Tips to Prepare for 2019 MIPS Reporting and How to Avoid the MIPS Penalty

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Quality Insights Presenters

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Learning Objectives

• Describe 2019 submission methods and their impact on your MIPS score
• Explain how to update NPPES and PECOs for QPP reporting
• Identify location of DIRECT and secure email addresses
• Review what documents should be saved for a possible audit
• Describe how to earn 30 MIPS points to avoid a penalty
What are the MIPS data reporting options in 2019?
Reporting Options

• Solo practitioners must submit MIPS data as an individual
• Groups of two or more can submit MIPS data as an individual or a group
• Virtual groups (who completed the virtual group election process between October 1 and December 31, 2018) must submit MIPS data as a group
# Reporting Periods

<table>
<thead>
<tr>
<th>MIPS Category</th>
<th>Reporting Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Full calendar year (365 days)</td>
</tr>
<tr>
<td>Promoting Interoperability</td>
<td>90 day minimum, up to 365 days</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>90 day minimum, up to 365 days</td>
</tr>
<tr>
<td>Cost</td>
<td>Full calendar year (365 days) *CMS collects data</td>
</tr>
</tbody>
</table>
How should I submit my data?
Submission Options

• Both individuals and groups have options to submit data within each performance category

• More than one submission method can be used to submit data for the Quality and Improvement Activity categories

• Only one submission method can be used for the Promoting Interoperability category
# Submitting Individual Data

<table>
<thead>
<tr>
<th>MIPS Category</th>
<th>Who Submits Data</th>
<th>Method to Submit Data</th>
</tr>
</thead>
</table>
| Promoting Interoperability | Individual OR Third-party intermediary (EHR vendor, registry, QCDR) | 1. Directly from EHR or registry  
2. Login to QPP Portal & upload QRDA III file  
3. Log in to QPP portal & manually enter data (attest) |
| Improvement Activities  | Individual OR Third-party intermediary (EHR vendor, registry, QCDR) | 1. Directly from EHR or registry  
2. Login to QPP Portal & upload QRDA III file  
3. Log in to QPP portal & manually enter data (attest) |
| Quality                | Individual OR Third-party intermediary (EHR vendor, registry, QCDR) | 1. Directly from EHR, registry, QCDR  
2. Login to QPP Portal & upload QRDA III file  
3. Attach QDCs to Medicare Part B Claims *only available for small practices |
## Submitting Group Data

<table>
<thead>
<tr>
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<th>Who Submits Data</th>
<th>Method to Submit Data</th>
</tr>
</thead>
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| Promoting Interoperability | Individual OR Third-party intermediary (EHR vendor, registry, QCDR) | 1. Directly from EHR or registry  
2. Login to QPP Portal & upload QRDA III file  
3. Log in to QPP portal & manually enter data (attest) |
| Improvement Activities   | Individual OR Third-party intermediary (EHR vendor, registry, QCDR) | 1. Directly from EHR or registry  
2. Login to QPP Portal & upload QRDA III file  
3. Log in to QPP portal & manually enter data (attest) |
| Quality                 |                                           | 1. Directly from EHR, registry, QCDR  
2. Login to QPP Portal & upload QRDA III file  
3. Attach QDCs to Medicare Part B Claims *only available for small practices  
4. CMS web interface *only available for groups with ≥ 25 clinicians |
Certified EHR Technology Requirement

• If using an EHR for a 2019 submission, you must have a 2015 Edition CEHRT
What is a third party intermediary?
Third Party Intermediary

• Third party intermediaries are organizations that submit MIPS data on behalf of a clinician or group
• They must be approved by CMS on an annual basis
• Examples include an EHR vendor, Qualified Registries, Qualified Clinical Data Registries (QCDR), and health IT vendors
• 2019 Qualified Clinical Data Registries (QCDRs) Qualified Posting updated 10/16/19
• 2019 Qualified Registries Qualified Posting updated 10/16/19
Is it too late in the year to think about using a registry for 2019?
Registry Enrollment

• It may not be too late to ask a registry to submit your 2019 MIPS data
• Check with your EHR vendor if to see if they are affiliated with a registry, or review the list of approved registries
• Some registries are able to extract data directly from your EHR, but others require you to manually enter data
What do I need to do for the Quality category?
Reporting the Quality Category

