

MHS Guidebook for the CMS QPP
Merit-based Incentive Payment System (MIPS)
Participation and Reporting

2019

Executive Summary – MHS Guidebook CMS QPP Merit-based Incentive Payment System (MIPS) Participation and Reporting

CMS has implemented the Quality Payment Program (QPP), which rewards value and outcomes in one of two ways: **Merit-based Incentive Payment System (MIPS)** and Alternative Payment Models (APMs). This guidebook provides program details and links to external resources for all eligible clinicians and groups who participate in MIPS.

Who Is Included: *Based on Program Eligibility criteria, the following providers may be included on the MIPS track:*

- Doctor of Medicine (MD)
- Doctor of Osteopathy (DO)
- Doctor of Dental Surgery (DDS)
- Doctor of Dental Medicine (DMD)
- Doctor of Podiatric Medicine (DPM)
- Doctor of Optometry (OD)
- Doctor of Chiropractic (DC)
- Physician Assistants (PA)
- Nurse Practitioners (NP)
- Clinical Nurse Specialists (CNS)
- Certified Registered Nurse Anesthetists (CRNA)
- Physical Therapists (PT)
- Occupational Therapists (OT)
- Speech-Language Pathologists (SLP)
- Audiologists (AuD)
- Clinical Psychologists (MPsych)
- Registered Dietitians (RD) or Nutritional Professionals

Why Participate: *MIPS eligible clinicians (ECs) are subject to performance-based payment adjustments for the services they provide to Medicare patients. The final MIPS score for 2019 will result in a payment adjustment in 2021. Four weighted categories comprise the score, based on the following formula:*



- The maximum potential positive, or negative, payment adjustment for 2021 will be ± 7 percent and will increase to ± 9 percent next year.
- The minimum performance threshold for 2019 is 30 points. Final scores above this performance threshold will receive a positive payment adjustment. There is an exceptional performance bonus threshold at 75 points, for which additional bonuses can be awarded to the maximum adjustment.
- Eligible Clinicians scoring below 30 points will receive a negative payment adjustment.
- MIPS data will be displayed publicly on Physician Compare.

MIPS Program Eligibility: Eligible Clinicians and groups include those who meet three criteria:

1. Bill more than \$90,000 a year in allowed charges for covered professional services under the Medicare Physician Fee Schedule.
2. Furnish covered professional services to more than 200 Medicare beneficiaries a year.
3. Provide more than 200 covered professional services under the Physician Fee Schedule.

Clinicians May Also Choose to Participate through Opt-In or Voluntary Reporting Options:

- **Opt-In:** If a clinician or group does not meet all three of the eligibility thresholds or requirements, they can opt-in to Merit-based Incentive Payment System (MIPS) by exceeding one or two (but not all three) of the criteria above.
- **Voluntary Participation:** A clinician or group that is not MIPS eligible can report voluntarily and will receive a MIPS final score but will *not* be eligible for a payment adjustment.

Clinicians Excluded from MIPS:

- Fail to meet MIPS Eligibility Thresholds for 2019.
- Enrolled in Medicare for the first time in 2019.
- Participate in an Advanced Alternative Payment Models (APM) and are determined to be a Qualifying APM Participant or a Partial Qualifying APM Participant and elect not to participate in MIPS.

How to Participate in MIPS:

Prepare:

- Check your status quarterly throughout the year at: <https://qpp.cms.gov/participation-lookup>
- Update PECOS with correct Legal Business Name (LBN) associated Tax Identification Number (TIN), Addresses, and National Provider Identifiers (NPIs) associated with the TIN.
- Identify other clinicians in the group who are eligible for reporting and consider the risks and benefits of their participation.
- Ensure current use a 2015 Edition Certified Electronic Health Record Technology (CEHRT) electronic health record (EHR)
- Complete a Security Risk Assessment in CY 2019, which includes plan for improvement.
- Don't Information Block – attestations to CMS are required.

Select and Improve:

- Identify and improve minimum of six Quality measures. Look for measures to maximize possible points.
- Improve workflows on Promoting Interoperability (PI) objectives. Monitor individual/group performance. Health Information Exchange objectives include sending and receiving/incorporating Summary of Care information. This includes reconciliation of Problems/Medications/Allergies, and preference for electronic information exchange.
- Implement and continue at least four Improvement Activities (IA)

Report:

- Data is reported for each of the MIPS categories: Quality, Promoting Interoperability (PI) and Improvement Activities (IA) measures, unless reweighted for certain eligible providers (example, hospital-based providers). Cost data is collected through claims filed with CMS.

Utilize this Guidebook to:

- Provide more insight into MIPS requirements, along with CMS and MHS resources.

Participating in MIPS and Reporting through MemorialCare Health System (MHS)

For those who choose to participate and report MIPS Quality, Promoting Interoperability (PI) and Improvement Activities (IA) measures through the MemorialCare Health System (MHS) this guidebook also serves as a resource to facilitate planning and coordination between clinicians/groups and the Clinical Training Specialists at MHS. Only eligible clinicians or groups using MHS's instance of Epic are eligible to participate in MIPS through MHS.

Introduction - CMS QPP Merit-based Incentive Payment System (MIPS) Participation and Reporting

The Centers for Medicare & Medicaid Services (CMS) seek to improve Medicare by helping clinicians focus on caring for their patients rather than filling out paperwork. Under the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA), CMS implemented the Quality Payment Program (QPP), which rewards value and outcomes in one of two ways: Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs). A summary of the QPP can be found at: <https://qpp.cms.gov/>. A more focused summary of the MIPS program can be found at: <https://qpp.cms.gov/mips/overview>.

In 2018, the median score for all providers who participated in the MIPS program through MemorialCare Health System (MHS) was 86.6. This is well above the 'Exceptional Bonus Threshold' established by CMS and reflects a positive adjustment in reimbursements from CMS in 2020.

This guidebook focuses on continuing the successful participation in the MIPS portion of the QPP Program through MHS. It is intended as a resource for all providers and clinic managers and. For those providers who utilize MHS to submit their Quality, Promoting Interoperability (PI) and Improvement Activities (IA) measures, this guidebook can be used in consultation with the Clinical Training Specialists (CTS).

