2021 MIPS Participation for Traveling Eligible Clinicians

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Agenda

- Who Are Traveling Eligible Clinicians?
- Common Barriers to Reporting MIPS Data
- Tips for MIPS Reporting
- Adjusting Expectations / Calculating ROI
- Performance Thresholds and Payment Adjustments
- Exploring Participation Options
- Influencing Program Changes
- Case Studies

Who Are Traveling Eligible Clinicians?

MIPS Eligible Clinicians (ECs) who see patients in atypical, non-clinic settings such as:

- **Nursing homes**
- **Short- or long-term care or rehabilitation facilities**
- **Hospitals**
- **Patient homes**

Common Barriers to Reporting MIPS Data

- **Access to Patient Care Data**
  - Data resides in the facility's EHR and cannot be accessed for reporting
  - If EC has their own EHR, requires double entry by clinician or support staff
- **Lack of Access to and/or Control Over EHR Technology**
- **Lack of Clinically Relevant Measures and Activities**
- **Handicapped in MIPS Cost Performance Category**
  - Complex patients
  - High cost associated with short- and long-term care facilities

Common Barriers to Reporting Quality

- **Lack of Clinically Relevant Measures**
  - Patient population exceptions
  - Completion of quality measure activities by others
  - Increasing number of measures with exclusions
    - Frailty
    - Dementia
    - Residents of long-term care facilities
- **Data Collection Barriers**
  - Claims
    - Few measures available, with many being Topped Out
    - Lack of access to medical records for coding by coder/biller
    - Coding often done manually by the clinician

Common Barriers to Reporting Quality

➢ Data Collection Barriers (continued)

- Registry
  - No access to EHR to interface data
  - Manual entry to registry portal is resource-intensive
  - Limited access to facility data
- Eligible Clinician's EHR
  - Lack of applicable measures within EHR dashboard
  - EHR data not updated in real time

Tips for Reporting MIPS Quality – SNF Specialty Measure Set

MEASURE NAME	MEASURE DESCRIPTION	QUALITY ID	MEASURE TYPE	HIGH PRIORITY MEASURE	DATA SUBMISSION METHOD		
					Part B Claims	MIPS CQMs (Registry)	Electronic CQMs
Advance Care Plan	Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	47	Process	TRUE	✓	✓	
Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy	Percentage of patients aged 18 years and older with nonvalvular atrial fibrillation (AF) or atrial flutter who were prescribed warfarin OR another FDA-approved oral anticoagulant drug for the prevention of thromboembolism during the measurement period.	326	Process	FALSE	✓	✓	
Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)	Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have diabetes OR a current or prior Left Ventricular Ejection Fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy.	118	Process	FALSE		✓	
Coronary Artery Disease (CAD): Antiplatelet Therapy	Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease (CAD) seen within a 12-month period who were prescribed aspirin or clopidogrel.	6	Process	FALSE		✓	
Coronary Artery Disease (CAD): Beta-Blocker Therapy - Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%)	Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12-month period who also have a prior MI or a current or prior LVEF < 40% who were prescribed beta-blocker therapy.	7	Process	FALSE		✓	✓
Elder Maltreatment Screen and Follow-Up Plan	Percentage of patients aged 65 years and older with a documented elder maltreatment screen using an Elder Maltreatment Screening tool on the date of encounter AND a documented follow-up plan on the date of the positive screen.	181	Process	TRUE	✓	✓	

Tips for Reporting MIPS Quality – SNF Specialty Measure Set

MEASURE NAME	MEASURE DESCRIPTION	QUALITY ID	MEASURE TYPE	HIGH PRIORITY MEASURE	DATA SUBMISSION METHOD		
					Part B Claims	MIPS CQMs (Registry)	Electronic CQMs
Falls: Plan of Care	Percentage of patients aged 65 years and older with a history of falls that had a plan of care for falls documented within 12 months.	155	Process	TRUE	✓	✓	
Falls: Risk Assessment	Percentage of patients aged 65 years and older with a history of falls that had a risk assessment for falls completed within 12 months.	154	Process	TRUE	✓	✓	
Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy either within a 12-month period when seen in the outpatient setting OR at each hospital discharge.	8	Process	FALSE		✓	✓
Pneumococcal Vaccination Status for Older Adults	Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.	111	Process	FALSE	✓		✓
Preventive Care and Screening: Influenza Immunization	Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.	110	Process	FALSE	✓	✓	✓
Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Percentage of patients aged 18 years and older seen during the submitting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	317	Process	FALSE	✓	✓	✓
Use of High-Risk Medications in Older Adults	Percentage of patients 65 years of age and older who were ordered at least two of the same high-risk medications.	238	Process	TRUE		✓	✓

