2020 MIPS Participation Without An EHR

Bruce Maki, MA

Candy Hanson, BSN, PHN, LHIT-HP

June 17, 2020

2020 MIPS Participation Without An EHR

- Scoring Comparison With and Without An EHR
- Quality Reporting Criteria
- Eligible Measure Applicability (EMA)
- Quality Measure Benchmarks
- Topped Out, Capped and Inverse Measures
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- Options for Reporting to CMS
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Scoring Comparison With and Without an EHR

	Without an EHR			With an EHR
Quality	With PI Reweighting	70%	⇐ 6-point Small Practice Bonus ⇒	45%
Promoting Interoperability (PI)	Apply for Exception	0%		25%
Improvement Activities (IA)	Small practices require only 1 high weight activity or 2 medium weight activities	15%	⇐ Groups: 50% of clinicians must do activity ⇒	15%
Cost	Scored by CMS	15%	Neutral	15%
Total	Performance Threshold	100%	⇐ 45% Exceptional 85% ⇒	100%

Quality Reporting Criteria

Requirement	Including	Potential Bonus Points
Submit 6 Quality Measures	1 Outcome or High Priority measure	• Up to 10% for submitting 2 or more Outcome or High Priority Quality measures • 6 points for clinicians in small practices who submit at least 1 quality measure • 10 points possible for performance improvement over 2019 quality score • Complex patient bonus
Or Specialty Measure Set	A minimum 6 measures from the set or all measures if set has fewer than 6	
Data Completeness	• Data completeness standard is reporting 70% of the patients who qualify for each measure • 3 points if <70% and a small practice • Minimum case requirement = 20 cases	
Can submit data using different collection types	• Electronic Clinical Quality Measures (e-CQMs) • MIPS Clinical Quality Measures (MIPS CQMs) • Qualified Clinical Data Registry Measures (QCDR) • Medicare Part B Claims Measures • Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey	

What is the Eligible Measures Applicability (EMA) Process?

IF . . .

- All Measures are Reported through Medicare Part B Claims and/or MIPS CQMs

and

- Fewer than 6 Quality Measures or No Outcome/High Priority Measures are Reported

The EMA process determines if additional quality measures or 1 outcome or high priority measure ***could*** have been submitted and, if needed, adjusts scoring to reflect the number of available clinically applicable measures

Watch a CMS Video on the EMA Process

How Do Benchmarks Impact Scoring?

Table 1: Using Data Benchmarks to Determine Achievement Points for Measures that Meet Data Completeness and Case Minimum Requirements

Decile	Number of Points Assigned for the 2020 MIPS Performance Period
No benchmark (historical or performance period)	3 points
Below Decile 3	3 points
Decile 3	3-3.9 points
Decile 4	4-4.9 points
Decile 5	5-5.9 points
Decile 6	6-6.9 points
Decile 7	7-7.9 points
Decile 8	8-8.9 points
Decile 9	9-9.9 points
Decile 10	10 points

How Do Benchmarks Impact Scoring?

Here is an example of a "MIPS CQM" measure with a benchmark which can be reported through a registry such as MIPScast®:

Measure Title	Measure ID	Collection Type	Average Performance Rate	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10	Topped Out	Seven Point Cap
Screening for Osteoporosis for Women Aged 65-85 Years of Age	39	MIPS CQM	47.917	0.28 - 3	3.01 - 16.2	16.21 - 48.65	48.66 - 76.99	77 - 94.42	94.43 - 99.53	99.54 - 99.99	100	N	N

In this example, if you have a perfect performance rate of 100%, you will earn 10 points for the measure. However, if the performance rate is 48.66% to 76.99%, the score falls in decile 6 which will earn you between 6 and 6.9 points for the measure.

Download the 2020 MIPS Historical Quality Benchmarks spreadsheet and 2020 MIPS Historical Quality Benchmarks Fact Sheet in this webinar's Handouts section.

How Do Benchmarks Impact Scoring?

Reporting Measures Without Benchmarks is Risky

- 196 quality measures can be reported through a registry such as MIPScast®, of which 53 are without benchmarks in 2020

- If no historical benchmark exists and no performance period benchmark can be calculated, then the measure will only receive 3 points regardless of actual performance (even if data completeness and case minimums have been met)

Topped Out Measures

- Topped out measures
- Topped out measures capped at 7 points

CMS Benchmark File (shows topped out measures)