- Worth **45%** of final MIPS score (**70%** if PI category is reweighted)
- Reporting period is the full calendar year
- Report six measures or a specialty measure set
- 60 performance points are needed to earn full credit for the Quality category
- Report at least one outcome or high priority measure
- Clinicians in SMALL practices automatically receive 6 points in their quality category numerator if **at least one quality measure is reported** - this is the called the small practice bonus
Quality Measure Options

- Although CMS approved over 250 quality measures for 2019, the number available to report is based on the submission method selected:
  - Medicare Part B Claims: 64 measures
  - EHR: 50 measures
  - Registry: 233 measures
  - CMS Web Interface: 10 measures
  - QCDR: 536 measures

- **MIPS 2019 Quality Measures by Submission Method**
Selecting Submission Method(s)

• Beginning in 2019, clinicians and groups can submit quality measures using more than one method
• One exception is that CMS web interface measures must be submitted via the CMS web interface
• **Reminder**: You cannot log in and manually enter quality measure data
Tip to Earn Extra Quality Points

• Report more than six quality measures
• CMS will add the scores of the six highest measures together to calculate the quality category score, regardless of the submission method
• One bonus point is awarded for each additional high priority measure and two bonus points are awarded for each additional outcome measure
Can I submit a Quality measure more than once by using different submission methods?
Submit One Measure Using Different Methods

- If the same quality measure is submitted using more than one method, the method that has the highest points will be used to calculate the quality category score.

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Measure ID</th>
<th>Submission Method</th>
<th>Ave</th>
<th>Decile 3</th>
<th>Decile 4</th>
<th>Decile 5</th>
<th>Decile 6</th>
<th>Decile 7</th>
<th>Decile 8</th>
<th>Decile 9</th>
<th>Decile 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes: Hemoglobin A1c (HbA1c) Poor Control (&gt;9%)</td>
<td>1</td>
<td>EHR</td>
<td>46.3</td>
<td>77.14 - 60.79</td>
<td>60.78 - 48.49</td>
<td>48.48 - 38.90</td>
<td>38.89 - 31.60</td>
<td>31.59 - 25.88</td>
<td>25.87 - 20.56</td>
<td>20.55 - 14.72</td>
<td>&lt;= 14.71</td>
</tr>
<tr>
<td>Diabetes: Hemoglobin A1c (HbA1c) Poor Control (&gt;9%)</td>
<td>1</td>
<td>Claims</td>
<td>24.6</td>
<td>44.44 - 29.04</td>
<td>29.03 - 19.52</td>
<td>19.51 - 14.72</td>
<td>14.71 - 11.12</td>
<td>11.11 - 8.34</td>
<td>8.33 - 5.57</td>
<td>5.56 - 2.79</td>
<td>&lt;= 2.78</td>
</tr>
<tr>
<td>Diabetes: Hemoglobin A1c (HbA1c) Poor Control (&gt;9%)</td>
<td>1</td>
<td>Registry/QCDR</td>
<td>36.5</td>
<td>68.31 - 50.63</td>
<td>50.62 - 37.51</td>
<td>37.50 - 28.70</td>
<td>28.69 - 20.01</td>
<td>20.00 - 13.60</td>
<td>13.59 - 9.03</td>
<td>9.02 - 2.71</td>
<td>&lt;= 2.70</td>
</tr>
</tbody>
</table>
Is there an advantage to submitting Quality measures using one method over another?
Quality Scoring by Benchmarks

- Benchmarking is the process of comparing your performance with an external standard so you can see how you compare to others.
- CMS uses benchmarks to determine how many points each quality measure will receive.
- Most measures have ‘historical’ benchmarks based on performance of those who reported that measure in the past (two years prior).
- Select quality measures with benchmarks advantageous to submission method selected.
- 2019 Quality Benchmarks
Benchmarks Vary By Submission Method

- **Example:** Influenza Immunization, ID 110, can be reported three ways: EHR, claims, or registry
- If the performance rate is 82.0%, it would be most beneficial to submit the measure via EHR because it would be worth 9.XX points versus 6.XX points if submitted using Medicare Part B claims