Tips for Reporting MIPS Quality – Note Exceptions/Exclusions

Measure ID	Name	Exclusion/Exception Patients				
		66 Years + Frailty + Advanced Illness Dx	66 Years + Frailty with Dimentia Meds	66 Years + SNP or Long Term Care Resident >90 Days	Hospice	Dementia
1	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	Y	Y	Y	Y	
112	Breast Cancer Screening	Y	Y	Y	Y	
113	Colorectal Cancer Screening	Y	Y	Y	Y	
117	Diabetes: Eye Exam	Y	Y	Y	Y	
119	Diabetes: Medical Attention for Nephropathy	Y	Y	Y	Y	
126	Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy					Y
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan					65+ Years Y
236	Controlling High Blood Pressure	Y	Y	Y	Y	
277	Sleep Apnea: Severity Assessment at Initial Diagnosis					Y
383	Adherence to Antipsychotic Medications For Individuals with Schizophrenia					Y
418	Osteoporosis Management in Women Who Had a Fracture	Y	Y	Y	Y	

Tips for Reporting MIPS Quality – Note Inclusions with Dementia Focus

Measure ID	Name
282	Dementia: Functional Status Assessment
286	Dementia: Safety Concern Screening and Follow-Up for Patients with Dementia
288	Dementia: Education and Support of Caregivers for Patients with Dementia

Tips for Reporting MIPS Quality – Claims

Appendix D – Sample Explanation of Benefits (EOB)

In the snapshot below, a sample EOB outlines 4 examples (1 correct and 3 incorrect) of Medicare Part B claims submissions for the purposes of reporting Quality data.

Sample EOB for Medicare Part B Claims Quality Data Reporting

Billing Provider	123456			Invoice Number							
Service Provider	123456			Check Number	56789						
Tax ID	999999			Payment Date	10/10/2021						
Correct	**Complete with CPT II Code and Correct POS, QDC, & DX Code**										
PERF Recipients	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PO
Name **A**	WALTER, TIM K		HIC 1234567890	ACCT WALTERT0005							
	123-567-9876	11	1	99213		100	75.95	0			
REM	N620		1	G9974		0.01	0	0			
PT RESP											
CLAIM INFO											
The Next Three Examples will not meet the Requirements for Claims-Based Measures for the MIPS Program											
	Complete without CPT II code										
Name **B**	WALTER, TIM K		HIC 1234567890	ACCT WALTERT0005							
	123-567-9876	11		99213		100	75.95	0			
PT RESP	15.19										
CLAIM INFO											
	Complete CPT II Code split off from Service										
Name **C**	WALTER, TIM K		HIC 1234567890	ACCT WALTERT0005							
REM	N620		1	G9974		0.01	0	0			
	Incorrect POS										
Name **D**	WALTER, TIM K		HIC 1234567890	ACCT WALTERT0005							
	123-567-9876	10	1	99213		100	75.95	0			
REM	N620		1	2027F		0.01	0	0			
PT RESP	15.19										
CLAIM INFO											

Valid, but unsuccessful 2021 MIPS QDC Submission

Example A: This claim was correct because the appropriate QDC (G-code) and place of service (POS) code were included; the line item charge is correct; and the procedure/service (CPT) code is present with the QDC. The N620 confirms that the QDC submitted is valid for the 2021 MIPS performance period, but **it doesn't mean the QDC was reported correctly for the intended measure or that you met the measure requirements**.

Example B: This claim was processed without the corresponding QDC (G-code). It either wasn't submitted on the original claim or was broken off from the procedure or service code on the claim during processing. The N620 is not present here, because there is no QDC to validate.

Example C: This claim was processed without the corresponding procedure/service (CPT) code. It either wasn't submitted on the original claim or was broken off from the QDC on the claim during processing. The N620 code is present here because the QDC is valid for 2021, but this claim was not a successful quality data submission for the patient encounter billed.