- 2020 Quality Measure Benchmark File

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
1	Measure Title	Measure ID	Collection Type	Measure Type	High Priority	Average Performance Rate	Measure has a Benchmark	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10	Topped Out	Seven Point Cap
35	Appropriate Follow-up Imaging for Incidental Thyroid Nodules in Patients	406	MIPS CQM	Process	Y	5.641	Y	66.08 - 29.91	29.9 - 16.92	16.91 - 4.53	4.52 - 0.01	--	--	--	0	Y	Y
36	Opioid Therapy Follow-up Evaluation	408	MIPS CQM	Process	Y	82.263	Y	0.38 - 29.59	29.6 - 74.99	75 - 98.9	98.91 - 99.99	--	--	--	100	Y	Y
37	Clinical Outcome Post Endovascular Stroke Treatment	409	MIPS CQM	Outcome	Y	--	N	--	--	--	--	--	--	--	--	N	N
38	Psoriasis: Clinical Response to Systemic Medications	410	MIPS CQM	Outcome	Y	66.917	Y	1.81 - 15.02	15.03 - 42.9	42.91 - 76.71	76.72 - 96.6	96.61 - 99.99	--	--	100	N	N
39	Documentation of Signed Opioid Treatment Agreement	412	MIPS CQM	Process	Y	84.007	Y	0.97 - 40.91	40.92 - 76.69	76.7 - 99.99	--	--	--	--	100	Y	Y
40	Door to Puncture Time for Endovascular Stroke Treatment	413	MIPS CQM	Intermediate Outcome	Y	--	N	--	--	--	--	--	--	--	--	N	N
41	Evaluation or Interview for Risk of Opioid Misuse	414	MIPS CQM	Process	Y	90.229	Y	4.64 - 59.54	59.55 - 96.32	96.33 - 99.99	--	--	--	--	100	Y	Y
	Emergency Medicine: Emergency Department																

Performance Results for Inverse Measures: the Lower the Better

Measure Title	Measure ID	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	001	79.99 – 70.01	70 – 60.01	60 - 50.01	50 – 40.01	40 – 30.01	30 – 20.01	20 – 10.01	<=10

This measure is not topped out or capped. Notice that the lower the performance results, the higher the decile and thus the more points awarded for this measure.

How Many Points Do I Need for a Neutral Payment Adjustment?

In 2020, 45 Points are Needed for a Neutral Payment Adjustment

- Maximum Improvement Activities category points are 15
- 42.86 gross points (= 30 net points) needed from the Quality and Cost categories
- Quality is weighted at 70% because the Promoting Interoperability exception application (as a small practice) has been submitted and approved
- Cost score is unknown during the performance year
- Small practices earn a 6-point bonus in the Quality performance category, which adds 4.2 points to the MIPS Final Score

How Many Points Do I Need for a Neutral Payment Adjustment?

45 Points are Needed for a Neutral Payment Adjustment

- Plan your work and work your plan
- Careful planning and copious record-keeping is needed
- Pick the measures that are most applicable to your practice
- Start planning and documenting now

The Promoting Interoperability and Extreme and Uncontrollable Circumstances exception applications for 2020 are available now!

Options for Reporting Quality to CMS

Facility-Based Measurement Scoring

Medicare Part B Claims Reporting

Registry Reporting

Options for Reporting Quality to CMS

KEEP IN MIND

- CMS has not yet announced changes to the 2020 program year in response to COVID-19
- The maximum payment adjustment is +/- 9%
- Payment adjustment year is 2 years after the corresponding performance year
- If you had planned on submitting data through claims, but haven't started for 2020, you can elect to either report only through a registry or both Medicare Part B Claims as well as Registry Reporting
- To achieve more than 3 points per measure (as a small practice), data completeness must be at least 70%
  - Claims-based Reporting = 70% of Medicare claims only
  - Registry Reporting = 70% measured across all payers

Facility-Based Measurement Scoring

Facility-Based Measurement Scoring

Offers clinicians and groups the opportunity to receive scores in the MIPS Quality and Cost performance categories based on the FY 2021 score for the Hospital Value-Based Purchasing (VBP) Program earned by their assigned facility.

Individual ECs qualify when they:

- Bill at least 75% of their covered professional services in a hospital setting (POS 21, 22 and/or 23);
- Bill at least one service in an inpatient hospital (POS 21) or emergency room (POS 22); and
- Can be assigned to a facility with a FY 2021 Hospital VBP Program score.
  (Note that FY 2021 scores will not be available before December 2020)

Groups and virtual groups qualify when:

- More than 75% of the clinicians in the practice/virtual group qualify for facility-based measurement as individuals

Eligibility for facility-based measurement scoring is found in the QPP NPI lookup tool

Facility-Based Measurement Scoring

Election

- **CMS will automatically apply facility-based measurement to MIPS eligible clinicians and groups who are eligible for facility-based measurement *and who would benefit from it***
- There are no submission requirements for individual clinicians in facility-based measurement, but a **group** would need to submit data for the Improvement Activities or Promoting Interoperability performance categories at the *group* level in order to be measured as a facility-based **group**
- **From the Facility-based Scoring Quick Start Guide:**

  If you choose to collect and submit additional MIPS quality measure data, we will use whichever submission results in a higher combined score for the Quality and Cost performance categories:

  The Quality and Cost performance category scores based on your facility's FY 2021 Hospital VBP Program score

  OR

  The Quality performance category score based on the data you collect and submit to MIPS, and the Cost performance category score based on the performance we collect and calculate for you.

