

Ohio Optometric Association  
Practice Management Institute 2018

**MACRA/MIPS:**  
**Everything You Need to Know to Succeed**

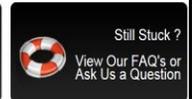
Disclosures: Dr. Henry is affiliated with www.EHRGURU.net and has lectured for numerous companies including Topcon, First Insight, RevolutionEHR, FoxFire, VisionWeb, SolutionReach, and the AOA.

Jay W. Henry, O.D., M.S.

Where to go for Help, Handouts, and Future Updates



Home Meaningful Use Incentive Programs PQRS ICD-10 EHR Software Sponsors GURUS Lecture Handouts



Game Plan

- MACRA / Quality Payment Program Overview
- MIPS in Detail
  - Quality
  - Cost
  - Clinical Practice Improvement Activities (CPIA)
  - Advancing Care Information (ACI)
- MIPS Changes for 2018
  - What you need to know to succeed in 2018
- Questions

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

3 Goals for our health care system

3 goals for our health care system:

**BETTER care**  
**SMARTER spending**  
**HEALTHIER people**

Via a focus on 3 areas



Medicare Payment Prior to MACRA

- Prior to MACRA Medicare payments were based on a Fee-for-service (FFS) system
  - Clinicians were paid based on **volume** of services not **value**
- **The Sustainable Growth Rate (SGR)**
  - Established in 1997 to control the cost of Medicare payments



## Medicare Payment Prior to MACRA

- The SGR was used to match the target Medicare budget to Physician payments
  - This was done via adjustments to the physician fee schedule for the following year
  - Many years this adjustment would have meant a 21-27% payment reduction in the physician fee schedule
  - Each year congress would pass temporary “doc fixes” to avert cuts (no fix in 2015 would have meant a 21% cut in Medicare payments in 2016)
  - The continual need for “doc fixes” led to the repeal of the SGR in 2015
- **MACRA replaces the SGR with a more predictable payment method that incentivizes value**

## The Quality Payment Program (QPP)

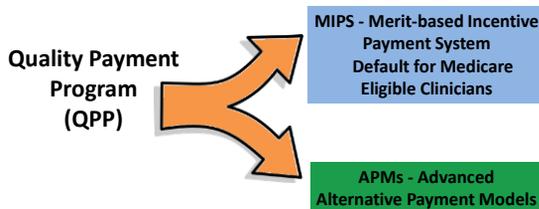
- CMS is calling the new program under MACRA the **Quality Payment Program (QPP)**
  - QPP takes a comprehensive approach to payment by basing consideration of quality on a set of evidenced-based measures that were primarily developed by clinicians
  - QPP encourages improvement in clinical practice
  - QPP is supported by advances in technology that allow for the easy exchange of information

## The Quality Payment Program (QPP)

The Quality Payment Program policy will:

- Reform Medicare Part B payments for more than 600,000 clinicians
- Improve care across the entire health care delivery system

Clinicians have two tracks to choose from:



## Benefits of the Quality Payment Program

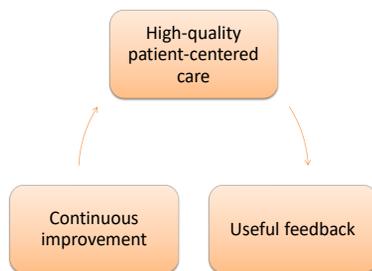
### Clinicians

- Streamlines reporting
- Standardizes measures
- Eliminates duplicative reporting
- Allows clinicians more time with patients
- Incentivizes care that focuses on improved quality outcomes

### Patients

- Increases access to better care
- Enhances coordination through a patient-centered approach
- Improves results

## Quality Payment Program



## Quality Payment Program Goals

- Improve beneficiary outcomes
- Increase adoption of Advanced APMs
- Improve data and information sharing
- Enhance clinician experience
- Maximize participation
- Ensure operational excellence in program implementation

## What Does the Quality Payment Program Do?

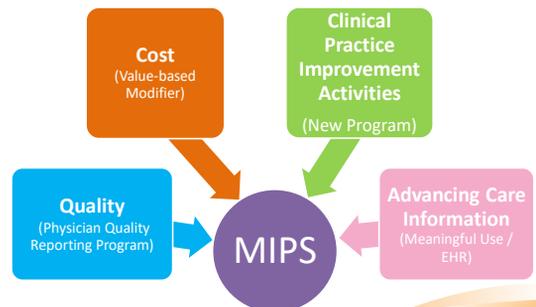
- **QPP creates Medicare payment methods that promote quality over volume by:**
  - Repealing the SGR
  - Creating two tracks:
    - **MIPS:** Merit-Based Incentive Payment System
    - **Advanced APMs:** Advanced Alternative Payment Models
  - Streamlining legacy programs
  - Establishing PTAC
    - The Physician-focused Payment Model Technical Advisory Committee

## Merit-Based Incentive Payment System (MIPS)

## Merit-based Incentive Payment System

- MIPS is the first step toward an outcome-based and performance-based payment system
  - Ends paying clinicians more based on the number of treatments, visits, procedures, and tests completed
  - Will pay more for better outcomes that are delivered with less time and cost to the patient and health care system
    - The good work that clinicians do is not limited to conducting tests or writing prescriptions, but also taking the time to have a conversation with a patient about test results, being available to a patient through telehealth or expanded hours, coordinating medicine and treatments to avoid confusion or errors, and developing care plans
- Provides clinicians with flexibility to choose the activities and measures that are most meaningful to their practice

## Merit-based Incentive Payment System (MIPS)



## Merit-based Incentive Payment System

- **Performance Category Weights**
  - Weights assigned to each category based on a 1 to 100 point scale

MIPS Performance Categories for Year 2 (2018)



## Merit-based Incentive Payment System

- What if you don't have an Certified EHR system?
  - You can still participate in MIPS but your ACI score will be 0%

## Merit-based Incentive Payment System

What is the Performance Period for MIPS in **2018**

- Minimum **90-day** performance period for:
  - Advancing Care Information
  - Improvement Activities
- Minimum **12 month** performance period for:
  - Quality
  - Cost

## Merit-based Incentive Payment System

How is MIPS tracked via TINs and NPIs

- Individuals: If you participate in MIPS as an individual CMS will use both your TIN and NPI
  - If you practice in more than 1 location or you move to a new practice you will be assessed separately for each TIN your NPI is linked to
- Groups: if you choose to participate jointly as a group the group's TIN alone will be your identifier for all performance categories

## Merit-based Incentive Payment System

Bonuses and Penalties:

- Payment adjustments will be applied at the TIN/NPI level regardless of whether you participate in MIPS as an individual or as part of a MIPS group

## Merit-based Incentive Payment System

- Your final MIPS score will follow you to your next practice
  - Your 2018 final score will impact your 2020 payments even if you move to a new practice
  - Your 2017 final score will impact your 2019 payments even if you move to a new practice

## Overview of Merit-Based Incentive Payment System for 2018

### 2018 MIPS Information

#### The Quality Payment Program (QPP) Year 2

- For Year 2 feedback was utilized and is being used to ensure that:
  - The program's measures and activities are meaningful
  - Clinician burden is minimized
  - Care coordination is better
  - Clinicians have a clear way to participate in Advanced APMs

## 2018 MIPS Information

- For Year 2 the QPP will keep:
  - Going slow while preparing clinicians for full implementation in year 3
  - Providing more flexibility to help reduce your burden
  - Offering new incentive for participation
- CMS is continuing to look for ways to reduce the clinicians burden and simplify the program

## 2018 MIPS Information

### Goals of 2018 QPP Year 2 Program:

1. To improve beneficiary outcomes and engage patients through patient-centered Advanced APM and MIPS policies
2. To enhance clinician experience through flexible and transparent program design and interactions with easy-to-use program tools
3. To increase the availability and adoption of robust Advanced APMs
4. To promote program understanding and maximize participation through customized communication, education, outreach and support that meet the needs of the diversity of physician practices and patients, especially the unique needs of small practices

## 2018 MIPS Information

### Goals of 2018 QPP Year 2 Program:

5. To improve data and information sharing on program performance to provide accurate, timely, and actionable feedback to clinicians and other stakeholders
6. To deliver IT systems capabilities that meet the needs of users for data submission, reporting, and improvement and are seamless, efficient and valuable on the front and back-end
7. To ensure operation excellence in program implementation and ongoing development; and to design the program in a manner that allows smaller independent and rural practices to be successful.

