



# Quality Payment Program- MACRA Helpful Hints for Program Year 2018 Reporting

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# Quality Payment Program Objectives



At the end of this session participants should be able to:

1. Understand 2018 Performance categories, weighting and scoring
2. Discuss results from 2017 Reporting Data Call
  - Identify top three challenges with reporting
  - Identify how many eligible clinicians will be able to report for 2018
3. Apply Ideas and helpful hints for reporting
  - Identify and analyze a quality measure for reporting
4. Identify what is needed to get ready for 2018 QPP reporting
  - Utilizing the Reporting Tools
  - Identifying available Resources



# The Quality Payment Program (QPP)

OVERVIEW YEAR 2 (CY2018) & YEAR 3 (CY2019)

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IHS DATA CALL RESULTS (CY2017)

# Origin of the Quality Payment Program (QPP)



- Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
- Bipartisan Legislation
- **Repeals** the Sustainable Growth Rate (SGR) Formula
- Increases focus on quality of care and value of care delivered
- Moving toward patient-centric healthcare system
  - Delivers better care
  - Smarter spending
  - Healthier People
- **Offers two tracks of participation**

# Year 3 (2019) Final Rule



On July 12, 2018, the CMS released its proposed rule for Year 3 (2019) of the Quality Payment Program [Notice of Proposed Rulemaking \(NPRM\)](#).

On November 1, 2018, the CMS released its final rule for Year 3 (2019) of the Quality Payment Program [2019 QPP Final Rule](#).

# Quality Payment Program Aims



## Considerations

Improve beneficiary outcomes

Reduce burden on clinicians

Increase adoption of  
Advanced APMs

Maximize participation

Improve data and  
information sharing

Ensure operational excellence  
in program implementation

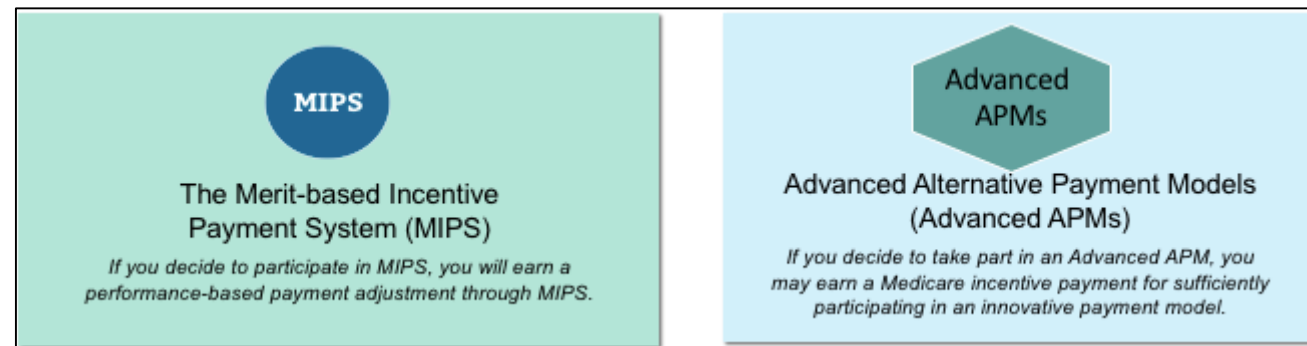
Deliver IT systems capabilities that  
meet the needs of users

# Quality Payment Program: Two Participation Tracks



Healthcare providers can take part in CMS's quality programs in one of two ways:

1. Merit-Based Incentive Payment System (MIPS)
2. Advanced Alternative Payment Models (**Advanced** APMs)







# Merit-Based Incentive Payment system (MIPs)

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## OVERVIEW

# MIPS Bipartisan Budget Act of 2018



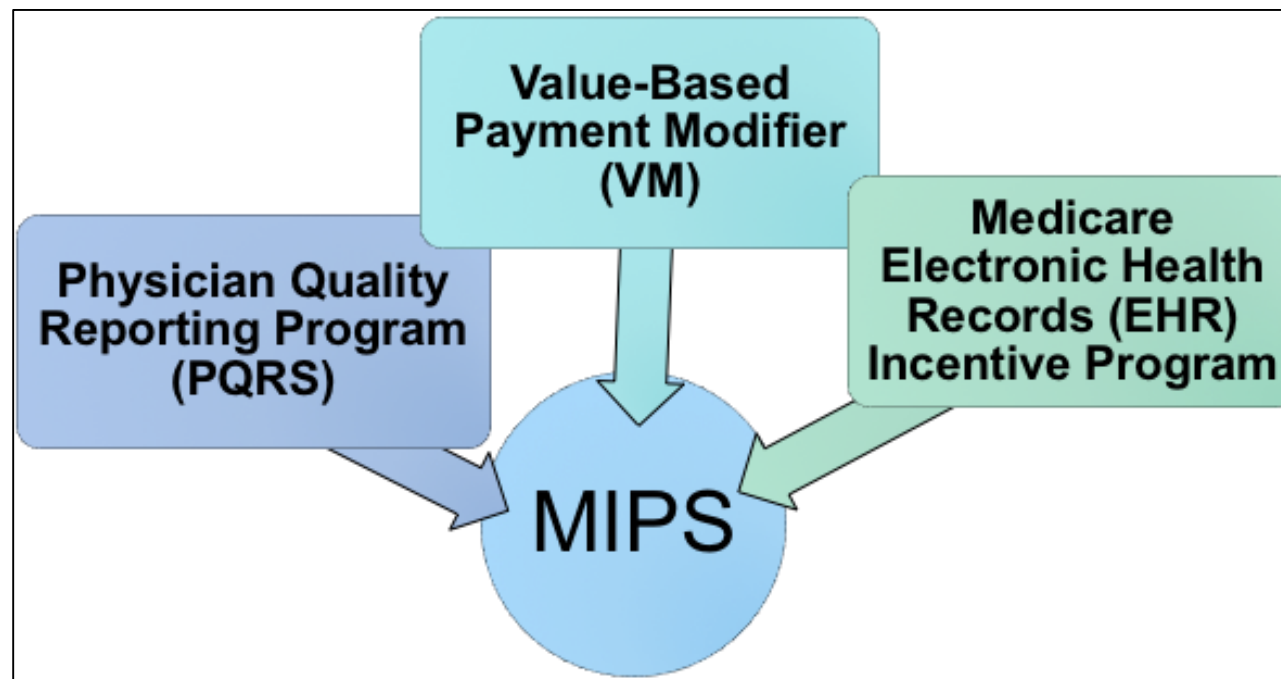
Provides additional authority to continue the gradual transition in MIPS, including:

- Changing the application of MIPS payment adjustments, so adjustments will *not* apply to all items and services under Medicare Part B, but will now apply only to covered professional services under the Physician Fee Schedule (PFS) beginning in 2019, which is the first payment year for MIPS.
- Changing the way MIPS eligibility is determined with respect to low-volume threshold. Beginning in 2018 (current performance period), low-volume threshold determinations are based on allowed charges for covered professional services under the PFS, *not* all Medicare Part B allowed charges.
- Providing flexibility in the weighting of the Cost performance category for three additional years.
- Allowing flexibility in establishing the performance threshold for three additional years to ensure gradual and incremental transition to the estimated performance threshold based on the mean or median of final scores from prior year that will apply in 6th year of program.

# What Is MIPS?



- The Quality Payment Program/MACRA Streamlines multiple quality and value reporting programs (legacy programs) for Medicare clinicians into a single, improved reporting program called MIPS



# Clinician Impact



Which clinicians does The Quality Payment Program affect? Will it affect me?

Short answer: Quality Payment Program affects clinicians who participate in Medicare Part B.



