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

Susy Postal DNP, RN-BC, Chief Health Informatics Officer

Elvira Mosely RN, MSHS, Phoenix Area CAC

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

Sarah Leake MBA, Health IT and Quality Consultant

March 8, 2019

Disclaimer

This presentation was current at the time it was published or uploaded onto the web. Medicare policy changes frequently, so links to the source documents have been provided within the document for your reference.

This presentation was prepared as a service to the public and is not intended to grant rights or impose obligations. This presentation may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

Important Note: Sections of this presentation were developed in collaboration with Centers for Medicare & Medicaid Services (CMS) and Indian Health Service (IHS) employees.

CMS and IHS employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error free and will bear no responsibility or liability for the results or consequences of the use of this presentation.

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)

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)

MIPS

The Merit-based Incentive Payment System (MIPS)

If you decide to participate in MIPS, you will earn a performance-based payment adjustment through MIPS.

Advanced APMs

Advanced Alternative Payment Models (Advanced APMs)

If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for sufficiently participating in an innovative payment model.
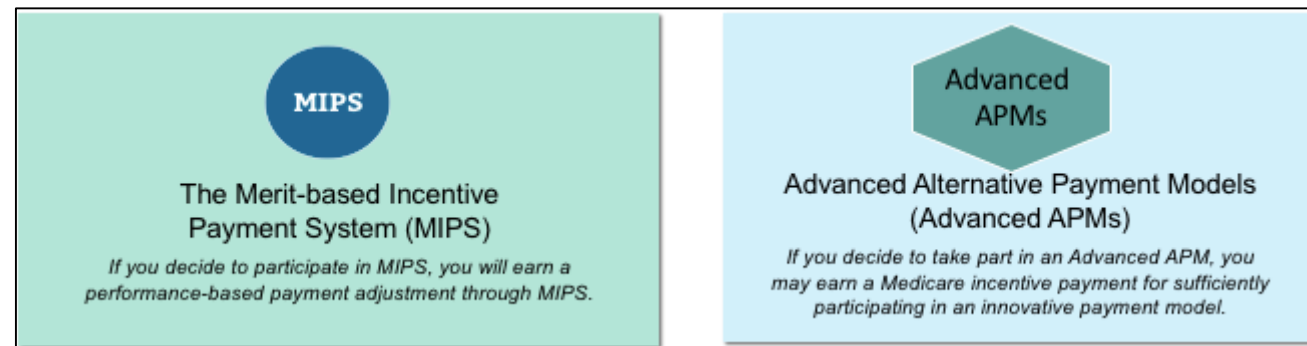
Merit-Based Incentive Payment system (MIPs)

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
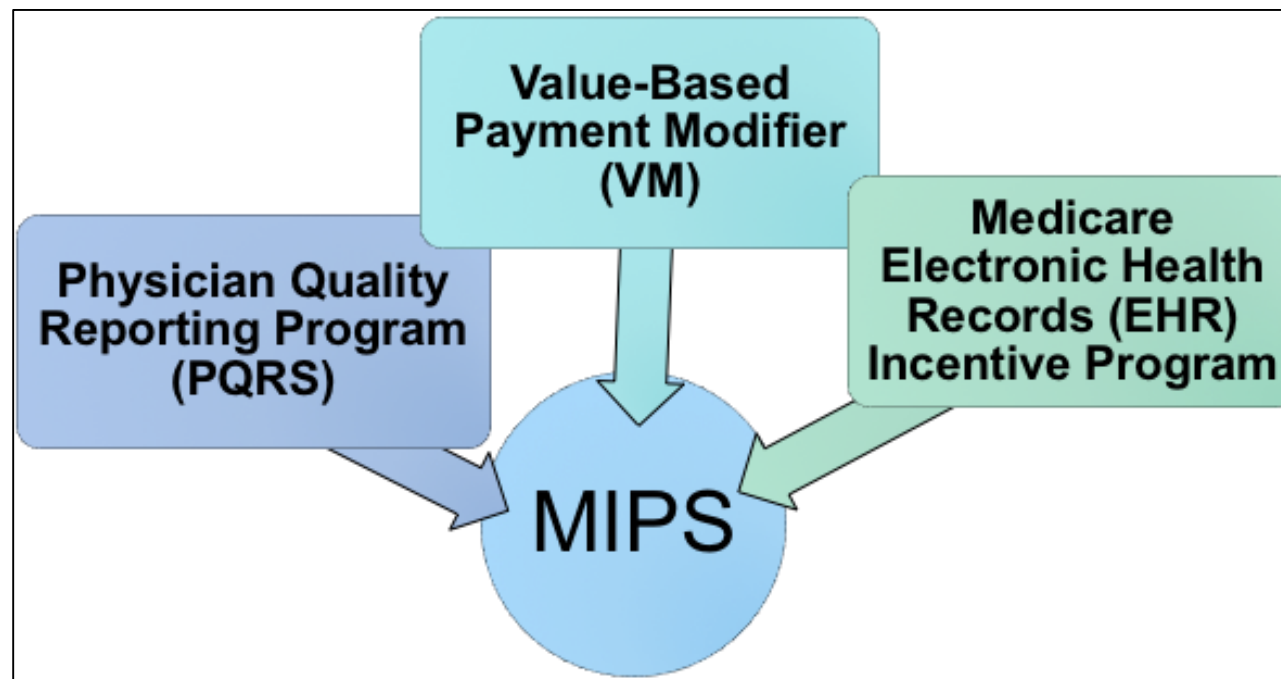
Clinician Impact