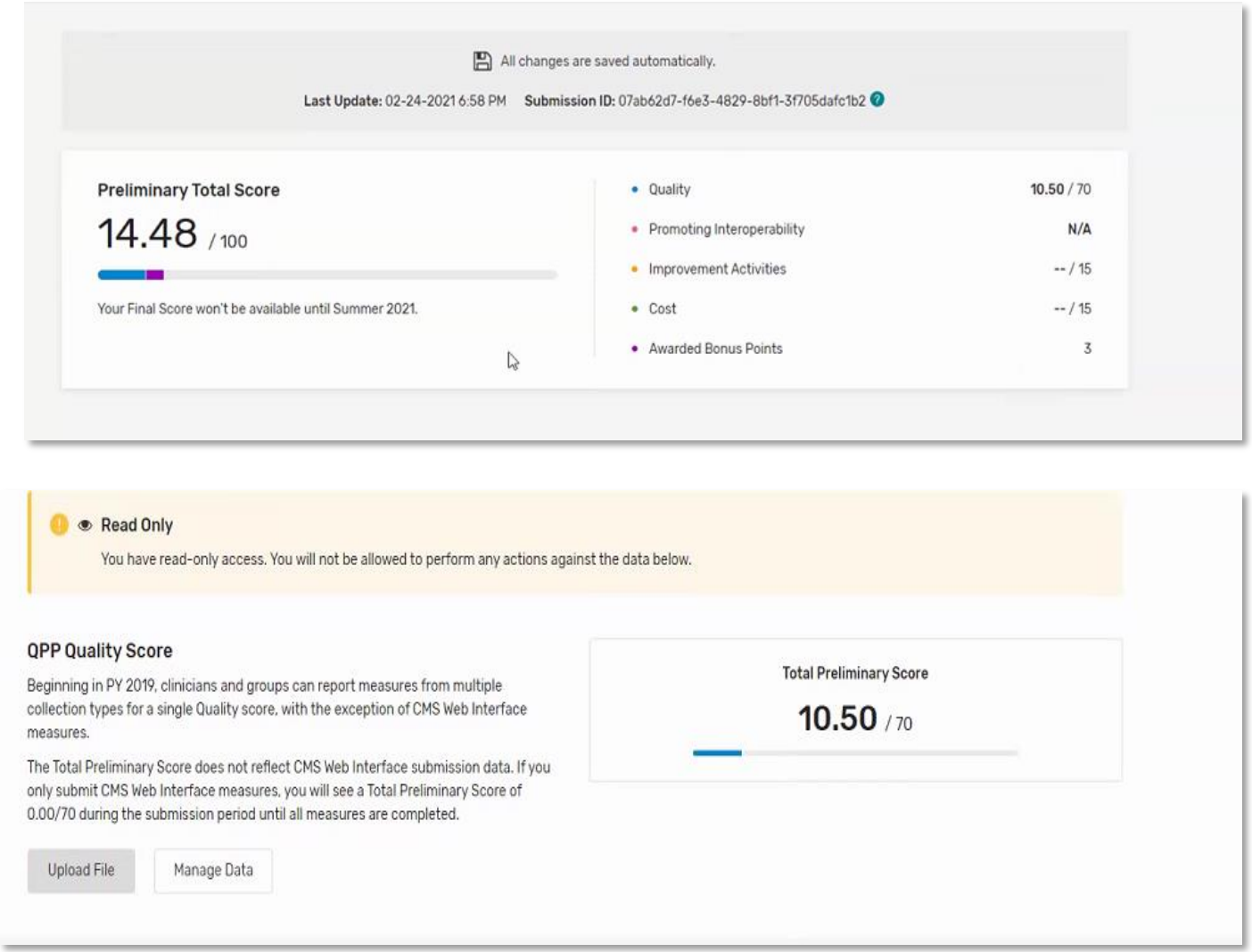
Example D: This claim has an incorrect POS code. The N620 code is present here because the QDC is valid for 2021, but this claim was not a successful quality data submission for the patient encounter billed.