# MIPS Eligible Clinician Types



Year 2 (2018 ) eligible clinicians include:

- Physicians
  - Doctors of Medicine
  - Doctors of Osteopathy
- Dentists
- Optometrists
- Chiropractors
- Podiatrists
- Physician assistants
- Nurse practitioners
- Clinical nurse specialists
- Certified registered nurse anesthetists

**\*\*Final Rule Year 3 (2019)\*\*** Expanding the definition of MIPS eligible clinicians to include the same clinician types from Year 2 AND six new clinician types:

- Physical therapist
- Occupational therapist
- Qualified speech-language pathologist
- Qualified audiologist
- Clinical psychologist
- Registered dietitian or nutrition professionals

# MIPS Year 3 (2019) Final Rule : Low-Volume Threshold Determination



The low-volume threshold includes MIPS eligible clinicians billing more than \$90,000 a year in allowed charges for covered professional services under the Medicare Physician Fee Schedule AND furnishing covered professional services to more than 200 Medicare Part B enrolled beneficiaries a year AND providing more than 200 covered professional services under the PFS. To be included, a clinician must exceed all three criterion.



**Note:** For MIPS APMs participants, the low-volume threshold determination will continue to be calculated at the APM Entity level.

# MIPS Year 3 (2019) Final Rule: Opt-in Policy



**Starting in Year 3**, clinicians or groups can opt-in to MIPS, if they meet or exceed at least one, but not all three, of the low-volume threshold criteria.

- A virtual group election in Year 3 is considered a low-volume threshold opt-in for any prospective member of the virtual group (solo practitioner or group) that exceeds at least one, but not all of the low-volume threshold criteria .

## MIPS Opt-in Scenarios

| Dollars | Beneficiaries | Professional Services (New) | Eligible for Opt-in?                                 |
|---------|---------------|-----------------------------|--|
| ≤ 90K   | ≤ 200         | ≤ 200                       | No – excluded  |
| ≤ 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                         |

# MIPS Year 3 (2019) Final Rule: MIPS Determination Period



## Year 2 (2018) Final

### Low Volume Threshold Determination Period:

- First 12-month segment: Sept. 1, 2016-Aug. 31, 2017 (including 30-day claims run out)
- Second 12-month segment: Sept. 1, 2017 to Aug. 31, 2018 (including a 30-day claims run out)
- 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

### Creation of a unified MIPS Determination Period:

- First 12-month segment: Oct. 1, 2017-Sept. 30, 2018 (including a 30-day claims run out)
- Second 12-month segment: Oct. 1, 2018-Sept. 30, 2019 (does not include a 30-day claims run out)
- Goal: consolidate the multiple timeframes and align the determination period (12 month segments) with the fiscal year.
- Goal: streamlined period will also identify MIPS eligible clinicians with the following special status:
- Low-volume threshold
  - Non-Patient Facing
  - Small Practice
  - Hospital-based
  - ASC-based

Note: Rural and HPSA status continue to apply in 2019

**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.

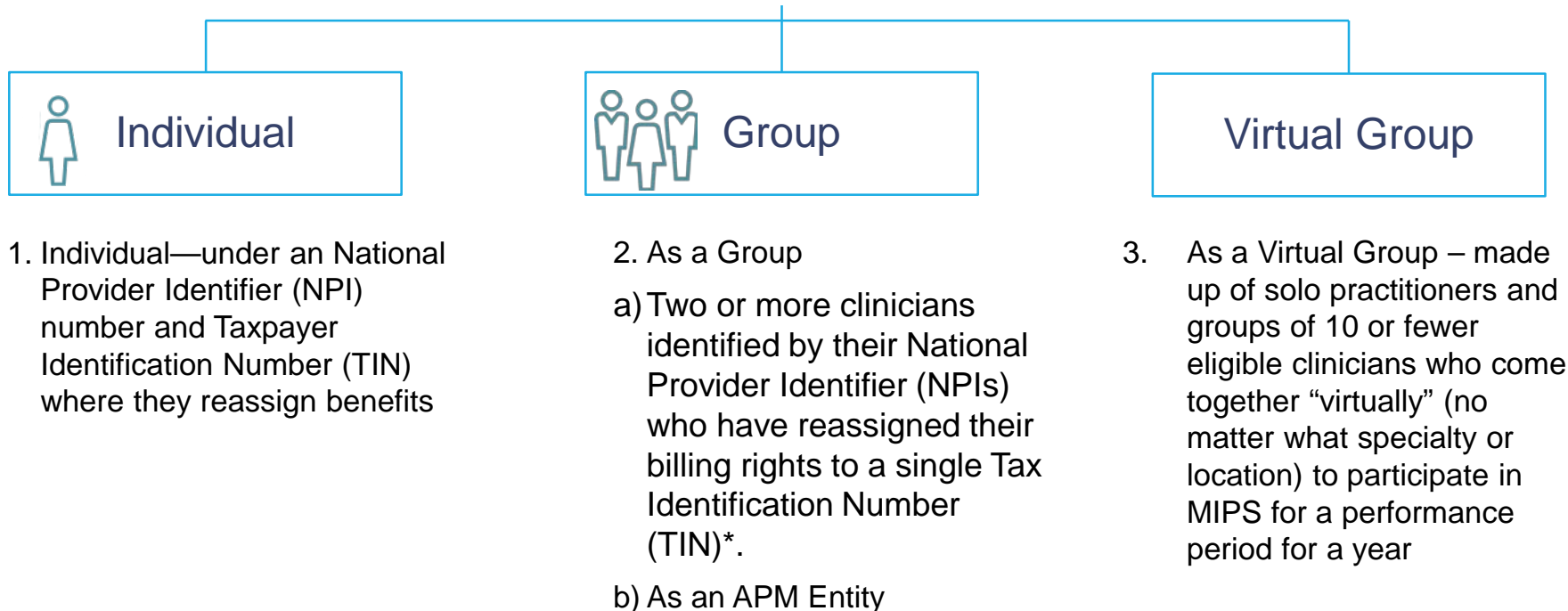


# MIPS Reporting Options

## Year 2 (2018) & Year 3 (2019) Final Rule



### OPTIONS



\* If clinicians participate as a group, they are assessed as a group across all 4 MIPS performance categories. The same is true for clinicians participating as a Virtual Group.

# Who Is Exempt? MIPS Year 2 (2018)



## 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

- Medicare Part B allowed charges less than or equal to \$90,000 a year OR See 200 or fewer Medicare Part B patients a year

## Significantly participating in Advanced APMs

- Receive 25% of their Medicare payments OR See 20% of Medicare patients through an Advanced APM

# Who Is Exempt? MIPS Year 3 (2019)



No change in Basic-Exemption Criteria—only change to low-volume threshold

## 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

- To be excluded from MIPS, clinicians or groups need to meet **one or more** of the following three criterion:
  1. Have ≤ \$90K in Part B allowed charges for covered professional services;
  2. Provide care to ≤ 200 Part B-enrolled beneficiaries; **OR**
  3. **Provide ≤ 200 covered professional services under the Physician Fee Schedule (PFS)**

## Significantly participating in Advanced APMs

- Receive 25% of their Medicare payments **OR** See 20% of Medicare patients through an Advanced APM

# Submission Methods: Year 2 (2018)



| Performance Category       | Submission Mechanisms for Individuals             | Submission Mechanisms for Groups (Including Virtual Groups)                                  |
|----------------------------|---|--|
| Quality                    | QCDR<br>Qualified Registry<br>EHR<br>Claims       | QCDR<br>Qualified Registry<br>EHR<br>CMS Web Interface (groups of 25 or more)                |
| Cost                       | Administrative claims<br>(no submission required) | Administrative claims (no submission required)   |
| Improvement Activities     | Attestation<br>QCDR<br>Qualified Registry<br>EHR  | Attestation<br>QCDR<br>Qualified Registry<br>EHR<br>CMS Web Interface (groups of 25 or more) |
| Promoting Interoperability | Attestation<br>QCDR<br>Qualified Registry<br>EHR  | Attestation<br>QCDR<br>Qualified Registry<br>EHR<br>CMS Web Interface (groups of 25 or more) |