- **For additional information, access the 2020 Facility-Based Quick Start Guide**

Medicare Part B Claims Reporting

Medicare Part B Claims Reporting

- 55 quality measures available to submit through claims:
  - 5 are Outcome measures (including 2 Intermediate-Outcome and 1 Patient-Reported)
  - 32 are High Priority
  - 13 measures do not have benchmarks
- Reference the specification PDFs for your measures selected
- When filing a claim, check the measure's specification sheet to see if the patient should be included and have the quality measures indicated on the HICF 1500
- Download the 2020 Medicare Part B Claims Measure Specifications and Supporting Documents zip file

Medicare Part B Claims – Specification Example

Specification Example:

Measure #236 - Controlling High Blood Pressure (download from the Handouts section of this webinar to follow along):

1. Is the patient between 18 and 85 years of age on the date of the encounter?
2. Does the patient have a diagnosis of hypertension (ICD-10-CM: I10) overlapping the measurement period?
3. Is the encounter code one of (CPT or HCPCS) 99201 to 99205, 99212 to 99215, 99341 to 99345, 99347 to 99350, G0438 or G0439?

If the answers to these 3 questions are yes, continue. If not, the patient isn't eligible for this measure.

Medicare Part B Claims – Specification Example (continued)

Denominator: Patients 18-85 years of age who had a visit and a diagnosis of hypertension overlapping the measurement period.

- DENOMINATOR NOTE: *Signifies that this CPT Category I code is a non-covered service under the Physician Fee Schedule (PFS). These non-covered services will not be counted in the denominator population for Medicare Part B claims measures.

- Denominator Criteria (Eligible Cases): Patients 18 to 85 years of age on date of encounter

  AND

- Diagnosis for hypertension (ICD-10-CM): I10

  AND

- Patient encounter during performance period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241*, 99242*, 99243*, 99244*, 99245*, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, G0438, G0439

Medicare Part B Claims – Specification Example (continued)

- This measure is to be submitted a minimum of once per performance period for patients with hypertension seen during the performance period
- The performance period for this measure is 12 months. The most recent quality code submitted will be used for performance calculation
- If no blood pressure is recorded during the measurement period, the patient's blood pressure is assumed "not controlled”

Medicare Part B Claims – Specification Example (continued)

Numerator: Patients whose systolic blood pressure is <140 mmHg and diastolic blood pressure is <90 mmHg during the measurement period.

- Only blood pressures performed by a clinician or remote monitoring device are acceptable for numerator compliance with this measure
- Do not include BP readings taken during an acute inpatient stay or ED visit, taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or medication on or one day before the day of the test or procedure, with the exception of fasting blood tests, or a reading reported by or taken by the patient
- If no blood pressure is recorded during the measurement period, the patient's blood pressure is assumed "not controlled"
- If there are multiple blood pressure readings on the same day, use the lowest systolic and the lowest diastolic reading as the most recent blood pressure reading

Medicare Part B Claims – Specification Example (continued)

Numerator codes to exclude patient from denominator:

- G9740 if hospice services were given to the patient at any time during the measurement period
- G9231 if documentation of ESRD, dialysis, renal transplant before or during the measurement period or pregnancy during the measurement period
- G9910 if patient is aged 66 or older and resides in an Institutional Special Needs Plan or long-term care with a POS code of 32, 33, 34, 54 or 56 for more than 90 days during the measurement period
- G2115 if patient is aged 66 or older with at least 1 claim/encounter for frailty during the measurement period and a dispensed medication (Donepezil, Galantamine, Rivastigimine, Memantine) for dementia during the measurement period or the year prior to the measurement period

Medicare Part B Claims – Specification Example (continued)

Numerator codes to exclude patient from denominator:

- G2116 if patient is aged 66 or older with at least 1 claim/encounter for frailty during the measurement period and either 1 acute inpatient encounter with a diagnosis of advanced illness or 2 outpatient, observation, ED, or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period

Medicare Part B Claims – Specification Example (continued)

Numerator codes:

- G8752 most recent systolic blood pressure <140 mmHg
- G8753 most recent systolic blood pressure ≥ 140 mmHg

