QPP SURS | Quality Payment Program

Upcoming Events

Below is a list of upcoming events you may want to attend as you continue to prepare for MIPS:

May 2019 LAN Webinar: How to Maximize your Score in the Cost Category for Solo and Small Group Practice

Tuesday, May 14, 2019, 3:30 p.m. – 4:30 p.m. ET

Thursday, May 16, 2019, 11:00 a.m. – 12:00 p.m. ET

June 2019 LAN Webinar: How to Succeed in the Promoting Interoperability Category for Solo and Small Group Practices

Tuesday, June 18, 2019, 11:00a.m. – 12:00p.m. ET

Thursday, June 20, 2019, 3:30p.m. – 4:30p.m. ET

Additional Upcoming Events and Links to Past Events

Upcoming and past CMS events related to MACRA, MIPS, and APMS: https://qpp.cms.gov/

Past QPP SURS events: https://qppsurs.wordpress.com/resources/

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This newsletter is produced by IMPAQ International who is functioning as the QPP SURS Central Support contractor. Questions or suggestions about the newsletter can be sent to QPPSURS@IMPAQINT.COM.

SURS Practice Spotlight: Lawrenceville Family Practice

Paige Stover is the office manager for Lawrenceville Family Practice, a small primary care practice in Lawrenceville, Georgia. In 2017, Paige supported her two MIPS-eligible providers at her practice in achieving a total score greater than 98. Paige attributes her practice's success with MIPS to "doing her homework" on the practice's MIPS measures, fully utilizing her EHR, and implementing new quality improvement efforts. See Paige's advice below on how to succeed in MIPS at your practice:

Fully research your MIPS measures and documentation practices.

Paige's QPP Technical Assistance Contractor put her in touch with the Georgia Health Information Technology Extension Center (GA HITEC), which assisted Paige's

practice in selecting MIPS measures that aligned with the services her clinicians were providing. Her practice reported the following six measures: pneumococcal vaccine (Quality ID: 111), Body Mass Index (BMI) screening (Quality ID: 128), tobacco screening (Quality ID: 226), high blood pressure (Quality ID: 236), fall risk (Quality ID: 318), and diabetes foot exam (Quality ID: 163). Paige began by familiarizing herself with the individual MIPS quality measures her clinicians were reporting. She conducted a "deep dive" into quality measure codes and observation terms using her EHR's MIPS reporting tool called the Clinical Quality Reporting (CQR) tool. Paige also utilized an EHR consultant through her vendor, GE Centricity, and went through every MIPS quality measure with the consultant to make sure measures were coded correctly so her providers would get full credit for reporting.

Constantly monitor your MIPS measures.

Paige frequently ran reports in her EHR's MIPS CQR reporting tool to monitor her providers' progress on MIPS measures. This frequent monitoring also helped her get an idea of her providers' MIPS quality scores in real time. The CQR highlighted which patients were eligible for each MIPS measure. If an eligible patient did not receive certain referrals or screenings, such as a hemoglobin A1c checks, Paige followed up with her providers to ask why they did not receive that screening. This helped the practice strengthen their MIPS measure scores by making sure to include all eligible patients in their reporting.

Utilize all EHR functionality.

To help her providers remember to address certain areas, Paige used her EHR's Quick Text functionality to give providers a snapshot of each patient's recent screenings and to flag which exams might be overdue. For example, for each diabetic patient, the Quick Text functionality populates the patient's last eye exam, foot exam, and hemoglobin A1c check, and helps providers remember to review these measures.

Try out new quality improvement activities.

Lawrenceville Family Practice has implemented depression screenings and on-site hemoglobin checks. The depression screenings are completed on tablets during registration in waiting rooms. The on-site hemoglobin checks allow doctors to get real-time feedback and adjust medications on the spot, if necessary.

Paige worked proactively with her EHR vendor to fully understand how to correctly code her MIPS measures. While this can be a time-intensive process, her efforts paid off when her providers received exceptional MIPS performance scores. If your practice has an EHR, or is considering purchasing an EHR, you can replicate Paige's success by closely monitoring your MIPS measures, finding patients who still need screenings, and ensuring proper coding and documentation of your MIPS measures. These tips can help you to achieve success in MIPS!

Are you eligible to participate in MIPS in 2019?

MIPS eligible for 2019?