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Measure ID</th>
<th>Submission Method</th>
<th>Decile_3</th>
<th>Decile_4</th>
<th>Decile_5</th>
<th>Decile_6</th>
<th>Decile_7</th>
<th>Decile_8</th>
<th>Decile_9</th>
<th>Decile_10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care and Screening: Influenza Immunization</td>
<td>110</td>
<td>EHR</td>
<td>15.50 - 23.63</td>
<td>23.64 - 31.20</td>
<td>31.21 - 38.65</td>
<td>38.66 - 46.76</td>
<td>46.77 so- 56.01</td>
<td>56.02 - 67.49</td>
<td><strong>67.50 - 84.98</strong></td>
<td>&gt;= 84.99</td>
</tr>
<tr>
<td>Preventive Care and Screening: Influenza Immunization</td>
<td>110</td>
<td>Medicare Part B Claims</td>
<td>29.52 - 41.41</td>
<td>41.42 - 56.31</td>
<td>56.32 - 71.18</td>
<td><strong>71.19 - 82.88</strong></td>
<td>82.89 - 94.14</td>
<td>94.15 - 99.41</td>
<td>99.42 - 99.99</td>
<td>100</td>
</tr>
<tr>
<td>Preventive Care and Screening: Influenza Immunization</td>
<td>110</td>
<td>Registry</td>
<td>29.85 - 41.42</td>
<td>41.43 - 53.84</td>
<td>53.85 - 66.02</td>
<td>66.03 - 76.93</td>
<td><strong>76.94 - 87.80</strong></td>
<td>87.81 - 96.40</td>
<td>96.41 - 99.99</td>
<td>100</td>
</tr>
</tbody>
</table>
How do I submit data for the Improvement Activity category?
Reporting the IA Category

- The IA Category is worth 15% of your total MIPS score
- 40 performance points are needed to earn full credit for the IA category
- Clinicians in SMALL practices receive full credit by reporting 1 high weight activity or 2 medium weight activities
- Clinicians in LARGE practices receive full credit by reporting 2 high weight activities, 4 medium weight activities, or 1 high weight plus 2 medium weight activities
Submitting Improvement Activity Data

• Clinicians and groups need to submit between one and four Improvement Activities (IA) to earn full credit for this category

• Each IA can be submitted using a different submission method:

  1. Directly from EHR or registry
  2. Log in to QPP portal & upload QRDA III file from EHR
  3. Log in to QPP portal & manually enter data (attest)
How do I submit data for the Promoting Interoperability category?
Reporting the PI Category

• The category weight is 25% unless reweighted to zero
• 100 performance points are needed to earn full credit for the PI category
• All required PI measures must be reported or excluded
• A Security Risk Analysis must be completed in 2019
Submitting Promoting Interoperability Data

• Clinicians and groups need to report data for all of the PI measures (or claim an exclusion for a measure if available)

• All data for the PI category must be submitted using the same method:
  1. Directly from EHR or registry
  2. Login to QPP portal & upload QRDA III file from EHR
  3. Log in to QPP portal & manually enter data (attest)
What can I do now to make sure our information in the QPP portal is correct?
Updating Medicare Systems for MIPS

- CMS draws information from the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) and the National Plan & Provider Enumeration System (NPPES) to supply participants' information for the QPP.
- Make sure your information is accurate in both of these systems.
- Verify information annually.
- Update no later than October of each year to ensure changes will appear in the QPP portal.
PECOS

• PECOS must be updated within 30 days when you experience a “reportable event” which is a change in:
  – Practice location
  – Ownership
  – General supervision
  – Banking arrangement
  – A final adverse action

• All other changes must be made within 90 days
How to Update PECOS

1. Update your information in PECOS [here](#) using your CMS Identity and Access login credentials
2. Select "Account Management"
3. Select "My Associates"
4. Update applicable information
NPPES

• CMS assigns National Provider Identifiers (NPIs) to clinicians through NPPES

• Information in each clinician’s NPPES record is used for:
  – Billing
  – Medicare quality reporting
  – Assignment of a QPP technical assistance contractor
  – Documenting a DIRECT email address to send secure messages for referrals and transitions of care
1. Update your information in NPPES using your CMS Identity and Access login credentials
2. Scroll down to "Manage Provider Information"
3. Click on the pencil icon under the “Action" column to edit provider information and make changes as needed
4. Click "Error Check" after all changes are made to ensure that the information provided is complete
5. Click "Save and Return to Main Page" in the lower right corner - this will activate a dialogue window
6. Select "Complete NPI Application" to submit changes
What to Update in NPPES

