QUALITY PAYMENT PROGRAM – YEAR 3: WE HAVE THE ANSWERS… CALL IN AND SEE

HOSTED BY

GREAT PLAINS QIN – NEBRASKA & TELLIGEN SURS

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QPP RESOURCE CENTER

Quality Improvement Organizations

Sharing Knowledge. Improving Health Care.

CENTERS FOR MEDICARE & MEDICAID SERVICES

Great Plains Quality Innovation Network

QPP YEAR 3: Q&A

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QPP YEAR 3: Q&A ELIGIBILITY

Q: How do we include the new eligibility types when we are reporting as a group?

A: New ECs for 2019 are: Clinical Psychologists, PTs, OTs, Speech-Language Pathologists, Audiologists, Registered Dietitians or Nutrition Professionals.

If reporting as a group with multiple specialties, and these new ECs are included in your TIN, you need to make sure that select measures that represent 60% or more of your work to meet the data completeness criteria. Data Completeness will be explained later in the presentation. CMS has identified a Cross-cutting measures list that is intended to provide clinicians with a list of measures that are broadly applicable to all clinicians regardless of the clinician's specialty.

QPP YEAR 3: Q&A
LOW VOLUME THRESHOLDS

Q: Please explain the changes to low volume thresholds and the Opt In Policy.

A: You must participate in MIPS if 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.**

If you exceed one or two of the three thresholds above, you can:

- **Elect to opt-in** - Receive a payment adjustment in 2021
    - **You do have to register to opt-in – locks you in to report**
- **Voluntarily report** - Will not receive a payment adjustment in 2021

If you don't exceed any of the three threshold criteria above, you can voluntarily report, but are not able to opt-in.

QPP YEAR 3: Q&A PARTICIPATION

Q: How do I find out if I am required to participate in MIPS?

A: If you're one of the eligible clinician types, you are required to participate in MIPS if you:

- Exceed the low volume threshold AND
- Enrolled in Medicare prior to January 1, 2019 AND
- Don't become a Qualifying APM Participant, or Partial Qualifying APM Participant

You can check the QPP Participation Look Up Tool to find out if:

- You are required to participate in MIPS – or can elect to opt-in
- You are identified as a Qualifying APM Participant, or Partial Qualifying APM Participant, in an Advanced APM Entity

To use the tool, just enter your 10-digit NPI

QPP YEAR 3: Q&A DETERMINATION PERIODS

Q: Please explain the MIPS determination periods.

A: CMS has aligned the date ranges used throughout the MIPS program with the federal fiscal year.

CMS looks at your Medicare claims from two 12-month segments, to assess the volume of care you provide to Medicare beneficiaries.

- October 1, 2017 – September 30, 2018
- October 1, 2018 – September 30, 2019

QPP YEAR 3: Q&A
SPECIAL STATUS

Q: What does "Special Status" mean when it is noted for clinicians on the Look up Tool?

A: Those with a special status qualify for reduced reporting requirements in certain performance categories

- Small practices, Rural or Health Professional Shortage Area (HPSA)
- Non-patient facing or hospital-based
- Ambulatory Surgery Center-based

QPP YEAR 3: Q&A GENERAL

Q: I am a new eligible clinician this year. What should I do right now?

A:

1. Check the QPP Participation Look Up Tool for initial eligibility information.
   - If you're **required to participate**, start by focusing on the Quality performance category. **Why?** The Quality performance category has a 12-month performance period, so you'll want to start collecting your performance data now.
2. Visit the 2019 Quality Requirements Page and explore the 2019 Quality Measures on the QPP website.
3. Review the 2019 Quality Performance Category Fact Sheet on the QPP Resource Library.
4. You'll also want to review your Participation Options and learn about the Promoting Interoperability and Improvement Activities performance categories.

QPP YEAR 3: Q&A
BONUS POINTS

Q: Are there bonus points for the 2019 reporting year?