To verify your eligibility status for the MIPS 2019 performance period, enter your National Provider Identifier (NPI) number into the Quality Payment Program (QPP) Participation Status Tool at https://qpp.cms.gov/participation-lookup/. CMS recently updated this tool with preliminary eligibility information for the 2019 performance period. Please note that this tool provides MIPS eligibility information for the 2017, 2018, and initial 2019 performance years, so make sure you select the 2019 tab before entering your NPI.

How does CMS determine MIPS eligibility?

CMS determines MIPS eligibility for each practice associated with your NPI number. Eligibility determinations are based on PECOS data and Medicare Part B claims during two 12-month segments known as MIPS determination periods. The QPP Participation Status Tool currently shows your preliminary 2019 eligibility status for each associated practice, based on data from the first determination period (October 1, 2017-September 30, 2018). CMS will update this tool later this year to incorporate data from the second determination period (October 1, 2018 – September 30, 2019).

Keep in mind that your eligibility status may change later in the year!

It is important to note that your final eligibility status can change based on the results of the second determination period noted above. Physicians and groups are excluded from MIPS if during either determination period they bill $90,000 or less in Medicare Part B allowed charges, furnish covered professional services to 200 or fewer Medicare Part B-enrolled beneficiaries, or provide 200 or fewer covered professional services to Medicare Part B-enrolled beneficiaries. It is important to check the QPP Participation Status Tool after CMS has applied the results of the second determination period to see if your eligibility status has changed. CMS typically updates the QPP Participation Status Tool in the fall of each performance period and sends a message to the QPP listserv alerting clinicians and practices that the final eligibility determination is available in the tool. To sign up for the QPP listserv, enter your email at the bottom of the QPP website under "Subscribe to Updates."

Can you still participate if you are not required to participate?

Beginning in 2019, if you are a MIPS-eligible clinician and meet one, or two, but not all three of the low-volume threshold criteria, you can elect to "opt-in" to MIPS or voluntarily report. CMS has updated the QPP Participation Status Tool to include information specific to whether you can opt-in or voluntarily report for each of your associated practices. It is important to remember that if you opt-in, you will be subject to the same requirements as MIPS-eligible clinicians and groups and will receive a MIPS payment adjustment (positive or negative) based on your performance. If you voluntarily report, you will report MIPS measures and receive feedback on your performance, similar to other MIPS-eligible clinicians, but you will not be subject to the MIPS payment adjustment. For more information on these options, please see the 2019 MIPS Participation and Eligibility Fact Sheet. If you are unsure of your status after checking the QPP Participation Status Tool, we encourage you to contact your region's Technical Assistance Contractor for further clarification. Information for your region's Technical Assistance Contractor can be found at https://qpp.cms.gov/about/small-underserved-rural-practices.

Care Management programs can be beneficial to your patients, as well as to your MIPS cost score!

Chronic Care Management (CCM) programs focus on better care management for patients with two or more chronic conditions by expanding access, improving medication adherence, and reducing unnecessary hospitalizations and emergency department visits. These steps can help you reduce the cost of care for your Medicare beneficiaries, thus improving your MIPS score for the cost performance category.

Here are some strategies for getting started with CCM at your practice:

Assess your workflow and CCM options.
- Determine whether an insourced or outsourced CCM program best suits your practice's existing workflow. If you need assistance with this decision, reach out to your local Technical Assistance Contractor for FREE advice! Information for your region's Technical Assistance Contractor can be found at https://qpp.cms.gov/about/small-underserved-rural-practices.

Identify eligible beneficiaries.
- Assess your patient population and identify patients with two or more chronic conditions. Ask each of your clinicians to review eligible patients assigned to them and mark off any patients that they believe are not a good fit for CCM. When starting out, consider focusing on patients with specific conditions, such as COPD and diabetes. Ideally, the patients that you identify for CCM services will include some of the same patients that are attributed to your practice by CMS and used to calculate your MIPS cost score. Patients are attributed to the physician or group that is providing the majority of primary care services, so by improving the care of this patient population, you are also working towards improving your MIPS score in the cost category!

Design a process and workflow for CCM at your practice.
- Consider implementing a dedicated phone line that is answered by designated CCM staff and/or that forwards to on-call clinicians after hours. It may be beneficial to set aside time during the day dedicated to clinician visits and nurse calls for CCM patients.
- Develop a process for creating a comprehensive care plan and documenting the time spent with each patient.