## Overview of Merit-Based Incentive Payment System Categories

## MIPS: Quality Category Overview

- 2018 Quality Category Requirements:
  - Replaces PQRS and Quality portion of the Value Modifier
  - Select 6 of about 270 quality measures
    - 1 measure must be:
      - Outcome measure OR
      - High-priority measure – defined as outcome measure, appropriate use measure, patient experience, patient safety, efficiency measures, or care coordination
      - May also select specialty-specific set of measures
      - 12 month quality performance period (Jan 1 – Dec 31 2018)

50 %  
of final  
score

## MIPS: Advancing Care Information Category Overview

- Promotes patient engagement and the electronic exchange of information using certified EHR technology
- Ends and replaces the Medicare EHR Incentive Program (Medicare Meaningful Use)
  - If you have already started the Medicaid EHR incentive program (last year to start was 2016) it continues for 6 years or until 2021
- Greater flexibility in choosing measures

25 %  
of final  
score

## MIPS: Advancing Care Information Category Overview

- In 2018, there are **2 measure sets for reporting based on EHR edition:**
  1. Advancing Care Information Objectives and Measures
  2. 2018 Advancing Care Information Transition Objectives and Measures
- The 2018 Transition Objectives and Measures will be the easier route for clinicians

25 %  
of final  
score

## MIPS: Improvement Activities Category Overview

- Attest to participation in activities that improve clinical practice
  - Examples: Shared decision making, patient safety, coordinating care, increasing access
- Clinicians choose from 100+ activities under 9 subcategories:
  1. Expanded Practice Access
  2. Population Management
  3. Care Coordination
  4. Beneficiary Engagement
  5. Patient Safety and Practice Assessment
  6. Participation in an APM
  7. Achieving Health Equity
  8. Integrating Behavioral and Mental Health
  9. Emergency Preparedness and Response

15 %  
of final  
score

## MIPS: Improvement Activities Category Overview

- Reporting Criteria for 2018
- You must attest by indication “yes” to each activity that meets the 90 day requirement (activities that you performed for at least 90 consecutive days)
  - You may report activities using:
    - Qualified registry
    - EHR technology
    - Qualified clinical data registry (QCDR)
    - CMS Web interface (groups of 25 or more)
    - Attestation via Quality Payment Program Website
  - You may choose to attest to the activities that are most meaningful to your practice
    - No subcategory reporting requirements

## MIPS: Cost Category Overview

### Why focus on Cost:

- Measuring cost is an important part of MIPS because cost measures show:
  - The resources clinicians use to care for patients
  - The Medicare payments for care given to beneficiary during an episode of care
- For 2018 MIPS uses cost measures that cover the total cost of care during the year or during a hospital stay
- Cost uses Medicare claims data to collect the cost information, therefore **you don't have to submit any extra data for the cost category**
- 10% of final score in 2018

10%  
of final  
score

## MIPS: Cost Category Overview

- Cost uses measures previously used in the Physician Value-Based Modifier program
  - These are reported in the Quality and Resource Use Report (QRUR)
- To understand your Cost performance you must download your Quality and Resource Use Report

10%  
of final  
score

## MIPS Composite Performance Score

- Each year ECs will get a single composite performance score from 0 – 100
- Composite score based on 4 weighted (changes by year) performance categories
  1. Quality (formerly PQRS)
  2. Advancing Care Information (formerly Meaningful Use)
  3. Cost (formerly VM)
  4. Practice Improvement Activities (new program)

## Calculating the Final Score Under MIPS

Final Score =



## Payment Adjustments

2017 Performance Year

Final Score	Payment Adjustment
≥ 70 points	<ul style="list-style-type: none"> <li>Positive adjustment</li> <li>Eligible for exceptional performance bonus</li> </ul>
4-69 points	<ul style="list-style-type: none"> <li>Positive adjustment</li> <li>Not eligible for exceptional performance bonus</li> </ul>
3 points	Neutral payment adjustment
0 points	<ul style="list-style-type: none"> <li>Negative payment adjustment of -4%</li> <li>0 points = does not participate</li> </ul>

2018 Performance Year

Final Score	Payment Adjustment
≥ 70 points	<ul style="list-style-type: none"> <li>Positive adjustment</li> <li>Eligible for exceptional performance bonus</li> </ul>
15.01-69.99 points	<ul style="list-style-type: none"> <li>Positive adjustment</li> <li>Not eligible for exceptional performance bonus</li> </ul>
15 points	Neutral payment adjustment
3.76-14.99 points	Negative payment adjustment between 0 – 4.99%
0 – 3.75 points	Negative payment adjustment of -5%

## Payment Adjustments

- The Quality Payment Program will have larger payment adjustments both positive and negative each year



In 2019, **exceptional** performers will be eligible for up to 12% increase (3 x base rate)

In 2020 to 2026, exceptional performers will be eligible for a 10% increase

Up to \$500M extra available each year from 2019 – 2024

Because MIPS adjustments are budget neutral a scaling factor may be applied to upward adjustments to make total upward and downward adjustments equal

## MIPS – Getting Started!

## Getting Started with MIPS in 2018

- Determine your eligibility status for 2018
- Choose if you will be reporting as an individual, group, or virtual group
- Decide if you will work with a third party intermediary
- Review the performance period for each category
- Review the program timeline for dates
- Assess your Feedback from QPP website and QRUR Reports

## MIPS Eligible Clinicians

- Are you Eligible?
- You must answer **YES** to these 3 questions:
  1. Are you a Physician (Optometrist), Physician's Assistant, Nurse Practitioner, Clinical Nurse Specialist, or Certified Registered Nurse Anesthetist?
  2. Do you bill Medicare Part B \$90,000 or more per year?
  3. Do you have 200 or more Medicare patients per year?
- If you answered YES to the above 3 questions you are qualified to participate in MIPS

## MIPS Excluded Clinicians



### Newly-enrolled in Medicare

- Enrolled in Medicare for the first time during the performance period (exempt until the following performance year)



### Below the low-volume threshold

- Medicare Part B allowed charges less than or equal to \$90,000 a year

OR

- See 200 or fewer Medicare Part B patients a year



### Significantly participating in Advanced APMs

- Receive 25% of your Medicare payments

OR

- See 20% of your Medicare patients through an Advanced APM

## How to Find Your MIPS Eligibility Status

## CMS MIPS Participation Status Tool

- Web based tool from CMS to determine if you are required to participate in MIPS
- You will need your NPI number
- <https://qpp.cms.gov/participation-lookup>

## MIPS Participation Status

Enter your 10-digit [National Provider Identifier \(NPI\)](#) or number to view your MIPS participation status by Performance Year (PY).

NATIONAL PROVIDER IDENTIFIER (NPI)

Check All Years >

PY 2017

PY 2018

### 2018 Participation Status

NPI: #1295771939

The first review of Performance Year 2018 is now available. If you're exempt from MIPS, you won't need to do anything for MIPS for Performance Year 2018. [Learn more about MIPS participation.](#)

**Included in MIPS**

PHILIP JAMES GROSS must submit data for MIPS by March 2019. This clinician will need to report as an individual or with a group.