A: Quality Category (capped at 10%)

- 1 point for reporting additional high priority measures
- 2 points for reporting additional outcomes measures
- 1 point for each measure submitted using end-to-end electronic reporting (using 2015 CEHRT)
- Up to 10% Improvement points based on the rate of improvement from the year before
- 6 points for small practices

Promoting Interoperability Category

- 5 points for Verify Opioid Treatment Agreement
- 5 points for Query the Prescription Drug Monitoring Program

Final Score

- Up to 5 points for treating medically complex patients (based on your average HCC risk score)

QPP YEAR 3: Q&A
CLAIMS REPORTING

Q: Can I still report using claims?

A: Yes – Only small practices (≤ 15 eligible clinicians) beginning in 2019

QPP YEAR 3: Q&A CATEGORY WEIGHTS

Q: What are the changes to the category weights for 2019?

A:

- Quality decreases from 50% in 2018 to 45% in 2019.
- Cost increases from 10% in 2018 to 15% in 2019.
- The other two category weights remain the same with Promoting Interoperability at 25% and Improvement Activities at 15%.
- The 2019 MIPS performance period is from January 1, 2019 to December 31, 2019.
  - For the Cost and Quality performance categories, data is collected for the full year.
  - For the Improvement Activities and Promoting Interoperability performance categories, data is collected for at least a continuous 90-day period.

QPP YEAR 3: Q&A
ELECTRONIC HEALTH RECORD

Q: I manage a group of PT/OTs and we don't have our own EHR. How can I report for any of these categories?

A: Quality Category

- If ≤15 ECs in TIN, can report via Claims
- If ≥25 ECs in TIN, can report via CMS Web Interface and/or CAHPS for MIPS
- MIPS CQMs or QCDR measures via a Qualified Registry or QCDR
- eCQMs via CEHRT, Qualified Registries, QCDRs or by clinicians themselves on QPP portal

Promoting Interoperability

- New ECs for 2019 will have their PI category reweighted to Quality automatically.

QPP YEAR 3: Q&A
SELECTING QUALITY MEASURES

Q: How do I select the quality measures to report?

A: Start by looking at the measures

- 250 Quality Measures
- Cross-Cutting Measures
- or QCDR Measures (may have more to choose from)
- or Web Interface Measures (10 specific measures to report)

- Select what fits your practice
  - What are you focused on?
  - What are you improving?

- Validate the data
  - How are you performing?
  - Does this fit the ECs if reporting in a group?

QPP YEAR 3: Q&A
2015 CEHRT REQUIREMENT

Q: When does the 2015 CEHRT need to be implemented to meet requirements for reporting?

A:

- For CY2019 of MIPS, the CEHRT edition required for Quality and PI performance categories is 2015 CEHRT.
- Clinicians must have their technology certified to 2015 edition no later than the last day of the performance period, so the last possible date that the technology could be updated to 2015 CEHRT is December 31, 2019.
- This applies for both the Quality and PI performance categories.
- Please know that upgrading technology during the performance period will NOT have any effect on the data captured.

QPP YEAR 3: Q&A
QUALITY

Q: For the Quality category, do I report just for my Medicare patients or do I report for all of my patients?

A: MIPS requires all-payer data for all collection types EXCEPT Medicare Part B Claims and for the CMS Web Interface collection types.

QPP YEAR 3: Q&A AUDITS

Q: Are there audits for MIPS?

A: CMS will conduct data validation and audit process

- 45 days to complete data sharing if requested unless alternate timeframe is agreed upon
- Third party intermediary – retain your own records too

QPP YEAR 3: Q&A
QUALITY

Q: Explain Collection Type, Submitter Type and Submission Type.

