT criteria. Clinicians voluntarily participating:
  – Will submit data to CMS and receive performance feedback.
  – Will not receive a MIPS payment adjustment.
To make an election to opt-in (or voluntarily report), individual eligible clinicians and groups will need to:

• Sign-in to [qpp.cms.gov](http://qpp.cms.gov).*

• Select the option to opt-in (or voluntarily report).

**Once an election has been made, the decision to opt-in to MIPS is irrevocable and cannot be changed.**

• Clinicians or groups who opt-in are subject to all of the MIPS rules, performance thresholds/requirements, special status, and MIPS payment adjustments.

**APM Entities interested in opting-in to participate in MIPS under the APM Scoring Standard must do so at the APM Entity level.**

*We encourage you to review the wireframe drawings on the three different approaches to MIPS participation on [qpp.cms.gov/design-examples](http://qpp.cms.gov/design-examples).*
Determination Period: Year 2/Year 3 Comparison

Year 2 (2018) Final
LVT Determination Period:
  – Including 30-day claims run out
  – Including 30-day claims run out

Year 3 (2019) Final
MIPS Determination Period:
• First 12-month segment: 10.1.2017–9.30.2018
  – Including 30-day claims run out
  – Does not include a 30-day claims run out

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.

Source: CMS. Quality Payment Program Year 3 Final Rule.
Link to Participation Look-up Tool. https://qpp.cms.gov/participation-lookup
### Year 2 (2018) Final

**LVT Determination Period:**
- To determine 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)

### Year 3 (2019) Final

**LVT Determination Period:**
- **Goal:**
  - Consolidate the multiple timeframes and **align** the determination period with the **fiscal year**.
- **Goal:**
  - Identify MIPS-eligible clinicians with the following special status:
    - Non-Patient Facing (anesthesiologist, pathologist, radiologist)
    - Small Practice
    - Hospital-based
    - Ambulatory surgical center-based (ASC-based)

*Note: Rural and HPSA status continue to apply in 2019*

Source: CMS. Quality Payment Program Year 3 Final Rule.

Link to Participation Look-up Tool: [https://qpp.cms.gov/participation-lookup](https://qpp.cms.gov/participation-lookup)
Extreme and Uncontrollable Circumstances Policy: How Does it Work?

- Applies to MIPS-eligible clinicians located in Federal Emergency Management Agency- (FEMA-) designated areas that have been affected by an extreme and uncontrollable circumstance.
- The location is *based on the associated address* in the Provider Enrollment, Chain, and Ownership System (PECOS).
  - Pecos.cms.hhs.gov
  - 866.484.8049

Source: CMS. Quality Payment Program Year 3 Final Rule.
Extreme and Uncontrollable Circumstances Policy: How Does it Work? (cont.)

• For MIPS-eligible clinicians who are subject to the policy, all four performance categories will be re-weighted to 0 percent.

• You will automatically receive a score equal to the performance threshold which will result in a neutral payment adjustment (neither a positive or negative adjustment) for the 2021 MIPS payment year unless you:
  – Submit data for two or more MIPS performance categories (Quality, Improvement Activities, and/or Promoting Interoperability) as an individual.
  – Are part of a group or virtual group that submits data on behalf of its clinicians.

**Note:** The Cost performance category will always be weighted at 0 percent, even if you submit data for the other performance categories.

Source: CMS. Quality Payment Program Year 3 Final Rule.
Year 3—MIPS
Data Collection, Data Submission, and Data Submitter Types
MIPS Year 3 (2019): Collection, Submission, and Submitter Types

**Year 2 (2018) Final**
Submission mechanisms used all-inclusively when referencing:
- Method by which data is submitted (e.g., registry, EHR, attestation)
- 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)

**Year 3 (2019) Final**
New language that more accurately reflects how clinicians and vendors interact with MIPS CMS is revising existing and defining additional **terminology**:
- Collection Types
- Submission Types
- Submitter Types

Source: CMS. Quality Payment Program Year 3 Final Rule.
Collection, Submission, and Submitter Types Defined

- **Collection type**

  A set of quality measures with comparable specifications and data completeness criteria including, as applicable:
  - Electronic clinical quality measures (eCQMs).
  - MIPS clinical quality measures* (CQMs).
    - Formerly referred to as Registry Measures.
  - Qualified Clinical Data Registry (QCDR) measures.
  - Medicare Part B claims measures.
  - CMS Web Interface measures.
  - The CAHPS** for MIPS survey measure.
  - Administrative claims measures.