[What Can I Do Now? >](#)

### Clinician Details

PHILIP JAMES GROSS, OD  
NPI: #1295771939

Provider Type	Doctor of Optometry
Associated TINs	1
Enrolled in Medicare Before January 1, 2018	Yes

## Practice Details

VISION QUEST EYE CARE CENTER INC  
820 WALKER ROAD DOVER, DE 19904-2727

If the clinician reports as an individual	If the clinician reports as a group *
<input checked="" type="checkbox"/> <b>Included in MIPS</b> This clinician has billed Medicare for more than \$90,000 and has provided care for more than 200 patients at this practice.	<input checked="" type="checkbox"/> <b>Included in MIPS</b> This practice has billed Medicare for more than \$90,000 and has provided care for more than 200 patients.

## Special Status At This Practice

[View descriptions of each special status](#)

For this clinician at this practice	For this practice
Ambulatory Surgical Center (ASC)-based	No
Hospital-based	No
Health Professional Shortage Area (HPSA)	No
Non-Patient Facing	No
Rural	No
<b>Small Practice</b>	<b>Yes</b>

## MIPS Participation Status

Enter your 10-digit [National Provider Identifier \(NPI\)](#) number to view your MIPS participation status by Performance Year (PY).

NATIONAL PROVIDER IDENTIFIER (NPI)

PY 2017 PY 2018

## 2018 Participation Status

NPI: #

The first review of Performance Year 2018 is now available. If you're exempt from MIPS, you won't need to do anything for MIPS for Performance Year 2018. [Learn more about MIPS participation.](#)

**Exempt from MIPS** is not required to submit data for MIPS for PY 2018 for the practice(s) listed below

## Practice Details

VISION QUEST EYE CARE CENTER INC  
820 WALKER ROAD DOVER, DE 19904-2727

If the clinician reports as an individual	If the clinician reports as a group *
<input type="radio"/> <b>Exempt from MIPS</b> This clinician has billed Medicare for \$90,000 or less at this practice.	<input checked="" type="checkbox"/> <b>Included in MIPS</b> This practice has billed Medicare for more than \$90,000 and has provided care for more than 200 patients.

## Getting Started with MIPS in 2018

- Determine your eligibility status for 2018
- Choose if you will be reporting as an individual, group, or virtual group
- Decide if you will work with a third party intermediary
- Review the performance period for each category
- Review the program timeline for dates
- Assess your Feedback from QPP website and QRUR Reports

## MIPS: Participating as an Individual or Group

### Reporting as an individual

- Your payment adjustment will be based on your performance (based on individual NPI)
- You will send your individual data for each MIPS category through an EHR, registry, or qualified clinical data registry. You may also send in quality data through your routine Medicare claims process

### Reporting as a group or virtual group

- The group will get one payment adjustment based on the group's performance. A group is defined as a set of clinicians (identified by NPI) sharing a common TIN, no matter the specialty or practice site
- Your group will send in group-level data for each MIPS category through CMS web interface or an EHR, registry, or a qualified clinical data registry
- To submit data through CMS web interface (for groups and virtual groups > 25 eligible clinicians only), you must register to us the CMS Web interface between April 1 - June 30, 2018
- Virtual groups had to be created between Oct 11, 2017 – Dec 31, 2017

## MIPS: Reporting Options

### OPTIONS



- Individual**—under an NPI number and TIN where they reassign benefits
- As a Group**
  - 2 or more clinicians (NPIs) who have reassigned their billing rights to a single TIN\*
  - As an APM Entity

\*If clinicians participate as a group, they are assessed as a group across all 4 MIPS performance categories

## How to Submit your MIPS Data to CMS

	Individual	Group
Quality	<ul style="list-style-type: none"> <li>✓ QCDR (Qualified Clinical Data Registry)</li> <li>✓ Qualified Registry</li> <li>✓ EHR</li> <li>✓ Claims</li> </ul>	<ul style="list-style-type: none"> <li>✓ QCDR (Qualified Clinical Data Registry)</li> <li>✓ Qualified Registry</li> <li>✓ EHR</li> <li>✓ Administrative Claims</li> <li>✓ CMS Web Interface (groups of 25 or more)</li> <li>✓ CAHPS for MIPS Survey</li> </ul>
Advancing Care Information	<ul style="list-style-type: none"> <li>✓ Attestation</li> <li>✓ QCDR</li> <li>✓ Qualified Registry</li> <li>✓ EHR Vendor</li> </ul>	<ul style="list-style-type: none"> <li>✓ Attestation</li> <li>✓ QCDR</li> <li>✓ Qualified Registry</li> <li>✓ EHR Vendor</li> <li>✓ CMS Web Interface (groups of 25 or more)</li> </ul>
Improvement Activities	<ul style="list-style-type: none"> <li>✓ Attestation</li> <li>✓ QCDR</li> <li>✓ Qualified Registry</li> <li>✓ EHR Vendor</li> </ul>	<ul style="list-style-type: none"> <li>✓ Attestation</li> <li>✓ QCDR</li> <li>✓ Qualified Registry</li> <li>✓ EHR Vendor</li> </ul>

## Getting Started with MIPS in 2018

- ✓ Determine your eligibility status for 2018
- ✓ Choose if you will be reporting as an individual, group, or virtual group
- Decide if you will work with a third party intermediary
- Review the performance period for each category
- Review the program timeline for dates
- Assess your Feedback from QPP website and QRUR Reports

## Working with a Third Party Intermediary

Intermediary	Approval Needed	Cost to Clinician
EHR Vendor	EHR Vendors Must be certified by ONC	X
QCDR	QCDRs must be approved by CMS	X
Qualified Registry	Qualified Registries must be approved by CMS	X
CMS Approved CAHPS Vendor	CAHPS Vendors must be approved by CMS	X

## Merit-Based Incentive Payment System (MIPS): 2017 CMS-Approved Qualified Clinical Data Registries (QCDRs)

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) streamlined a collection of quality programs into a single system where Medicare physicians and other clinicians have a chance to be rewarded for better care. There are two paths to the Quality Payment Program:

- Merit-Based Incentive Payment System (MIPS)
- Advanced Alternative Payment Models (AAPMs)

Under MIPS, there are four performance categories: Quality, Clinical Practice Improvement Activities (referred to as "Improvement Activities"), meaningful use of certified EHR technology (referred to as "Advancing Care Information"), and Resource Use (referred to as "Costs").

QCDR Name	Contact Information	Cost	Submission Options Supported	Services Offered	Performance Categories Supported	MIPS Quality Measure Supported	QCDR Measure Supported (formerly referred to as MIPS measures)	iCCMs Supported
ACA MIPS Merit and Outcomes Registry for Experts	241 N. Congress Blvd. St. Louis, MO 63141  Qualified Registry 800-365-2279  www.aia.org	Included as an ACA member benefit \$1,800 per year for non-members	Individual MIPS clinicians, Groups	ACA MIPS will provide: • Data collection • Quality Payment Program Support • Data analysis for clinical outcomes for the benefit of improving care • Demographic analysis to ensure diverse patient access to care • Benchmarking against national performance rates of all registry participants (benchmark is adjusted weekly) • QIP Measures • Diagnosis • Procedures • Demographics ACA MIPS will support individual and QIP reporting. Email at <a href="mailto:www.aia.org/MSR">www.aia.org/MSR</a>	Improvement Activities, Quality	Q112-Q116 Q117-Q118	None	Q101, Q102, Q108, Q109, Q117, Q118, Q206, Q208, Q214

## Getting Started with MIPS in 2018

- ✓ Determine your eligibility status for 2018
- ✓ Choose if you will be reporting as an individual, group, or virtual group
- ✓ Decide if you will work with a third party intermediary
- Review the performance period for each category
- Review the program timeline for dates
- Assess your Feedback from QPP website and QRUR Reports

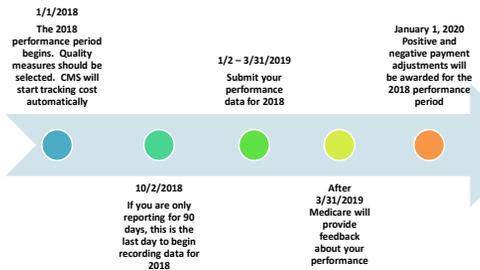
## Performance Periods for MIPS 2018

- Minimum **90-day** performance period for:
  - Advancing Care Information
  - Improvement Activities
- Minimum **12 month** performance period for:
  - Quality
  - Cost

