Quality Payment Program:
2019 Update

by Don Gettinger

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Presentation Overview

- Quality Payment Program overview
- MIPS general overview, eligibility, and updates
- MIPS performance category updates and improvement strategies
- Establishing a MIPS checklist

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Qsource.

IQH Information & Quality HEALTHCARE

AQAF THE BUSINESS OF QUALITY

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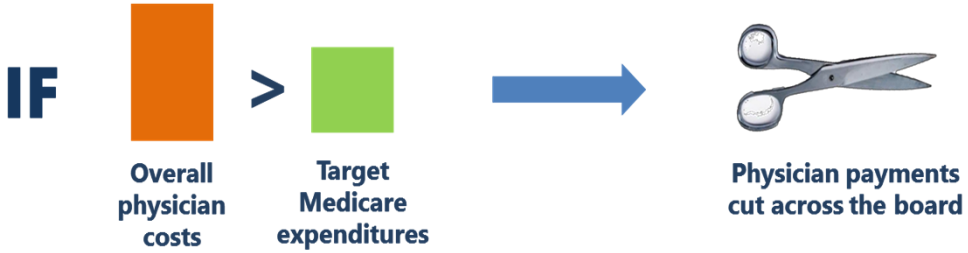
The Quality Payment Program (QPP)

Medicare Access and Chip Reauthorization Act (MACRA)

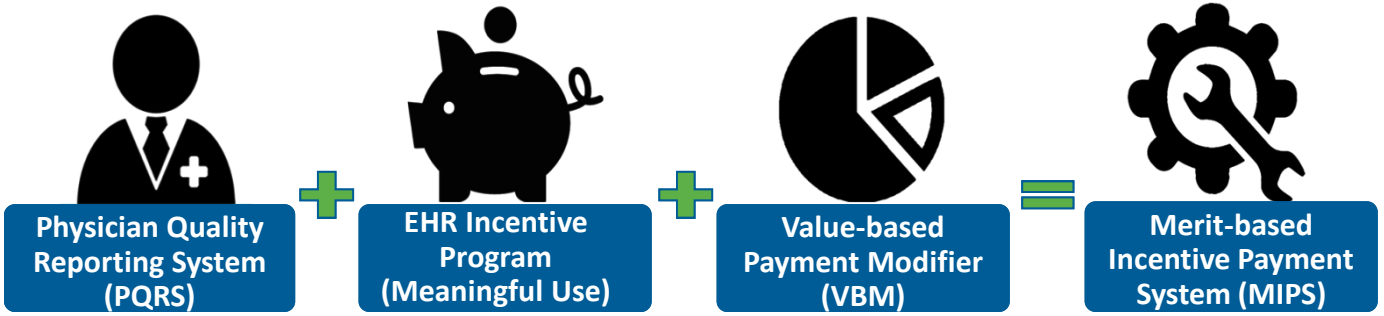
- **Repeals** the Sustainable Growth Rate (SGR)



- **Changes** Medicare reimbursement framework (QPP)

The Merit-based Incentive Payment System (MIPS) **or** Advanced Alternative Payment Models (APMs)

- **Consolidates** existing quality reporting programs (MIPS)



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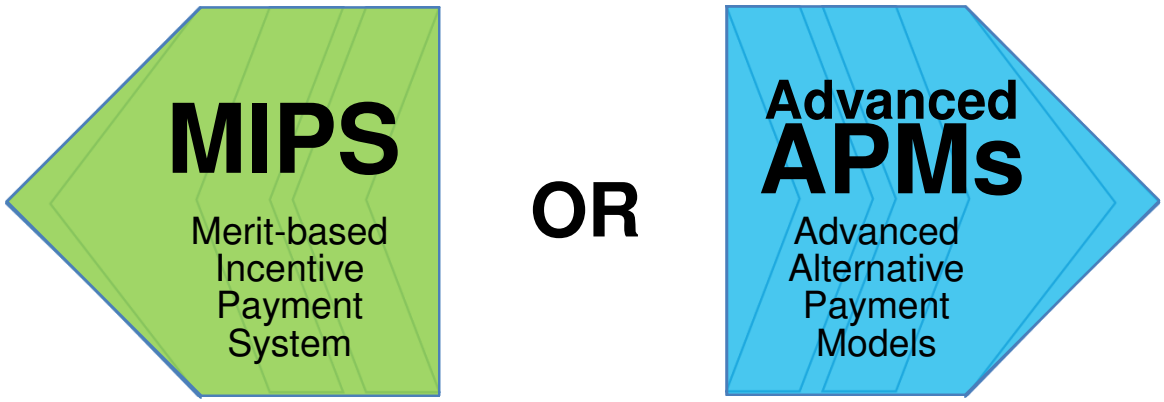
Quality Payment Program

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

Two different pathways to participate in the Quality Payment Program:



Positive or negative adjustment based upon performance and applied to all Part B PFS allowable charges

Receive greater financial reward for taking on some risk related to patient outcomes