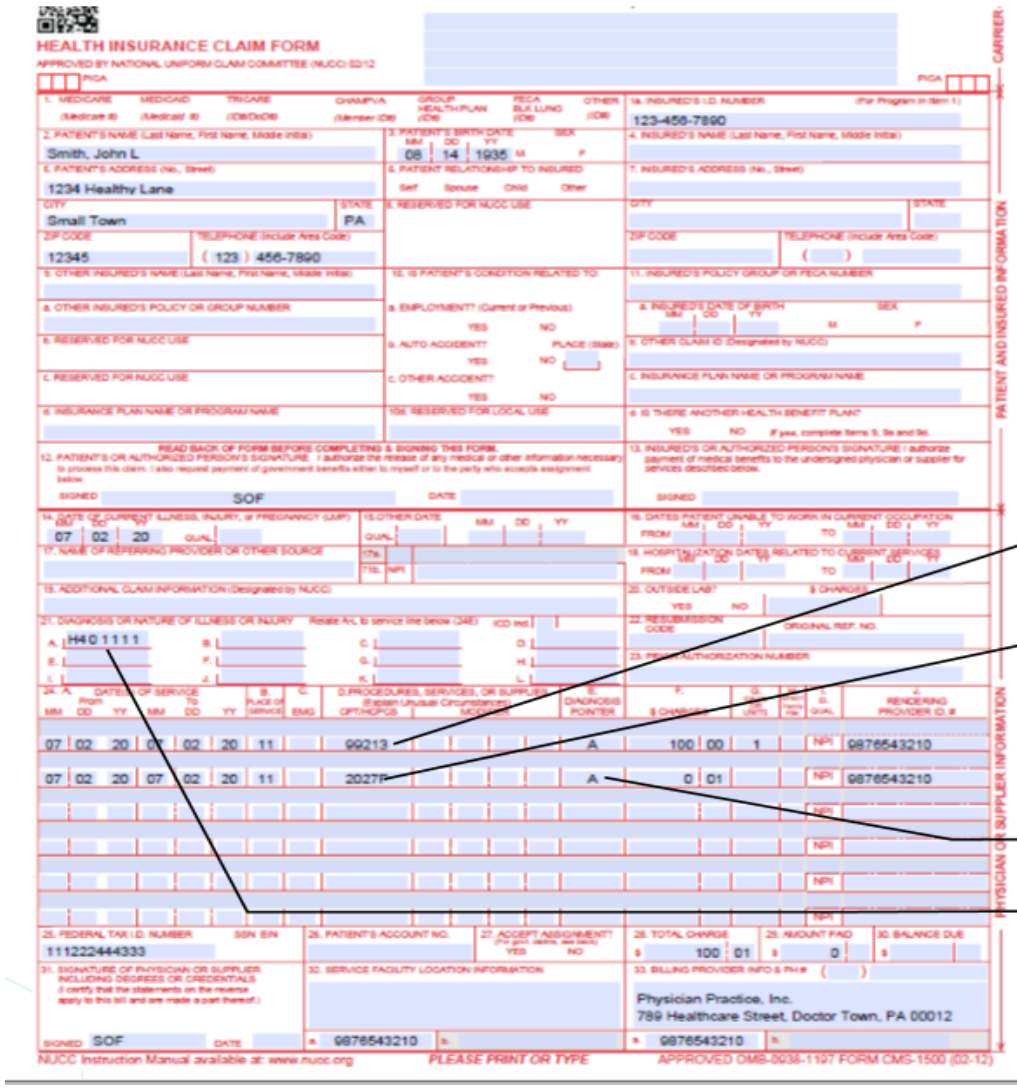
AND

- G8754 most recent diastolic blood pressure <90 mmHg
- G8755 most recent diastolic blood pressure ≥90 mmHg

OR

- G8756 no documentation of blood pressure measurement, reason not given

Sample CMS 1500 Claim


HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE (CHAMPUS) CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER

1a. INSURED'S I.D. NUMBER: 123-456-7890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, John L

3. PATIENT'S BIRTH DATE: 08 14 1935 SEX M

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 1234 Healthy Lane

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: Small Town STATE: PA

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (123) 456-7890

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SOF DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 07 02 20 QUAL

15. OTHER DATE MM DD YY QUAL

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. H40 1111 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL | J. RENDERING PROVIDER ID. #

24A	24B	24C	24D	24E	24F	24G	24H	24I	24J
07 02 20 07 02 20	11		99213	A	100 00	1		NPI	9876543210
07 02 20 07 02 20	11		2027F	A	0 01			NPI	9876543210
								NPI	
								NPI	
								NPI	
								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 111222444333

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE: $ 100 01

29. AMOUNT PAID: $ 0

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED SOF DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. 9876543210 b.

33. BILLING PROVIDER INFO & PH# ( )

Physician Practice, Inc.
789 Healthcare Street, Doctor Town, PA 00012

a. 9876543210 b.

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION

CARRIER

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

In the snapshot to the left, we have provided an example of an individual NPI reporting on a single CMS-1500 claim a quality measure on one patient encounter.