*The term MIPS CQMs replaces what was formerly referred to as “registry measures” since entities other than registries may submit data on these measures.

**Consumer Assessment of Healthcare Providers and Systems®

Source: CMS. Quality Payment Program Year 3 Final Rule.
Collection, Submission, and Submitter Types Defined (cont.)

• **Submission type**
The mechanism by which a submitter type submits data to CMS, including, as applicable:
  – Direct.
  – Log in and upload.
  – Log in and attest (Not available for Quality Measures)
  – Medicare Part B claims
  – The CMS Web Interface.

• **Submitter type**
The MIPS-eligible clinician, group (including APM Entities and virtual groups), or third party intermediary acting on behalf of a MIPS-eligible clinician or group, as applicable, that submits data on measures and activities.

We encourage you to review the proposed terms and wireframes for the submission types on [qpp.cms.gov/design-examples](qpp.cms.gov/design-examples).

Source: CMS. Quality Payment Program Year 3 Final Rule.
# Collection, Submission, and Submitter Types: Individuals/Groups

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Submission Type</th>
<th>Submitter Type</th>
<th>Collection Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>• Direct</td>
<td>• Individual</td>
<td>• eCQMs</td>
</tr>
<tr>
<td></td>
<td>• Log-in and Upload</td>
<td>• Group</td>
<td>• MIPS CQMs</td>
</tr>
<tr>
<td></td>
<td>• Medicare Part B Claims</td>
<td>• Third Party Intermediary</td>
<td>— Registries</td>
</tr>
<tr>
<td></td>
<td>— Small practices only</td>
<td></td>
<td>• QCDR Measures</td>
</tr>
<tr>
<td></td>
<td>• CMS Web Interface</td>
<td></td>
<td>• Medicare Part B Claims Measures</td>
</tr>
<tr>
<td></td>
<td>— Groups 25 or more</td>
<td></td>
<td>— Small practices only</td>
</tr>
<tr>
<td></td>
<td>• CMS Web Interface Measures</td>
<td></td>
<td>• CMS Web Interface Measures</td>
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<tr>
<td></td>
<td>• CMS Approved Survey Vendor Measures</td>
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<td>• CMS Approved Survey Vendor Measures</td>
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<tr>
<td></td>
<td>• Administrative Claims Measures</td>
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<td>• Administrative Claims Measures</td>
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Source: CMS. Quality Payment Program Year 3 Final Rule.
<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Submission Type</th>
<th>Submitter Type</th>
<th>Collection Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost $</td>
<td>• No data submission required</td>
<td>• Individual • Group</td>
<td>-</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>• Direct • Log-in and Upload • Log-in and Attest</td>
<td>• Individual • Group • Third Party Intermediary</td>
<td>-</td>
</tr>
<tr>
<td>Promoting Interoperability</td>
<td>• Direct • Log-in and Upload • Log-in and Attest</td>
<td>• Individual • Group • Third Party Intermediary</td>
<td>-</td>
</tr>
</tbody>
</table>

Source: CMS. Quality Payment Program Year 3 Final Rule.
Year 3—MIPS

Reporting Options
Reporting Options

Same reporting options as Year 2. Clinicians can report as:

- **Individual**: As an **Individual** under an NPI number and TIN where they reassign benefits.
- **Group**: As a **Group** of two or more clinicians (NPIs) who have reassigned their billing rights to a single TIN* as an APM Entity.
- **Virtual Group**: 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.

Source: CMS. Quality Payment Program Year 3 Final Rule.
Year 3—MIPS

Performance Categories
Performance Periods—Performance Detail
## Performance Categories, Performance Periods and Performance Weights

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Year 2 (2018)</th>
<th>Year 3 (2019)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Performance Period</td>
<td>Weight</td>
</tr>
<tr>
<td><strong>Quality</strong></td>
<td>12-months</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Cost</strong></td>
<td>12-months</td>
<td>10%</td>
</tr>
<tr>
<td><strong>Improvement Activities</strong></td>
<td>90-days</td>
<td>15%</td>
</tr>
<tr>
<td><strong>Promoting Interoperability</strong></td>
<td>90-days</td>
<td>25%</td>
</tr>
</tbody>
</table>

Source: CMS. Quality Payment Program Year 3 Final Rule.
Reducing Burden

- Moving clinicians to a single, **smaller set of objectives** and measures with scoring based on measure performance for the Promoting Interoperability performance category.