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Hospital Readmission Rates

According to America's Health Rankings from United Health Foundation[1] - TN ranked 38th for hospital readmissions

STATE	HOSPITALS PENALIZED	HOSPITALS NOT PENALIZED	% PENALIZED	HOSPITALS NOT EVALUATED
AL	70	14	83%	6
IN	62	23	73%	35
KY	59	6	91%	29
MS	53	9	85%	33
TN	80	10	**89%**	17

Source: Kaiser Health News https://khn.org/news/under-trump-hospitals-face-same-penalties-embraced-by-obama/

[1] https://www.americashealthrankings.org/explore/senior/measure/hospital_readmissions_sr/state/TN

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Merit-based Incentive Payment System (MIPS)

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MIPS Program Updates

2019 Participation Estimates

Qualifying Advanced APM Participants (QPs):

- Between 165,000 to 220,000 clinicians

MIPS eligible clinicians:

- Approximately 798,000 clinicians
  - New Opt-in Option
  - New eligible clinician types

Money on the table:

- Estimated $390 million to be collected from negative payment adjustments and redistributed to positive payment adjustments

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New Terminology

Collection Type: set of quality measures with comparable specs and data completeness criteria

- eCQMs, MIPS CQMs, QCDR Measures, Part B Claims Measures

Submission Type: mechanism by which data gets submitted to CMS

- Direct, Login and upload, Part B claims, Login and Attest, CMS Web Interface (group of 25+)

Submitter Type: the individual or entity that submits the data

- Individual, Group, Virtual Group, Third Part Intermediary

New Terminology Examples

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

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Account Management System Change

New name:

- From Enterprise Identity Data Management system (EIDM) to HCQIS Access Roles and Profile system (HARP)

Benefit:

- Single location for registering/managing access and viewing/reporting data
- Doesn't impact those with existing accounts

Change to the Payment Adjustment Amount

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

MIPS Performance Threshold Requirements

Performance Period	Minimum Performance Threshold	Exceptional Performance Threshold
2017	3	70
2018	15	70
2019	30	75

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MIPS Performance Threshold and Payment Adjustments

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

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General Performance Category Weight Changes

Performance Category	2017 Category Weights	2018 Category Weights	2019 Category Weights
Quality	**60%**	**50%** -10% ↓	**45%** -5% ↓
Cost	**0%**	**10%** ↑ +10%	**15%** ↑ +5%
Improvement Activities	**15%**	**15%** =	**15%** =
Promoting Interoperability	**25%**	**25%** =	**25%** =

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Eligible Clinicians

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Eligible Clinician Types

Previous MIPS eligible clinicians:

- Physicians, Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, Certified Registered Nurse Anesthetists

AND Newly Included:

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

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MIPS Special Circumstances

Hospital Based, Ambulatory Surgical Center-based	• >=75% of services in hospital setting (POS 19, 21,22,or 23) or ASC setting (POS 24) • 100% of ECs meet individual criteria • Automatically exempt from PI category
Non-patient-facing	• <=100 patient-facing encounters • >75% non-patient-facing clinicians qualifies group • Automatically exempt from PI category • Double points for IA category
Small practices, Practices located in rural or HPSAs	• Double points for IA category • >75% rural or HPSA clinicians qualifies group • Small practice exemption from PI category
Non-physician MIPS eligible clinicians and newly eligible clinician types	• Automatically exempt from PI category

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Who is Exempt from MIPS?

Clinicians who are:

Newly-enrolled in Medicare

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

Below the low-volume threshold

- Three criteria, one new for 2019
- Applies to groups and individuals separately

Participating in Advanced APM

- Receive 40/50% of their Medicare payments

OR

See 25/35% of their Medicare patients through an Advanced APM

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Low-volume Threshold Determination

Required to participate if the following are met:

Bill **>$90,000** a year in allowed Medicare Physician Fee Schedule charges

AND

Furnish covered professional services to **>200** Medicare Part B beneficiaries

AND

New

Provide **>200** Covered Professional Services

*Excluded from the MIPS in 2019 if all three criteria aren't met

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Excluded but Want to Participate

Two options:

Opt-in	Voluntary Participation
If a MIPS eligible clinician and meet or exceed at least one of the low-volume threshold criteria	Submit data to CMS and receive performance feedback
You will receive a positive or negative MIPS payment adjustment	You will not receive a positive or negative MIPS payment adjustment

New

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New Opt-in Policy

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

MIPS Opt-in Scenarios

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

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New Opt-in Policy Important Things to Remember

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

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Individual vs. Group Reporting

1. As an Individual—under an National Provider Identifier (NPI) number and Taxpayer Identification Number (TIN) where they reassign benefits

2. As a Group

a) 2 or more clinicians (NPIs) who have reassigned their billing rights to a single TIN*

b) As an APM Entity

3. As a Virtual Group – made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together "virtually" (no matter what specialty or location) to participate in MIPS for a performance period for a year