Image extracted from the 2021 Part B Claims Reporting Quick Start Guide

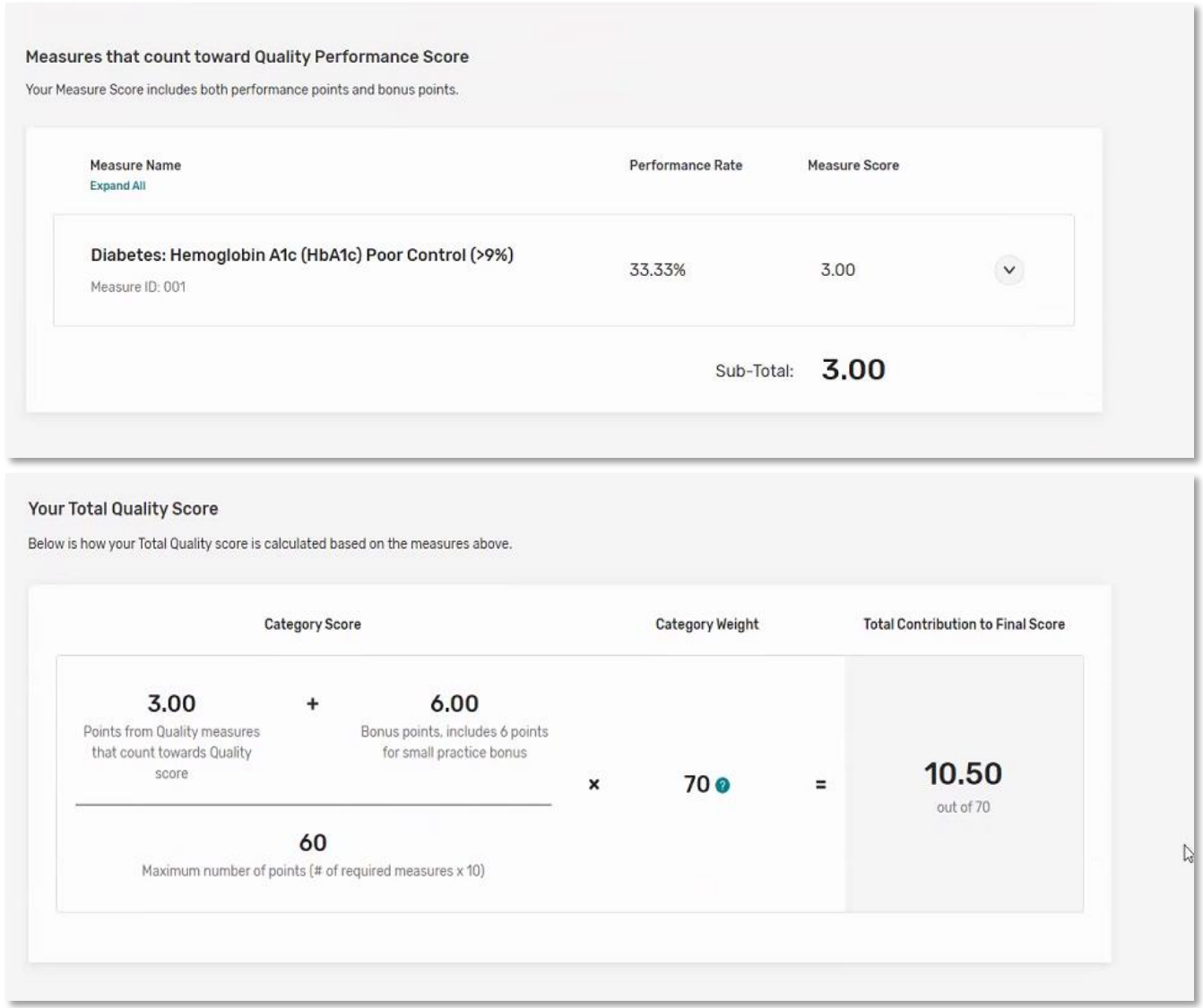
For more information, access the 2021 Medicare Part B Claims Measure Specifications and Supporting Documents

QPP Resource Center®

Tips for Reporting MIPS Quality – Claims feedback example



Tips for Reporting MIPS Quality – Claims feedback example



Measures that count toward Quality Performance Score

Your Measure Score includes both performance points and bonus points.

Measure Name Expand All	Performance Rate	Measure Score
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) Measure ID: 001	33.33%	3.00

Sub-Total: **3.00**

Your Total Quality Score

Below is how your Total Quality score is calculated based on the measures above.