- Providing an application-based reweighting option for the Promoting Interoperability performance category for clinicians in small practices.
  - Application available in August.

- Allowing the use of a **combination of collection types** for the Quality Performance category.
Reducing Burden (cont.)

- Increasing the small practice bonus to six points.
  - Included in the Quality Category.
- Continuing to award small practices three points for submitted quality measures that don’t meet the data completeness requirements.
- **New option** to use **facility-based scoring** for facility-based clinicians.
The Meaningful Measures Initiative is aimed at identifying the highest priority areas for quality measurement and quality improvement and to reduce the reporting burden.

To achieve this goal, in 2019 CMS is:

- **Removing 26 quality measures**, including those that are process, duplicative, and/or topped out.
- **Adding eight measures.**
  - Four of which are Patient-Reported Outcome Measures.
  - Six of which are High Priority Measures.

There are a total of **257 quality measures** for 2019.
## Quality Performance Category: Bonus Points

### Basics
- **Change:** 45 percent of Final Score in 2019
- You select six individual measures
  - One of the six must be an outcome measure or high priority measure
- If less than six measures apply, then report on each applicable measure
- You may also select a specialty-specific set of measures

### Bonus Points

<table>
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<tr>
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<tbody>
<tr>
<td>• Two points for additional outcome or patient experience measure</td>
<td>Same as Year 2, with the following changes:</td>
</tr>
<tr>
<td>• One point for other high-priority measures</td>
<td>• Add <strong>small practice bonus</strong> of six points to the numerator of <strong>Quality</strong> performance category for MIPS eligible clinicians in small practices who submit data on at least one quality measure</td>
</tr>
<tr>
<td>• One point for each measure submitted using electronic end-to-end reporting</td>
<td>• Updated the definition of high priority to include opioid-related measures</td>
</tr>
<tr>
<td>• Cap bonus points at 10% of category denominator</td>
<td></td>
</tr>
</tbody>
</table>

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

Source: CMS. Quality Payment Program Year 3 Final Rule.
Quality Performance Category: Data Completeness

### Year 2 (2018) Final

**You must report:**
- 60% for all submission mechanisms, except for **Web Interface** and CAHPS:
  - If you are unable to meet the data completeness requirement for a measure, you will receive:
    - **Large** practices—one point
    - **Small** practices—three points
- **Collection Type:**
  - **Claims** report 60% of Medicare Part B FFS patients meeting the description of the measure.
  - **eCQMs, MIPS CQMs** (Registry) report 60% of all patients/all payors.

### Year 3 (2019) Final

**You must report:**
- The same requirements as in Year 2, except for the following **scoring change**:
  - For groups that submit five or fewer Quality measures or do not meet the CAHPS for MIPS sampling requirements, the quality denominator will be reduced by 10 and the measure will receive zero points.

**Case Minimum** is **20** for all of your measures (Must have 20 patients in the denominator to be scored against a benchmark)

**Note:** Data completeness and case minimums are required to be scored against a benchmark

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

Source: CMS. Quality Payment Program Year 3 Final Rule.
## Cost Performance Category

### Basics

- **Change:** 15 percent of Final Score in 2019
- **Measures:**
  - Medicare Spending Per Beneficiary (MSPB)
  - Total Per Capita Cost (TPCC)
  - Adding eight episode-based measures
- **No** reporting requirement.
  - Data pulled from administrative claims
- **No** improvement scoring in Year 3

### Year 2 (2018) Final

- Case minimum of 20 for TPCC measure
- Case Minimum of 35 for MSPB measure

### Year 3 (2019) Final

Same requirements as Year 2, with the following additions:

- Case minimum of 10 for **Procedural** episodes
- Case minimum of 20 for **Acute Inpatient Medical** episodes

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Source: CMS. Quality Payment Program Year 3 Final Rule.