Important to Note:

* If clinicians participate as a group, they are assessed as group across all 4 MIPS performance categories

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Individual Reporting

Individual 

Report on measures to all MIPS categories as an Individual

Score and subsequent payment adjustment applies only to individual

Allows reporting on measures that are most applicable to each clinician

Claims-based submissions are still available to individual reporting, but only for small groups

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Group/Virtual Reporting

Group/Virtual Group

Allows clinicians considered exempt as individuals due to being below the low-volume threshold (LVT) to participate if the group is collectively above the LVT

Potential decreased administrative burden by reporting one set of data for whole group, although might require manual aggregation of data across more than one practice locations

Report on measures to all MIPS categories collectively as a group

Specialists or other clinicians struggling to meet eligibility/ measure requirements can "piggy back" on others' performance

Score and subsequent payment adjustment applies the same to all clinicians in the group

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Significance Towards Outcome

Significance towards outcome as seen in 2017 performance data

Mean and Median Final Scores by Submitter Type*

	INDIVIDUALS	GROUPS
MEAN	55.08 points	76.2 points
MEDIAN	60.00 points	91.04 points

*An individual is a single TIN/NPI; a group is two or more NPIs billing under a single TIN or as an APM Entity

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Complex Patient Bonus Points

Up to 5 points

Determination

Two Indicators:

1. Medical complexity of Part B patients as measured through annual HCC risk scores
   - Beneficiary's age and gender
   - Eligibility for Medicaid, disability-based Medicare qualification, or lives in an institution (ie. nursing home)
   - Diagnosis
2. Social risk identified as proportion of Part B Dual eligible patients.

How is it calculated?

10/1/2018 – 9/30/2019

1. Identify Part B patients, average 2018 risk scores
2. Determine dually eligible, multiply by 5
3. Add 1 & 2

Important to Note:

To earn bonus points:
1. Must submit data for at least one performance category

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MIPS Performance Categories

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Quality

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Quality Category Scoring

*Total points = 60

Select 6 of the 257 available quality measures

- Including 1 Outcome or 1 High Priority measure
- Or a specialty set
- Or CMS Web Interface measures

Clinicians receive 3 to 10 points on each quality measure submitted based on performance against benchmarks

Keep in mind:

To earn more than minimal points for a measure it must meet:
1. The 60% data completeness,
2. Include >= 20 patients
3. Have a benchmark

Readmission measure for group submissions that have ≥ 16 clinicians and a sufficient number of cases (no requirement to submit)

*Total points can vary based upon group size, data collection type, etc.

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Quality Category Bonus Points

*Additional High Priority Measure:

2 points for each additional outcome and patient experience measure

1 point for each additional high-priority measure

Small Practice:

New

6 points for eligible clinicians in small practices who submit data on at least 1 quality measure

Important to Note:

To earn bonus points for a measure it must meet:
1. The 60% data completeness,
2. Include >= 20 patients
3. >0 percent performance rate

*End-to-end Electronic Reporting:

1 point for submitting a measure electronically end-to-end*

*Capped at 10% of total possible Quality performance category score

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Quality Category Improvement Scoring Points

*Total points: up to 10

How is it calculated?

Compare performance score earned by measures from the previous reporting period to those earned in the most recent reporting period.

- Measure bonus points are not included in the calculation.
- If previous score was less than or equal to 30% then improvement points will be calculated based upon a previous score of 30%.

Important to Note:

To earn points:

1. Requires full participation in Quality category for current performance period
2. All submitted measures meet data completeness requirements (60%)

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Quality Category Submission Methods

	Individual	Group
Quality 45%	• QCDR Measures • MIPS CQMs • eCQMs • Claims	• QCDR Measures • MIPS CQMS • eCQMs • Administrative Claims • CMS Web Interface • CAHPS for MIPS Survey*

If reporting via CMS Web Interface:

- Report on all 15 CMS Web Interface measures for a full year
- Report on the sample of patients identified by CMS
- Will be scored against MSSP benchmarks

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Quality Category Example

Anatomy of a Quality Category Measure

Measure# 130	**Documentation of Current Medications in the Medical Record**
Numerator	MIPS eligible professional or MIPS eligible clinician attests to documenting, updating or reviewing a patient's current medications using all immediate resources available on the date of encounter.
Denominator	Patients aged 18 years of age and older with a visit during the measurement.