In addition to providing an overview of MIPS, the four performance categories within MIPS, the formula for calculating a final score for the year, and options for reporting on specific measures within each category, this guidebook reviews each aspect of program participation, including:

- Provider onboarding and offboarding
- Provider eligibility and thresholds for participation
- Registration and reporting timelines
- Individual provider and group options for reporting

Continuing Provider Checklist:

For providers who are continuing with MIPS reporting in 2019, the following checklist is designed to provide a quick check-up for participation in MIPS in 2019:

- Review the prior year's Submitted Reports and Feedback. Determine best opportunities for improvement.
- Improve understanding of regulations, guidelines and formulas.
- Ensure that Provider Enrollment, Chain, and Ownership System (PECOS) information is up to date and correct, including the Legal Business Name (LBN) associated with the Tax Identification Number (TIN), and Addresses associated with the LBN, and National Provider Identifiers (NPIs) associated with the TIN.
- Check each provider's QPP participation status quarterly throughout the year.
- List the clinicians who may want to Opt-in for 2019 reporting and understand the associated risks.
- Review Group versus Individual reporting options and the influence of the individual workflows on group scores.
- Select and review available Quality Measures, optimize workflows, and communicate with the group.
- Confirm workflows for Reconciling Problems from outside sources, as well as Medications and Allergies, are in place and emphasized.
- Review and optimize clinical referral workflows with appreciation of downstream reporting.
- Note that future Cost Category scores will eventually increase to 30% of the total MIPS score. Understand how it is calculated and attributed.
- Perform Security Risk Assessment in CY 2019.
- Optimize EHR data quality – Promoting Interoperability measure and Quality measure capture.

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I. MIPS versus APMs

In the Merit-based Incentive Payment System (MIPS), eligible clinicians (ECs) may earn performance-based payment adjustments for the services they provide to Medicare patients, while the Alternative Payment Models (APMs) are customized payment approaches, often designed to provide incentives to clinicians who are providing high-quality, high value care. APMs can focus on specific clinical conditions, care episodes, or populations. While it is anticipated that eventually many clinicians will participate through APMs, the focus of this guidebook is to support clinicians as they prepare and submit documentation to CMS through MIPS. Each EC should check their participation status, to determine if they already qualify to participate in MIPS through an APM.


 An EC can check on their Quality Payment Program (QPP) reporting status by entering their 10-digit National Provider Identifier (NPI) at: <https://qpp.cms.gov/participation-lookup>.

More information about APMs can be found at: <https://qpp.cms.gov/apms/overview>.

II. MIPS – Who are Eligible Clinicians (ECs)?

Eligible Clinicians include:

<p>Physicians, Including:</p> <ul style="list-style-type: none"> • Doctor of Medicine (MD) • Doctor of Osteopathy (DO) • Doctor of Dental Surgery (DDS) • Doctor of Dental Medicine (DMD) • Doctor of Podiatric Medicine (DPM) 	<ul style="list-style-type: none"> • Doctor of Optometry (OD) • Doctor of Chiropractic (DC) • Physician Assistants (PA) • Nurse Practitioners (NP) • Clinical Nurse Specialists (CNS) • Certified Registered Nurse Anesthetists (CRNA)
<p>Starting in 2019, Eligible Clinicians also Include:</p> <ul style="list-style-type: none"> • Physical Therapists (PT) • Occupational Therapists (OT) • Speech-Language Pathologists (SLP) • Audiologists (AuD) • Clinical Psychologists (MPsych) • Registered Dietitians (RD) or Nutritional Professionals 	

 See Appendices A. and B. at the end of this guidebook for special instructions when EC and groups need to onboard or offboard, including importing or exporting partial year data to MHS.

III. MIPS – Eligibility and Thresholds

For the purpose of establishing eligibility for participating in the Merit-based Incentive Payment System (MIPS), an eligible clinician (EC) can meet the Threshold criteria as an:

- individual, or
- a member of a group using the same billing TIN, or
- a member of a virtual group that has agreed to work together on MIPS

Eligibility is determined using:

- National Provider Identifier (NPI) and
- Associated Taxpayer Identification Numbers (TINs)

If an EC assigns their Medicare billing rights to a TIN, then the EC’s NPI becomes associated with that TIN. This association is referred to as a TIN/NPI combination.

If an EC assigns their billing rights to multiple TINs, there will be multiple TIN/NPI combinations. Each TIN/NPI combination is evaluated for MIPS eligibility.

Based on the TIN/NPI combination, the EC must meet three eligibility thresholds or requirements to participate in MIPS, including:

4. Bill more than \$90,000 a year in allowed charges for covered professional services under the Medicare Physician Fee Schedule (PFS).
5. Furnish covered professional services to more than 200 Medicare beneficiaries a year.
6. Provide more than 200 covered professional services under the PFS.

A complete overview of the MIPS eligibility determination process can be found at: <https://qpp.cms.gov/mips/how-eligibility-is-determined>.



An EC can check on their Quality Payment Program (QPP) reporting status by entering their 10-digit National Provider Identifier (NPI) at: <https://qpp.cms.gov/participation-lookup>.

A. Opting In

If an eligible clinician (EC) does not meet all three of the eligibility thresholds or requirements, they can opt-in to Merit-based Incentive Payment System (MIPS) by exceeding one or two (but not all three) of the low-volume threshold criteria during either of two retrospective review periods. These three criteria are described above, in “Section III. – MIPS Eligibility and Thresholds”.



Although the MIPS program deadline for opting in for 2019 is March 31, 2020, any EC or group desiring to opt-in and report MIPS Quality, Promoting Interoperability (PI) and Improvement Activities (IA) measures through MHS must initiate contact not later than September 30, 2019.

For determining eligibility to Opt-in for participation in 2019, one or two of the low-volume thresholds must be met for one of the earlier review periods:

- October 1, 2017 – September 30, 2018
- October 1, 2018 – September 30, 2019



If an EC opts-in to MIPS for 2019, the decision is irreversible. The EC will receive a MIPS final score and a payment adjustment in 2021. The decision to participate cannot be rescinded.