## Getting Started with MIPS in 2018

- ✓ Determine your eligibility status for 2018
- ✓ Choose if you will be reporting as an individual, group, or virtual group
- ✓ Decide if you will work with a third party intermediary
- ✓ Review the performance period for each category
- Review the program timeline for dates
- Assess your Feedback from QPP website and QRUR Reports

## 2018 MIPS Timeline



## Getting Started with MIPS in 2018

- ✓ Determine your eligibility status for 2018
- ✓ Choose if you will be reporting as an individual, group, or virtual group
- ✓ Decide if you will work with a third party intermediary
- ✓ Review the performance period for each category
- ✓ Review the program timeline for dates
- Assess your Feedback from QPP website and QRUR Reports

## Performance Data on CMS QPP Website

The screenshot shows the CMS Quality Payment Program website interface. The user is logged in as Jay Henry. The main content area displays a timeline of events:

- 1/1/2018**: Submission window opens.
- 10/2/2018**: Preliminary 2017 Performance Feedback Available. A red arrow points to a "VIEW PERFORMANCE FEEDBACK" button.
- 1/2 - 3/31/2019**: Final Performance Feedback Available.
- January 1, 2020**: 2018 Submission Window Opens.

Below the timeline, there are two notification boxes:

- Preliminary 2017 Performance Feedback Available**: Your preliminary 2017 performance year feedback is now available. Your final score will be available Summer 2018. Your performance feedback could change based on additional information being entered into the system.
- 2017 Submission Window has Closed**: All of January, April 30th at 11:59pm EDT. You are no longer able to submit your information. 2018 submission window will open January 1, 2019.

## Performance Data on CMS QPP Website

### Performance Feedback Data is Still Pending

We are still in the middle of processing your feedback data. The information displayed on the following pages is NOT your final score or feedback. Your final score and feedback will be available Summer 2018. Between now and summer your final score could change based on the following piece of data that will become available:

- All-Cause Readmission Measure for the Quality Category
- Claims Measures
- CAHPS from MIPS Survey results
- Handicap Application status
- Improvement Study Participation and Results
- Any benchmark updates for Quality measures that have met minimum threshold criteria

I understand that the information displayed on the following pages is NOT my final score or feedback. My performance score could change between now and summer. Final feedback data will be available Summer 2018.

YES, I AGREE.

OK

## Performance Data on CMS QPP Website

### Quality Payment PROGRAM

MIPS

APMs

About

Jay

#### Performance Feedback

HERMANN & HENRY EYECARE INC  
TIN #31705887

#### Practice Feedback

Overview

Quality

Advancing Care Information

Improvement Activities

Cost

Connected Clinicians

The information being displayed below is NOT your Final Score. Your Final Feedback will be available no later than Summer 2018. [View Pending Data](#)

#### Practice Details

HERMANN & HENRY EYECARE INC

TIN #31705887 (550 HILL ROAD NORTH, PERRININGTON, OH 4307201)

VIEW CONNECTED CLINICIANS

### Your Final Score At A Glance

Your Final Score is achieved by adding the points you earn in each Performance Category.



#### Performance Category Scores

- Quality: 60 of 60
- Advancing Care Information: 25 of 25
- Improvement Activities: 7.8 of 15

## Performance Data on CMS QPP Website

### Quality Details

The following is a detailed review of your Quality category information



#### At A Glance:

Performance Period Date: 1/1/2017 - 12/31/2017  
Highest Score Submission Method: EHR  
Reported Measures: 10  
High-Priority Measures: 5

## Performance Data on CMS QPP Website

### 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
54 Points from Quality measures that count towards Quality score	6 Additional Performance or Bonus Points	60 Total out of 60
60 Maximum number of points (4 of required measures x 10)	× 60%	

## Performance Data on CMS QPP Website

### Advancing Care Information Details

The following is a detailed review of your Advancing Care Information category information



#### At A Glance:

Performance Period Date: 1/1/2017 - 12/31/2017  
Highest Score Submission Method: Attestation  
Base Measures: 4 out of 4  
Optional Measures: 5

## Performance Data on CMS QPP Website

### Your Total Advancing Care Information Score

Below is how your Total Advancing Care Information score is calculated based on the measures above.

Category Score	Category Weight	Total Contribution to Final Score
90 Base Score	36 Additional Performance or Bonus Points	25 Total out of 25
100 Maximum number of points	× 25%	

## Performance Data on CMS QPP Website

### Improvement Activities Details

The following is a detailed review of your Improvement Activities category information



#### At A Glance:

Performance Period Date	1/1/2017 - 12/31/2017
Highest Score Submission Method	Attestation
High Priority Activities	1
Medium Priority Activities	N/A

## Performance Data on CMS QPP Website

### How You Could Have Done Better?

In 2017, your practice successfully completed 0 Medium Priority Activities. You can increase your score by doing one of the following:

1

You could achieve full credit for this category by submitting 1 additional High Weighted Activity.

2

You could achieve full credit for this category by submitting 2 additional Medium Weighted Activities.

#### Important Information

##### Small Practice Consideration

Your practice participated in the MIPS as a **Small Practice**. Small Practices (typically defined as 15 or fewer clinicians) are automatically awarded **2X points** for all reported measures in the Improvement Activities Performance Category.

## Performance Data on CMS QPP Website

### Your Total Improvement Activities Score

Below is how your Total Improvement Activities score is calculated based on the measures above. You cannot receive more than 15 total points for Improvement Activities.



## Access Your Feedback Report: Prepare for the Following Year

SEPT  
18

- The QRUR released on Sept. 18, 2017 (referred to as the 2016 Annual QRUR) shows how providers did on quality and cost in 2016



- The 2016 QRUR is available and can be accessed at: <https://portal.cms.gov/wps/portal/unauth/portal/home/>

Quality Payment Program

- Physicians should access their report and review the quality and cost information to prepare for the Quality Payment Program

## Quality & Resource Use Reports

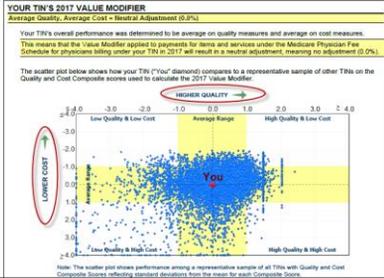
## Quality and Resource Use Report DOWNLOAD THEM

- Quality and Resource Use Report (QRUR)
- Download your 2016 annual report now to understand your TIN's current quality and cost performance
- Review quality measures benchmarks and your performance

## QRUR Report

### 2015 ANNUAL QUALITY AND RESOURCE USE REPORT AND THE 2017 VALUE-BASED PAYMENT MODIFIER

Simplex Medical Practice A  
LAST FOUR DIGITS OF YOUR MEDICARE-ENROLLED TAXPAYER IDENTIFICATION NUMBER (TIN): 0000  
PERFORMANCE PERIOD: 01/01/2015 – 12/31/2015



## QRUR Report

- This shows you your "Value" which will become part of the MIPS Cost Category

The Value Modifier calculated for your TIN is shown in the highlighted cell in Exhibit 1. The Value Modifier applied to payments for items and services under the Medicare Physician Fee Schedule for physicians billing under your TIN in 2017 will result in a neutral adjustment, meaning no adjustment (0.0%).