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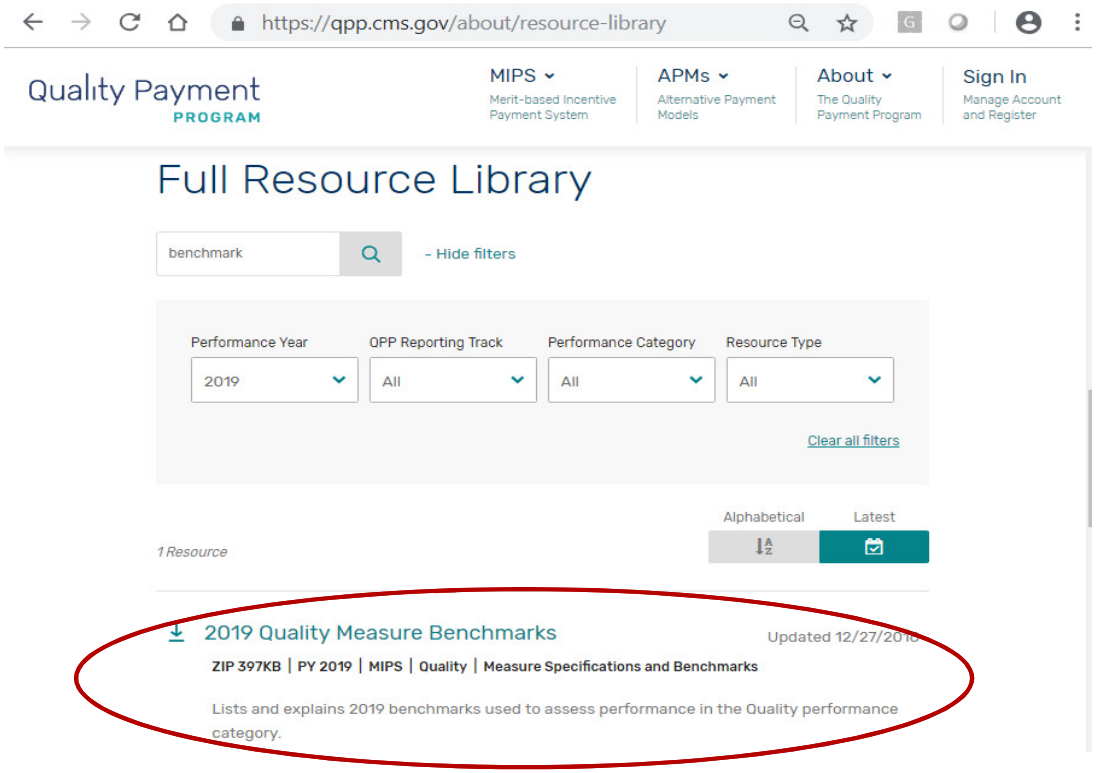
Understanding Benchmarks

- Benchmarks vary by collection type
- Deciles = Points
- Measures with low variability (i.e. topped out) are worth less points



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MIPS Reporting Requirements: Quality Points

Example: Assigning Points Based on Deciles

DECILE	Decile 1	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Possible POINTS	1.0-1.9	2.0-2.9	3.0-3.9	4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10

0% 7% 16% 23% 36% 41% 62% 69% 79% 85% 100%

Example of decile breaks for a specific quality measure

No less than 3 points for reporting data on any measure if in a small practice

Eligible clinician with 19% performance rate would get approximately 3.3 points (based on distribution within the decile).

Eligible clinician with 95% performance rate would get 10 points.

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Documentation of Current Medications in the Medical Record

Measure_Name	Measure_ID	Submission_Method	Benchmark	Decile_3	Decile_4	Decile_5	Decile_6	Decile_7	Decile_8	Decile_9	Decile_10	TOPPED_OUT
Documentation of Current Medications in the Medical Record	130	EHR	Y	87.55 - 93.48	93.49 - 96.28	96.29 - 97.98	97.99 - 98.99	99.00 - 99.57	99.58 - 99.88	99.89 - 99.99	100	Yes
Documentation of Current Medications in the Medical Record	130	Claims	Y	97.95 - 99.51	99.52 - 99.91	99.92 - 99.99	--	--	--	--	100	Yes
Documentation of Current Medications in the Medical Record	130	Registry/QCDR	Y	68.06 - 90.27	90.28 - 97.23	97.24 - 99.50	99.51 - 99.99	--	--	--	100	Yes

- Assume that you saw 100 patients during your performance period, and 98 of those patients had all current medications documented in the medical record
- Your performance rate on this measure is 98% (98/100)
- If you reported this measure via claims, your performance rate would earn you approximately 3 points on this measure (3rd decile)
- If you reported this measure via your eCQM (EHR), your performance rate would earn you approximately 6 points on this measure (6th decile)
- If you reported this measure via a MIPS CQM (registry/QCDR), your performance rate would earn you approximately 5 points on this measure (5th decile)

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Body Mass Index Screening and Follow-up Plan

Measure_Name	Measure_ID	Submission_Method	Benchmark	Decile_3	Decile_4	Decile_5	Decile_6	Decile_7	Decile_8	Decile_9	Decile_10	TOPPED_OUT
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	128	EHR	Y	21.15 - 24.58	24.59 - 28.51	28.52 - 34.20	34.21 - 43.84	43.85 - 60.30	60.31 - 78.24	78.25 - 93.28	>= 93.29	No
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	128	Claims	Y	37.52 - 47.77	47.78 - 74.47	74.48 - 95.19	95.20 - 99.26	99.27 - 99.99	--	--	100	Yes
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	128	Registry/QCDR	Y	34.35 - 54.25	54.26 - 74.56	74.57 - 90.59	90.60 - 97.55	97.56 - 99.86	99.87 - 99.99	--	100	No