A complete summary of the requirements and benefits for the MIPS Opt-in option can be found at: <https://qpp.cms.gov/mips/reporting-options-overview#mips-opt-in-eligible-clinician>.

B. Voluntary Reporting



A clinician or group that is not MIPS eligible can report voluntarily and will receive a MIPS final score but will not be eligible for a payment adjustment.

IV. MIPS – Timelines for Reporting

The ‘Performance Year’ mirrors the calendar year. In 2019, it begins January 1, 2019 and ends December 31, 2019.



All data must be submitted by March 31, 2020.

Additional information regarding specific reporting timelines can be found at: <https://qpp.cms.gov/about/deadlines?py=2019>.



Although the MIPS program reporting deadline for 2019 is March 31, 2020, any EC or group using MHS’s instance of Epic and desiring to report MIPS Quality, Promoting Interoperability (PI) and Improvement Activities (IA) measures through MHS must initiate contact not later than September 30, 2019. Contact MHS at: MHSEpicRegulatory@memorialcare.org.

V. MIPS – Options for Reporting

Eligible Clinicians (ECs) can participate in Merit-based Incentive Payment System (MIPS) as an individual, a group, or both.

Individual Only – An EC reporting as an individual only, is defined as a single clinician, identified by their individual National Provider Identifier (NPI) tied to a single Taxpayer Identification Number (TIN). If an EC reports only as an individual, they will report measures and activities for the practice(s)/TIN(s) under which they are MIPS-eligible and be assessed across all four performance categories at the individual level. The resulting payment adjustment will be based on the Final Score derived from the four MIPS performance categories.

Group Only – A group is defined as a single TIN with two or more clinicians. At least one clinician within the group must qualify throughout the entire reporting period an EC, as defined in the ‘Eligibility and Thresholds’ section above, and must have reassigned their Medicare billing rights to a single TIN. The group’s performance data will be aggregated across the 4 MIPS performance categories for a single TIN. Each MIPS-eligible clinician in the group will receive the same payment adjustment based on the group’s performance across all four MIPS performance categories.

Individual and Group Only – MIPS-eligible clinicians can report data as an individual and as part of a group under the same TIN. In this instance, the clinician will be evaluated across all four MIPS performance categories on their individual performance and on the group’s performance, with a final score calculated for each evaluation. The clinician will receive a payment adjustment based on the higher of the two scores.

Virtual Groups – CMS does have provisions for MIPS reporting in virtual groups. A virtual group is defined as a combination two or more TINs that include:

- Solo practitioners who are EC's, and/or
- Groups that have 10 or less practitioners, including one clinician within the group must qualify throughout the entire reporting period an EC, as defined in the 'Eligibility and Thresholds' section above.

More information on participating as a Virtual Group can be found at: <https://qpp.cms.gov/mips/individual-or-group-participation>.

i An EC can check on their Quality Payment Program (QPP) reporting status by entering their 10-digit National Provider Identifier (NPI) at: <https://qpp.cms.gov/participation-lookup>.

VI. MIPS – Program Overview

As summarized above, the Merit-based Incentive Payment System (MIPS), eligible clinicians (ECs) may earn performance-based payment adjustments for the services they provide to Medicare patients. For the reporting year 2019, an EC will receive a MIPS final score and a payment adjustment in 2021. For 2019, this score is based on the following weighted formula:



Performance in each category is used to calculate a final score (0-100). The EC or group's final score is compared to a performance threshold to determine the payment adjustments.

- The MIPS final score for 2019 will result in a payment adjustment in 2021.
- The maximum potential positive or negative payment adjustment for 2021 will be ± 7 percent.
- The performance threshold for 2019 is 30 points.
- Final scores above the performance threshold will receive a positive payment adjustment.
- Final scores below the performance threshold will receive a negative payment adjustment.
- Final scores equal to the performance threshold will receive a neutral payment adjustment.
- The exceptional performance bonus threshold for 2019 is 75 points.
- Final scores above the exceptional performance bonus threshold will receive an even larger positive payment adjustment.

i MIPS data will be displayed publicly on Physician Compare starting in 2019.

Moving forward to 2020 and 2021:

- The weight of each category will continue to change, with a decreased weight on Quality, and increased weight on Cost.
- The maximum potential positive or negative payment adjustment will be increased to ± 9 percent.

A general summary of the reporting process can be found at: <https://qpp.cms.gov/mips/individual-or-group-participation>. The specific guidelines for reporting for each of the four categories, including Quality, Promoting Interoperability (PI), Improvement Activities (IA), and Cost, are provided in subsequent sections of this Guidebook.

How each Eligible Clinician (EC) chooses to report and which methods are available to each EC depend on:

- Whether the EC belongs to a group
- The size of the EC's practice
- The type of information technology the EC uses
- Which performance categories the EC will report
- Whether the EC has implemented MHS's instance of Epic

Each EC, group, and virtual group should consider which submission method(s) best fits their practice. Most methods are available to individuals, groups, and virtual groups, however, there are two exceptions:

- CMS Web Interface can only be used by groups and virtual groups of at least 25 clinicians, who pre-register with CMS.



If an EC, group, or virtual group is considering participating and reporting MIPS through MHS, remember that the CMS Web interface option for submitting Quality, Promoting Interoperability (PI) and Improvement Activities (IA) measures is not supported through MHS.

- In 2019, claims can only be used by individual ECs in practices with less than 15 ECs for reporting data in the Quality performance category. Starting in 2020, this options for reporting Quality measures will be discontinued.



ECs or groups choosing to report Quality, Promoting Interoperability (PI), and Improvement Activities (IA) through MHS, should contact their Clinical Training Specialist (CTS) to determine registration status, reporting timelines, and determination for reporting individually or as a part of a group.

VII. Exemptions

The Centers for Medicare and Medicaid (CMS) understands that there may be circumstances beyond the control of eligible clinicians (ECs) or groups that make it difficult to meet the requirements of the Merit-based Incentive Payment System (MIPS) program. Two exemptions are available in 2019. A brief summary of each is provided below:

1. Promoting Interoperability (PI) Hardship Exemption. An EC or group can apply for this exception for any of the following reasons:
 - small practice
 - decertified EHR technology
 - insufficient Internet connectivity
 - extreme and uncontrollable circumstances such as disaster, practice closure, severe financial distress or vendor issues
 - lack of control over the availability of certified electronic health record technology (CEHRT)

Application for this exemption must be submitted not later than December 31, 2019. Applicants will be notified via e-mail regarding approval or denial of their application. If approved, the EC or group would not be required to report PI category data and the formula for determining a final MIPS score would be rebalanced.