# The Quality Payment Program (QPP)

2017 REPORTING DATA CALL

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# 2017: QPP Data Call Responses Measure Reporting Challenges



## Top three challenges

1. Data Extraction
2. Staffing Limitations
3. Other

| Measure Reporting Challenges |                 |                  |                     |                      |                   |  |       |
|------------------------------|-----------------|------------------|---------------------|----------------------|-------------------|--|-------|
| Data Extraction              | Data Submission | Using Web Portal | RPMS Infrastructure | Staffing Limitations | Knowledge Deficit | Difficulty in Meeting Performance Measures | Other |
| 16                           | 3               | 0                | 10                  | 14                   | 8                 | 7  | 11    |

Note: Includes tribal data for some areas. No Data to report for Alaska, Nashville and Tucson Areas

# 2018 QPP Eligibility



1. How many Clinicians are 2018 eligible: Merit Based Incentive Payment System (MIPS)
2. Are the Groups 2018 Eligible

| Area  | Name of Facility | Are the Groups 2018 Eligible | How Many Clinicians are 2018 Eligible |
|-------|------------------|------------------------------|---------------------------------------|
| Total |                  | 16                           | 537                                   |



# QPP – MIPS Eligibility

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Sarah Leake MBA, Health IT and Quality Consultant



# Participation Status



The screenshot shows the 'Quality Payment PROGRAM' website. At the top right, there are navigation links: 'MIPS Merit-based Incentive Payment System', 'APMs Alternative Payment Models', 'About The Quality Payment Program', and 'Sign In Manage Account and Register'. A blue arrow labeled '2' points to the 'Sign In' link. On the left, a teal box titled 'PERFORMANCE YEAR 2019 Eligibility Data Available' contains a button labeled 'Check Participation Status', which is pointed to by a blue arrow labeled '1'. Below this, there is a section for 'PERFORMANCE YEAR 2018' with submission window information. The main content area is titled 'QPP Participation Status' and includes instructions to enter a 10-digit NPI number to view participation status by performance year (PY). It also states that QPP Participation Status includes APM Participation as well as MIPS Participation. At the bottom of this section, there is a form with an 'NPI Number' input field and a 'Check All Years' button with a right-pointing arrow. A footer note states: 'Please note that the QPP Participation Status Tool is only a technical resource and is not dispositive of any eligible clinician's, group's, or organization's status under QPP. For more information, please refer to the Quality Payment Program regulations at 42 C.F.R. part 414 subpart O.'

Source: <https://qpp.cms.gov/>

# Login for Eligibility Screen



A screenshot of the Quality Payment Program web application. The page title is "Quality Payment PROGRAM". In the top right, there are navigation links for "MIPS" (Merit-based Incentive Payment System), "APMs" (Alternative Payment Models), "About" (The Quality Payment Program), and "My Account". A dropdown menu for "Select Performance year (PY)" is set to "2018". On the left, a dark sidebar contains navigation items: "Home", "Eligibility &amp; Reporting" (highlighted with a blue arrow), "Performance Feedback", "Physician Compare Preview", "Manage Access", and "Help and Support". The main content area has a teal header with "Eligibility" and "Performance Year [PY] 2018". Below this, the heading is "Review Practice-Level PY 2018 Eligibility", followed by instructions: "Confirm eligibility status of your practice(s) for PY 2018. You can view eligibility for all clinicians within each practice for PY 2018." At the bottom, it shows "PRACTICES (2)" and a "Download" button.

# Clinician Eligibility Screen



The screenshot shows a web application interface for 'Eligibility &amp; Reporting'. At the top right, there is a dropdown menu for 'Select Performance year (PY)' set to '2018'. The main heading is 'Clinician Eligibility' with a subtitle 'U S HEALTH DEPT OF HEALTH &amp; HUMAN SERVICES | Performance Year (PY) 2018'. Below this, it says 'CONNECTED CLINICIANS (150)'. A paragraph explains that the list contains all clinicians who submitted claims data to CMS for Performance Year 2018. There is a search box labeled 'Search by last name' with a magnifying glass icon. At the bottom left of the main content area, it says '150 Clinicians' followed by a 'Download' button with a dropdown arrow, which is highlighted with a red box. A 'COLLAPSE' button is visible in the bottom left corner of the sidebar.

Download list of clinicians so easy to sort and search for eligibility.

# How will Reporting affect Payment



- Clinicians can choose to submit data for each TIN that they are affiliated.
- Highest score will be assigned to the Eligible Clinician.
- The Payment Adjustment is “carried with you”
- Payment adjustment is for the second year following the reporting year.
  - 2018 Reporting → 2020 Adjustment to Medicare Part B Payments



# Closer Look at MIPS Categories:





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## QUALITY PAYMENT PROGRAM

# 2018 MIPS Performance Categories



## Year 2 (2018) Final

| Performance Category   | Minimum Performance Period |
|--|----------------------------|
| Quality   | 12 months                  |
| Cost    | 12 months                  |
| Improvement Activities                                     | 90 days                    |
| Advancing Care Information<br>Promoting Interoperability  | 90 days                    |

| Performance Category  | Performance Category Weight |
|---|-----------------------------|
| <br>Quality                      | 50%                         |
| <br>Cost                         | 10%                         |
| <br>Improvement Activities       | 15%                         |
| <br>Promoting Interoperability | 25%                         |

# MIPS Years 1, 2 and 3: Performance Threshold and Payment Adjustment



## *Change: Increase in Performance Threshold and Payment Adjustment*

### Transition Year 1 (2017) Final

- 3 point threshold
- Exceptional performer set at 70 points
- Payment adjustment set at +/- 4%



### Year 2 (2018) Final

- 15 point threshold
- Exceptional performer set at 70 points
- Payment adjustment set at +/- 5%

### Year 3 (2019) Final

- The Final 30 points threshold
- Exceptional performance bonus set at 75 points
- Payment adjustment could be set at +/- 7%\*

\* A positive payment adjustment generally can be up to 7% (but then the upward payment adjustment factor is multiplied by a scaling factor to achieve budget neutrality, which could result in an adjustment above or below 7%).



# Improvement Activity Category

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# Tips for 2018 Improvement Activity



- 110 + Improvement Activities to select from
- 90 Day minimum Period
  - *If you're in a group or virtual group, you can attest to an Improvement Activity as long as one clinician in your group or virtual group participated in the activity for at least 90 continuous days during the performance period.*
- Improvement Activity Alignment
  - Consider Projects and Activities you were participating in for 2018 - QAPI program, IPC, PCMH, PDSA's
  - Does the IA support the Quality Measures chosen?
  - Is the IA eligible for the PI Performance Category Bonus
    - CEHRT Functionality used in Improvement Activity
    - 29 IA's are CEHRT Identified
    - Appendix B of the 2018 PI fact sheet outlines IA's eligible for the PI performance category bonus

# Improvement Activity Resources



## Full Resource Library

Search  - Hide filters

Performance Year: 2018 | OPP Reporting Track: MIPS | Performance Category: Improvement Acti | Resource Type: All

[Clear all filters](#)

Alphabetical | Latest

3 Resources

↓ 2018 Improvement Activities 101 Guide Updated 11/21/2018  
PDF 3MB | PY 2018 | MIPS | Improvement Activities | Technical Guides and User Guides  
Guide detailing how to participate in the Improvement Activities performance category of MIPS in 2018.

↓ 2018 Improvement Activities Performance Category Fact Sheet Created 05/24/2018  
PDF 571KB | PY 2018 | MIPS | Improvement Activities | Fact Sheets  
Provides an overview of the 2018 Improvement Activities performance category

- QPP Resource Library → search under 2018 Resources,  
<https://qpp.cms.gov/about/resource-library>
  - 2018 Improvement Activities Fact Sheet
  - 2018 List of Improvement Activities
  - Improvement Activities Requirements
- Data Validation File - Document detailing the Improvement Activities performance category data validation criteria.