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

Year 2 (2018) Final

BILLING >$90,000 AND >200

Year 3 (2019) Final

BILLING >$90,000 AND >200 AND SERVICES >200

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 <u>are included in MIPS</u> and qualify for special rules. Having a special status <u>does not exempt</u> a clinician from MIPS.

MIPS Reporting Options
Year 2 (2018) & Year 3 (2019)Final Rule

OPTIONS

Individual	Group	Virtual Group

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

2. As a Group

a) Two or more clinicians identified by their National Provider Identifier (NPIs) who have reassigned their billing rights to a single Tax Identification Number (TIN)*.

b) As an APM Entity

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

* 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 Qualified Registry EHR Claims	QCDR Qualified Registry EHR CMS Web Interface (groups of 25 or more)
Cost	Administrative claims (no submission required)	Administrative claims (no submission required)
Improvement Activities	Attestation QCDR Qualified Registry EHR	Attestation QCDR Qualified Registry EHR CMS Web Interface (groups of 25 or more)
Promoting Interoperability	Attestation QCDR Qualified Registry EHR	Attestation QCDR Qualified Registry EHR CMS Web Interface (groups of 25 or more

The Quality Payment Program (QPP)

2017 REPORTING DATA CALL

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 Infastructure	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

Sarah Leake MBA, Health IT and Quality Consultant

Participation Status

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

Login for Eligibility Screen

Clinician Eligibility Screen

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:

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~~ Promoting Interoperability	90 days

Performance Category	Performance Category Weight
Quality	**50%**
Cost	**10%**
Improvement Activities	15%
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

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

- QPP Resource Library → search under 2018 Resources, https://qpp.cms.gov/about/resource-library

  o 2018 Improvement Activities Fact Sheet

  o 2018 List of Improvement Activities

  o Improvement Activities Requirements

- Data Validation File - Document detailing the Improvement Activities performance category data validation criteria.

Promoting Interoperability Category

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
*Report to 1 or more of the following public health reporting registries not reported for the performance score: • Immunization Registry Reporting • Syndromic Surveillance Reporting • Specialized Registry Reporting	5%
Report certain Improvement Activities using CEHRT	10%

50% Required Base score (50%)

90% Performance score (up to 90%)

25% Bonus score (up to 25%)

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

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

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	
	Diabetes Measures	
CMS122v6	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)	
CMS131v6	Diabetes: Eye Exam	
CMS134v6	Diabetes: Medical Attention for Nephropathy	
CMS165v6	Controlling High Blood Pressure	
	Other Adult Measures	
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