2. Extreme and Uncontrollable Circumstance Exception. An EC or group can apply for this exception if they have been impacted by extreme or uncontrollable circumstances. These are defined by CMS as “rare events entirely outside of your control and the control of the facility in which you practice.” These circumstances would cause the EC or group to be:
 - unable to collect information necessary to submit for a performance category, or
 - unable to submit information that would be used to score a performance category for an extended period of time

The Extreme and Uncontrollable Circumstance Exception is automatically applied for Federal Emergency Management Agency (FEMA) designated major disasters.

Applications for exemption are not required for EC or group participants who already meet the guidelines for PI exemptions as outlined below, in “Section IX, Part B, 1. – Exemptions from the PI Reporting Requirements”.

VIII. MIPS – Support for Participation through MemorialCare Health System

MemorialCare Health System (MHS) supports many eligible clinicians (ECs) and groups who choose to submit their Quality, Promoting Interoperability (PI), and Improvement Activities (IA) data to the Quality Payment Program (QPP) submission site through MHS. Only ECs or groups using MHS’s instance of Epic are eligible to participate in MIPS through MHS. Those who report through MHS will also receive support to complete the following attestations:

- 2015 Edition Certified Electronic Health Record Technology (CEHRT) Attestation
- Prevention of Information Blocking Attestation
- Direct Review by the Office of the National Coordinator (ONC) Attestation
- Security Risk Assessment (SRA) Attestation



Although the MIPS program reporting deadline for 2019 is March 31, 2020, any EC or group desiring to report MIPS Quality, Promoting Interoperability (PI) and Improvement Activities (IA) measures through MHS must initiate contact not later than September 30, 2019. Contact MHS at:

MHEpicRegulatory@memorialcare.org.



For more information and technical assistance for participating in MIPS, please contact the Health Services Advisory Group (HSAG), CMS’s contracted agency in the State of California: <https://www.hsag.com>.

IX. MIPS – Performance Categories

As outlined in “Section VI. – MIPS Program Overview” there are four performance categories for participating in the Merit-based Incentive Payment System (MIPS). These performance categories constitute the final MIPS score, which, in turn, determines the payment adjustment for the EC or group. These categories are:

- **Quality**
- **Promoting Interoperability (PI)**
- **Improvement Activities (IA)**
- **Cost**

The following sections provide details for reporting in each of the four categories, and for consideration of Special Statuses.

A brief overview of the four performance categories can be found at: <https://qpp.cms.gov/mips/overview>.

A. Quality

- This category covers the quality of the care delivered, based on performance measures created by the Centers for Medicare & Medicaid Services (CMS), as well as medical professional and stakeholder groups.
- Eligible Clinicians (ECs) or groups should pick six measures of performance that best fit their practice.
- For each Quality performance measure data will be reported for the entire year.
- This category counts for 45% of the total Merit-based Incentive Payment System (MIPS) score in 2019.
- Two specific requirements include:
 1. One of these measures should be an outcome measure; if there is no applicable outcome measure, another high priority measure should be submitted instead.
 2. In addition, for groups of 16 or more clinicians who meet the case minimum of 200, the administrative claims-based all-cause readmission measure will be automatically scored as a seventh measure.

A more complete review of the Quality measure reporting guidelines can be found at:

<https://qpp.cms.gov/mips/quality-measures>.

For 2019 there are 50 EHR based electronic Clinical Quality Measures (eCQMs) available through the Centers for Medicare & Medicaid Services (CMS). A complete list of these measures can be found at:

<https://ecqi.healthit.gov/eligible-professional/eligible-clinician-ecqms/2019-performance-period-ep/ec-ecqms>.

Through MemorialCare Health System’s (MHS) version of Epic, 25 of these eCQMs are currently available and tracked for MIPS reporting. Available measures include:

2019 eCQM Quality Reporting

CMS ID	Measures that Epic is certified on AND MHS has built	Process/ Outcome	Priority
2	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Process	
22	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Process	
68	Documentation of Current Medications in the Medical Record	Process	High Priority
69	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Process	
117	Childhood Immunization Status	Process	
122	Diabetes: Hemoglobin A1c Poor Control	Intermediate Outcome	High Priority
124	Cervical Cancer Screening	Process	
125	Breast Cancer Screening	Process	
127	Pneumococcal Vaccination Status for Older Adults	Process	
130	Colorectal Cancer Screening	Process	
134	Diabetes: Medical Attention for Nephropathy	Process	
138	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Process	
139	Falls: Risk Assessment (Screening for Future Fall Risk)	Process	High Priority
146	Appropriate Testing for Children with Pharyngitis	Process	High Priority
147	Preventive Care and Screening: Influenza Immunization	Process	
153	Chlamydia Screening for Women	Process	
154	Appropriate Treatment for Children with Upper Respiratory Infection (URI)	Process	High Priority
155	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Process	
156	Use of High-Risk Medications in the Elderly	Process	High Priority
159	Depression Remission at Twelve Months	Outcome	High Priority
161	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	Process	
165	Controlling High Blood Pressure	Intermediate Outcome	High Priority
177	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	Process	High Priority

1. Selecting Measures to Reflect each Practice

- ECs and groups are urged to give careful consideration to the “value” of the selected quality measures, as it is possible that some measures may be retired in future years and/or the benchmark for the measure may be reset. For example, if a benchmark is reset, reporting on that selected measure may result in a minimal score on a quality measure as there is nothing to benchmark against. Therefore, even though the score may be high on for the selected measure, it may not add as much value for MIPS reporting.
- ECs and groups could choose to submit a specialty or subspecialty measure set, but currently this is not supported through the MHS reporting process. If an EC or group chooses to submit a specialty or subspecialty set, they must submit data on at least six measures within that set. If the set contains fewer than six measures, the EC or group should submit each measure in the set.