The boxes identify the key items to include so your claim is used to capture your quality data. Otherwise, follow normal coding rules for filing a claim.

The patient in this example encounter was seen for an office visit (99213).

The eligible clinician is reporting a quality measure (Quality ID# 012) related to Primary Open-Angle Glaucoma (POAG):

Measure Quality ID #012 is reported with quality data code (QDC) 2027F + the POAG diagnosis (Item 24e points to the diagnosis code in item 21, line a, H40.1111

Registry Reporting

Registry Reporting

- Use the 2020 MIPS Historical Quality Benchmarks file (download now from the webinar's Handout section) to identify measures most appropriate to your practice. Filter for Collection Type "MIPS CQM" for measures that can be submitted through a Qualified Registry (QR), like MIPScast®, or a Qualified Clinical Data Registry (QCDR)
- There are 196 quality measures available to submit through a Registry (QR or QCDR):
  - 57 are Outcome measures (including 6 Intermediate-Outcome and 17 Patient-Reported)
  - 136 measures are High Priority
  - 53 measures do not have benchmarks
- Download the 2020 Clinical Quality Measure Specifications and Supporting Documents zip file
- Reference the specification sheet PDFs for the selected measures

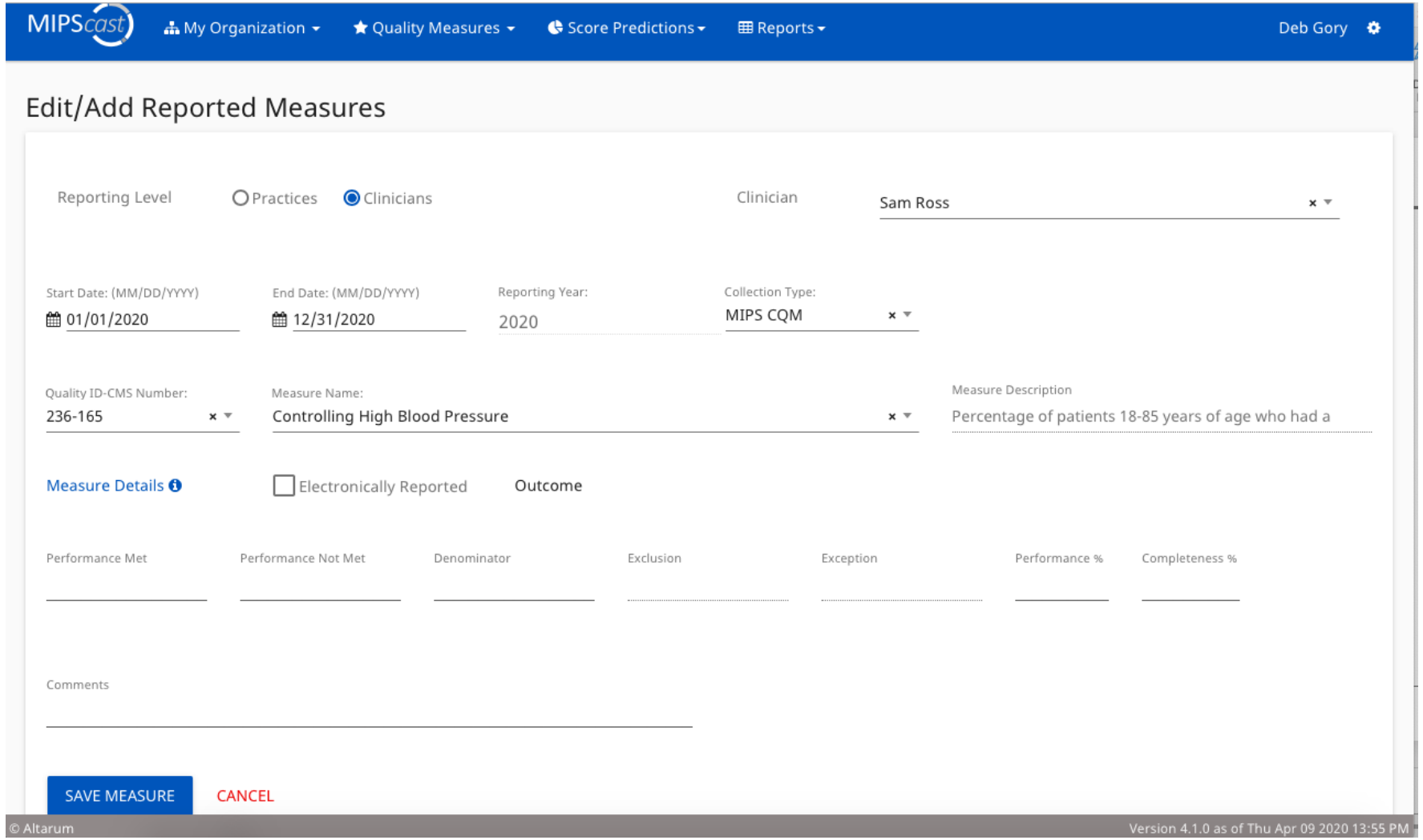
Registry Reporting

- Gathering data for reporting to a registry requires systematized record-keeping and documentation of all patients seen across all payers which CMS can audit
- Aggregated reporting through a Qualified Registry (QR) such as MIPScast® can be simple when the data has been compiled over the span of the reporting period
- Let's look at the information needed for our Qualified Registry, MIPScast®