# Promoting Interoperability Category

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# 2018 Promoting Interoperability (PI) Transition Measures and Scoring



| Required Measures for 50% Base Score |
|--------------------------------------|
| Security Risk Analysis               |
| e-Prescribing                        |
| Provide Patient Access*              |
| Health Information Exchange*         |

| Measures for Performance Score              | % Points  |
|---|-----------|
| Provide Patient Access*                     | Up to 20% |
| Health Information Exchange*                | Up to 20% |
| View, Download, or Transmit (VDT)           | Up to 10% |
| Patient-Specific Education                  | Up to 10% |
| Secure Messaging                            | Up to 10% |
| Medication Reconciliation                   | Up to 10% |
| One of the Public Health Reporting Measures | 0 or 10%  |

| Requirements for Bonus Score  | % Points |
|---|----------|
| <p>*Report to 1 or more of the following public health reporting registries not reported for the performance score:</p> <ul style="list-style-type: none"> <li>Immunization Registry Reporting</li> <li>Syndromic Surveillance Reporting</li> <li>Specialized Registry Reporting</li> </ul> | 5%       |
| Report certain Improvement Activities using CEHRT   | 10%      |



Source: <https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Promoting-Interoperability-Fact-Sheet.pdf>

# Considerations for PI Reporting



- 90 day reporting Period in calendar year 2018
- “At Least One” for the View/Download/Transmit and Secure Message Measures
- Group Reporting – Add all MU Performance Measures for Clinicians under Group TIN
- Choose one of 29 the Improvement Activities eligible for the PI Performance Category Bonus (use of EHR)



# Cost Category

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Carol Smith RN, MS, Great Plains Area Promoting Interoperability (MU) Consultant

# Cost Measures



## Two Cost Measures Measured

- Total Per Capita Cost measure, measures of all Medicare Part A and Part B costs during the MIPS performance period.
- Medicare Spending Per Beneficiary measure determines what Medicare pays for services performed by an individual clinician during an MSPB episode: the period immediately before, during, and after a patient's hospital stay.

## Cost Calculations Based on Attributed Patients

- TPCC measure information form (MIF) contains a list of the primary care Evaluation & Management codes used to attribute beneficiaries to TIN-NPIs for this measure.

*CMS uses Medicare claims data to calculate cost measure performance which means clinicians do not have to submit any data for this performance category. Cost Performance Category fact sheet: <https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Cost-Performance-Category-Fact-Sheet.pdf>*



# Quality Category

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Elvira Mosely RN, MSHS, Phoenix Area CAC



# Quality Measure Reporting



- 284 Quality Measures through various submission methods
- Submit at least six (6) measures for the 12-month performance period
  - RPMS / EHR Submission Method through QPP Portal
  - Registry
- IHS RPMS eCQM Reporting
  - 13 eCQMs developed for Eligible Clinicians
  - December 2018: Training for eCQM Data Extraction
  - January – February 2019: Training for eCQM Measure Reporting (recording available)
  - January 2 – April 2, 2019: Submission period for MIPS Quality Measure
- Web Interface is more than 25 clinicians and 15 required measures

# IHS Update: eCQM for 2018 Reporting Eligible Clinicians(EC)



| Version     | Pediatric Measures  |
|-------------|---|
| CMS2v7      | Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan (Pediatric)   |
| CMS117v6    | Childhood Immunization Status   |
| CMS155v6    | Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents |
|             | <b>Diabetes Measures</b>  |
| CMS122v6    | Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)  |
| CMS131v6    | Diabetes: Eye Exam  |
| CMS134v6    | Diabetes: Medical Attention for Nephropathy   |
| CMS165v6    | Controlling High Blood Pressure   |
|             | <b>Other Adult Measures</b>   |
| CMS2v7      | Preventive Care and Screening: Screening for Depression and Follow-Up Plan (Adult)                |
| CMS69v VTE: | Venous Thromboembolism Patients with Anticoagulation Overlap Therapy                              |
| CMS127v6 *  | Pneumococcal Vaccination Status for Older Adults  |
| CMS138v6    | Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention                  |
| CMS139v6 *  | Falls: Screening for Future Fall Risk   |
| CMS156v6    | Use of High-Risk Medications in the Elderly   |

Note: \* New measure added for 2018 Reporting Period

***Consider measures that will benefit across Programs – MIPS, Comprehensive Primary Care Plus (CPC+), Patient Centered Medical Home (PCMH), Improving Patient Care (IPC), and Government Performance & Results Act of 1993 (GPRA)***



# Analysis of a Clinical Quality Measure

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# Falls: Screening for Future Fall Risk CMS139v6 - Quality



|                                    |   |
|------------------------------------|---|
| <b>Initial Patient Population:</b> | Patients aged 65 years and older with a visit during the measurement period   |
| <b>Numerator:</b>                  | Patients who were screened for future fall risk at least once within the measurement period<br><i>Exclusions: Not Applicable</i>  |
| <b>Denominator:</b>                | Equals Initial Population<br><i>Exceptions: None Exclusions: Exclude patients whose hospice care overlaps the measurement period.</i><br><i>Exclude patients who were non-ambulatory at some point in the measurement period.</i> |

# Selection Criteria - Denominator



Any patient aged 65 y/o or older during the measurement period

**Patient Selection**

**Patient Lists**

- No Default
- Providers
- Teams
- Specialties
- Clinics
- Wards
- Personal Lists
- All

**Patients**

- Demo,Alice Janene
- Demo,Alice Janene**
- Demo,Barbara
- Demo,Burris
- Demo,Carol
- Demo,Father
- Demo,Infant
- Demo,Israel

**Demographics**

**Demo,Alice Janene**

HRN: 109629  
Female, age: 66

DOB: 30-Nov-1952

# Exclusions – Patients in Hospice Care during the measurement Period



IPL | Family Hx | Patient Hx | Asthma | Pt Goals | Anticoag | Eye/lass | AML | Stroke

Integrated Problem List | Expand All

Core Problems | Chronic | Personal Hx | Episodic | Routine / Admin | Inactive

- Recorded By: USER,BSTUDENT RN  
 - Last Modified: DEC 11, 2018@08:59:38  
 - Modified User: USER,BSTUDENT RN  
 - Concept CT: 385765002

| Status  | Onset Date | Priority | Provider Narrative   | Comments   | Freq | PHx | PIP | IP | POV | ICD     |
|---------|------------|----------|--|--|------|-----|-----|----|-----|---------|
| Chronic |            |          | Atrial fibrillation  |  | 0    |     |     |    |     | I48.91  |
| Chronic | 03/08/2007 |          | *Diabetes Mellitus Without Mention Of Complication, Type II Or Unspecified Type, |  | 0    |     |     |    |     | 250.00  |
| Chronic | 03/08/2007 |          | *hypertension with neuropathy  |  | 0    |     |     |    |     | .9999   |
| Chronic |            |          | Hospice care management  | Patient has terminal breast cancer and is managed by Hospice of the Valley : | 0    |     |     |    |     | ZZZ.999 |

Intervention

Intervention, Performed: Hospice care ambulatory

(2016-09) [Hospice care ambulatory](#)  
 2.16.840.1.113762.1.4.1108.15 (Version: eCQM Update 2017-05-05)  
 SNOMEDCT [385763009](#), [385765002](#)  
 (2016-09)

**385765002 (SNOMEDCT, 2016-09)**  
 Hospice care management (procedure)

# Exclusions – Patient Non-Ambulatory



|         |  |                  |
|---------|--|------------------|
| Chronic |  | Wheelchair bound |
| Chronic |  | Unable to walk   |
| Chronic |  | Bed-ridden       |