- Assume that you saw 100 eligible patients during your reporting period, and 95 of those patients met the numerator performance requirements for the measure
- Your performance rate on this measure is 95% (95/100)
- If you reported this measure via claims, your performance rate would earn you 7 points on this measure (7th decile)
- If you reported this measure via your EHR, your performance rate would earn you 8 points on this measure (10th decile)
- If you reported this measure via a registry/QCDR, your performance rate would earn you 6 points on this measure (6th decile)

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Quality Category Measure Considerations

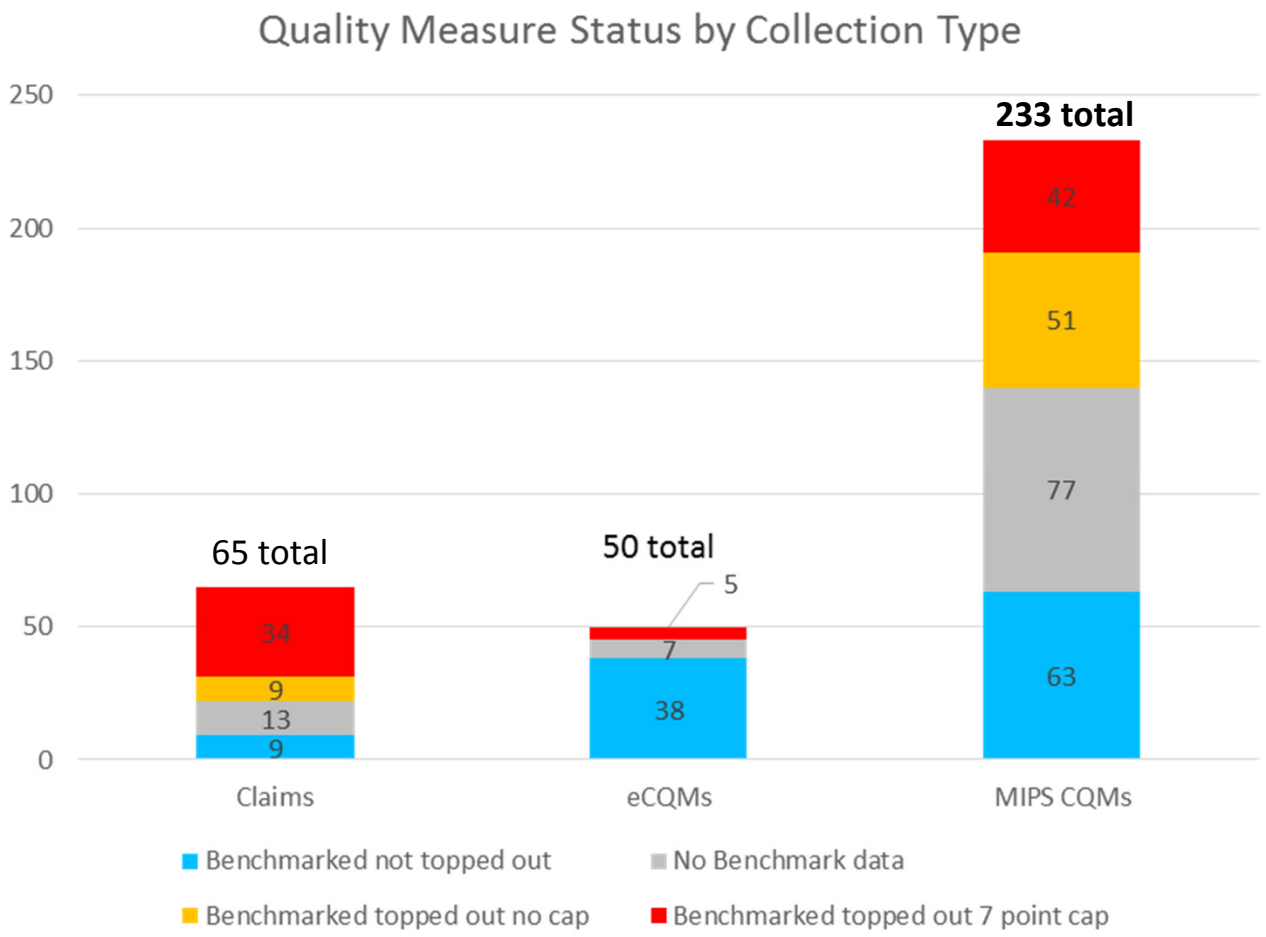

*Chart data based upon existing data from CMS 2019 MIPS Quality Historic Benchmarks spreadsheet

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Facility-based Quality/Cost Scoring

Hospital-based designation:

Individual EC: Provide 75% or more covered professional services in a hospital setting.
Group: 75% or more of eligible clinicians billing under the group's T IN are eligible for facility-based measurement as individuals

Attribution:

Clinician would be attributed to hospital where most services provided.