A:

- **Collection Type:** Set of quality measures with comparable specifications and data completeness criteria including: MIPS CQMs (formerly Registry measures), electronic CQMs (eCQMs); Qualified Clinical Data Registry measures (QCDR); Medicare Part B claims measures; CMS Web Interface measures, CAHPS for MIPS survey measures and administrative claims measures.
- **Submitter Type** is the MIPS eligible clinician, group, or third party intermediary acting on behalf of a MIPS eligible clinician or group, as applicable, that submits data on measures and activities.
- **Submission Type** is the mechanism by which the submitter type submits data to CMS, including, as applicable: direct, log in and upload, log in and attest, Medicare Part B claims, and the CMS Web Interface. There is no submission type for cost data because the data is collected and calculated by CMS from administrative claims data submitted for payment.

QPP YEAR 3: Q&A
DATA COMPLETENESS

Q: What does "data completeness" mean?

A: CMS will check to determine that 60% of possible data on each Quality measure you select to report is submitted

- If data completeness is not met on a measure, the measure will earn 1 point (small practices will earn 3 points)
- CMS Web Interface and/or CAHPS for MIPS Survey must meet the data submission requirement on the sample of Medicare Part B patients.

QPP YEAR 3: Q&A

Q: What does improvement scoring mean? Can I apply for that?

A: Up to 10 percentage points for improvement over last year's Quality score

Example:

* In 2018, EC earned 25 measure achievement points and 2 measure bonus points for reporting an additional outcome measure.
* For 2019, the same EC earned 33 measure achievement points and 6 measure bonus points for end-to-end electronic reporting.
* 2018 Quality score = 42% (25/60) (Excludes the 2 bonus points)
* 2019 Quality score = 55% (33/60) (Excludes the 6 bonus points)

The increase in Quality score from prior performance period to current performance period = 13% (55% - 42%)

(13%/42%)*10% = 3.1%

The improvement percent score is 3.1% which will be added to the percent score earned for reported measures.

QPP YEAR 3: Q&A QUALITY

Q: What if a quality measure doesn't have a national benchmark?

A:

- Quality measures that can't be reliably scored against a benchmark, or quality measures without a benchmark, will receive 3 points (assuming the measure meets data completeness) unless a benchmark can be established with performance period data.
- If the measure does not also meet data completeness, it will receive 1 point (except for small practices which would receive 3 measure achievement points).
- This applies to measures across all collection types except for CMS Web Interface measures and administrative claims measures.

QPP YEAR 3: Q&A
TOPPED-OUT MEASURES

Q: What are topped-out quality measures? Extremely topped-out measures?

A: Topped-out measures - measure performance that is so high and unvarying that improvement in performance can no longer be made

- Capped at 7 points

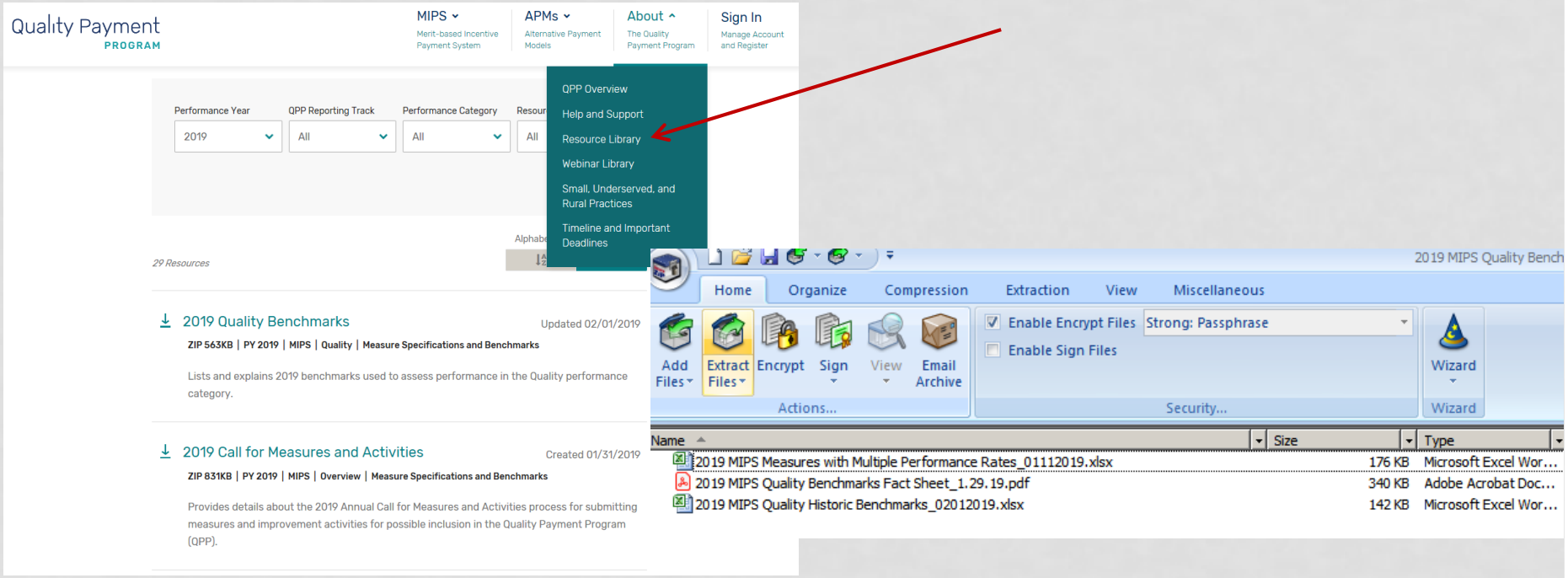
Extremely Topped Out Measures- measures with an average mean performance within the 98th to 100th percentile range.