Category Score				Category Weight		Total Contribution to Final Score
3.00 Points from Quality measures that count towards Quality score	+	6.00 Bonus points, includes 6 points for small practice bonus	×	70	=	10.50 out of 70
60 Maximum number of points (# of required measures x 10)						

Common Barriers to Reporting Improvement Activities

- **Few applicable activities appropriate for patient population and care setting**
- **Lack of clinical support staff**
- **Difficulty in collecting proof of activity implementation for audit file**

Tips for Reporting Improvement Activities

- **Curated list of Activities to consider implementing/reporting**

ACTIVITY ID	ACTIVITY NAME
IA_PSPA_23	Completion of CDC Training on Antibiotic Stewardship
IA_PSPA_6	Consultation of the Prescription Drug Monitoring Program
IA_ERP_2	Participation in a 60-day or greater effort to support domestic or international humanitarian needs.
IA_CC_19	Tracking of clinician's relationship to and responsibility for a patient by reporting MACRA patient relationship codes.
IA_CC_11	Care transition standard operational improvements
IA_PSPA_28	Completion of an Accredited Safety or Quality Improvement Program
IA_BE_3	Engagement with QIN-QIO to implement self-management training programs
IA_BE_16	Evidenced-based techniques to promote self-management into usual care
IA_BE_8	Participation in a QCDR, that promotes collaborative learning network opportunities that are interactive.
IA_PSPA_1	Participation in an AHRQ-listed patient safety organization.
IA_PSPA_13	Participation in Joint Commission Evaluation Initiative
IA_PM_17	Participation in Population Health Research
IA_PSPA_12	Participation in private payer CPIA
IA_EPA_5	Participation in User Testing of the Quality Payment Program Website (https://qpp.cms.gov/)
IA_ERP_1	Participation in Disaster Medical Assistance Team, registered for 6 months.
IA_BE_18	Provide peer-led support for self-management.
IA_PM_11	Regular Review Practices in Place on Targeted Patient Population Needs
IA_CC_7	Regular training in care coordination
IA_CC_18	Relationship-Centered Communication
IA_BE_12	Use evidence-based decision aids to support shared decision-making.

- **Review "Suggested Documentation" in the MIPS Data Validation Criteria file for audit file guidance**

Common Barriers to Reporting Promoting Interoperability

- **Lack of Access to and/or Control Over EHR Technology**
  - If EC has their own EHR, requires double entry by clinician or support staff
- **Point of Service Eliminates Most Measures**
  - eRX - Facility submits prescriptions to internal pharmacy
    - Not necessarily electronic
    - May not include formulary checks
  - Patient Electronic Access
    - Patients do not have computer or smartphone access
    - Family members not available to offer patient portal
  - Health Information Exchange
    - Send/Receive Transitions of Care (ToC)
    - Data required to create CCD document resides in and would be sent by facility EHR
    - Receiving ToC would be sent to facility's not EC's EHR

Tips for Reporting Promoting Interoperability

➢ Consider Applying for a PI Hardship Exception

- The MIPS Promoting Interoperability Performance Category Hardship Exception application allows you to request reweighting specifically for the Promoting Interoperability performance category if you qualify for one of these reasons:
  - **You're a small practice** (15 or fewer clinicians)
  - You have decertified EHR technology
  - You have insufficient Internet connectivity
  - You face extreme and uncontrollable circumstances such as disaster, practice closure, severe financial distress or vendor issues
  - **You lack control over the availability of CEHRT**

Common Barriers in the Cost Performance Category

Patient Population

- Complex with multiple issues and generally in poor health
- Acute Care inpatient and/or facility stays are highest cost points of service

Attribution Methodology Changes

- Total Per Capita Cost of Care (TPCC) attribution is complicated, making it difficult to predict which patients will attributed to a given TIN or NPI
- Medicare Spending per Beneficiary (MSPB) attribution changes mean that ECs who regularly see patients in the inpatient setting are more likely to be attributed patients and scored for this measure

Tips for the Cost Performance Category

- **Understand which Cost measure might apply to you**
  - The following acute condition episode-based measures are triggered by an inpatient admission and require 20 attributed patients to receive a measure score
    - Intracranial Hemorrhage or Cerebral Infarction
    - Simple Pneumonia with Hospitalization
    - ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)
    - Inpatient COPD Exacerbation
    - Lower Gastrointestinal Hemorrhage (applies to groups only)
- **Consider submitting an Extreme and Uncontrollable Circumstances (EUC) Exception Application**
  - https://qpp.cms.gov/mips/exception-applications?py=2021
  - See slide 24 for additional details

Adjusting Expectations/Calculating ROI on Avoiding Penalty and Earning Incentives

- **Avoid/Minimize the penalty vs. Earning a positive adjustment**
  - Your best course of action may be working to minimize the penalty
- **Don't spend more $ than you're earning back**
  - Calculate what penalties will cost you (1% - 9%)
  - TIN vs NPI level reporting could make a difference. Not necessarily all or nothing.