Group would be attributed to hospital where most clinicians are attributed.

Election:

Automatically applied. No submission requirements for individual clinicians but Groups would need to submit data for Improvement Activity and Promoting Interoperability categories to be measured as facility-based group.

Performance Score:

Based on attributed hospital's performance in the Hospital Value-Based Purchasing Program.

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Quality Category: Improving Performance

- Set short and long-term performance goals
- Review measure changes and specifications for each collection type
- Select most applicable MIPS approved measures first but assess performance across more
- Consider QCDRs if MIPS quality measures aren't best
- Evaluate greatest long-term ROI for patients and providers
- Review benchmarks to determine possible points per collection type
- Compare individual vs group performance rates
- Maximize opportunities to earn additional bonus points
- Avoid topped out measures
- Evaluate possible submission across multiple collection types
- Fully report for possibility of improvement points

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Cost

Cost Category Scoring

Total points: up to 100

- All measures are worth up to 10 points each
- Measures only apply if case minimums are met
- No submission requirements

Topic	What's New?
New Measures	8 episode-based measures; 5 procedural and 3 Acute inpatient medical condition.
Measure Case Minimums	TPCC still 20, MSPB still 35 and now with the addition of Episode-based measures Procedural ones are 10 and Acute Inpatient Medical Conditions are 20

Cost Performance Category Scoring

Measure	Measure Type	Maximum Points
Medicare Spending Per Beneficiary (MSPB)	N/A	10 points
Total Per-Capita Cost for All Attributed Beneficiaries (TPCC)	N/A	10 points
Episode-based Measures		
Elective Outpatient Percutaneous Coronary Intervention (PCI)	Procedural	10 points
Knee Arthroplasty	Procedural	10 points
Revascularization for Lower Extremity Chronic Critical Limb Ischemia	Procedural	10 points
Routine Cataract Removal with Intraocular Lens (IOL) Implantation	Procedural	10 points
Screening/Surveillance Colonoscopy	Procedural	10 points
Intracranial Hemorrhage or Cerebral Infarction	Acute inpatient medical condition	10 points
Simple Pneumonia with Hospitalization	Acute inpatient medical condition	10 points
ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)	Acute inpatient medical condition	10 points

Cost Performance Category Scoring

Measure	Measure Attribution
Medicare Spending Per Beneficiary (MSPB)	• For MSPB we "attribute" each episode to the clinician who provided the most Part B/Physician Supplier (Part B) services—in terms of the dollar amount of Medicare-allowed charges—during the index admission. • In the case of a tie, an episode will be attributed to the clinician who has the highest count of Part B services. • We attribute episodes at the individual clinician level via the clinician's TIN/NPI. However, those who participate as groups will have a single score for their group, based on the combined data.

Total Per-Capita Cost for All Attributed Beneficiaries (TPCC)	• CMS uses the Total Per Capita Cost (TPCC) measure to measure all of Medicare Part A and Part B costs during the MIPS performance period.
	• For the TPCC measure, beneficiaries are assigned to a single Medicare clinician TIN-NPI in a two step process that considers:
	  ◦ The level of primary care services they received (as measured by Medicare allowed charges during the performance period) and,
	  ◦ The clinician specialties that performed these services.

Cost Performance Category Scoring

Episode-based Measure Type	Measure Attribution
*Procedural	Once an episode has been triggered and defined, it is attributed to one or more clinicians of a specialty that is eligible for MIPS. Clinicians are identified by Taxpayer Identification Number (TIN) and National Provider Identifier (NPI) pairs (TIN-NPI), and clinician groups are identified by TIN. Only clinicians of a specialty that is eligible for MIPS or clinician groups where the triggering clinician is of a specialty that is eligible for MIPS are attributed episodes.
*Acute Inpatient Medical Condition	An episode is attributed to a: • TIN if that TIN billed at least 30 percent of the IP E&M codes on identified Part B Physician/Supplier claim lines during the trigger IP stay, and to a • TIN-NPI if a clinician within an attributed TIN billed any IP

*Precise attribution varies per measure

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Tips to Maximize Performance

- Verify primary specialties in NPPES/PECOS
- Determine if measure exclusions/reweighting apply
- Research attribution / calculation process for each applicable measure
- Use resources available to bring awareness to the needs of your patient population
    - Identify patients most in need of better coordinated care
        - Patients with chronic/comorbid conditions (complex patient bonus)
            - Chronic Care Management services
        - Care coordination manager/lead
    - Look for ways to close the referral loop
    - Ensure medical complexity is captured on claims
        - Medical record documentation supports claims
        - Communication between office and clinical staff
    - Regularly assess cost/utilization data where available
- Review MIPS and other payer feedback reports

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Improvement Activities

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Scoring for Improvement Activities