Falls: Screening for Future Fall Risk CMS139v6 - Quality

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

Selection Criteria - Denominator

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

Exclusions – Patients in Hospice Care during the measurement Period

Exclusions – Patient Non-Ambulatory

Fall Risk Assessment - Numerator


```
                                        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: Falls Screening	Falls Screening 2.16.840.1.113883.3.464.1003.118.12.1028 (Version: eCQM Update 2017-05-05)	
		LOINC (2.56)	52552-7, 57254-5, 73830-2
		SNOMEDCT (2016-09)	401196007, 408422004, 408423009, 408589008, 414191008, 426938003, 427206005, 443731004, 445990009, 711054005

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

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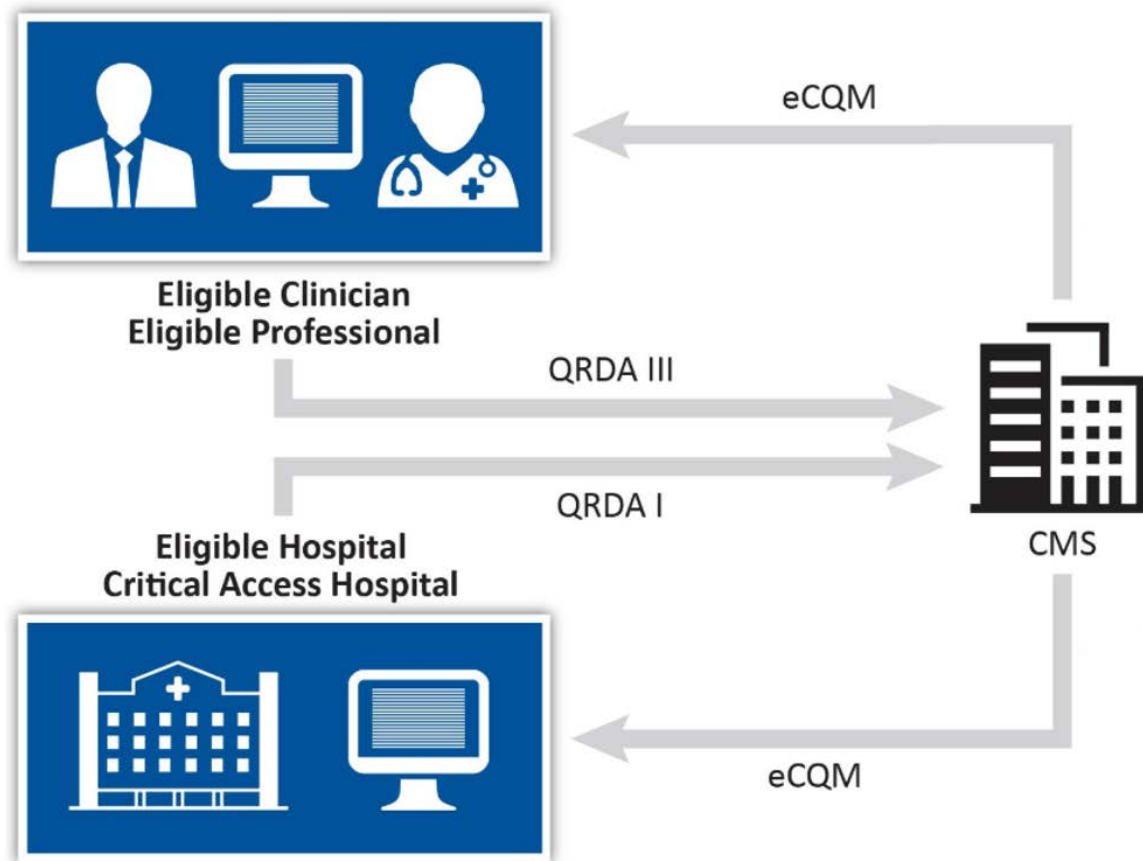
Reference: https://ecqi.healthit.gov/qrda-quality-reporting-document-architecture

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

Been there before?

Use your credentials set up on the EIDM system.

Quality Payment Program Portal: New User

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

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

o Check your Access

o New Users:
  o Link to an organization
  o Security Official