**Problem Details**

PROBLEM DATA

ID: 27

Problem: Bed-ridden |

# Edited: 03/07/2019 by: USER,BSTUDENT RN

- Mapped ICD: Z74.01

# Edited: 03/07/2019 by: USER,BSTUDENT RN

- Status: CHRONIC

# Edited: 03/07/2019 by: USER,BSTUDENT RN

- Date of Onset: UNKNOWN

- Date Entered: MAR 07, 2019

- Recorded By: USER,BSTUDENT RN

- Last Modified: MAR 07, 2019@13:03:39

- Modified User: USER,BSTUDENT RN

Concept CT: 160685001

# Edited: 03/07/2019 by: USER,BSTUDENT RN



|            |  |   |
|------------|--|---|
| Assessment | Assessment, Performed:<br>Patient not ambulatory | <b>Patient not ambulatory</b><br>2.16.840.1.113883.3.464.1003.118.12.1009 (Version: eCQM Update 2017-05-05)   |
|            |  | SNOMEDCT <a href="#">160684002</a> , <a href="#">160685001</a> , <a href="#">165243005</a> , <a href="#">165244004</a> , <a href="#">225612007</a> , <a href="#">282145008</a> , <a href="#">282147000</a> , <a href="#">282204009</a> , <a href="#">282206006</a> , <a href="#">413121008</a><br>(2016-09) |

**160685001 (SNOMEDCT, 2016-09)**

Bed-ridden (finding)

# Fall Risk Assessment - Numerator



**Document an Exam**

Exam: FALL RISK

Result: NORMAL/NEGATIVE

Comment:

Provider: USER,BSTUDENT RN

Current  
 Historical  
 Not Done

Add

Cancel

```

----- V EXAM -----
EXAM: FALL RISK                PATIENT NAME: DEMO,ALICE JANENE
VISIT: DEC 10, 2018@13:58      RESULT: NORMAL/NEGATIVE
EVENT DATE AND TIME: DEC 11, 2018@09:19:41
ENCOUNTER PROVIDER: USER,BSTUDENT RN DATE/TIME ENTERED: DEC 11, 2018@09:19:41
ENTERED BY: USER,BSTUDENT RN
DATE/TIME LAST MODIFIED: DEC 11, 2018@09:19:41
LAST MODIFIED BY: USER,BSTUDENT RN
SNOMED CT: 408589008
SNOMED PREFERRED TERM (c): Falls assessment
EXAM CODE (c): 37
    
```

|            |   |   |
|------------|---|---|
| Assessment | Assessment, Performed:<br>Falls Screening | <a href="#">Falls Screening</a><br>2.16.840.1.113883.3.464.1003.118.12.1028 (Version: eCQM Update 2017-05-05)                             |
|            |   | LOINC <u>52552-7, 57254-5, 73830-2</u><br>(2.56)  |
|            |   | SNOMEDCT <u>401196007, 408422004, 408423009, 408589008, 414191008, 426938003, 427206005, 443731004, 445990009, 711054005</u><br>(2016-09) |

**408589008 (SNOMEDCT, 2016-09)**

Falls assessment (procedure)



# Training Repository Link



Link to video repository :

[https://ihscqpub.cosocloud.com/content/connect/c1/7/en/events/event/shared/1812032102/event\\_landing.html?sco-id=1812096787& charset =utf-8](https://ihscqpub.cosocloud.com/content/connect/c1/7/en/events/event/shared/1812032102/event_landing.html?sco-id=1812096787& charset =utf-8)

**OIT Training**

- Vista Imaging
  - Clinical Capture and Updates ★ [Open](#)
- Women's Health
  - Office Hours1 [Open](#)
  - Office Hours2 [Open](#)
- Data Entry & Management, Reports and Mea:
  - Clinical Quality Measures
    - EH Measures [Open](#)
    - Reporting Tool [Open](#)
    - EP Measures [Open](#)
    - Patch 2 [Open](#)
    - Patch 2 Batch Extract [Open](#)
    - Patient Extract Module [Open](#)
    - QRDA1 Extract [Open](#)
    - eCQM Overview ★ [Review](#)
    - Hearing Screen prior to Hospital Discharge ★ [Open](#)
    - Primary PCI Received Within 90 Minutes o ★ [Open](#)
    - Preventive Care and Screening\_ Screenin ★ [Open](#)
    - Childhood Immunization Status ★ [Open](#)
    - Pneumococcal Vaccination Status for Olde ★ [Open](#)
    - Screening for Future Fall Risk ★ [Open](#)
    - Assessed for Rehabilitation ★ [Open](#)
    - Median time from ED Arrival to Departure I ★ [Open](#)
    - Diabetes Eye Exam ★ [Open](#)
    - Home Management Plan of Care (HPMC) ★ [Open](#)

**OIT Training**

Name: OIT Training

Summary: To view available recordings first click the arrow next to OIT Training. Yo

Open Date 04/21/2017 8:30 AM

Close Date

Status In Progress

Cumulative Score 0/0

Certificate

Completion Requirements

- ★ Electronic Health Record
- ★ Health Information Management
- ★ Practice Management
- ★ RPMS General
- ★ RPMS Network

Next Suggested Item [IHS EDR Webinar Dentrix Interface Update](#)

# QRDA Files



- QRDA stands for Quality Reporting Document Architecture
- This is the data submission standard used for a variety of quality measurement and reporting initiatives.
- QRDA creates a standard method to report quality measure results in a structured, consistent format and can be used to exchange eCQM data between systems.

Reference: <https://ecqi.healthit.gov/qrda-quality-reporting-document-architecture>

# QRDA CAT I Files



QRDA CAT I stands for Quality Reporting Document Architecture Category I

- It is an individual-patient-level report.
- Contains quality data for one patient for one or more eCQMs.
- Export files are created in the \*BQRE application
- Used by eligible hospitals or critical access hospitals to submit to CMS programs

Reference: <https://ecqi.healthit.gov/qrda-quality-reporting-document-architecture>