2. Special Considerations for Small Practice

- A small practice, which is defined as, “a group that has 15 or fewer clinicians identified by individual NPIs billing under the group’s TIN,” and has a small practice designation, may submit the data for their quality measures through Medicare Part B claims in 2019.



To determine whether an EC has a small practice designation, check on the [Quality Payment Program \(QPP\) reporting status](https://qpp.cms.gov/participation-lookup) by entering the 10-digit National Provider Identifier (NPI) at: <https://qpp.cms.gov/participation-lookup>.

- If an EC is one of 15 or fewer clinicians billing under the practice's TIN, or if a group has 15 or fewer clinicians under the practice’s TIN, or if a virtual group has 15 or fewer clinicians in the TIN, the EC or group will qualify as a Small Practice and will receive six bonus points in the Quality performance category if they submit at least one Quality measure.

B. Promoting Interoperability (PI)

- This category is based on performance measures that promote patient engagement and electronic exchange of information using certified electronic health record technology (CEHRT).
- Promoting Interoperability (PI) performance measure data will be reported for a minimum of 90 consecutive days.
- For most Eligible Clinicians (ECs) and groups this category will count for 25% of the total Merit-based Incentive Payment System (MIPS) score.
- A more complete review of the PI measure reporting guidelines can be found at: <https://qpp.cms.gov/mips/promoting-interoperability>.
- Four specific measures are included in this category. They are:
 1. e-prescribing
 2. Health Information Exchange
 3. Provider to Patient Exchange
 4. Public Health and Clinical Data Exchange

Additionally, in 2019, five additional bonus points are available for participation in each of following measures within the e-prescribing requirement. These include:

1. Query of Prescription Drug Monitoring Program (PDMP)
2. Verify Opioid Treatment Agreement

A brief explanation of each of the PI measures can be found in following sections.

1. Promoting Interoperability (PI) Measures

ePrescribing

For this measure, there is one requirement. Eligible clinicians (EC) must provide prescriptions which are queried for a drug formulary and transmitted electronically using certified electronic health record technology (CEHRT).

Additionally, there are two optional ePrescribing measures. These are specific to electronically prescribing Schedule II opioid medications. They include:

1. Query of Prescription Drug Monitoring Program (PDMP). This measure requires that the EC uses data from CEHRT to conduct a query of a PDMP for prescription drug history, except where prohibited and in accordance with applicable law.
2. Verify Opioid Treatment Agreement. This measure requires that the EC seeks to identify the existence of a signed opioid treatment agreement and incorporates it into the patient's electronic health record using CEHRT for patients with prescriptions of at least 30 cumulative days within a six-month look back period.

Health Information Exchange

Within this measure, there are two requirements. ECs must meet both:

1. Supporting electronic referral loops by sending health information. This measure requires that an EC who transitions or refers patients to another setting of care or health care provider must create a summary of care record using CEHRT and electronically exchange the summary of care record.
2. Supporting electronic referral loops by receiving and incorporating health information. This measure requires that an EC receive transition of care documents or referrals, and conduct clinical information reconciliation for medication, allergies, and current problems using CEHRT and electronically exchanged the summary of care record.

Provider to Patient Exchange

For this measure, there is one requirement. The EC must provide patients (or their patient-authorized representative) timely access to view online, download, and transmit his or her health information; and must ensure the patient's health information is available for the patient's (or their patient-authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the Application Programming Interface (API) in the CEHRT.

Public Health and Clinical Data Exchange

Within this measure, there are five requirements. The EC must submit at least **two of the five measures** in the Public Health and Clinical Data Exchange objective for 10 total points. If the EC qualifies for an exclusion and can only report one measure, then the point value for that measure will be reweighted to 10 points. The five requirements include:

1. Immunization registry reporting. This measure requires that an EC attests “YES” to being in active engagement with a Public Health Agency (PHA) to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS).
2. Electronic case reporting. This measure requires that an EC attests “YES” to being in active engagement with a PHA to electronically submit case reporting of reportable conditions.
3. Clinical data registry reporting. This measure requires that an EC attests “YES” to being in active engagement to submit data to a clinical data registry.



For immunization, electronic case and clinical data registry reporting, EC can earn extra points for reporting to multiple registries.

4. Public health registry reporting. This measure requires that an EC attests “YES” to being in active engagement with a PHA to submit data to public health registries. Because MHS reports to the California Parkinson’s Disease Registry at the California Department of Public Health some ECs and groups reporting MIPS data through MHS can select this option.
5. Syndromic surveillance reporting. This measure requires that an EC attests “YES” to being in active engagement with a public health agency to submit syndromic surveillance data from an urgent care setting.



At this time the Orange County Department of Public Health does not accept syndromic data electronically and Los Angeles County Department of Public Health limits electronic data submission to hospitals and urgent care facilities.

2. Promoting Interoperability – Additional Requirements

In 2019 there are four additional requirements related specifically to the Promoting Interoperability (PI) performance category for eligible clinician (EC) or group participation in the Merit-based Incentive Payment System (MIPS). These include:

1. **Use of a 2015 Edition Certified Electronic Health Record Technology (CEHRT) electronic health record (EHR) for at least 90 consecutive days.** The 2015 Edition CEHRT does not have to be implemented on January 1, 2019 but must be in place and fully functioning by the first day of the reporting period for PI measures. Check that the EMR being used meets 2015 CEHRT requirements at: <https://chpl.healthit.gov/#/search>.

2. **Prevention of Information Blocking.** Each EC or group must attest to three statements that they did not knowingly or willfully limit the electronic exchange of information in 2019. These statements include the EC or group:
 - a. did not take actions to limit or restrict the compatibility or interoperability of CEHRT. This includes actions such as purposefully disabling certain functionalities within the CEHRT
 - b. did implement technology, standards, and workflows that ensured the CEHRT was connected according to applicable law, compliant with information exchange standards, allowed patients timely access to electronic health information, and allowed the timely bi-directional exchange of information with other health care providers
 - c. did use CEHRT during the reporting period and the EC or group responded in a timely manner to requests to retrieve or exchange electronic health information with patients and other health care providers, regardless of the requestor's affiliation.
3. **Direct Review by the Office of the National Coordinator (ONC) for Health Information Technology (HIT).** Direct review of HIT is conducted by the ONC to evaluate the performance of certified HIT, including response to problems and complaints regarding the performance of CEHRT. Every EC or group must attest that they:
 - a. are aware of the requirement to cooperate in good faith with ONC direct review of their HIT if a request is received.
 - b. did cooperate in ONC direct review, if a request was received from the ONC.