Exhibit 1. 2017 Value Modifier Payment Adjustments under Quality-Tiering (TINs with 10 or More Eligible Professionals)

	Low Quality	Average Quality	High Quality
Low Cost	0.0%	+2.0 x AF	+4.0 x AF
Average Cost	-2.0%	0.0%	+2.0 x AF
High Cost	-4.0%	-2.0%	0.0%

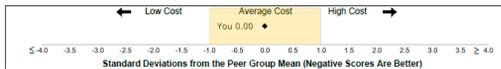
## QRUR Report

- This shows your "Cost" score which is also part of the MIPS Cost category score

### PERFORMANCE ON COST MEASURES

Your TIN's Cost Tier: Average

Exhibit 4. Your TIN's Cost Composite Score



## QRUR Report

- This shows how you did on certain Quality measures which will be used to calculate your MIPS Quality score



Measure Identification Number(s)	Measure Name	Number of Eligible Cases	Performance Rate	Your TIN		All TINs in Peer Group	
				Standardized Performance Score	Included in Domain Score?	Benchmark (National Mean)	Standard Deviation
130 (GPRO Care-3, CMS66v4)	Documentation of Current Medications in the Medical Record	0	0.00%	0.00	No	0.00%	0.00
318 (GPRO Care-2, CMS139v3)	Falls: Screening for Fall Risk	0	0.00%	0.00	No	0.00%	0.00

## How to Obtain a QRUR

**How to Obtain a QRUR**

CMS transitioned Individuals Authorized Access to CMS Computer Services (AACCS) accounts to the Enterprise Management System (EMS). Beginning on July 11, 2015, an AACCS account can no longer be used to log in and Resource Use Reports (QRURs). Instead, an EIDM account will be required to access QRURs at <https://qrur.cms.gov>. Instructions for obtaining an EIDM account are provided below.

You can access a QRUR on behalf of a group or sole practitioner at <https://qrur.cms.gov>. QRURs are each Medicare-enrolled Taxpayer Identification Number (TIN). You or one person from your group will need an EIDM account with the correct role first. The sections below "Setting up an EIDM account to access a QRUR" and "Logging on an EIDM account to access a sole practitioner's QRUR" will help you how. Once you have an account with the correct role, follow the step-by-step instructions provided in the reference guide located in "Downloads" section below to access the QRUR.

To find out whether there is already someone who can access your or your group's QRUR, please call QualityNet Help Desk at the number provided in the "Technical Assistance" section below and provide your TIN.

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html>

## QRUR Report – GET THEM!

- Must have an EIDM account with a Physician Quality and Value Programs Role
- Follow the steps in this guide to set up your account at

<https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Resource-library.html>

## Setting up your EIDM Account

- Visit website <https://portal.cms.gov> and select New User Registration



## Setting up your EIDM Account

- Accept terms and conditions



## Setting up your EIDM Account

- Enter your information

## Setting up your EIDM Account

- Create your User ID and Password

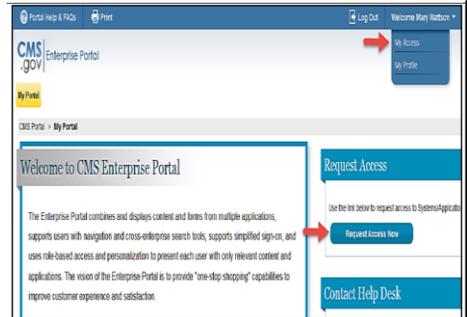
## Setting up your EIDM Account

- Use your newly created account to login



## Setting up your EIDM Account

- Request Access Now then select My Access



## Setting up your EIDM Account

- Request Access for Physician Quality and Value Programs

<b>Physician Quality and Value Programs</b> Physician Value - Physician Quality Reporting System Program. This portal allows access to data. Help Desk Information: 888-388-8172 Request Access	<b>POLIC/APP</b> POLIC/APP Help Desk Information: 330 Request Access	<b>PSAR/STAR</b> Provider Statistical and Reimbursement System for Tracking and Benchmarking Data. Help Desk Information: 888-444-0344 <a href="mailto:star@cms.gov">star@cms.gov</a> Request Access
<b>PVP/QRS RDP/IMA</b> Physician Value - Physician Quality Reporting System Program. This portal allows access to data. Help Desk Information: 888-388-8172 <a href="mailto:ima@cms.gov">ima@cms.gov</a> Request Access	<b>QMAT</b> The Quality Measures Assessment Tool (QMAT) application allows users to submit clinical data. Help Desk Information: 330 Request Access	<b>SHM</b> SHM is the Small Business Health Options Program Marketplace that helps businesses provide care. Help Desk Information: 330 Request Access
<b>SPOT-Facet Coast Service Options Internet portal (FCSO)</b> The SPOT offers a range of services associated with Coast-based Medicare practices. Help Desk Information: 888-444-0344 Request Access	<b>TEST/MA</b> TEST: Test and CAP Program Help Desk Information: 330 Request Access	<b>TEST/MA</b> Test Application to test IFA. Help Desk Information: 330 Request Access

## Setting up your EIDM Account

- Select your role

By Portal

CMS Portal > EIDM user menu page > My Access

Request New Application Access \* Required Field

My Access

Request New Application Access

Application Description: Physician Quality and Value Programs

Physician Value - Physician Quality Reporting System Program. This portal allows access to applications such as Submissions, Web Interface, Feedback Dashboard and Reports and, if applicable, eCRG/CHPS.

Select a Role:  OIG/Hub Desk User  Provider

Provider Approver

PQRS Provider

Select a Role: Individual Practitioner

Role Description: Role for an Individual Eligible Professional for PQRS and PVP/QRS to approve users with the Individual Practitioner Role. Within PVP/QRS can view PVP/QRS Registration and view OIG/Hub Reports (IPI Data, Dashboard), Letter PQRS on submit data, view the Feedback Dashboard and Feedback reports.

This role requires Identity Verification and may require multi-factor authentication enrollment to be set up. If your Level of Assurance has not been met for Identity, you will be asked to provide additional information to verify your identity and if applicable, register a device for multi-factor authentication. Please select "Next" to continue.

Next Cancel

## Setting up your EIDM Account

- Complete the identity verification process

Request New Application Access

Identity Verification

To protect your privacy, you will need to complete Identity Verification successfully, before requesting access to the selected role. Below are a few items to keep in mind:

- Ensure that you have entered your legal name, current home address, primary phone number, date of birth and E-mail address correctly. We will only collect personal information to verify your identity with Experian, an external identity verification provider.
- Identity Verification involves Experian using information from your credit report to help confirm your identity. As a result, you may see an entry called a "soft inquiry" on your Experian credit report. Soft inquiries do not affect your credit score and you do not incur any charges related to them.
- You may need to have access to your personal and credit report information, as the Experian application will pose questions to you, based on data in their files. For additional information, please see the Experian Consumer Assistance website - <http://www.experian.com/help/>

If you elect to proceed now, you will be prompted with a Terms and Conditions statement that explains how your Personal Identifiable Information (PII) is used to confirm your identity. To continue this process, select "Next".

Next Cancel

## Setting up your EIDM Account

- Complete the identity verification process

Request New Application Access

Terms and Conditions

OMB No. 0938-1038 | Expiration Date: 04-30-2017 | [Privacy/Revision/Ask](#)

Protecting Your Privacy

Protecting your privacy is a top priority at CMS. We are committed to ensuring the security and confidentiality of the user information we collect. Please read the [CMS Privacy Act Statement](#), which describes how we use the information you provide.

Personal information is described as data that is related to an individual, such as a name, address, telephone number, Social Security Number, and date of birth (DOB). CMS is very aware of the privacy concerns of our users and we have implemented measures to protect your privacy and any other personal information you provide. Our privacy protection will not be used for research, an external authentication service provider, to help us verify your identity. If authorized, we will validate your Social Security Number with Experian only for the purpose of verifying your identity. However, we will not release your personal information to Experian. We may also use your information for the challenge systems and other PII to help identify you in case you forget or misplace your User ID (Password).

HRSG Rules of Behavior

We encourage you to read the [HRSG Rules of Behavior](#), which provides the appropriate use of all HRSG information technology resources for Department users, including Federal employees, contractors, and other system users.