- Proposal can be made to remove in next rule making cycle as opposed to the 4-year lifecycle for Topped Out Measures

QPP YEAR 3: Q&A
MULTI-STRATA MEASURES

Q: How is my quality measure scored if I have more than one numerator / denominator captured for the measure?

A: https://qpp.cms.gov/about/resource-library Quality Benchmarks zip file



QPP YEAR 3: Q&A
MULTI-STRATA MEASURES – CONTD.

Measure Title	Measure Number			Overall Performance Rate	Number of Performance Rates
	CMS	NQF	Quality Number		
Medication Reconciliation Post-Discharge	N/A	0097	046	3rd Performance Rate	3
HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis	CMS52v7	0405	160	Weighted Average	3
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	CMS138v7	0028	226	2nd Performance Rate	3
Use of High-Risk Medications in the Elderly	CMS156v7	0022	238	1st Performance Rate	2
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	CMS155v7	0024	239	Simple Average	3

2019 MIPS Multiple Performance | BACKGROUND | WEIGHTED AVG EXAMPLE | SIMPLE AVG EXAMPLE | SPECIFIC PERF RATE EX

QPP YEAR 3: Q&A
COST

Q: How has the Cost performance category changed from last year ?

A:

- The weight has increased from 10% in 2018 to 15% in 2019.
- 10 cost measures
- Two of the ten measures were used to evaluate performance in the 2017 and 2018 MIPS performance periods. These two measures are:

  1. The Total Per Capita Costs for All Attributed Beneficiaries measure, or "TPCC," and

  2. The Medicare Spending Per Beneficiary measure, or "MSPB."

  - Case minimum of 20 for TPCC and 35 for MSPB

QPP YEAR 3: Q&A
COST – CONTD.

Q: How has the Cost performance category changed from last year ?

A: Beginning with the 2019 MIPS performance period, eight episode-based measures will also be used to evaluate cost.

- Case minimum of 10 for procedural episodes and 20 for acute inpatient medical condition episodes

Measure Topic	Measure Type
Elective Outpatient Percutaneous Coronary Intervention (PCI)	Procedural
Knee Arthroplasty	Procedural
Revascularization for Lower Extremity Chronic Critical Limb Ischemia	Procedural
Routine Cataract Removal with Intraocular Lens (IOL) Implantation	Procedural
Screening/Surveillance Colonoscopy	Procedural
Intracranial Hemorrhage or Cerebral Infarction	Acute inpatient medical condition
Simple Pneumonia with Hospitalization	Acute inpatient medical condition
ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)	Acute inpatient medical condition

QPP YEAR 3: Q&A
FACILITY-BASED QUALITY AND COST

Q: How will I know if I qualify for the Facility-Based Quality and Cost Performance scoring?