The definition of cooperating in good faith means the EC or group responds in a timely manner to requests for information and accommodating requests by ONC to access the EC or group's CEHRT.


4. **Security Risk Analysis (SRA).** The required completion of the SRA reflects the high priority that CMS places on data security and the protection of patient health information. This SRA helps to:
 - ensure compliance with HIPAA's administrative, physical, and technical safeguards,
 - reveal how protected health information (PHI) could be at risk, and
 - form the basis of an annual improvement plan, by identifying what steps need to be taken to reduce risks associated with organizational policies, processes, and systems.


To support these efforts, the ONC and Department of Health and Human Services Office for Civil Rights (OCR), have developed a Security Risk Assessment tool, which is available at:

<https://www.healthit.gov/topic/privacy-security-and-hipaa/security-risk-assessment-tool>.

The attestation requirement documents the completion of SRA. Specifically, the SRA must be completed:

- annually
- within the calendar year of the performance period (January 1 to December 31, 2019), and
- for the 2015 Edition CEHRT used during the MIPS reporting period.

 ECs and groups who choose to submit their Quality, Promoting Interoperability (PI), and Improvement Activities (IA) data through MHS can contact their Clinical Training Specialist (CTS) for assistance to complete these attestations.


 Documentation of the evidence to support each of these four attestations should be maintained by each EC or group as a component of each practice's records and in anticipation of an audit from CMS. Later in this guidebook, "Section XII. – Audits," provides instructions on organizing this documentation.

3. Exemptions from the PI Measure Reporting Requirements

The following ECs are exempt from reporting PI data, unless they are reporting as a part of a group:

- Physician assistants
- Nurse practitioners
- Clinical nurse specialists
- Certified registered nurse anesthetists
- Physical therapists
- Occupational therapists
- Qualified speech-language pathologists
- Qualified audiologists
- Clinical psychologists
- Registered dietitian or nutrition professionals

Additionally, MIPS participants who are identified as Ambulatory Surgical Centers (ASC), Hospital-based, or Non-patient facing, are exempt from PI reporting.

 An EC can check on their Quality Payment Program (QPP) reporting status by entering their 10-digit National Provider Identifier (NPI) at: <https://qpp.cms.gov/participation-lookup>.

In instances where an EC or group is determined to be exempt from PI reporting, the percentage or weight of each of the other three reporting categories, including: Quality, Improvement Activities (IA), and Costs, will be adjusted. A summary of the PI reporting requirements can be found at: <https://qpp.cms.gov/mips/promoting-interoperability>.

C. Improvement Activities (IA)

- This category is based on improvement activities that are designed to improve clinical practice or delivery of care, and that lead to improved patient outcomes.
- Improvement Activities (IA) performance measure data will be reported for a minimum of 90 consecutive days.
- For most Eligible Clinicians (ECs) and groups this category will count for 15% of the total Merit-based Incentive Payment System (MIPS) score.
- To earn full credit in this performance category, participants must submit for four activities.
- If EC or groups is a participant in a recognized or certified patient-centered medical home (PCMH) or comparable specialty practice, they will earn the maximum IA performance category score by attesting to this during the submission period.

A more complete review of the IA measure reporting guidelines can be found at: <https://qpp.cms.gov/mips/improvement-activities>.

For 2019 there are 118 electronic Improvement Activities Measures available through the Centers for Medicare & Medicaid Services (CMS). A complete list of these measures can be found at: <https://qpp.cms.gov/mips/explore-measures/improvement-activities>.

At MemorialCare Health System (MHS), four of these Improvement Activities are available and tracked. Available measures include:

2019 Improvement Activities Reporting

CMS ID	Measures that Epic is certified on AND MHS has built	Measure Weight
IA_BE_4	Engagement of Patients through Implementation of Improvements in Patient Portal	Medium
IA_CC_13	Practice Improvements for Bilateral Exchange of Patient Information	Medium
IA_CC_2	Implementation of Improvement that Contribute to More Timely Communication of Test Results	Medium
IA_PM_16	Implementation of Medication Management Practice Improvements	Medium

Special Considerations for Small Practice

If an EC is one of 15 or fewer clinicians billing under the practice's TIN, or if a group has 15 or fewer clinicians under the practice's TIN, or if a virtual group has 15 or fewer clinicians in the TIN, the EC or group will qualify as a Small Practice and will earn double points for each improvement activity they submit.

D. Costs

There is no data submission requirement for the Cost performance category, as Cost measures are evaluated automatically through administrative claims data and CMS uses Medicare claims data to calculate Cost measure performance. All EC and groups will be evaluated on the same ten cost measures if they meet or exceed the measures' minimum case volume necessary for the specific measure to be evaluated and scored.

For 2019, MIPS uses cost measures that assess the beneficiary's:

- total cost of care during the year, or
- during a hospital stay, and/or
- during eight episodes of care.

More information about the Cost measures can be found at: <https://qpp.cms.gov/mips/cost>.

E. Special Statuses

The Quality Payment Program (QPP) automatically assigns special statuses to Merit-based Incentive Payment System (MIPS) eligible clinicians (ECs), groups, and virtual groups who meet certain criteria. Some special statuses include:

- Ambulatory Surgery Center (ASC)-based
- Hospital-based

- Non-patient facing
- Small Practice
- Health Professional Shortage Areas (HSPA)
- Rural-based

A more complete summary of the various Special Statuses for MIPS participation can be found at: <https://qpp.cms.gov/mips/special-statuses#hpsa-2019>.

If a special status is assigned, reporting requirements may be affected. To determine if a special status has been automatically assigned, use the [QPP Participation Status Tool](#). If an EC or group believes that they qualify for special status or believe there is a mistake in the designation of a special status, they should contact the [Quality Payment Program](#).