• Address
  – Physical address of practice (primary site if more than one)
  – Mailing address

• Phone number

• Health Information Exchange endpoint*
What is a Health Information Exchange endpoint?
Health Information Exchange Endpoint

• “HIE Endpoint” is a new field added to NPPES in 2019
• Indicates how a clinician can receive and send Summary of Care records for referrals and transitions of care
• This should help everyone improve their Promoting Interoperability health information exchange (HIE) measures
• Examples of endpoints:
  – DIRECT email address
  – Fast Healthcare Interoperability Resource (FHIR) URL
  – Connect URL
  – PERSONAL email addresses cannot be used to send Personal Health Information (PHI)
Screenshot of Endpoint Field in NPPES
How to Check A Clinician’s ‘Endpoint’

• You can check to see who has a secure email address or URL by opening the NPI Registry and entering the provider's name.

• Then open the provider's record and scroll down to "Health Information Exchange" on the left side to see if anything is entered.
Is there anything I should do now in the QPP portal?
QPP Portal Access

• **Make sure you can log in to the QPP portal now** so you can enter 2019 data on January 2, 2020 when the submission period opens and you can view your 2019 preliminary MIPS score after data is submitted

• [QPP Access User Guide](#)
QPP Portal

Logging into the QPP Portal

• Use your **HCQIS Authorization Roles and Profile (HARP)** account user ID and password to log in to the portal

• Multi-factor authentication required for first time login
Reset QPP Portal Password Every 60 Days

- Change your password by going to qpp.cms.gov>My Profile>Edit>Change Password, or call 1.866.288.8292
- Passwords must have at least 12 characters and include:
  - An uppercase letter
  - A lowercase letter
  - A number (0-9)
  - A symbol (!, @, #, $, %, ^, &, *)
- Passwords cannot contain your user ID, first name, last name, or the following symbols (, < > +)
- A challenge question will be used if you need to reset your password. The challenge answer is not case sensitive and must be between 4 and 100 alphanumeric characters.
How do I submit my data in the QPP portal?
QPP Portal Overview

- Easy to use: Includes prompts to assist users with manual data entry (attestation) and file uploads
- Data is automatically saved without a “save” button
- Real time scoring appears as data is entered
- Data can be changed anytime until the submission period closes on March 31, 2020 at 8:00 p.m.
Home Screen View

Account Home > Eligibility & Reporting

Practice Details & Clinicians
Elig Org 27 | Performance Year (PY) 2018

☐ MIPS EXEMPT Small practice
+ View complete eligibility details

Clinicians
The following is a list of all clinicians who submitted claims data to CMS for Performance Year 2018 for this practice. Here you can view their MIPS Participation, APM Participation, and Special Status details.

Search

17 Clinicians | Download
Eligibility & Reporting View
Report Each Category Separately
Reporting Overview

Garcia, Barrera and Johnson
TIN: 000444646
5140 Andrew Springs, Gonzalezberg, MS 413497234613174

Start reporting
You can start reporting by uploading properly formatted OPP 350N, OPP XML and ORDA-3 files that can contain Quality measures, and/or Promoting Interoperability measures, and/or Improvement Activities. You can also scroll down and report for each category separately.

Remember: These files will be calculated immediately and the page below will update with your preliminary scoring information. Your information will be automatically saved in our system.
Is there a list of what I should do now?
Summary Checklist

1. Review and update each clinician’s NPPES account, including entry of ‘endpoint’ secure email address or URL
2. Review and update practice’s PECOS account information
3. Log in to the QPP portal to ensure you have access
   – Create a HARP account if new to the QPP portal
4. Submit application for hardship exception(s), if applicable
5. Submit application for 2020 virtual group reporting, if interested
6. Collect supporting documentation for the 2019 performance year
December 31 Deadlines

**PI Hardship Exception Application**

- Everyone in a small practice (15 or fewer clinicians) can request the PI category be reweighted to zero

- Other reasons to apply:
  - Decertified electronic health record (EHR) technology
  - Insufficient internet connectivity
  - You face extreme and uncontrollable circumstances such as disaster, practice closure, severe financial distress or vendor issues
  - Lack of control over the availability of certified EHR technology (CEHRT)

- You can submit the application and still report PI data if you want to
December 31 Deadlines (cont.)