MIPS eligible Clinicians meeting the following criteria are eligible for facility-based scoring of Quality and Cost measures in 2019:

- Clinician furnishes **75 percent or more** of his/her **covered professional services** (as determined by claims submitted for reimbursement) in Place of Service (POS)
  - Inpatient hospital (POS 21)
  - On-campus outpatient hospital (POS 22)
  - Emergency room (POS 23)
- Clinician has at least a one service billed with POS code used for inpatient hospital or emergency room.
- Facility-based group would be one in which **75 percent or more of eligible clinicians billing under the group’s TIN** are eligible for facility-based measurement.
• Facility-based measurement does not require data submission for Quality and Cost Performance Categories.

• The Value-based Purchasing (VBP) scores of the hospital at which the clinicians work determines the corresponding MIPS scores for facility-based clinicians. (Quality & Cost)

• Facility-based clinicians and Groups must submit data for the Improvement Activity or Promoting Interoperability performance categories.

Expected to release a facility-based scoring preview end Q1 of 2019
### Basics
- **Final**: 25 percent 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

<table>
<thead>
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<tbody>
<tr>
<td>• Comprised of a base, performance, and bonus score</td>
<td>• Eliminated the base, performance, and prior bonus scores</td>
</tr>
<tr>
<td>• Must fulfill the base score requirements to earn a Promoting Interoperability score</td>
<td>• New performance-based scoring at the individual measure level</td>
</tr>
<tr>
<td></td>
<td>• Must report the required measures under each objective, or claim the exclusion</td>
</tr>
</tbody>
</table>

Source: CMS. Quality Payment Program Year 3 Final Rule.
### Promoting Interoperability Performance Category: Reporting Requirements (cont.)

<table>
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<th>Basics</th>
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<tr>
<td><strong>Final</strong>: 25 percent of Final Score in 2019</td>
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<table>
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<tr>
<th>Reporting Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 2 (2018) Final</strong></td>
</tr>
<tr>
<td>Two measure set options for reporting based on the MIPS-eligible clinician’s edition of CEHRT</td>
</tr>
<tr>
<td>• Either 2014 or 2015</td>
</tr>
<tr>
<td><strong>Year 3 (2019) Final</strong></td>
</tr>
<tr>
<td>One set of objectives and measures based on <strong>2015 Edition</strong> CEHRT</td>
</tr>
<tr>
<td>Four Objectives: e-Prescribing, Health Information Exchange, Provider to Patient Exchange, and Public Health and Clinical Data Exchange</td>
</tr>
<tr>
<td>Added two new measures to the <strong>e-Prescribing Objective</strong>: Query of Prescription Drug Monitoring Program (PDMP) and Verify Opioid Treatment Agreement</td>
</tr>
<tr>
<td>• Five bonus points for each</td>
</tr>
</tbody>
</table>

Source: CMS. Quality Payment Program Year 3 Final Rule.
# Promoting Interoperability Performance Category

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Measures</th>
<th>Maximum Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>e-Prescribing</td>
<td>• e-Prescribing</td>
<td>10 points</td>
</tr>
<tr>
<td></td>
<td>• Query of Prescription Drug Monitoring Program (PDMP) (new)</td>
<td>5 bonus points</td>
</tr>
<tr>
<td></td>
<td>• Verify Opioid Treatment Agreement (new)</td>
<td>5 bonus points</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>• Support Electronic Referral Loops by Sending Health Information — Formerly Send a Summary of Care</td>
<td>20 points</td>
</tr>
<tr>
<td></td>
<td>• Support Electronic Referral Loops by Receiving and Incorporating Health Information (new)</td>
<td>20 points</td>
</tr>
<tr>
<td>Provider to Patient Exchange</td>
<td>• Provide Patients Electronic Access to their Health Information — Formerly Provide Patient Access</td>
<td>40 points</td>
</tr>
</tbody>
</table>
| Public Health and Clinical Data Exchange| Choose two:  
• Immunization Registry Reporting  
• Electronic Case Reporting  
• Public Health Registry Reporting  
• Clinical Data Registry Reporting  
• Syndromic Surveillance Reporting   | 10 points           |

Source: CMS. Quality Payment Program Year 3 Final Rule.
Promoting Interoperability Performance Category: Automatic Exceptions

• The PI score will be automatically reweighted to zero for the following MIPS-eligible clinicians:
  – Hospital-based MIPS-eligible clinicians.
  – Non-patient facing clinicians.
  – ASC-based MIPS-eligible clinicians.
  – Nurse practitioners, physician assistants, clinical nurse specialists, certified registered nurse anesthetists, physical therapists, occupational therapists, speech-language pathologists, audiologists, registered dieticians, nutrition professionals, and clinical psychologists.