I have read the HRSG Rules of Behavior (HRSG Rules), version 2014-09-02 (014), signed August 28, 2014 and understand and agree to comply with the provisions. I understand that violations of the HRSG Rules of Behavior may result in disciplinary action, up to and including termination of employment, revocation of all benefits, suspension of all federal benefits, and/or other consequences of such a nature as to constitute a permanent record. I understand that the HRSG Rules of Behavior may also include criminal penalties and/or imprisonment. I understand that violations of the HRSG Rules of Behavior may be referred to the Privacy Act of 1974 for investigation and may be referred to the Inspector General for review. I understand that violations of the HRSG Rules of Behavior may result in monetary fines and/or criminal charges that may result in imprisonment.

Identity Verification

I understand that the identity verification service being requested was required by the Fast Care Reporting Act and that my explicit consent is required to use these services. I understand that any approval procedures established by CMS for identity verification using Experian have been met and the approval requested by CMS to Experian will be used solely to confirm the applicant's identity to avoid fraudulent transactions in the applicant's name.

I agree to the terms and conditions

Next Cancel

## Setting up your EIDM Account

- Complete the identity verification process

Your Information

Enter your first last name and last name, as it may be required for identity verification.

First Name:  Last Name:

Enter your E-mail address, as it will be used for account-related communications.

E-mail Address:

Re-enter your E-mail address.

Re-enter E-mail Address:

Enter your full 10-digit social security number, as it may be required for identity verification.

Social Security Number:

Enter your date of birth in MM/DD/YYYY format, as it may be required for identity verification.

Date of Birth:

U.S. Home Address (Foreign address, Enter your current or most recent home address, as it may be required for identity verification.)

Home Address Line 1:

Home Address Line 2:

City:  State:  Zip Code:  Country: USA

Enter your primary phone number, as it may be required for identity verification.

Primary Phone Number:

Next Cancel

## Setting up your EIDM Account

- Complete the identity verification process

Verify Your Identity

You have been opened a mortgage loan as of around August 2012. Please select the lender to whom you currently make your mortgage payments. If you do not have a mortgage, select NONE OF THE ABOVE/DOES NOT APPLY.

MORTGAGE LENDER

MORTGAGE LENDER

MORTGAGE LENDER

MORTGAGE LENDER

MORTGAGE LENDER

Which of the following is a current or previous employer? If there is not a matched employer name, please select NONE OF THE ABOVE/DOES NOT APPLY.

EMPLOYER

EMPLOYER

EMPLOYER

EMPLOYER

EMPLOYER

NONE OF THE ABOVE/DOES NOT APPLY

Please select the number of bedrooms in your home from the following choices. If the number of bedrooms in your home is not one of the choices please select NONE OF THE ABOVE/DOES NOT APPLY.

1

2

3

4

5

NONE OF THE ABOVE/DOES NOT APPLY

Please select the county for the address you provided.

COUNTY

COUNTY

COUNTY

COUNTY

NONE OF THE ABOVE/DOES NOT APPLY

Next Cancel



## MIPS Scoring Calculations

## CMS Bonus & Penalty Calculations

- 2018 MIPS Final Score will determine your 2020 Medicare reimbursement (**up** or **down**)
- CMS will calculate your 2018 final score which will range from 0 to 100 points
  - 2018 Composite score based on 4 categories
    - Quality 50%
    - Advancing care information 25%
    - Improvement activities 15%
    - Cost 10%

## CMS Bonus & Penalty Calculations

- CMS will check if your 2017 final score exceeds, meets, or falls below the 3-point performance threshold
  - **Bonus:** Exceed the 15 point payment adjustment threshold, and you can expect a small positive payment adjustment
  - **Exceptional performance bonus:** Meet or exceed the 70 point additional performance threshold, and you will receive an additional payment adjustment factor
    - Taps you into a \$500 million dollar annual bonus pool!

## Advanced Alternate Payment Models (APMs)

## MACRA Pathway #2: Alternate Payment Models (APMs)

- APMs are new approaches to paying for medical care through Medicare that **incentivize quality and value**
- APM participants who are not using eligible APMs will receive favorable scoring under MIPS clinical practice improvement activities category plus APM specific rewards
- As defined by MACRA APMs Include:
  - CMS Innovation Center Model
  - Medicare Shared Savings Program (MSSP)
  - Demonstration under the Health Care Quality Demonstration Program
  - Demonstration required by federal law

## MACRA – Alternate Payment Models

- Only some APMs will be considered “**Eligible APMs**”
- Eligible APM entities
  - Most Advanced APMs
  - Require the use of certified EHR technology
  - Provide for payment for covered professional services based on quality measures comparable to those measures in MIPS performance category
  - Participants must bear financial risk for monetary losses under the APM that are in excess of a nominal amount or are medical homes

## MACRA – Eligible APMs Participation

- Qualifying APM participants (QPs)
  - Physicians who have a certain % of their patients or payments through an eligible APM
  - QPs are not subject to MIPS
  - Receive 5% lump sum **bonus payments** for years 2019-2024
  - Receive a **higher fee schedule update** for 2026 onward

## MIPS – Performance Categories The Details

## Understanding the MIPS Performance Categories



## Detailed look



## 2018 MIPS: Quality



- Remember replaces PQRS and Quality portion of Value Modifier
- 50% of final MIPS score = 60 points
- Select 6 of 270 quality measures
  - 1 must be outcome measure or high-priority measure
- Groups (25 or more providers) using the web interface report 15 quality measures
- Clinicians receive 3 to 10 points on each quality measure based on performance against benchmarks
- Failure to submit performance data for a measure = 0 points
- Bonus Points are available

50 %  
of final  
score

## 2018 MIPS: Quality



### Bonus Points:

- Starting in 2018 you can earn up to 10 percentage points as bonus points based on the rate of your improvement in the Quality performance category from the year before
- You will receive 1 bonus point per measure for reporting your quality data directly from your EHR to a qualified registry, QCDR, or via CMS Web interface
- You will receive 1 bonus point for each additional high priority measure, and 2 bonus points for each additional outcome and patient experience measure submitted

## MIPS: Quality

### Steps to get the most points under Quality Category

- Select a Reporting Mechanism
  - If you don't have a Certified EHR you can report via claims based reporting as an individual (**not available to groups**)
  - If you have an EHR you can report via:
    - EHR Vendor Direct
    - AOA More
  - Large Practice (25 or more providers) can report via the CMS Web Interface
- **Your choice of reporting mechanism will determine which quality measures you can report**
- Select the one reporting mechanism that best fits your practice needs

## MIPS: Quality

### • What if you use more than 1 reporting mechanism?

- Suppose you use both claims and EHR vendor to report quality measures
- CMS **will not** give you an aggregate score that combines claims based submission with EHR based submission
- CMS **will** assess your score for both claims based and EHR based submission and assign you the higher score

## MIPS: Quality

### • AOA More - Supported EHR Integrations as of January 2018

#### Complink

The December 28, 2017 release of Complink Advantage Version 12.0 x.x gives Complink the distinction of being the first of the AOA MORE EHR Partners to achieve ONC 2015 Edition certified CEHRT status! In order to have your 2017 data submitted to AOA MORE in time for the March 2018 reporting deadline, please update to Complink Version 12, 2015 CEHRT Edition as soon as possible. This update will allow Complink AOA MORE clients access to seamless integration of Quality Reporting data for the entire 2017 reporting year (January 1-December 31, 2017). Doctors will transition to the 2018 Quality Reporting Performance Year while Complink EHR data is communicated on a weekly basis with the AOA MORE dashboard.

Complink CNC 2015 Edition will allow doctors of optometry to earn bonus incentive payments recently announced by CMS tied to exclusive use of 2015 Edition CEHRT. Download this update as soon as possible for access to the newest features and AOA integration available to your practice. See detailed instructions on the [Complink Advantage website](#) under 'What's New V12' to expedite your retrieval of this new release.