• **Extreme and Uncontrollable Circumstances Application**: Request one or more categories be reweighted if impacted by extreme and uncontrollable circumstances that prevent you from collecting or submitting MIPS information for an extended period of time.

• **2020 Virtual Group Application**: Solo practitioners and groups with 10 or fewer clinicians (including at least one MIPS eligible clinician) can submit a request to participate in MIPS as a virtual group in 2020.
How can I get organized so I can easily submit my 2019 data?
Use Quality Insights’ Guide to Get Organized

• Quality Insights created a guide to assist you with collecting & saving MIPS documentation

• This is especially important in case you are audited in the future because CMS can request information for up to six years after the submission period ends (2025 for 2019 MIPS submission)

• 2019 QPP Data Validation & Audit Documents
Documentation Required by CMS

• The 2019 MIPS Data Validation Criteria posted on the QPP resource page includes specific documentation that CMS will look for if they conduct an audit or data validation

• There are separate documents for each category:
  – Improvement Activities - 57 pages
  – Promoting Interoperability - 17 pages
  – Quality - 34 pages
## 2019 MIPS Data Validation – Year 3 Improvement Activities

### Performance Category Criteria

<table>
<thead>
<tr>
<th>ID</th>
<th>Subcategory Name</th>
<th>Activity Name</th>
<th>Activity Description</th>
<th>Activity Weighting</th>
<th>Validation</th>
<th>Suggested Documentation</th>
<th>FY</th>
<th>Examples of Additional Qualifiers for Allocation</th>
</tr>
</thead>
</table>
| IA_EHad | Expanded Practice Access  | Provide 24/7  | Provide 24/7 access to MIPS eligible clinicians, groups, or care teams for advice about urgent and emergent care. For example, eligible clinicians and care teams access to medical records, cross-coverage with access to medical record, or protocol-driven nurse visits with access to medical records that could include one or more of the following:  
- Expanded hours in evenings and weekends with access to the patient medical record. For example, coordinate with small practices to provide alternate hour office visits and urgent care;  
- Use of alternatives to increase access to care loan by MIPS eligible clinicians and groups, such as telehealth, phone visits, group visits, home visits and alternate locations (for example, senior centers and assisted living centers); and/or  
- Provision of same-day or next-day access to a consistent MIPS eligible clinician, group or care team when needed for urgent care or transition management. | High               |           | 1) Patient record from EMR - All patients in the Enhanced Reporting Program (ERP) for patient care to an EMR with date and timestamp indicating services provided outside of normal business hours for that clinician.  
2) Patient Encounter/Health Record - Patient encounter/health record claims indicating patient was seen for services provided outside of normal business hours for that clinician, including use of alternate visits; or  
3) Same- or Next-Day Patient Encounter/Health Record - Patient encounter/health record claims indicating patient was seen same-day or next-day to a consistent clinician for urgent or transitional care. | 2017  |                                                 |
| IA_EHad | Expanded Practice Access  | Use of telehealth services that expand practice access | Use of telehealth services and analysis of data for quality improvement, such as participation in remote specialty care consults or teleoncology visits that assess ability to deliver quality care to patients. | Medium             |           | 1) Use of Telehealth Services - Documented use of telehealth services through a) claims adjudication (may use CPM codes to validate), b) EMR or O code, or c) other Medical record documentation showing specific telehealth services, consults, or referrals performed for a patient. | 2017  |                                                 |
# PI Category Data Validation