- i** As noted previously, an EC can check on their Quality Payment Program (QPP) reporting status by entering their 10-digit National Provider Identifier (NPI) at: <https://qpp.cms.gov/participation-lookup>.

X. Onboarding or Offboarding

Participation in the Quality Payment Program (QPP) and Merit-based Incentive Payment System (MIPS) begins with each new calendar year.

- i** Continuing eligible clinicians (ECs) and groups should carefully review the Continuing Provider Checklist at the beginning of this Guidebook.
- i** For more information and technical assistance for participating in MIPS, please contact the Health Services Advisory Group (HSAG), CMS's contracted agency in the State of California: <https://www.hsag.com>.


A. Onboarding

- 1. Onboarding to MIPS effective January 1, 2019:** The list of eligible clinicians (ECs) expanded in 2019. New categories of providers include:
 - Physical Therapists (PT)
 - Occupational Therapists (OT)
 - Speech-Language Pathologists (SLP)
 - Audiologists (AuD)
 - Clinical Psychologists (MPsych)
 - Registered Dietitians (RD) or Nutritional Professionals

For ECs and groups who are joining QPP and MIPS effective January 1, 2019 should become familiar with this Guidebook and work closely with their Clinical Training Specialist (CTS), paying careful attention to:

- Section III. – MIPS – Eligibility and Thresholds
- Section IV. – MIPS – Timelines for Reporting
- Section VIII. – MIPS – Support for Participation through MemorialCare Health System (MHS)
- Section IX. – MIPS – Performance Categories

2. **Onboarding to MIPS mid-year:** There are special considerations for ECs and groups who desire to onboard to MIPS at MHS mid-year. Mid-year onboarding includes ECs and groups who have not previously participated in MIPS, and those who have participated in MIPS, but are now affiliating with MHS, and may need assistance to migrate patient data in order to meet all reporting requirements.


 “Appendix A – Mid-Year Onboarding to MIPS at MHS” provides detailed guidance for ECs and groups who desire to onboard to MIPS and report through MHS.


B. Offboarding

1. **Offboarding to MIPS effective December 31, 2019:** ECs who are ending their participation in MIPS effective December 31, 2019, will need to conform to all MIPS program participation requirements and reporting timelines.


 **NOTE: ECs are required to participate in MIPS in 2019, if they meet all three of the following requirements:**

- a. exceed the low volume threshold
- b. enrolled in Medicare prior to January 1, 2019, and
- c. do not become Qualifying Alternative Payment Model (APM) or partial Qualifying APM.

 An EC can check on their Quality Payment Program (QPP) reporting status by entering their 10-digit National Provider Identifier (NPI) at: <https://qpp.cms.gov/participation-lookup>.

 For more information and technical assistance for participating in MIPS, please contact the Health Services Advisory Group (HSAG), CMS’s contracted agency in the State of California: <https://www.hsag.com>.

2. **Offboarding to MIPS mid-year:** There are special considerations for ECs and groups who desire to offboard from MIPS at MHS mid-year. Mid-year offboarding includes ECs and groups who have participated in MIPS through MHS, and are transitioning to another system for MIPS reporting, and may need assistance to migrate their patient data in order to meet all reporting requirements.

 “Appendix B – Mid-Year Offboarding from MIPS at MHS” provides detailed guidance for ECs and groups who participate in MIPS through MHS, and desire to offboard from MIPS mid-year.

XI. Audits

Audits from the Centers for Medicare and Medicaid Services (CMS) can be anticipated.



If an eligible clinician (EC) or group participates in MIPS through MemorialCare Health System (MHS) and is contacted regarding the initiation of an audit request, they should notify their Clinical Technical Specialist (CTS) at MHS for assistance in responding to the request.



Because any EC or group could be audited, it is recommended that all Merit-based Incentive Payment System (MIPS) participants create an electronic folder to save all audit materials. Remember to de-identify patient data in the documents where applicable. Examples of documentation that should be maintained include:

- Proof of use of Certified Electronic Health Record Technology (CEHRT)
- Supporting Documentation for the Prevention of Information Blocking
- Supporting Documentation of any responses to request for Direct Review by the Office of the National Coordinator (ONC) for Health Information Technology
- Copy of completed Security Risk Analysis (SRA) Report and plans to address identified weaknesses
- Objective Reports for Performance-Based Objectives
- Supporting Documentation for Attestation-Only Objectives
- Any other applicable documentation (i.e. Hardship Exemption)

If an EC or group participates in MIPS through MHS, they can contact their CTS for assistance with documents to support the audit process, including:

- An EPIC license summary
- Screenshots and other supporting documentation as needed
- Copies of the submitted reports
- Any applicable measure exclusion documentation
- Additional reports that show use of the features related to attestation-only objectives, if requested
- Copies of the QRDA III submitted files

XII. Resources

-  For more information and technical assistance for participating in MIPS, please contact the Health Services Advisory Group (HSAG), CMS’s contracted agency in the State of California: <https://www.hsag.com>.
-  ECs or groups desiring to report MIPS Quality, Promoting Interoperability (PI) and Improvement Activities (IA) measures through MHS must initiate contact not later than September 30, 2019. Contact MHS at: MHSEpicRegulatory@memorialcare.org.

Common Acronyms are used throughout this guidebook. For ease of reference:

Acronym	Definition
APMs	Alternative Payment Models
AAPM	Advanced Alternative Payment Models
ASC	Ambulatory Surgery Center
CMS	Centers for Medicare & Medicaid Services
CEHRT	Certified Electronic Health Record Technology
CHIP	Children’s Health Insurance Program
CTS	Clinical Training Specialist
EC	Eligible Clinician
eCQM	Electronic Clinical Quality Measure
EHR	Electronic Health Record
HPSA	Health Professional Shortage Areas
ISS	Immunization Information System
LBN	Legal Business Name
MACRA	Medicare Access and CHIP Reauthorization Act
MHS	MemorialCare Health System
MIPS	Merit Based Incentive Payment System
NPI	National Provider Identifier
ONC	Office of the National Coordinator for Health Information Technology
PCMH	Patient-Centered Medical Home
PDMP	Prescription Drug Monitoring Program
PECOS	Provider Enrollment, Chain, and Ownership System
PHA	Public Health Agency
QPP	Quality Payment Program
SRA	Security Risk Analysis
TIN	Tax Identification Number

Appendix A. – Mid-Year Onboarding to MIPS at MemorialCare Health System

It is anticipated that there will be instances when eligible clinicians (EC) and groups may need to onboard into the MemorialCare Health System (MHS) reporting process for the Merit-based Incentive Payment System (MIPS) during the calendar year. For some clinicians, participation in MIPS may be new, while for others, this transition may be related to a change of practice, affiliation, location, or associated Tax Identification Number (TIN).