#### Crystal Practice Management

AOA MORE will be able to report at least one quality measure for some doctors AND support two clinical practice improvement activities for all doctors. For guidance on completing CPIAs via AOA MORE review page 3 of the Merit-Based Incentive Payment System Guidebook Evaluating and Tracking Your Progress

## MIPS: Quality

### • AOA More - Supported EHR Integrations as of January 2018

#### MaximEyes EHR

MaximEyes encourages their users to submit 2017 quality measures via MaximEyes EHR. No quality measures will be reported by AOA MORE for 2017. For additional information on how MaximEyes EHR can support you in meeting quality measure requirements, please contact MaximEyes at 800.520.1940, Ext. 9633 or email [joanmigliorini@maximeyes.com](mailto:joanmigliorini@maximeyes.com). To access comprehensive training guides, log in to MaximEyes For Customers website at <https://customer-first-insight.com>, click the "Training Resources" tab then navigate to the Incentive Program Resources section. AOA MORE can also support two clinical practice improvement activities for doctors. For guidance on completing CPIAs via AOA MORE review page 3 of the Merit-Based Incentive Payment System Guidebook Evaluating and Tracking Your Progress

#### OfficeMate ExamWRITER

AOA MORE will be able to report at least one quality measure AND support two clinical practice improvement activities for doctors. For guidance on completing CPIAs via AOA MORE review page 3 of the Merit-Based Incentive Payment System Guidebook Evaluating and Tracking Your Progress

#### Eyefinity EHR

Eyefinity EHR has successfully and fully executed the AOA MORE integration for the 2017 reporting year. Effective Tuesday evening, December 26th, the Eyefinity EHR and AOA MORE integration will be complete, allowing doctors to submit all MIPS quality measures for the 2017 reporting year. All finalized exam data from January-December 2017 will automatically be pushed to the AOA MORE registry weekly, every Friday. AOA MORE can also support clinical practice improvement activities. For guidance on completing CPIAs via AOA MORE review page 3 of the Merit-Based Incentive Payment System Guidebook Evaluating and Tracking Your Progress

## MIPS: Quality

### • AOA More - Supported EHR Integrations as of January 2018

#### Eyefinity EHR

Eyefinity EHR has successfully and fully executed the AOA MORE integration for the 2017 reporting year. Effective Tuesday evening, December 26th, the Eyefinity EHR and AOA MORE integration will be complete, allowing doctors to submit all MIPS quality measures for the 2017 reporting year. All finalized exam data from January-December 2017 will automatically be pushed to the AOA MORE registry weekly, every Friday. AOA MORE can also support clinical practice improvement activities. For guidance on completing CPIAs via AOA MORE review page 3 of the Merit-Based Incentive Payment System Guidebook Evaluating and Tracking Your Progress

#### Practice Director

Practice Director has successfully and fully executed AOA MORE integration for the 2017 reporting year. AOA MORE also supports two clinical practice improvement activities for doctors. For guidance on completing CPIAs via AOA MORE review page 3 of the Merit-Based Incentive Payment System Guidebook Evaluating and Tracking Your Progress

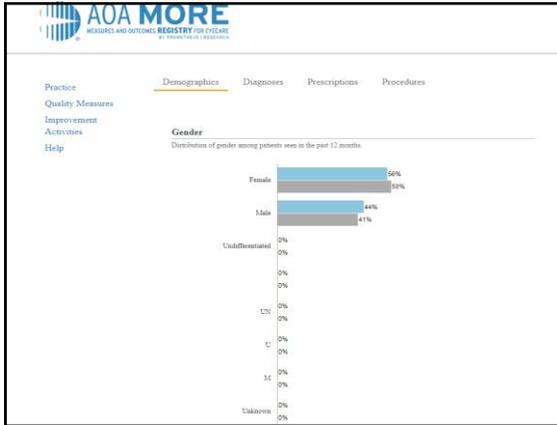
#### RevolutionEHR

RevolutionEHR has not submitted live production data to AOA MORE in 2017. For additional information on how RevolutionEHR can support you in meeting quality measure requirements, please contact RevolutionEHR at [qa@revolutionehr.com](mailto:qa@revolutionehr.com). AOA MORE can also support two clinical practice improvement activities for doctors. For guidance on completing CPIAs via AOA MORE review page 3 of the Merit-Based Incentive Payment System Guidebook Evaluating and Tracking Your Progress

#### FUTURE INTEGRATIONS:



Practice Quality Measure	Performance Rate	Numerator	Denominator	My Status	Registry Average
<b>CMS14</b> Closing the Refill Loop Recpt of Operator Report	0%	00	0%	None	None
<b>CMS124</b> Diabetic (Strengths A1c) Poor Control	0%	00	0%	None	None
<b>CMS164</b> Controlling High Blood Pressure	0%	00	0%	None	None
<b>CMS164</b> Diabetic Retinopathy: Documentation of Presence or Absence of Macula Edema and Level of Severity of Retinopathy	0%	00	0%	None	None
<b>PQRS9</b> Diabetic Retinopathy: Communication with Physician Regarding Ongoing Diabetes Care	0%	00	0%	None	None



### Claims Based Reporting of MIPS Quality Measures

Claims Reporting is only available for MIPS individuals not for MIPS groups

Dx A: H35.3111 (early dry AMD right eye)    Dx B:

Date Service	Place Service	Procedure (CPT I) and QDC (CPT II)	Procedure Description	Dx
1/14/2018	11	92014	Exam	1
1/14/2018	11	92015	Refraction	1
1/14/2018	11	2019F	Dilated Macular Exam Performed including documentation of macular thickening or hemorrhage and the level of macular degeneration severity	1

### EHR Reporting of MIPS Quality Measures

Find Criteria    View Previous QDM Report Measure Calculation

Report Year: 2017    YTD    Last Year    Clear Filters

Date Range: 01/01/2017 To 11/13/2017    Run Report

Select	Quality ID	eCQM	NQF	Domain	Measure	Info	Num	Den	Exc	Exp	Perf. Rate	Not Met	Medicare Num	Medicare Den
	236	156v5	0018	Effective Clinical Care	Controlling High Blood Pressure		26	66	0	0	39.4%	36	9	18
	238	156v5	0022	Patient Safety	High Risk Meds (1+) in the Elderly		0	103	0	0	0%	103	0	68
	238	156v5	0022	Patient Safety	High Risk Meds (2+) in the Elderly		0	103	0	0	-	103	0	68
	226	138v5	0028	Community, Population and Public Health	Tobacco use: Screening & Cessation/Intervention		216	219	0	0	98.6%	3	33	26
	117	131v5	0050	Effective Clinical Care	Diabetes: Eye Exam		155	157	0	0	98.7%	2	18	18
	12	143v5	0088	Effective Clinical Care	POAG: Optic nerve Eval		41	43	0	0	95.4%	2	12	13
	18	167v5	0088	Effective Clinical Care	Diabetic Retinopathy: Documentation		147	149	0	0	98.7%	2	23	24
	19	142v5	0089	Effective Clinical Care	Diabetic Retinopathy: Communication		141	147	0	0	95.9%	5	20	23
	130	68v6	0419	Patient Safety	Documentation of current Meds in Medical Record		2488	2497	0	0	99.6%	3	213	213
	128	69v5	0421	Community, Population and Public Health	BMI Screening & Follow-Up Plan		366	429	0	0	85.3%	63	54	85
	374	50v5	xxxx	Community & Care Coordination	Closing Referral Loop: Receipt of Specialist Report		0	1	0	0	0%	1	0	1

### MIPS: Quality

#### Scoring

- Your performance rate will be compared against a benchmark (if one exists)
- Provided that a measure has a benchmark you can attain 3-10 points if you meet the data submission thresholds
  - If there is not a benchmark then you can only receive a maximum of 3 points