• PI performance category will be re-weighted to 0 percent of the final score and the PI performance category weight of 25 percent reallocated to the Quality performance category.

Note: Exempt clinicians who submit PI data (as an individual or group) will be scored on their submitted data.
Promoting Interoperability Performance Category: Hardship Exception Application

- Applications for hardship exceptions are likely to become available in August 2019, and must be submitted by December 31, 2019.
- If the hardship application is approved, the PI performance category will be re-weighted to 0 percent of the final score and the PI performance category weight of 25 percent will be reallocated to the Quality Performance Category.
Improvement Activity Performance
Category: Reporting Requirements

<table>
<thead>
<tr>
<th>Basics</th>
<th>Reporting Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Final</strong>: 15 percent of Final Score in 2019</td>
<td><strong>Year 2 (2018) Final</strong></td>
</tr>
<tr>
<td>Activity weights remain the same:</td>
<td>• Report for two high-weighted or four medium-weighted activities</td>
</tr>
<tr>
<td>• Medium = 10 points</td>
<td>• Small practices, non-patient facing clinicians, and/or clinicians located in rural areas or HPSAs receive double-weight and report on no more than two medium or one high-weighted activities to receive the highest score</td>
</tr>
<tr>
<td>• High = 20 points</td>
<td><strong>Year 3 (2019) Final</strong></td>
</tr>
<tr>
<td>Select Improvement Activities and Attest “yes” (check mark) to complete</td>
<td>• Same requirements as Year 2.</td>
</tr>
<tr>
<td>• 40 points needed to receive full credit.</td>
<td>• Total of 118 Improvement Activities for MIPS 2019.</td>
</tr>
<tr>
<td></td>
<td>• <strong>Change</strong>: Improvement Activities qualifying for CEHRT bonus under PI category discontinued.</td>
</tr>
</tbody>
</table>

Source: CMS. Quality Payment Program Year 3 Final Rule.
### Improvement Activity Performance

**Category: Six New IAs for Year 3 (2019)**

<table>
<thead>
<tr>
<th>Improvement Activity Added for Year 3 (2019)</th>
<th>Activity ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Eye Exams</td>
<td>IA_AHE_7</td>
</tr>
<tr>
<td>Financial Navigation Program</td>
<td>IA_BE_24</td>
</tr>
<tr>
<td>Completion of Collaborative Care Management Training Program</td>
<td>IA_BMH_10</td>
</tr>
<tr>
<td>Relationship-Centered Communication</td>
<td>IA_CC_18</td>
</tr>
<tr>
<td>Patient Medication Risk Education</td>
<td>IA_PSPA_31</td>
</tr>
<tr>
<td>Use of CDC Guideline for Clinical Decision Support to Prescribe Opioids for Chronic Pain via Clinical Decision Support</td>
<td>IA_PSPA_32</td>
</tr>
</tbody>
</table>
Improvement Activity Performance Category: Five Modified IAs for Year 3 (2019)/One Removed

<table>
<thead>
<tr>
<th>Improvement Activity Modified for Year 3 (2019)</th>
<th>Activity ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care transition documentation practice improvements</td>
<td>IA_CC_10</td>
</tr>
<tr>
<td>Chronic Care and Preventative Care Management for Empaneled Patients</td>
<td>IA_PM_13</td>
</tr>
<tr>
<td>Participation in MOC Part IV</td>
<td>IA_PSPA_2</td>
</tr>
<tr>
<td>Use of Patient Safety Tools</td>
<td>IA_PSPA_8</td>
</tr>
<tr>
<td>Implementation of analytic capabilities to manage total cost of care for practice population</td>
<td>IA_PSPA_17</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Improvement Activity Removed for Year 3 (2019)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation in Population Health Research</td>
<td>IA_PM_9</td>
</tr>
</tbody>
</table>
Improvement Activity Performance
Category: Tips

• Remember these are activities, not measures.
  – Your focus should be on improvement.