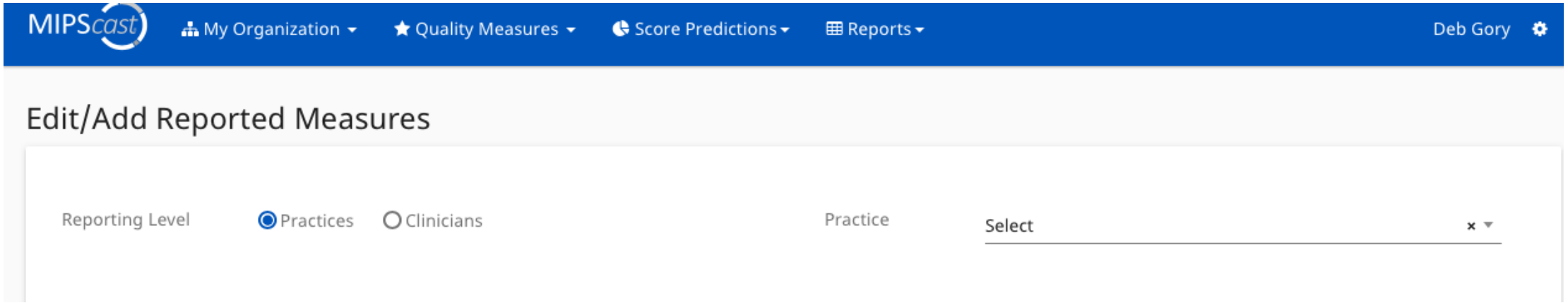
Registry Reporting

- Add 1 measure manually from aggregated data compiled throughout the year

- Now to zoom in...



Registry Reporting



- You've logged in, so "My Organization" only contains data about your practice
- You've selected Quality Measures – Add measures manually
- Next choose if you will report by Practice or Clinician, then click on the down arrow on the far right and select the Practice or Clinician to work with

Registry Reporting

- While you can enter data early to forecast your score, this sample represents the calendar year 2020 so enter the start and end dates that correspond
- Reporting Year should be 2020
- For Collection Type click on the down arrow and select “MIPS CQM”

Registry Reporting

- You can simply begin keying in the value in the Quality ID field or use the down arrow to scroll and find it. The other fields auto-fill

- Here we've selected Quality ID 236, Controlling High Blood Pressure as we covered much of this information in Medicare Part B Claims

- However, the measure's criteria is different for the MIPS CQM collection type (i.e. each collection type for a measure is treated as its own distinct measure)

Registry Reporting

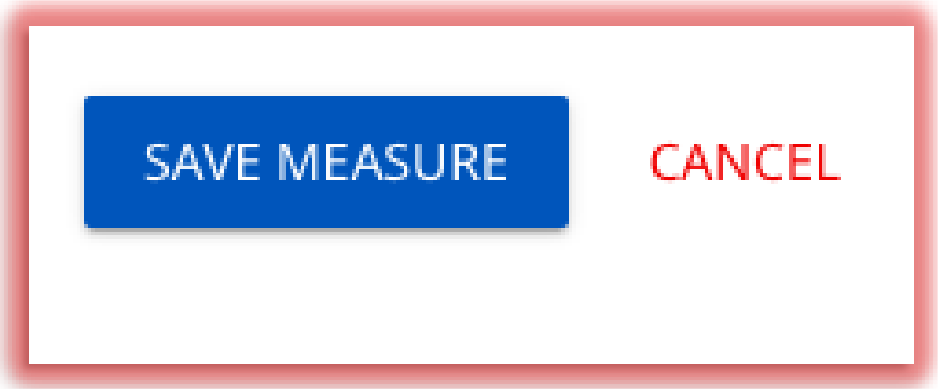
- The next section shows that the measure selected is an Outcome measure
- If you'd like more information about the measure you've selected, click on "Measure Details" which will bring up the same PDF linked to earlier in this webinar

Registry Reporting

The fields which you will need to be prepared to fill in:

- Performance Met
- Performance Not Met
- Denominator
- Exclusion
- Exception
- Comments

Don’t forget to “**Save Measure**”!