Total points = 40

Activity Weights

- Medium = 10 points
- High = 20 points

Alternate Activity Weights*

- Medium = 20 points
- High = 40 points

*Applies clinicians and groups/virtual groups in small, rural, and underserved practices, as well as those designated as non-patient facing

Full credit for clinicians in a patient-centered medical home, Medical Home Model, or similar specialty practice

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Improvement Activities

- Attest to participation in activities that improve clinical practice
  - Examples: Screening and treatment of depression, Shared decision making, Consultation of prescription drug monitoring program, Provide 24/7 access to clinicians/care team
- 118 activities to choose from (added 6, modified 5, and removed 1)

Tips to maximize performance

1. Determine if eligible for alternate activity weighting
2. Review list and look for activities already in place or easier to implement
3. Look for alignment with other performance categories
4. Look at activity weights
5. Assess cost and ROI (to practice and patients)
6. Establish a baseline before implementing compare to results after 90 day period.
7. Retain evidence of activity and any improvement

Improvement Activities Submission Methods

	Individual	Group
Improvement Activities (IA) 15%	• Direct • Log-in and Upload • Log-in and Attest	• Direct • Log-in and Upload • Log-in and Attest

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Promoting Interoperability

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Promoting Interoperability Scoring

Total points = 100

Must use 2015 CEHRT during entire performance period

Category reweighting available for the following:

- *Non-Patient facing
- *Hospital-based
- *ASC-based
- *PAs
- *NPs
- *CNSs
- *CRNAs
- *Newly Eligible Clinician Small Practices
- Significant Hardships

*Automatically applied

Removed Base scoring requirement, now only performance based scoring.

- Bonus optional measures added

Note:

Must report the required measures under each Objective and submit a numerator of 1 or "yes" or claim an exclusion (where applicable) or will score zero points for the performance category.

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Promoting Interoperability Scoring cont.

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

*Exclusion available. Points reweighting to another measure.

Promoting Interoperability Scoring Example

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

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Promoting Interoperability Measure Reweighting

Measure	Reweighting Description
ePrescribing	The 10 points will be redistributed equally among the measures associated with the Health Information Exchange objective.
HIE Objective: …Sending Health Information	An exclusion is available, but it was not address in the proposed rule how the points would be redistributed if an exclusion is claimed. "We intend to propose in next year's rulemaking how the points will be redistributed if an exclusion is claimed."
HIE Objective: …Receiving and Incorporating Health Information	The 20 points would be redistributed to the Send Health Information measure in the HIE Objective
Public Health and Clinical Data Exchange	If an exclusion is claimed for one measure, but the MIPS eligible clinicians submits a "yes" response for another measure, they would earn the 10 points for the Public Health and Clinical Data Exchange objective. If a MIPS eligible clinician claims exclusions for both measures they select to report on, the 10 points would be redistributed to the Provide Patients Electronic Access to Their Health Information measure

Promoting Interoperability

Tips to maximize performance

1. Determine if category reweighting is applicable
2. Ensure EHR is 2015 CEHRT
3. Establish an audit folder
4. Begin regular and frequent communication with EHR vendor and get a good understanding of the EHR's capabilities and costs
5. Review list of measures and their specifications – determine any exclusions
6. Verify with EHR vendor documentation requirements for meeting measures
7. Establish a regular schedule to assess and save measure performance reports
8. Address performance gaps, if any, identified by reports in team meetings
9. Look for alignment with other performance categories
10. Begin Security Risk Analysis process early
11. Retain and review evidence of satisfying measure requirements

PI Category Submission Methods

	Individual	Group
Promoting Interoperability (PI) 25%	• Direct • Log-in and Upload • Log-in and Attest	• Direct • Log-in and Upload • Log-in and Attest

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Performance Category Reweighting

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Category Reweighting Scenarios

Reweighting Scenario	Quality	Cost	Improvement Activities	Promoting Interoperability
No Reweighting Needed				
Performance Category Scores	45%	15%	15%	25%
Reweight One Performance Category				
No Cost	60%	0%	15%	25%
No Promoting Interoperability	70%	15%	15%	0%
No Quality	0%	15%	40%	45%
No Improvement Activities	60%	15%	0%	25%
Reweight Two Performance Categories				
No Cost and no Promoting Interoperability	85%	0%	15%	0%
No Cost and no Quality	0%	0%	50%	50%
No Cost and no Improvement Activities	75%	0%	0%	25%
No Promoting Interoperability and no Quality	0%	15%	85%	0%
No Promoting Interoperability and no Improvement Activities	85%	15%	0%	0%
No Quality and no Improvement Activities	0%	15%	0%	85%

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Where can I go to learn more?