## 2019 MIPS Data Validation – Year 3 Promoting Interoperability Performance Category Criteria

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Description</th>
<th>Requirements</th>
<th>Reporting</th>
<th>Validation</th>
<th>Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1-PHI-1</td>
<td>Security Risk Analysis</td>
<td>Conduct of review a security risk analysis in accordance with the requirements in 45 CFR 164.302(a)(1), including addressing the security (to include encryption) of PHI data created or maintained by certified electronic health record technology (CEHRT) in accordance with requirements in 45 CFR 164.312(c)(2)(i) and 45 CFR 164.306(e)(2).</td>
<td>Required</td>
<td>Yes/No Statement</td>
<td>Security risk analysis of the CEHRT was performed or reviewed prior to the date of attestation on an annual basis and for the CEHRT used during the reporting period. * If you choose to submit for a 90-day MIPS performance period, it is acceptable for the security risk analysis to be conducted outside the performance period; however, it must be conducted within the 180-day reporting period.</td>
</tr>
</tbody>
</table>

Documentation needs to be from certified electronic health record technology (CEHRT) and be inclusive of:

1. The time period the report covers (performance period).
2. Clinician Identification, e.g., National Provider Identifier (NPI).
3. Evidence to support that the report was generated by the CEHRT (e.g., screenshot of the report notice it was printed from the system). Because some CEHRT is unable to generate reports that limit the calculation of measures to a prior time period, CMS suggests that clinicians download and/or print a copy of the report used at the time of data submission for their records.
### 2019 MIPS Data Validation – Year 3 Quality Performance Category Criteria

<table>
<thead>
<tr>
<th>Measure Number</th>
<th>Measure Title</th>
<th>Measure Description</th>
<th>Measure Type</th>
<th>Data Submission Method</th>
<th>Primary Measure Source</th>
<th>Specialty Measure Source</th>
<th>Age Range</th>
<th>HCPCS/CPIT Codes</th>
<th>ICD-10 Codes</th>
<th>Drug Prescription Data Include</th>
<th>Other</th>
<th>Other Indicators</th>
<th>Reporting Documentation</th>
</tr>
</thead>
</table>
| 001            | Diabetic Hemoglobin A1c (HbA1c) Post Controls (-%) | Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c ≥ 9% during the measurement period | Interim Outcome | Medicare Part D Claims, QC, CMS | National Committee for Quality Assurance | Family Medicine, Internal Medicine, Preventive Medicine, Hematology, Endocrinology | Yes | Yes | Yes | Yes | Yes | Yes | Quality Assurance
| 005            | Heart Failure (HF) Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD) | Percentage of patients aged 18 and older with a diagnosis of heart failure (HF) who were prescribed an ACE inhibitor or ARB therapy for ≥ 12 consecutive weeks during the measurement period | Process | ICD-9-CM, HCPCS, CMS | American Heart Association | Cardiology, Family Medicine, Internal Medicine, Midlevel Providers | Yes | Yes | Yes | Yes | Yes | Yes | Quality Assurance
| 009            | Coronary Artery Disease (CAD) Blood Pressure Control | Percentage of patients aged 18 and older with a diagnosis of coronary artery disease (CAD) who were prescribed blood pressure control (BP) therapy within 12 months of a diagnosis or a BP measurement that was not controlled during the measurement period | Process | ICD-9-CM, HCPCS, CMS | American Heart Association | Cardiology, Family Medicine, Internal Medicine, Midlevel Providers | Yes | Yes | Yes | Yes | Yes | Yes | Quality Assurance
| 016            | Heart Failure (HF) Diabetes, Antithrombotic Therapies for Left Ventricular Systolic Dysfunction (LVSD) | Percentage of patients aged 18 and older with a diagnosis of heart failure (HF) who were prescribed antithrombotic therapy for ≥ 12 consecutive weeks during the measurement period | Process | ICD-9-CM, HCPCS, CMS | American Heart Association | Cardiology, Family Medicine, Internal Medicine, Midlevel Providers | Yes | Yes | Yes | Yes | Yes | Yes | Quality Assurance
| 019            | AF-Diabetes Medication Management | Percentage of patients 18 years of age and older who were treated with antidiabetic medication, had a diagnosis of major depression, and also remained on an antidepressant medication treatment. Two rules are met. | Process | eCQM, HCPCS, CMS | National Committee for Quality Assurance | Family Medicine, Internal Medicine, Behavioral Health | Yes | Yes | Yes | Yes | Yes | Yes | Quality Assurance

*Note: The table above provides a summary of the measures required for the various quality categories, including HCPCS codes, CMS codes, and other relevant data.*
What do I need to do to avoid the 2019 penalty?
2019 Performance Threshold

A MIPS score of **30 points** is needed to avoid a penalty.