Enroll patients and bill for reimbursement.
- Invite the identified patients to enroll in CCM and educate them on how the program will work and how it may benefit them. Make sure to review the participation agreement and secure written consent.
- There are three CPT codes associated with CCM: CPT 99490, CPT 99487, and CPT 99489. Although the service elements between CCM and complex CCM are similar, complex CCM requires greater involvement, time, and care planning by the billing provider. For more information, see the FAQ about billing for CCM services.

February 2019 LAN Q&A

The following questions were asked by the audience during the February 2019 LAN webinar titled "Submitting Your 2018 MIPS Data: Advice for Solo and Small Group Practices." For access to the full Q&A document and previous LAN webinar presentations, see the QPP SURS WordPress website: https://qppsurs.wordpress.com/resources/.

Q: We received a hardship exception due to an EHR error in calculations. Do I still say "yes" to the security risk analysis measure?

A: If you received a Promoting Interoperability (PI) Hardship Exception, you do not need to report for the PI category; you just have to indicate that your exception was granted. Make sure to retain the document that approved your exception. The exception allows your PI category to be reweighted to your Quality category. However, please note that if you enter data for the PI category in the QPP portal, CMS will score the category regardless of the hardship exception.

Q: Our EMR will not create the QRDA-III file for a group submission and our providers do not qualify to submit as individuals. Is there any recourse to get our data to CMS as a group without this file? We have currently submitted data as individuals for the feedback but would love to be eligible for participation as a group.

A: Some Electronic Health Records (EHRs) do not have the ability to report data at the group level. However, MIPS-eligible groups or virtual groups can still submit data for MIPS as a group by working with a third-party intermediary, like a Qualified Registry (QR) or a Qualified Clinical Data Registry (QCDR). A QR is an entity that collects clinical data from an individual MIPS-eligible clinician, group, or virtual group and submits it to CMS on their behalf. Clinicians work directly with their registry to submit data on the selected measures or specialty set of measures. A QCDR is a CMS-approved entity that collects clinical data on behalf of clinicians for data submission. Unlike QRs, QCDRs are not limited to measures within the Quality Payment Program.

As an alternative to registries, you may be able to generate a non-certified QRDA III report from your EHR and manually upload this file into the QPP MIPS Submission Portal. CMS offers a number of free resources to do just that. For more information, see the following link: https://qpp.cms.gov/developers. You can also hire a company to combine the individual QRDA III files. Please contact your local Technical Assistance Contractor for further help with this upload. Information for your region's Technical Assistance Contractor can be found at https://qpp.cms.gov/about/small-underserved-rural-practices.

Q: We are submitting as a group for MIPS, but one provider is a Qualifying Participant (QP). Are we to include their data in the group data submission even though the QP is not eligible for MIPS?

A: A group electing to submit data at the group level will have its performance assessed and scored across the TIN, which should include items and services furnished by individual NPIs within the TIN who are not required to participate in MIPS. For example, in addition to clinicians who do not meet the low-volume threshold, clinicians are also excluded if they are a new Medicare-enrolled clinician, a qualified APM participant (QP), or a partial QP that chooses not to participate. These excluded clinicians are still part of the group, and therefore, would be considered in the group's score. However, if a group participates at the group level, the MIPS payment adjustments would only apply to payments for covered professional services furnished by MIPS eligible clinicians. The adjustments would not apply to the excluded clinicians. Any individual provider (i.e., NPI) excluded from MIPS because they are identified as new Medicare-enrolled, QP, or partial QP (and choose not to participate) would not receive a MIPS payment adjustment, regardless of their MIPS participation.

Monthly Observance: National Minority Health Month

April is National Minority Health Month, and this year, the U.S. Department of Health and Human Services (HHS) Office of Minority Health encourages us to join our partners in raising awareness about the important role an active lifestyle plays in keeping us healthy. It can be challenging to add movement to your day when you lack access to sidewalks, a gym, or a safe neighborhood. Clinicians can play an important role in raising awareness and helping individual patients and community organizations find solutions.

If your electronic health record (EHR) can show data by race, ethnicity, language, gender, and other patient characteristics, take a moment this month to see how your different patient populations are doing on select MIPS measures. Do any populations need extra attention, such as those patients with multiple chronic diseases? Would more physical activity help to improve these MIPS measures for these groups? Are there community organizations with whom you can partner to encourage and support physical activity? How else might you partner with community organizations to help all of your patient populations achieve their health goals?

For more information on how to address health disparities, see the U.S. Department of Health and Human Services Office of Minority Health website:

https://minorityhealth.hhs.gov/omh/Content.aspx?ID=12481&lvl=2&lvlid=12