This can create a challenge, not only with respect to determining clinician eligibility and thresholds for MIPS participation, but also for meeting registration and reporting timelines, and reporting scores that reflect the highest quality performance.



Based on the MIPS requirements, every eligible clinician (EC) or group must report:

- Quality data for the entire calendar year, and
- Promoting Interoperability (PI) and Improvement Activities (IA) data for a period of at least 90 continuous days during the calendar year.

To minimize the disruptions for an EC or group that has not previously participated in MIPS, or those that are transitioning from another reporting process, and to maximize the benefits of participation, MHS will work with each EC or group to build a plan that incorporates the logistics, reporting details, and technical aspects of the onboarding process. Any onboarding EC or group should take the following steps, as early as possible, to ensure a smooth transition:

- Contact the MHS Clinical Training Specialist (CTS), who will coordinate with others at MHS to determine the best options for onboarding. This coordination will include Performance Improvement staff responsible to provide MIPS data to CMS, as well as other MHS staff as needed.
- Identify the date for onboarding. This date is critical for planning to meeting certain data completeness standards which require that at least 60 percent of possible data is submitted for the Quality Measures.
- Become familiar with this MHS Guidebook for CMS QPP Merit-based Incentive Payment System.
- Ensure that Provider Enrollment, Chain, and Ownership System (PECOS) information is up to date and correct, including the Legal Business Name and Address.
- Visit the MIPS resource library and download the [MIPS Quick Start Guide](#).
- Visit the MIPS site to review a general summary of the MIPS program: <https://qpp.cms.gov/mips/overview>
- Visit the MIPS site to determine the best options for individual versus group participation: <https://qpp.cms.gov/mips/individual-or-group-participation>.
- Check your QPP Participation Status at: <https://qpp.cms.gov/participation-lookup>.
- Identify the National Provider Identifier (NPI) and Tax Identification Number (TIN) used for any prior MIPS reporting.
- Identify any clinicians who will be required to participate and those who may want to opt-in for 2019.
- Provide Proof of use of Certified Electronic Health Record Technology (CEHRT).
- Perform a Security Risk Assessment in calendar year 2019 and develop a plan to address identified weaknesses.
- Review and select six Quality Measures available for reporting through MHS, as outlined in “Section IX. A. – Quality”. Remember, one of the measures must be an outcome measure.
- Review and select two Public Health and Clinical Data Exchange measures within the Promoting Interoperability category, as outlined in “Section IX. B. 1. – Public Health and Clinical Data Exchange”.
- Confirm workflows for reconciling patient Problem List, Medications, and Allergies from outside sources, are in place and emphasized.
- Review Clinical Referral workflows.
- Optimize Electronic Health Record (EHR) data quality.

Appendix B. – Mid-Year Offboarding from MIPS at MemorialCare Health System

It is anticipated that there will be instances when eligible clinicians (ECs) and groups may need to offboard from the MemorialCare Health System (MHS) reporting process for the Merit-based Incentive Payment System (MIPS) during the calendar year. This transition may be related to a change of practice, affiliation, location, or associated Tax Identification Number (TIN). ECs and groups who have participated in MIPS through MHS, and are transitioning to another system for MIPS reporting, will need assistance to migrate their participation to meet all reporting requirements and to report scores that reflect the highest quality performance.



Based on the MIPS requirements, every eligible clinician (EC) or group must report:

- Quality data for the entire calendar year, and
- Promoting Interoperability (PI) and Improvement Activities (IA) data for a period of at least 90 continuous days during the calendar year.

To minimize the disruptions for an EC or group that will transition to another process for participating in MIPS, MHS will work with each EC or group to build a plan that incorporates the logistics, reporting details, and technical aspects of the offboarding process. Any offboarding EC or group should take the following steps, as early as possible, to ensure a smooth transition:

- Contact the MHS Clinical Training Specialist (CTS), who will coordinate with others at MHS to determine the best options for offboarding. This coordination will include Performance Improvement staff responsible to provide MIPS data to CMS, as well as other MHS staff as needed.
- Provide the name of the CTS or similar staff from the system or network to which the ECs or groups will transition.
- Identify what Electronic Health Record (EHR) system to which they will be migrating.
- Identify the National Provider Identifiers (NPI) and Tax Identification Numbers (TIN) through which ECs and groups will participate in MIPS after the onboarding process.
- Identify the date for offboarding. This date is critical for planning to meeting certain data completeness standards which require that at least 60 percent of possible data is submitted for the Quality Measures. It is also vital for MHS to determine what data has been submitted and to provide data files for the period of participation in MIPS through MHS.
- Offboarding ECs or groups should provide the following information to the CTS or similar staff to which the ECs or groups will transition:
 1. The six Quality Measures used for MIPS reporting at MHS.
 2. The two Public Health and Clinical Data Exchange measures within the Promoting Interoperability category, as outlined in “Section IX. B. 1. – Public Health and Clinical Data Exchange” used for MIPS reporting at MHS.
- Maintain an audit file to provide evidence of participation in MIPS through MHS prior to transition. At a minimum, this audit file should include:
 1. Proof of use of Certified Electronic Health Record Technology (CEHRT).
 2. Proof of a completed Security Risk Assessment in calendar year 2019 and development a plan to address identified weaknesses.
 3. Copy of Attestation for Prevention of Information Blocking.
 4. Copy of Attestation of willingness to participate in an Office of the National Coordinator (ONC) Direct Review.