# QRDA CAT III Files

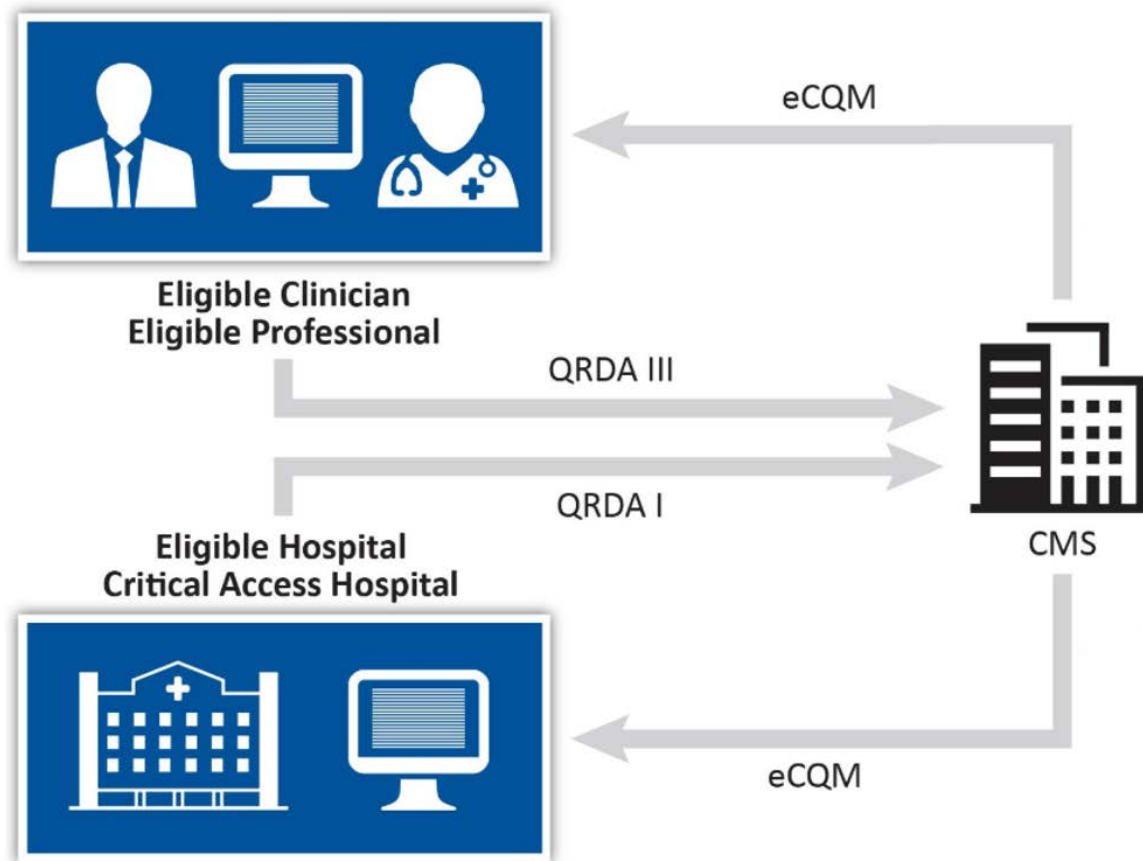


QRDA CAT III stands for Quality Reporting Document Architecture Category III

- It is an aggregate quality report.
- Contains quality data for a set of patients for one or more eCQMs
- Files are created in the ECQM application
- Used by eligible professionals or clinicians to submit to CMS programs
- RPMS ECQM CMS Program options: MIPS\_INDIV or MIPS\_GROUP

Reference: <https://ecqi.healthit.gov/qrda-quality-reporting-document-architecture>

# QRDA CAT I and III Files



Reference: <https://ecqi.healthit.gov/qrda-quality-reporting-document-architecture>



# HCQIS Access Roles and Profile System (HARP): Access for Quality Payment Program Reporting

Carol Smith RN, MS, Great Plains Area Promoting Interoperability (MU) Consultant

# Quality Payment Program Portal



The screenshot shows the Quality Payment Program Portal. At the top, there are navigation links for MIPS, APMs, About, and Sign In. The 'Sign In' link is circled in red. Below this, there is a 'New QPP Resource Library' section with a 'Resource Library' button. The main content area is titled 'QPP Account' and features a 'SIGN IN' button and a 'REGISTER' button. A red arrow points from the circled 'Sign In' link to the 'SIGN IN' button. Below the buttons, there is a 'Sign in to QPP' section with input fields for 'USER ID' and 'PASSWORD', a 'Show password' checkbox, and a link for 'Forgot your user id or password? Recover ID or reset password'.

Been there  
before?

Use your  
credentials set  
up on the  
EIDM system.

# Quality Payment Program Portal: New User



Quality Payment PROGRAM

MIPS ▼ Merit-based Incentive Payment System

APMs ▼ Alternative Payment Models

About ▼ The Quality Payment Program

**Sign In** Submit and Manage Data

## New QPP Resource Library

Check out the redesigned QPP resource library, the one-stop shop for all QPP resources.

Resource Library >

## QPP Account

SIGN IN REGISTER

### Register for QPP

The Quality Payment Program uses the HCQIS Access Roles and Profile (HARP) system for credential management.

## What Happens Next?

You will be redirected to HARP to register. This process could take 5-15 minutes depending on how quickly your data is verified. HARP uses a third party service provided by Experian to verify your identity. This may require your social security number. [Learn more about the HARP identity proof process](#)

Register with HARP >



# HARP



- HARP (December 19, 2018 for QPP)
- [QPP User Guide](#): includes system access links in “Getting Started”
- New users:
  - Profile: Personal information including Social Security Number
  - Experian identity proofing: Financial information
  - Log in to set up two factor authentication
- User Roles:
  - Security Official (at least one from a group, may already be assigned)
  - Group Representative
  - Individual Practitioner or Representative

Profile Information Account Information Remote Proofing Confirmation

## Remote Proofing

All fields marked with an asterisk (\*) are required.

1. You may have opened a mortgage loan in or around February 2018. Please select the lender to whom you currently make your mortgage payments. If you do not have a mortgage, select 'NONE OF THE ABOVE/DOES NOT APPLY'. \*

- BANK OF AMERICA
- FLEET MORTGAGE
- BANK ONE
- WASHTENAW MTG CO
- NONE OF THE ABOVE/DOES NOT APPLY

# Account Application



- New User Registration Link
- Requires entry of *personal* information
- Choose username and password
- Security questions
- CMS uses *Experian* for external authentication service provider
- Multi-factor Authentication (MFA): Symantec Validation and Identity Protection (VIP) service using computer, phone or e-mail.

# Quality Payment Portal Account



- Check your Access
- New Users:
  - Link to an organization
  - Security Official
    - At least one per organization
    - Approves users
- Review account information, feedback reports, clinician lists, NPI and TIN information

The screenshot shows the Quality Payment Program portal account dashboard. The header includes the program name, navigation links for MIPS, APMs, and About, and a user profile icon. The main content area features a 'Welcome back' message, a progress bar with five steps (Submission Window Closes, Preliminary Performance Feedback Available, Summer 2018 Final Performance Feedback is available, Physician Compare Preview Available, January 1, 2019 2018 Submission Window Opens), and four featured sections: 'Final 2017 Performance Feedback Available', 'Review PY 2018 Eligibility', 'Review 2018 Claims Data', and '2017 Physician Compare Preview'. A left sidebar contains navigation options like Home, Eligibility & Reporting, Performance Feedback, Physician Compare Preview, Review Claims-based Submission, Manage Access, and Help and Support.



# Getting Ready to Participate

---

Susy Postal DNP, RN-BC

# 2018 MIPS Reporting Deadline



- ❑ **December 31, 2018**
  - Performance Year 2018 ends
  - Quality Payment Program Exception Applications Window Closes
- ❑ **January 2, 2019- 10:00 am EST**
  - Submission Window Opens for Performance Year 2018
- ❑ **January 22, 2019**
  - CMS Web Interface Submission Period Begins for Performance Year 2018
- ❑ **March 2, 2019**
  - MIPS Claims Data Submission deadline
- ❑ **March 22, 2019- 8:00 pm EDT**
  - CMS Web Interface Submission Window Ends for Performance Year 2018
- ❑ **April 2, 2019- 8:00 pm EDT**
  - Submission Window Closes for Performance Year 2018
  - You may submit and update your data any time while the submission window is open.

Source: <https://qpp.cms.gov/about/deadlines>

# Getting Ready to Participate in MIPS 2018



- **Confirm participants' eligibility status**
  - Use CMS website to confirm eligibility
  
- **Choose if participants are reporting as an individual or a group**  
**Choose participants' submission mechanism and verify its capabilities**
  - Some sites are engaged with a third party intermediary (e.g. Qualified Registries)
  - Attestation – CMS's Data Submission Tool
    - Obtain your Enterprise Identity Management (EIDM) credentials
    - Access Quality Payment Program portal

# Getting Ready to Participate in MIPS 2018 (2)



- **Choose measure(s) and activities**
  - Use CMS resources (website) to explore options on which measures to use
- **Follow reporting requirements (2018)**
  - Follow reporting durations for performance categories (e.g., 12 months for Quality and Cost Performance Period)
  - Verify the information needed to report successfully
- **Record data based on participants' care for patients**
- **Submit data: QPP Portal**
- **Retain Documentation for potential audit (7 years)**