- **So, how can the data be compiled to fill in the fields for each measure?**
  - The following slides have one idea using the Quality Measure 236 - Controlling High Blood Pressure

Registry Reporting – Specification Example

Specification Example:

MIPS CQM Measure #236 - Controlling High Blood Pressure (download from the Handouts section of this webinar to follow along):

1. Is the patient between 18 and 85 years of age on the date of the encounter?
2. Does the patient have a diagnosis of hypertension (ICD-10-CM: I10) overlapping the measurement period?
3. Is the encounter code one of (CPT or HCPCS) 99201 to 99205, 99212 to 99215, 99241* to 99245*, 99341 to 99345, 99347 to 99350, 99385* to 99387*, 99395* to 99397*, G0438, G0439?

AND…

Registry Reporting – Specification Example (continued)

Denominator Exclusions:

- G9740 Hospice services were given to the patient at any time during the measurement period
- G9231 Documentation of ESRD, dialysis, renal transplant before or during the measurement period or pregnancy during the measurement period
- G9910 Patient is aged 66 or older and in Institutional Special Needs Plan or residing in long-term care with a POS code of 32, 33, 34, 54 or 56 for more than 90 days during the measurement period
- G2115 Patient is aged 66 or older with at least 1 claim/encounter for frailty during the measurement period and a dispensed medication (Donepezil, Galantamine, Rivastigimine, Memantine) for dementia during the measurement period or the year prior to the measurement period

Registry Reporting – Specification Example (continued)

Denominator Exclusions (continued):

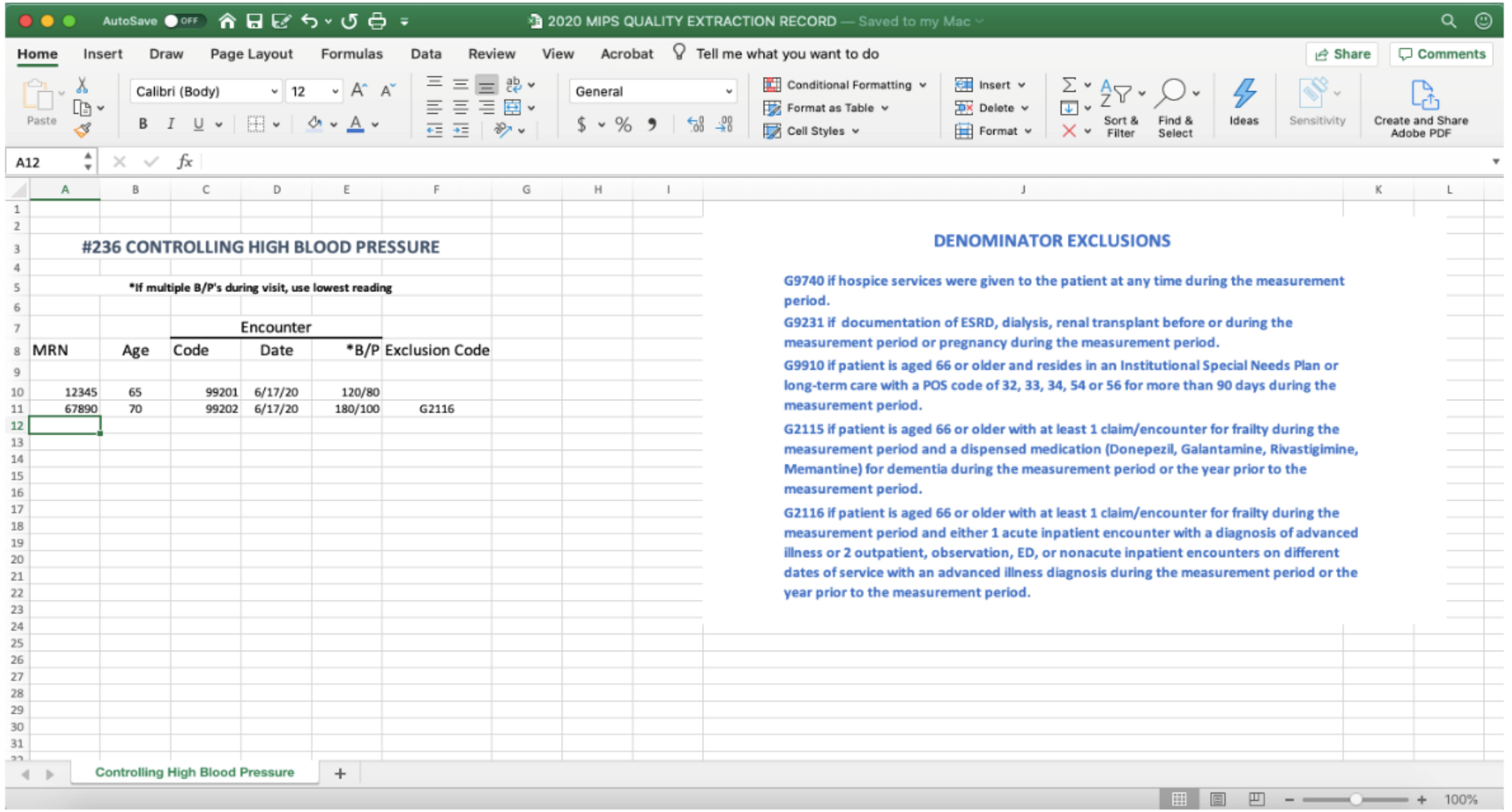
- G2116 Patient is aged 66 or older with at least 1 claim/encounter for frailty during the measurement period and either 1 acute inpatient encounter with a diagnosis of advanced illness or 2 outpatient, observation, ED, or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period