MIPS Participation Details

CLINICIAN LEVEL INFORMATION	PRACTICE LEVEL INFORMATION
Exceeds Low Volume Threshold: Yes	Exceeds Low Volume Threshold: Yes
Medicare Patients: 655	Medicare Patients: 1,330
Allowed Charges: $123,592	Allowed Charges: $696,624
Covered Services: 1,140	Covered Services: 9,788
Eligible Provider Type: Yes: Doctor of Medicine	
Years Enrolled in Medicare: > 1 year	

Adjusting Expectations/Calculating ROI on Avoiding Penalty and Earning Incentives

- **Investigate available Alternative Payment Models (APMs) in your area**
  - Some Physician Organizations (POs) manage APMs/ACOs
  - 2021 Comprehensive List of APMs
  - Medicare Shared Savings Program ACOs
- **Investigate new Direct Contracting Entity (DCE) models**
  - Direct Contracting Model Options
    - Standard DCEs
    - New Entrant DCEs
    - High Needs Population DCEs
    - MCO-based DCEs
  - CMS Direct Contracting Entity website

Performance Thresholds & Payment Adjustments

2021 Point Breakdown and Payment Adjustment

Final Score 2021	Payment Adjustment 2023
≥85 points	• Positive adjustment greater than 0% • Eligible for additional payment for exceptional performance—minimum of additional 0.5%
60.01-84.99 points	• Positive adjustment greater than 0% • Not eligible for additional payment for exceptional performance
60 points	• Neutral payment adjustment
15.01-59.99 points	• Negative payment adjustment greater than -9% and less than 0%
0-15 points	• Negative payment adjustment of -9%

Note:

- The performance threshold has incrementally increased each program year
- For the 2022 program year, the performance threshold (the number in the green box) will be based on the mean or median of the final scores for all MIPS eligible clinicians in a previous year
- This means we will likely see a 2022 **minimum** performance threshold somewhere in the range of 70-85 points
- In 2022, participants will need to achieve scores that were previously considered "exceptional performance" in order to avoid a significant Medicare penalty!

MIPS Value Pathways (MVP)

- Aims to align and connect measures and activities across the 4 performance categories of MIPS for different specialties or conditions
- CMS believes a combination of administrative claims-based measures and specialty/condition specific measures will streamline MIPS reporting, reduce complexity and burden, and improve measurement
- MVP framework will simplify MIPS, create a more cohesive and meaningful participation experience, improve value, reduce clinician burden, and better align with APMs to help ease the transition between the two tracks
- MIPS Value Pathways Overview Fact Sheet
- Submit an MVP candidate to CMS?
  - MVP Candidate Submission Template

2021 Extreme & Uncontrollable Circumstances Exception Application

- **The Extreme and Uncontrollable Circumstances Exception application allows you to request reweighting for any or all MIPS performance categories if you encounter an extreme and uncontrollable circumstance or public health emergency, such as COVID-19, that is outside of your control**
- **These circumstances would:**
  - Cause you to be unable to collect information necessary to submit for a MIPS performance category;
  - Cause you to be unable to submit information that would be used to score a MIPS performance category for an extended period (for example, if you were unable to collect data for the Quality performance category for 3 months), and/or;
  - Impact your normal processes, affecting your performance on cost measures and other administrative claims measures.
- **For additional information, click the link above and review the COVID-19 Response Fact Sheet**
- **Consider EUC application for at least the Cost category? Others as well?**
- **The 2021 EUC application is now available with a filing deadline of 12/31/21.**

What Else Can You Do?