# QPP Related Resources

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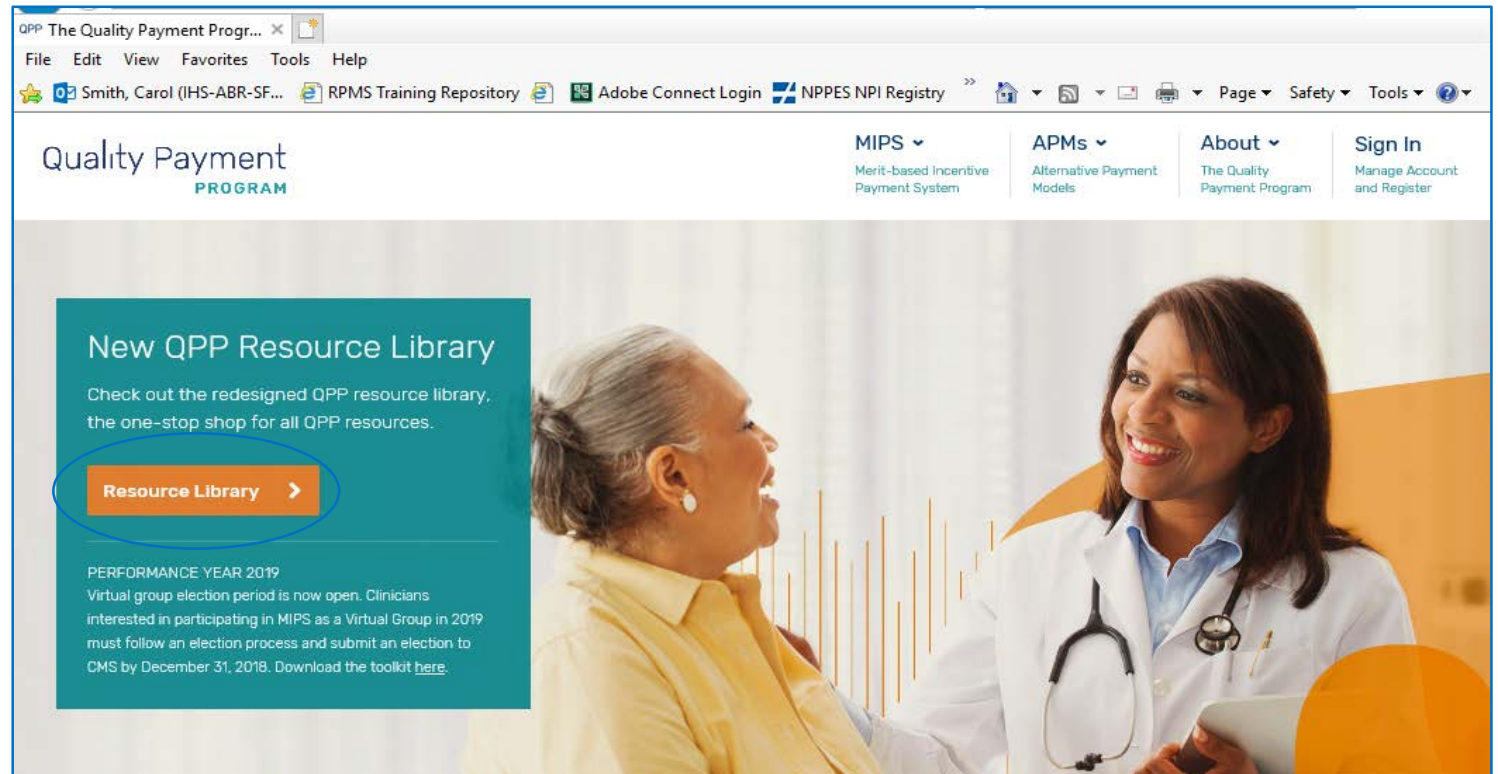


# QPP Website Resources



## Search Options

- General Resources
  - Quick Start
  - Overview
  - Scoring
- Regulatory Resources
- Keyword search
- Search by filters (year, track, category, resource type)



# CMS Medicare Learning Network



- MLN Homepage
- Publications & Multimedia
- News & Updates
- Events & Training
- Continuing Education Credits
- Provider Compliance

**Did You Know?**  
Your Medicare patients are getting their new Medicare cards and new Medicare numbers. [Learn how](#) we will mail the new Medicare cards in phases by geographic location.  
Visit the [New Medicare Card](#) website and read our [Fact Sheet](#).

**National Association Partnerships**  
National provider associations can [partner with CMS](#) to share the latest news with their members.

## The Medicare Learning Network®



Free educational materials for health care professionals. Get quick access to the information you need.

### Publications & Multimedia

- Publications
- MLN Matters Articles
- Multimedia

### News & Updates

- MLN Connects® Newsletter
- Electronic Mailing Lists
- Social Media



7 results for *mips* in Catalog

Show available content only

« < Page 1 of 1 > »

Categories

- Provider-Specific (3)

Content Type

- Online (7)

Course Provider

- CMS MLN (4)
- None (3)

Rating

★★★★★

**Quality Payment Program in 2018: MIPS APMs (September 2018) (Contact hours: 30 minutes)**  
Online  
Learn about the Quality Payment Program in 2018 Merit-based Incentive Payment System (MIPS) Alternative Payment Models (APMs), including what a MIPS APM is, how to recognize if you are a part of a MIPS APM, the benefits of the special APM scoring  
English (United States)

**Quality Payment Program: Merit-based Incentive Payment System (MIPS) Participation in 2018 (Contact hours: 42 minutes)**  
Online  
Learn about Participation in 2018 in the Quality Payment Program Merit-based Incentive Payment System (MIPS), including who is a MIPS eligible clinician and who is exempt for 2018, the difference between individual, group, and virtual group reporting, data  
English (United States)

**Quality Payment Program Merit-based Incentive Payment System (MIPS): Promoting Interoperability Performance Category Year 2 (2018) (July 2018) (Contact Hours: 64 min)** ★★★★★  
Online In Provider-Specific

# RPMS Training Repository

(filed under Data Entry and Management, Reports and Measures)



| Item   | Action |
|--|--------|
| Data Entry & Management, Reports and Clinical Quality Measures |        |
| EM Measures  | Open   |
| Reporting Tool   | Open   |
| EP Measures  | Review |
| Patch 2  | Open   |
| Patch 2 Batch Extract  | Review |
| Patient Extract Module   | Review |
| QRDA1 Extract  | Review |
| eCQM Overview  | Review |
| Hearing Screen prior to Hospital Dis                           | Open   |
| Primary PCI Received Within 90 Min                             | Open   |
| Preventive Care and Screening_ Scr                             | Open   |
| Childhood Immunization Status                                  | Open   |
| Pneumococcal Vaccination Status fo                             | Open   |
| Screening for Future Fall Risk                                 | Open   |
| Assessed for Rehabilitation                                    | Review |
| Median time from ED Arrival to Depa                            | Open   |
| Diabetes Eye Exam  | Review |
| Home Management Plan of Care (HP                               | Open   |
| Exclusive Breast Milk Feeding                                  | Open   |
| Use of High Risk Medications in the I                          | Open   |
| Venous Thromboembolism Prophylax                               | Open   |
| Intensive Care Unit Venous Thrombu                             | Open   |

| Item                                 | Action |
|--------------------------------------|--------|
| MU and QPP Macra Bootcamp            |        |
| Meaningful Use Revisited             | Review |
| Meaningful Use for 2017              | Open   |
| RPMS MU Reports                      | Open   |
| Challenging Objectives- Health Info  | Review |
| PHR- Patient electronic access for v | Open   |
| Secure Messaging                     | Review |
| MU Audit                             | Open   |
| Ad Hoc Questions and Answer Day 1    | Open   |
| QPP Overview and Proposed 2018 L     | Open   |
| MIPS Categories and Scoring QPP      | Open   |
| MIPS Quality Category- QPP           | Open   |
| CMS and QPP                          | Open   |
| Advancing Care Info for 2017         | Open   |
| Q & A                                | Open   |
| MIPS Participation Scenarios         | Open   |
| RPMS Feedback Enhancement Reque      | Open   |
| Improvement Activities Performance   | Review |
| QPP MACRA Overview and Year 2 U      | Open   |

Source: [https://ihscqpub.cosocloud.com/content/connect/c1/7/en/events/event/shared/1812032102/event\\_landing.html?sco-id=1812096787&\\_charset\\_=utf-8](https://ihscqpub.cosocloud.com/content/connect/c1/7/en/events/event/shared/1812032102/event_landing.html?sco-id=1812096787&_charset_=utf-8)