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Quality Payment Program Technical Assistance

Medicare Learning Network (select Quality Initiatives under the Training Catalog)

- https://learner.mlnlms.com/Default.aspx

atom Alliance/Qsource Quality Payment Program Assistance

- Resource Center Website: Providers.Exchange
- Email Support: TechAssist@Qsource.org
- Toll-Free Phone Support: 1-844-205-5540

Quality Payment Program Service Center

- Phone: 866-288-8292
- Email: qpp@cms.hhs.gov

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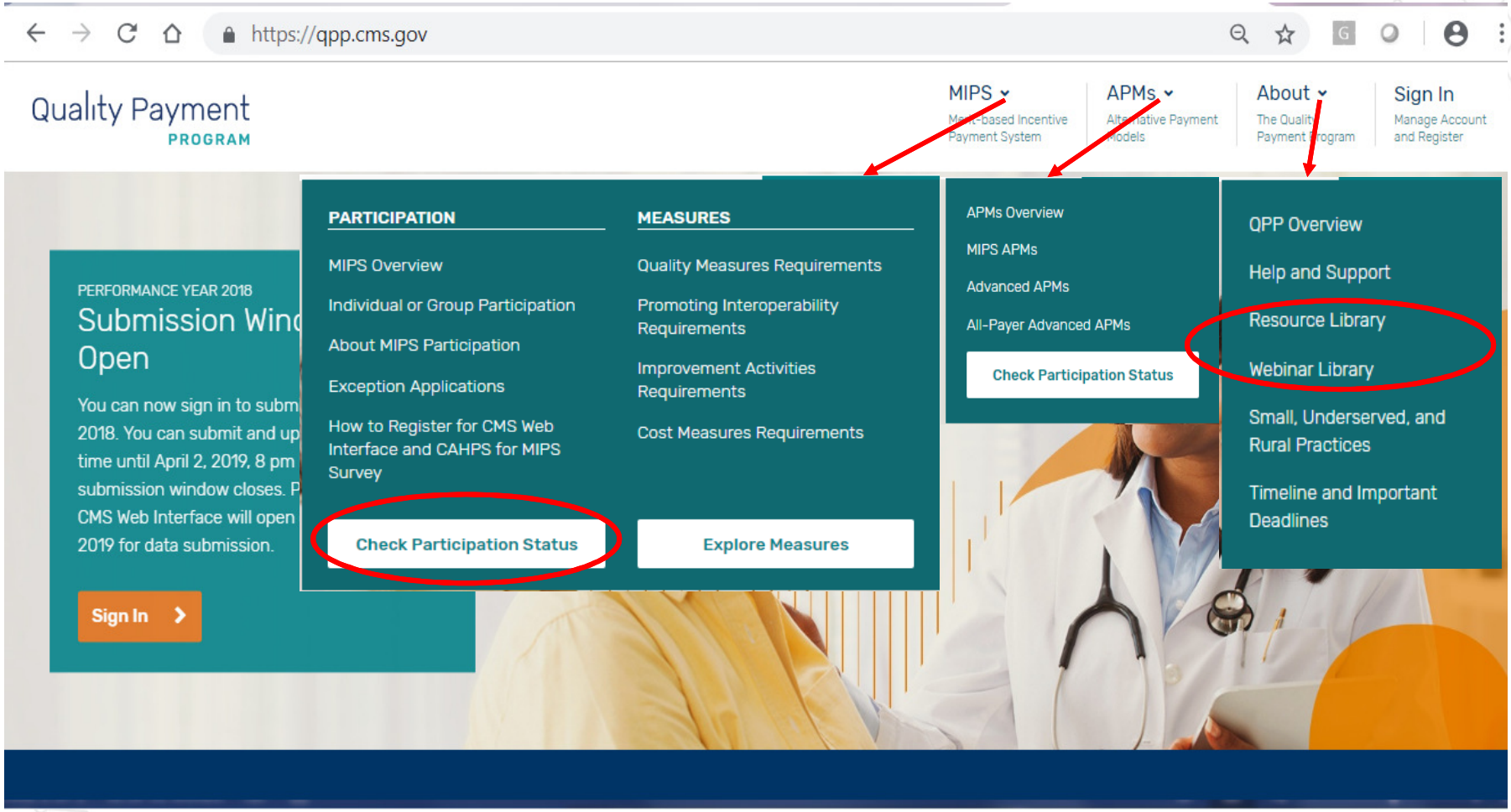

https://qpp.cms.gov/

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Participating in MIPS: A Checklist

- ❑ Determine eligibility and understand reporting requirements.
- ❑ Assess practice readiness and ability to report.
- ❑ Determine financial and organizational impact
- ❑ Establish a organization-wide team with specific roles and responsibilities
- ❑ Set performance goals
- ❑ Create an audit folder both paper and electronic, where possible
- ❑ Select measures for each category, if possible.
- ❑ Regularly check progress towards meeting goals
- ❑ Choose whether to submit data as an individual or as a part of a group.
- ❑ Choose collection type and check its requirements.
- ❑ Verify the information needed to report successfully is complete and ready.
- ❑ Ensure patient care is properly documented in medical record/Coded on claims.
- ❑ Submit data
- ❑ Celebrate your successes however small they may be!

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