• Determine your reporting period.
  – Must be a minimum of 90 consecutive days.

• Retain documentation for at least six years and three months.
  – In the event of an audit.

• Remember that registries cannot do IA changes for you; they can only attest on your behalf.

• Check with the registry to verify if they would attest on your behalf and if there is any additional cost to attest.

• Find a list of all IAs at https://qpp.cms.gov/about/resource-library.
Final Rule for Year 3—MIPS
Performance Threshold and Payment Adjustments
## Performance Threshold and Payment Adjustments

### Year 2 (2018) Final
- **15 point** performance threshold
- **Exceptional performance** bonus set at 70 points
- Payment adjustment could be up to +5% or as low as -5%
- Payment adjustment (and exceptional performer bonus) is based on comparing final score to performance threshold and additional performance threshold for exceptional performance

### Year 3 (2019) Final
- **30 point** performance threshold
- **Exceptional performance** bonus set at 75 points
- Payment adjustment could be up to +7% or as low as -7%
- Payment adjustment (and exceptional performer bonus) 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.*

Source: CMS. Quality Payment Program Year 3 Final Rule.
## Performance Threshold and Payment Adjustments (cont.)

### Year 2 (2018) Final

<table>
<thead>
<tr>
<th>Final Score 2018</th>
<th>Payment Adjustment 2020</th>
</tr>
</thead>
</table>
| >70 points       | • Positive adjustment >0%  
|                  | • Eligible for exceptional performance bonus—min. of additional 0.5% |
| 15.01–69.99 points | • Positive adjustment >0%  
|                  | • Not eligible for exceptional performance bonus |
| 15 points        | • Neutral payment adjustment |
| 3.75–14.99       | • Negative payment adjustment >5% and <0% |
| 0–3.74 points    | • Negative payment adjustment of -5% |

### Year 3 (2019) Final

<table>
<thead>
<tr>
<th>Final Score 2019</th>
<th>Payment Adjustment 2021</th>
</tr>
</thead>
</table>
| >75 points       | • Positive adjustment >0%  
|                  | • Eligible for exceptional performance bonus—min. of additional 0.5% |
| 30.01–74.99 points | • Positive adjustment >0%  
|                  | • Not eligible for exceptional performance bonus |
| 30 points        | • Neutral payment adjustment |
| 7.50–29.99       | • Negative payment adjustment >7% and <0% |
| 0–7.49 points    | • Negative payment adjustment of -7% |

Source: CMS. Quality Payment Program Year 3 Final Rule.
Advanced APMs Year 3 (2019)
Overview
Advanced APMs Year 3 (2019): Overview

APMs:
• Are a payment approach that provides added incentives to clinicians to provide high-quality, cost-efficient care.
• Can apply to a specific condition, care episode, or population.
• May offer significant opportunities for eligible clinicians who are not ready to participate in Advanced APMs.

Advanced APMs are a Subset of APMs

Source: CMS. Quality Payment Program Year 3 Final Rule.
Clinicians and practices can receive greater rewards for taking on some risk related to patient outcomes.

**Advanced APM-Specific Rewards**

It is important to understand that the QPP does not change the design of any particular APM. Instead, it creates *extra incentives* for a sufficient degree of participation in Advanced APMs.

Source: CMS. Quality Payment Program Year 3 Final Rule.
Final Rule for Year 3 (2019)
Advanced APMs
Criteria
Advanced APMs Year 3 (2019): Criteria

To be an Advanced APM, the following three requirements must be met. The APM:

1. Requires participants to use certified EHR technology;

2. Provides payment for covered professional services based on quality measures comparable to those used in the MIPS quality performance category; and

3. Either:
   - Is a Medical Home Model expanded under CMS Innovation Center authority OR
   - Requires participants to bear a more than nominal amount of financial risk.

Source: CMS. Quality Payment Program Year 3 Final Rule.
Advanced APMs Year 3 (2019): Criteria

MIPS APM Criteria

Years 1 & 2 (2017 & 2018)

- Currently, one of the MIPS APM criteria is that an APM “bases payment on cost/utilization and quality measures.”
- CMS did not intend to limit an APM’s ability to meet the cost/utilization part of this criterion solely by having a cost/utilization measure.