<table>
<thead>
<tr>
<th>MIPS Points</th>
<th>Payment Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 7.50</td>
<td>Negative 7%</td>
</tr>
<tr>
<td>7.51 - 29.99</td>
<td>Negative between 0.01% and 6.99%</td>
</tr>
<tr>
<td>30</td>
<td>No payment adjustment</td>
</tr>
<tr>
<td>30.01 - 74.99</td>
<td>Positive between 0.01% and 7%</td>
</tr>
<tr>
<td>75 - 100</td>
<td>Positive between 0.01% and 7% plus the exceptional performance bonus</td>
</tr>
</tbody>
</table>
How to Earn 30 Points

• The easiest way for SMALL practices to earn 30 points is:
  – Report the Improvement Activity category
  – Report the Quality category
  – Submit a PI Hardship Exception Application

• The MIPS score will be calculated based on:
  \[ \text{IA score} + \text{Quality score} = \text{MIPS score} \]
  \((15\% \text{ weight}) \quad (70\% \text{ weight})\)

• The PI category has a zero weight when the PI Hardship Exception is approved, making the Quality category worth 70%
What can I do to avoid the penalty if I don’t have an EHR?
Practices Without an EHR

• Earn at least 30 points by reporting the Quality and Improvement Activity (IA) categories and submit an Application for PI Hardship Exception
No EHR: PI Category Reweighted

- Report **three** quality measures (without meeting the 20 case minimum or 60% data completeness requirements) and the IA category

- In this example, a PI Hardship Exception application was approved

\[
\begin{align*}
CQM 1 & + CQM 2 & + CQM 3 & + \text{Small practice bonus} & = 15 \text{ quality points} \\
3 \text{ pts} & + 3 \text{ pts} & + 3 \text{ pts} & + 6 \text{ pts} & = 15 \text{/60 quality points} = 25 \text{ points} \times 0.70 \text{ (category weight 70\%)} = 17.5 \text{ MIPS points} \\
17.5 \text{ points (Quality category)} & + 15 \text{ points (IA category)} & = 32.5 \text{ MIPS score}
\end{align*}
\]

**NOTE:** Reporting a measure with a benchmark, at least a minimum of 20 cases and a minimum of 60% of eligible patients will result in the quality measure being scored based on performance. The measure will receive between 3-10 points (unless the measure is topped-out and capped at 7 points)
No EHR: PI Category NOT Reweighted

- Report 5 quality measures (\textbf{without} meeting the 20 case minimum or 60% data completeness requirements) and the IA category

- In this example, the clinician did not submit a PI Hardship Exception application

\[
\begin{align*}
\text{CQM 1} + \text{CQM 2} + \text{CQM 3} + \text{CQM 4} + \text{CQM 5} + \text{Small practice bonus} & = 21 \text{ quality points} \\
(3 \text{ pts}) & (3 \text{ pts}) & (3 \text{ pts}) & (3 \text{ pts}) & (3 \text{ pts}) & (6 \text{ pts}) \\
\frac{21}{60} \text{ quality points} & = 25 \text{ points} \times 0.45 \text{ (category weight 45\%)} = 15.75 \text{ MIPS points} \\
15.75 \text{ points (Quality category)} + 15 \text{ points (IA category)} & = 30.75 \text{ MIPS score}
\end{align*}
\]

\textbf{NOTE}: Reporting a measure with a benchmark, at least a minimum of 20 cases and a minimum of 60\% of eligible patients will result in the quality measure being scored based on performance. The measure will receive between 3-10 points (unless the measure is topped-out and capped at 7 points).
What should I do to avoid the penalty if I have an EHR?
Options with an EHR

• Having an EHR allows more flexibility, although you can still report quality measures using claims if you are in a small practice

• Other benefits:
  – You can report PI category to earn points
  – You can submit quality measures directly from your EHR or use a registry or QCDR to earn a 1 point additional bonus point per measure for “end-to-end reporting”
EHR: PI Reweighted and Quality Submitted Electronically

- Report 3 quality measures (without meeting the 20 case minimum or 60% data completeness requirements)