    o At least one per organization
    o Approves users

o Review account information, feedback reports, clinician lists, NPI and TIN information

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.

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

QPP Website Resources

Search Options

- **General Resources**
  - Quick Start
  - Overview
  - Scoring

- **Regulatory Resources**

- **Keyword search**

- **Search by filters (year, track, category, resource type)**
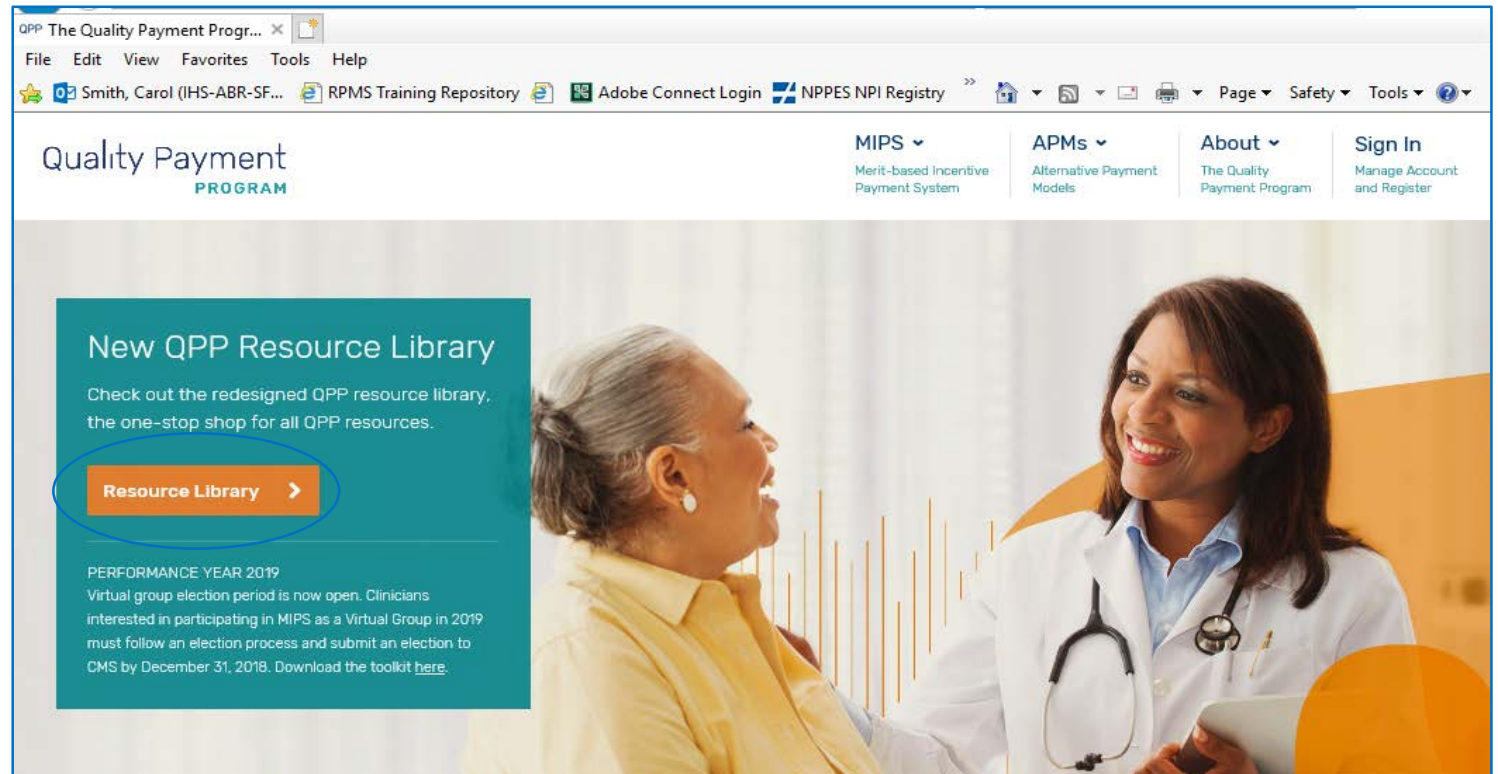
CMS Medicare Learning Network

RPMS Training Repository
(filed under Data Entry and Management, Reports and Measures)

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/r45akhjhqfy/

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/r45akhjhqfy/

Call: 800-832-0736 Room: 1429651

IHS Promoting Interoperability
(formerly known as Meaningful Use) Website

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

IHS QPP – MACRA Resources

- IHS Website: https://www.ihs.gov/qpp/

- LISTSERV Email: MACRA@listserv.ihs.gov

- Subscribe URL: https://www.ihs.gov/listserv/topics/signup/?list_id=357

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

Slide prepared by IHS

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

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

Susy.Postal@IHS.gov