Year 3 (2019)

- Reorder the wording of this criterion to state that the APM bases payment on quality measures and cost/utilization.
- This would clarify that the cost/utilization part of the policy is broader than specifically requiring the use of a cost/utilization measure.

Source: CMS. Quality Payment Program Year 3 Final Rule.
Advanced APMs Year 3 (2019): CEHRT Use

Minimum CEHRT Use Threshold

Years 1 & 2 (2017 & 2018)
- To qualify as an Advanced APM (across both Medicare and other payers), a payment arrangement must satisfy the criterion of requiring that at least 50% of the eligible clinicians in each APM Entity use CEHRT
- Two measure set options for reporting based on the MIPS-eligible clinician’s edition of CEHRT
  - Either 2014 or 2015

Year 3 (2019)
- Increase the CEHRT use criterion so that an Advanced APM must require at least 75% of eligible clinicians in each APM Entity use CEHRT
- Must use 2015 edition CEHRT in 2019

Source: CMS. Quality Payment Program Year 3 Final Rule.
Advanced APMs Year 3 (2019): Aligning PI Under the APM Scoring Standard

MIPS APM Criteria

Years 1 & 2 (2017 & 2018)

- Under previously finalized policy for the APM scoring standard, Shared Savings Program ACOs are required to report PI at the participant TIN level.
- This differs from all other MIPS APMs, which allow MIPS eligible clinicians to report PI in any manner permissible under MIPS
  - At either the individual or group level.

Year 3 (2019)

- Align PI reporting requirements under the APM scoring standard so that MIPS-eligible clinicians in any MIPS APMs, including the Shared Savings Program, can report PI in any manner permissible under MIPS
  - At either the individual or group level.

Source: CMS. Quality Payment Program Year 3 Final Rule.
Advanced APMS Year 3 (2019): Category Weights by Category

Advanced APMS are comprised of only three performance categories in 2019. The points from each performance category are added together to give the APM a Final Score.

- Quality: 50%
- Improvement Activities: 20%
- Promoting Interoperability: 30%

100 Possible Final Score Points

*Source: CMS*
Advanced APMs Year 3 (2019): Terms at a Glance

- **APM Entity**—An entity 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.

- **Advanced APM**—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.

- **Affiliated Practitioner**—An eligible clinician identified by a unique APM participant identifier on a CMS-maintained list who has a contractual relationship with the Advanced APM Entity for the purposes of supporting the Advanced APM Entity's quality or cost goals under the Advanced APM.

- **Affiliated Practitioner List**—The list of Affiliated Practitioners of an APM Entity that is compiled from a CMS-maintained list.

Source: CMS. Quality Payment Program Year 3 Final Rule.
• **MIPS APM**—Most Advanced APMs are also MIPS APMs so that if an eligible clinician participating in the Advanced APM does not meet the threshold for sufficient payments or patients through an Advanced APM in order to become a Qualifying APM Participant (QP), thereby being excluded from MIPS, the MIPS-eligible clinician will be scored under MIPS according to the APM scoring standard. The APM scoring standard is designed to account for activities already required by the APM.

• **Participation List**—The list of participants in an APM Entity that is compiled from a CMS-maintained list.

• **Qualifying APM Participant (QP)**—An eligible clinician determined by CMS to have met or exceeded the relevant QP payment amount or QP patient count threshold for a year based on participation in an Advanced Entity.

Source: CMS. Quality Payment Program Year 3 Final Rule.
Key Takeaways

• Submit your data for 2018. April 2, 2019 MIPS deadline

• Focus on the Quality and Cost categories as they require a full year reporting period.

• Consider adding in Promoting Interoperability and Improvement Activities gradually after you have selected your Quality Measures.
  – Minimum continuous 90-day reporting period.

• Upgrade your EHR to a 2015 edition CEHRT prior to last day of the performance period.
  – Perform annual Security Risk Analysis (SRA) prior to December 31, 2019.
Key Takeaways (cont.)

- Generate reports often to ensure you are hitting your performance targets.
  - Share the results with clinicians and staff.
  - It is important to involve all and to work as a team.

- Identify and contact with your ACO/APM administrator to ensure you are following the ACO/APM terms.

- Keep your HARP/EIDM account active.
  - Create a reminder in your calendar every 60 days to log in and update your password.
Key Takeaways Poll
Thanks for Attending!

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