- In this example, a PI Hardship Exception application was approved and quality measures were submitted electronically via EHR, registry, or QCDR

\[
\text{CQM 1} + \text{CQM 2} + \text{CQM 3} + \text{Small practice bonus} + \text{End-to-End reporting bonus} = 18 \text{ quality points}
\]

\[
(3 \text{ pts}) + (3 \text{ pts}) + (3 \text{ pts}) + (6 \text{ pts}) + (3 \text{ pts})
\]

\[
18/60 \text{ quality points} = 30 \text{ points} \times 0.70 \text{ (category weight 70%)} = 21 \text{ MIPS points}
\]

\[
21 \text{ points (Quality category)} + 15 \text{ points (IA category)} = 36 \text{ MIPS score}
\]

**NOTE:** Reporting a measure with a benchmark and a minimum of 20 cases and a minimum of 60% of eligible patients will result in the quality measure being scored based on performance. The measure will receive between 3-10 points (unless the measure is topped-out and capped at 7 points).
Reporting PI Data with One Other Category

• To receive 15 MIPS points for the PI category, a minimum of 60 PI performance points must be earned
  – If PI data is reported only with the Quality category, five quality measures must be reported by a small practice
  – If PI data is reported only with the IA category, full credit must be earned in the IA category

• NOTE: If the PI category is reported with the IA and Quality categories, fewer PI points will be needed, based on the scores of the IA and Quality categories
More Tips on How to Avoid the Penalty

• For more tips on what you can do to earn 30 points and avoid the 7% penalty, download the Quality Insights’ resource, How to Avoid the 7% MIPS Penalty in 2019.
Is there anyway to save time selecting measures and activities?
Aligned Measures and Activities

• Some ‘topics’ cross-over MIPS categories
• Selecting one of these topics should save time and help you earn MIPS points more efficiently
• Examples of cross-over topics:
  – Opioids
  – Antibiotic stewardship
  – Vaccinations
  – Diabetes
  – Behavioral Health
  – Care coordination and health information exchange
# Opioid Related Measures and Activities

<table>
<thead>
<tr>
<th>Topic</th>
<th>Quality Category</th>
<th>IA Category</th>
<th>PI Category</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Opioid Crisis</strong></td>
<td>Opioid therapy follow-up evaluation</td>
<td>Consultation of the PDMP</td>
<td>e-Prescribing</td>
</tr>
<tr>
<td></td>
<td>Documentation of signed opioid treatment agreement</td>
<td>CDC Training on CDC’s Guideline for Prescribing Opioids for Chronic Pain</td>
<td>Query of the PDMP</td>
</tr>
<tr>
<td></td>
<td>Evaluation or interview for risk of opioid misuse</td>
<td>Use of CDC Guideline for Clinical Decision Support to Prescribe Opioids for Chronic Pain via Clinical Decision Support</td>
<td>Verify opioid treatment agreement</td>
</tr>
<tr>
<td></td>
<td>Continuity of pharmacotherapy for opioid use disorder</td>
<td>Completion of training and receipt of approved waiver for provision opioid medication-assisted treatments</td>
<td></td>
</tr>
</tbody>
</table>
# Antibiotic Stewardship and Vaccinations

<table>
<thead>
<tr>
<th>Topic</th>
<th>Quality Category</th>
<th>IA Category</th>
<th>PI Category</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antibiotic Stewardship</strong></td>
<td>Adult sinusitis: antibiotic prescribed for acute sinusitis</td>
<td>Implementation of antibiotic stewardship program</td>
<td>ePrescribing</td>
</tr>
<tr>
<td></td>
<td>Adult sinusitis: appropriate choice of antibiotic: amoxicillin, with or without calvulante prescribed for patients with acute bacterial sinusitis</td>
<td>Completion of CDC Training on Antibiotic Stewardship</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Avoidance of antibiotic treatment in adults with acute bronchitis</td>
<td>Implementation of medication management practice improvements</td>
<td></td>
</tr>
<tr>
<td><strong>Vaccinations</strong></td>
<td>Preventive Care and Screening: Influenza Immunization</td>
<td>Chronic care and preventative care management for empaneled patients</td>
<td>Immunization registry reporting</td>
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</table>
Thank You

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