A: CMS is planning to include a flag to identify ECs that are eligible for facility based scoring in the NPI Lookup Tool for Year 3.

Applicability:

- Individual: MIPS ECs furnish 75% or more of their covered professional services in POS code 21, 22, or 23
- Group: Facility based group with 75% or more of the ECs billing under the group's TIN are eligible as individuals

QPP YEAR 3: Q&A IMPROVEMENT ACTIVITY DOCUMENTATION

Q: What documentation is required for the improvement activities I choose to report?

A: 2019 MIPS Data Validation Criteria zip file

- IA 2019 Validation Criteria
  - Lists by Improvement Activity
  - Description
  - Weighting
  - Suggested documentation
  - First performance year
  - Examples

- Minimum of 90 day reporting period *
  - *Some may be longer

QPP YEAR 3: Q&A
NEW IMPROVEMENT ACTIVITIES

Q: Are there new improvement activities for 2019?

A: Yes, there are 6 new improvement activities:

- High-weighted
  - Patient Medication Risk Education
  - Use of CDC Guideline for Clinical Decision Support to Prescribe Opioids for Chronic Pain via Clinical Decision Support
- Medium-weighted
  - Comprehensive Eye Exams
  - Financial Navigation Program
  - Completion of Collaborative Care Management Training Program
  - Relationship-Centered Communication Training

QPP YEAR 3: Q&A
PI REWEIGHTING

Q: When is an application required to have the PI category reweighted?

A: Application-based reweighting:

- Small practice
- Decertified EHR technology
- Insufficient internet connectivity
- Extreme and uncontrollable circumstances
- No control over whether CEHRT is available

QPP YEAR 3: Q&A
APM & PROMOTING INTEROPERABILITY

Q: If I am reporting my quality measures for an APM, ACO or MSSP program, do I still need to report to Promoting Interoperability?

A: Yes – Report Promoting Interoperability

- Must report PI in your QPP Account (Secure Portal)
- Quality category is reported for you via APM
- Improvement Activity is met
- Cost is calculated through the APM

QPP YEAR 3: Q&A
PUBLIC HEALTH & CLINICAL DATA EXCHANGE

Q: Two public health and clinical data exchange measures are required; what if I only report to one registry and no others are available?

A: Report Yes to 1st Registry

- Exclusion to 2nd Registry if none available
- If Exclusion is needed for both
  - Reallocation to Provide Patient Electronic Access to Health Information

QUESTIONS??

- Type your questions using the Chat feature on the right of the screen

OR

- Dial #6 to unmute your phone

POLLING QUESTION #1

Will I do something different as a result of this webinar?

a. Yes

b. No

POLLING QUESTION #2

Did I take away something I can use?

a. Yes
b. No

POLLING QUESTION #3

Do I know more now about QPP Year 3 requirements than before I participated in this webinar?

a. Yes

b. No

NEBRASKA
QUALITY PAYMENT PROGRAM (QPP) COALITION

The coalition is committed to work together to prepare Nebraska clinicians to thrive in the patient-centric and value-based payment environment

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RESOURCES

- QPP Resource Library
  - 2019 QPP Final Rule Overview Fact Sheet
  - 2019 MIPS Participation and Eligibility Fact Sheet
  - 2019 MIPS Quick Start Guide
  - 2019 MIPS Quality Performance Category Fact Sheet
  - 2019 MIPS Cost Performance Category Fact Sheet
  - 2019 Cross Cutting Quality Measures
- Resource Library Zip Files
  - 2019 Improvement Activities Inventory
  - 2019 Promoting Interoperability Measure Specifications
  - 2019 Clinical Quality Measure Specifications and Supporting Documents
  - 2019 MIPS Data Validation Criteria
  - 2019 Quality Benchmarks

CONTACT US

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