- **Call your State's congressional legislators to discuss**
  - Needed program changes for Traveling Clinicians
  - CMS-funded Technical Assistance Contractor support is ending 2/15/2022. Additional congressionally-allocated funding is needed to continue state-level program support
- **Provide CMS feedback regarding your ongoing participation struggles**
  - 2022 QPP Proposed Rule comment period
  - Contact the QPP Service Center
    - 1-866-288-8292 (Monday - Friday 8 am - 8 pm ET)
    - QPP@cms.hhs.gov
- **Work with a professional society to influence program changes**
  - For example, The Society for Post-Acute and Long-Term Care Medicine: https://paltc.org/

Case Studies for Traveling ECs

- Small primary care, geriatric practice with 3 physicians, 5 PAs, and 1 NP
- No physical office; patients seen in Skilled Nursing (SNF), Long-Term Care (LTC), and assisted living facilities
- Practice-owned EHR software for clinician notes and MIPS quality tracking
- Quality - Reports MIPS Quality via registry through multi-step process
- Promoting Interoperability - Applies for small practice PI exception each year
- Improvement Activities - Attested to “Implementation of medication management practice improvements” and “Annual registration in the Prescription Drug Monitoring Program”
- Cost - Applied for Extreme & Uncontrollable Circumstances hardship for Cost category in 2020 due to unknown impact of COVID-19 on overall patient costs
- Outcome - Practice has avoided penalty each year, and earned a small incentive in 2017 & 2018

Case Studies for Traveling ECs

- Small practice with only one clinician with a specialty in internal medicine
- The office also has a RN and a scribe to help with the administration
- The clinician sees over 800 patients monthly
- Patients are in 13 different nursing facilities and hospitals across the state
- To combat the lack of access to patient records, they write their own notes during each patient visit
- The scribe then uploads the notes to the clinician's EHR
- This has been the practice's preferred method of MIPS reporting for 2017 and 2018. Exempt in 2019

Case Studies for Traveling ECs

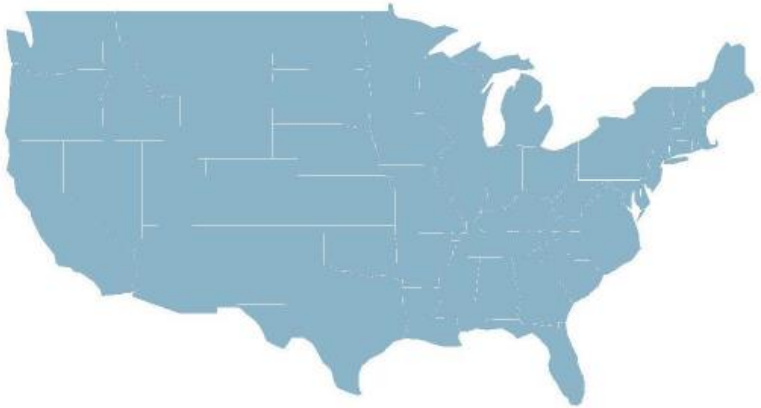
- Small multispecialty group, (7) Physical Medicine & Rehab MDs, (1) Neurologist
- No physical office; patients seen in Skilled Nursing Facilities (SNF), Long-Term Care (LTC), Sub-acute Care, Step-down Units, In-patient Rehabs
- Practice-owned EHR: Advanced Document Management (ADM) (Allscripts)
- Quality - Reports via claims – (20) case minimum for most measures (although fails data completeness so only 3pts/measure)
- Promoting Interoperability - Applies for small practice PI exception each year
- Improvement Activities – entered via QPP data submission portal, full points
- Cost – Scores well each year
- Outcome - Practice has avoided the penalty each year, and earned a small incentive in PYs 2017 & 2018 (payment years ‘19 & ‘20)
- EUC for Quality in 2020 and likely again in 2021
- Not expecting to meet minimum threshold to avoid a penalty in 2022+

Resources

- QPP Resource Center for the Midwest
- CMS QPP Website, including Data Submission Portal
- 2021 Part B Claims Reporting Quick Start Guide
- 2021 Medicare Part B Claims Measure Specifications and Supporting Documents
- MIPS Data Validation Criteria
- MIPS Promoting Interoperability Performance Category Hardship Exception
- Extreme and Uncontrollable Circumstances (EUC) Exception Application
- 2021 Comprehensive List of APMs
- Medicare Shared Savings Program ACOs
- CMS Direct Contracting Entity website
- MIPS Value Pathways Overview Fact Sheet
- COVID-19 Response Fact Sheet

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.

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Questions?

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