Registry Reporting – Specification Example (continued)

Numerator: Patients whose systolic blood pressure is <140 mmHg and diastolic blood pressure is <90 mmHg during the measurement period

- Only blood pressures performed by a clinician or remote monitoring device are acceptable for numerator compliance with this measure
- Do not include BP readings taken during an acute inpatient stay or ED visit, taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or medication on or one day before the day of the test or procedure, with the exception of fasting blood tests, or a reading reported by or taken by the patient
- If no blood pressure is recorded during the measurement period, the patient's blood pressure is assumed "not controlled"
- If there are multiple blood pressure readings on the same day, use the lowest systolic and the lowest diastolic reading as the most recent blood pressure reading

Registry Reporting – Record Extraction Example



TODAY'S TAKEAWAY

- **YOU CAN BE A SUCCESSFUL REPORTER FOR MIPS IN 2020 WITHOUT AN EHR!!!**

- **Be Aware:** The MIPS Final Score minimum performance threshold (to avoid a penalty) will continue to increase (i.e. 60pts in 2021) … which makes participating in MIPS without an EHR more challenging each year

Resources

QPP Resource Center
https://www.qppresourcecenter.org/

QPP CMS Web site
www.qppcms.gov

CMS Claims Quick Start Guide
Claims Quick Start Guide

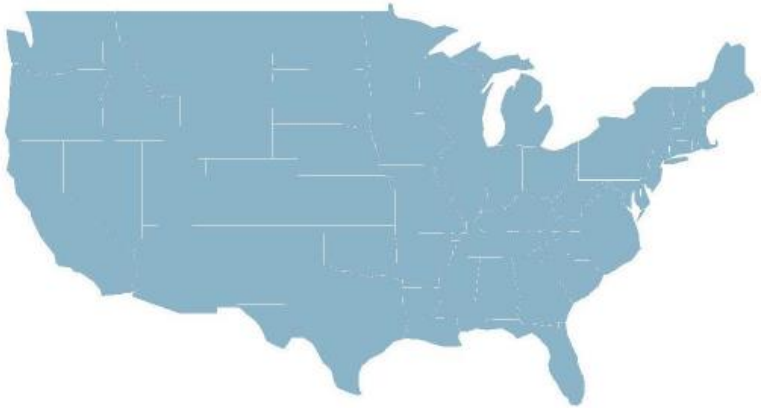
2020 Medicare Part B Claims Measure Specifications
2020 Medicare Part B Claims Measure Specifications and Supporting Documents zip file (this will take you to the page and then you have to choose this document)

2020 Clinical Quality Measure Specifications
2020 Clinical Quality Measure Specifications and Supporting Documents zip file (this will take you to the page and then you have to choose this document

Promoting Interoperability and Extreme and Uncontrollable Circumstances exception applications

Free Technical Assistance

CMS has no cost resources and organizations on the ground to provide help to clinicians who are participating in the Quality Payment Program:



Small & Solo Practices

Small, Underserved, and Rural Support (SURS)

- Provides outreach, guidance, and direct technical assistance to clinicians in solo or small practices (15 or fewer), particularly those in rural and underserved areas, to promote successful health IT adoption, optimization, and delivery system reform activities.
- Assistance will be tailored to the needs of the clinicians.
- There are 11 SURS organizations providing assistance to small practices in all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands.
- For more information or assistance getting connected, contact QPPSURS@IMPAQINT.com.

Technical Support

All Eligible Clinicians Are Supported By:

- **Quality Payment Program Website: qpp.cms.gov**
  Serves as a starting point for information on the Quality Payment Program.
- **Quality Payment Program Sevice Center**
  Assists with all Quality Payment Program questions.
  1-866-288-8292 TTY: 1-877-715-622 QPP@cms.hhs.gov
- **Center for Medicare & Medicaid Innovation (CMMI) Learning Systems**
  Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs. More information about the Learning Systems is available through your model's support inbox.

Go to www.qppresourcecenter.org and click "Join Now"

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