# Office Hours



Ask question during RPMS/EHR Office Hours for FY 2019 except during Holidays

**Every Mondays, 11:00 am AKT, 12:00 pm PT, 1:00 pm MT, 2:00 pm CT, 3:00 pm ET**

Adobe Connect Link: : <https://ihs.cosocloud.com/r45akhjqfy/>

Call: 800-832-0736 Room: 1429651

**Every Wednesdays, 7:30 am AKT, 8:30am PT, 9:30 am MT, 10:30 am CT, 11:30 am ET**

Adobe Connect Link: : <https://ihs.cosocloud.com/r45akhjqfy/>

Call: 800-832-0736 Room: 1429651

# IHS Promoting Interoperability (formerly known as Meaningful Use) Website



U.S. Department of Health and Human Services

**Indian Health Service**  
The Federal Health Program for American Indians and Alaska Natives

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## Meaningful Use

- RPMS EHR Certification
- Eligibility Requirements
- Modified Stage 2 Overview
- Patient Volume - General
- EHR Incentive Payments and Timelines
- Clinical Quality Measures
- CMS Registration and Attestation
- Resources
- Training/Office Hours
- Previous Requirements
- FAQs
- National MU Team
- Contact Us

## Meaningful Use

Under the authority of Centers for Medicare and Medicaid Services (CMS), the Medicare and Medicaid EHR Incentive Programs provide financial incentives to eligible professionals (EPs) and eligible hospitals (EHs), including critical access hospitals (CAHs), as they adopt, implement, upgrade, and demonstrate meaningful use (MU) of certified electronic health record technology (CEHRT). Learn about the specific eligibility requirements for these incentive payments.

The [CMS Final Rule](#), which was released in October 2015, details criteria that must be met by EPs and EHs in order to qualify for these EHR incentive payments. This criteria must be met in 2015 through 2017 (Modified Stage 2) and in Stage 3 in 2018 and beyond.

More information about the specific requirements for Modified Stage 2 is available by clicking on the links below.

- [Modified Stage 2 Overview](#)
- [2015 Program Requirements](#)
- [2016 Program Requirements](#)

### Webinar

#### Overview of the Multi-Purpose Agreement (MPA)

[Webinar Recording](#)  
[Webinar Slides](#) [PDF - 547 KB]

The Multi-Purpose Agreement (MPA) has been signed by the IHS Director. The MPA is entered into by health programs operated by Indian tribes, tribal organizations, and urban Indian organizations that are covered entities, that desire to engage in electronic health information exchange as part of the Meaningful Use Incentive Program. To engage in the electronic health information exchange, review the MPA and return the completed MPA Joinder Agreement.

[MPA Agreement](#) [PDF - 2.28 MB]  
[MPA Joinder Agreement](#) [PDF - 77 KB]  
[Approved Interim IHM Policy - Resource and Patient Management System Network](#) [PDF - 305 KB]

### STAY CONNECTED

Use our [MU LISTSERV](#) to stay connected. MU LISTSERV is a mailbox where Meaningful Use questions and information can be communicated.

Source: <https://www.ihs.gov/meaningfuluse/>

# IHS QPP – MACRA Resources



- IHS Website: <https://www.ihs.gov/qpp/>
- LISTSERV Email: [MACRA@listserv.ihs.gov](mailto:MACRA@listserv.ihs.gov)
- Subscribe URL: [https://www.ihs.gov/listserv/topics/signup/?list\\_id=357](https://www.ihs.gov/listserv/topics/signup/?list_id=357)

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**LISTSERV Email Groups**

Topics

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Subscribers Area

Archives

Contact Us

### Sign Up

Purpose of this list is to serve as an avenue for community outreach and mission critical education about Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and the Quality Payment Program, which include two paths: The Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMS).

If you'd like to subscribe to this list fill out the below form fields and press subscribe.

\* indicates a required field

\* Name:  \* Email:

Subscribe

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The Federal Health Program for American Indians and Alaska Natives

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IHS Home Quality Payment Program (QPP)

### Quality Payment Program (QPP)

New Medicare Cards

IHS and the QPP

Medicare Changes

CMS Resources

Contact Us

### Quality Payment Program (QPP)

This webpage is for staff to learn more and amplify guidance about the [CMS Quality Payment Program](#). The Quality Payment Program is established under the [Medicare Access and Children's Health Insurance Program Reauthorization Act of 2015](#) (also known as MACRA). MACRA reforms Medicare payments and creates the Quality Payment Program to pay clinicians for the value and quality of health care provided.

#### What is the Quality Payment Program (QPP)?

The QPP helps move the national healthcare system toward the goal of paying for value and quality care by establishing two paths to Medicare payment:

- a [Merit-Based Incentive Payment System \(MIPS\)](#) and
- an advanced [Alternative Payment Models \(APMs\)](#)

Please click on the links above or the links in the resources section to learn more about these programs.

Source: <https://www.ihs.gov/qpp/>



# QPP/MACRA – Next Steps for IHS



- Continue to Operationalize the Quality Payment Program
- IHS's Quality Payment Program – MACRA National Working Group
- Encourage using resources – IHS Website and LISTSERV
- Provide Community Outreach – training and education
  - Webinar
  - Utilize CMS resources for technical assistance
  - Address care coordination utilizing technology
- Health Information Technology Modernization

# QPP Resources



Centers for Medicare & Medicaid Services. A. Abrams. Group and/or Individual data submission for MIPS (January 2, 2018). (video) Available at <https://www.youtube.com/watch?v=q0Cvke6fnrg>

Centers for Medicare & Medicaid Services. MACRA: What's MACRA. Available at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html>

Centers for Medicare & Medicaid Services. The Merit-Based Incentive Payment Systems (MIPS) Overview. Available at <https://qpp.cms.gov/mips/overview>

Centers for Medicare & Medicaid Services. Quality Payment Program: Quality payment program year 3 proposed rule overview. ( July 17, 2018) (slide deck- webinar).



# QPP Resources (2)



Centers for Medicare & Medicaid Services. Quality Payment Program: Modernizing Medicare to provide better care and smarter spending for a healthier America. Available at <https://qpp.cms.gov/>

Centers for Medicare & Medicaid Services. Quality Payment Program: Resource Library. Available at <https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Resource-library.html>.

Centers for Medicare & Medicaid Services. Quality Payment Program Year 2, Final Rule Overview. (November 28, 2017). Available at <https://qpp-cm-prod-content.s3.amazonaws.com/uploads/273/2018%20QPP%20Final%20Rule%20Overview%20Factsheet.pdf>.

# QPP Resources (3)



Centers for Medicare & Medicaid Services. CY 2019 Updates to the Quality Payment Program, Executive Summary Final Rule. (November 1, 2018). Available at [https://qpp-cm-prod-content.s3.amazonaws.com/uploads/257/2019%20QPP%20Final%20Rule%20Executive%20Summary\\_FINAL.pdf](https://qpp-cm-prod-content.s3.amazonaws.com/uploads/257/2019%20QPP%20Final%20Rule%20Executive%20Summary_FINAL.pdf)

Federal Register. Final Rule with Comments 42 CFR Parts 414 and 495. Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models. (November 4, 2016) Available at <https://www.federalregister.gov/documents/2016/11/04/2016-25240/medicare-program-merit-based-incentive-payment-system-mips-and-alternative-payment-model-apm>.

Federal Register. Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year. (November 16, 2017). Available at <https://www.federalregister.gov/documents/2017/11/16/2017-24067/medicare-program-cy-2018-updates-to-the-quality-payment-program-and-quality-payment-program-extreme>

Federal Register. Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; Medicaid Promoting Interoperability Program; Quality Payment Program-Extreme and Uncontrollable Circumstance Policy for the 2019 MIPS Payment Year; Provisions From the Medicare Shared Savings Program-Accountable Care Organizations-Pathways to Success; and Expanding the Use of Telehealth Services for the Treatment of Opioid Use Disorder Under the Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act. (November 23, 2018). Available at <https://www.federalregister.gov/documents/2018/11/23/2018-24170/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions>

# Questions



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