### MIPS: Quality

- Quality submission thresholds and data completeness**
  - To be eligible to receive more than 1 point (3 for small practices) a quality measure must meet both the case minimum requirement and the data completeness criteria
    - Case minimum requirement is 20 patients**
      - You must report the measure on at least 20 unique patients
    - Data completeness criteria is reporting on at least 60% of applicable patients and at least 1 Medicare patient**
      - For each measure you report, submit data on at least 60% of applicable patients seen during the reporting period
      - Applicable patients:
        - When submitting via claims is Medicare patients
        - When submitting via Registry or EHR vendor is all patients both Medicare and Non-Medicare for whom the measure applies

### MIPS: Quality

- Your score (3-10 points) will depend on how your performance compares against the benchmark
  - There are separate benchmarks for each reporting mechanism (claims based, AOA more, EHR vendor) for the exact same Quality measures
  - These benchmarks are based on performance data drawn from all clinicians who use the measure (typically using data from 2 years prior)

## MIPS: Quality

- Each benchmark is broken into deciles and the number of points you receive will depend on which of the deciles you fall into
- Benchmarks can be found online  
<https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Quality-Benchmarks.zip>

## MIPS: Quality

- Understanding Benchmarks
  - Each benchmark is presented in terms of deciles
  - Points are awarded within each decile
  - Clinicians who receive a score in the first or second decile will receive 3 points
  - Clinicians who are in the 3<sup>rd</sup> decile will receive somewhere between 3 and 3.9 points depending on their exact position in the decile
  - Clinicians in the 4<sup>th</sup> decile will receive somewhere between 4 and 4.9 points
  - Clinicians in the 8<sup>th</sup> decile will receive somewhere between 8 and 8.9 points

## MIPS: Quality

- Benchmark deciles will be different for each measure and each submission method (even for the same measure)
- Once you know your success rate on a measure (look at your EHR report or AOA MORE dashboard) you can look at the particular decile table for that measure and the submission method you will be using to determine how many points you will receive for that specific measure

## MIPS: Quality

Decile	Benchmark % (Different for each measure/ submission method)	Number of Points Assigned for 2018 MIPS Performance Period
Below Decile 3		3 points
Decile 3	2.70 – 6.24	3-3.9 points
Decile 4	6.25 – 11.46	4-4.9 points
Decile 5	11.47 – 18.15	5-5.9 points
Decile 6	18.16 – 25.57	6-6.9 points
Decile 7	25.58 – 36.95	7-7.9 points
Decile 8	36.96 – 51.17	8-8.9 points
Decile 9	51.18 – 71.87	9-9.9 points
Decile 10	≥ 71.88	10 points

## MIPS: Quality

- Example: You submit data on 83 patients out of 100 patients that the measure applied to
  - Your performance score is 83% on that measure..... How many points do you get??
  - You will receive between 5 and 5.9 points because 83% falls in the 5<sup>th</sup> decile

Decile	Benchmark	Points
3	32.26 – 48.38	3 – 3.9
4	48.39 – 71.99	4 – 4.9
5	72.00 – 84.99	5 – 5.9
6	85.00 – 89.99	6 – 6.9
7	90.00 – 97.43	7 – 7.9
8	97.44 – 99.99	8 – 8.9
9	-	-
10	100	10

## MIPS: Quality

### Things to watch out for when choosing Quality measures to report

- Watch for measures that **don't have benchmarks** for the reporting mechanism you are using to submit measures
  - If a measure lacks a benchmark you can't score more than 3 points for that measure
- Watch out for measures that are **topped out**
  - CMS defines a topped out measure as a measure where the performance is consistently high across providers and meaningful distinctions and improvement in performance can no longer be made
  - These are measures that reach or almost reach maximum performance value well before the tenth decile
  - When a measure is topped out you will need a perfect performance rate (100%) to get 10 points
  - Even though you may have a high performance rate in a topped out measure, it will be significantly harder to earn high points for that measure

## MIPS: Quality

### Example scoring on a topped out measure:

- For claims reporting: Documentation of current medications in the medical record
  - Reporting a performance rate of 99.9% would only earn 5.9 points
  - To earn 10 points the performance rate would have to be 100%

Decile	Benchmark	Points
3	97.20 – 99.23	3 – 3.9
4	99.24 – 99.79	4 – 4.9
5	99.80 – 99.99	5 – 5.9
6	-	-
7	-	-
8	-	-
9	-	-
10	100	10

## MIPS: Quality

### Reporting Quality Measures

- If you are reporting by claims, AOA more, or your EHR vendor maximize your payment by:
  - Report **at least** 6 quality measures
    - Suggest 8
  - Select your quality measures appropriately
    - Attempt the ones you are already performing / tracking
    - Remember measures available to you will depend on your reporting mechanism**
  - At least 1 quality measure should be an outcome measure
    - If no outcome measure is available you must report another high priority measure instead
  - Be prepared to make changes if the measures you are tracking don't result in good numbers or the measure is topped out

## MIPS: Quality

- What if you can't report on 6 quality measures**
  - Report on as many as you can
  - You should be able to find at least 6 that are applicable
- What if you report on more than 6 quality measures**
  - If you report on 7 or more measures, CMS will determine which 6 of those will give you the highest quality score
  - Therefore we encourage you to report on more than 6 quality measures**

## MIPS: Quality

- Picking quality measures
- CMS, under the Quality Payment Program (QPP), has developed a web based tool to help you pick quality measures

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

## MIPS: Quality

Quality Payment PROGRAM

MIPS - Merit-based Incentive Payment System

APMs - Alternative Payment Models

About - The Quality Payment Program

### Quality Measures

Instructions

- Review and select measures that best fit your practice.
- Add up to six measures from the list below, including one outcome measure. You can use the search and filters to help find the measures that meet your needs or specialty.
- If an outcome measure is not available that is applicable to your specialty or practice, choose another high priority measure.
- Download a CSV file of the measures you have selected for your records.

2017 MIPS Performance

- Quality (80%)
- Advancing Care Information (25%)
- Improvement Activities (19%)

## MIPS: Quality

Quality Payment PROGRAM

MIPS - Merit-based Incentive Payment System

APMs - Alternative Payment Models

About - The Quality Payment Program

Note: This tool is only for informational and estimation purposes. You can't use it to submit or attest to measures or activities.

### Select Measures

SEARCH BY KEYWORD

Filtered Search for... SEARCH

FILTER BY:

High Priority Measure Data Submission Method Specialty Measure Set

Showing 271 Measures

Add All Measures

## MIPS: Quality

### Select Measures

SEARCH BY KEYWORD

Filtered Search for... SEARCH

FILTER BY:

High Priority Measure Data Submission Method Specialty Measure Set

Yes  
 No

Showing 271 measures Add All Measures

Acute Otitis Externa (AOE) Systemic Antimicrobial Therapy Selected Measures

## MIPS: Quality

### Select Measures

SEARCH BY KEYWORD

Filtered Search for... SEARCH

FILTER BY:

High Priority Measure Data Submission Method Specialty Measure Set

Administrative Claims  
 Claims  
 CSV  
 CMS Web Interface  
 EHR  
 Registry

Showing 271 Measures Add All Measures

Acute Otitis Externa (AOE) Avoidance of Inappropriate Selected Measures

## MIPS: Quality

### Select Measures

SEARCH BY KEYWORD

Filtered Search for... SEARCH

FILTER BY:

High Priority Measure Data Submission Method Specialty Measure Set

Allergy/Immunology  Neurology  
 Anesthesiology  Obstetrics/Gynecology  
 Cardiology  Ophthalmology  
 Dermatology  Orthopedic Surgery  
 Diagnostic Radiology  Otolaryngology  
 Electrophysiology/ Cardiac Specialist  Pathology  
 Emergency Medicine  Pediatrics  
 Gastroenterology  Physical Medicine

Showing 271 Measures Add All Measures

Acute Otitis Externa (AOE) Avoidance of Inappropriate Selected Measures

## MIPS: Quality

### Select Measures

FILTER BY:

High Priority Measure Data Submission Method Specialty Measure Set

Clear All Filters Ophthalmology

Showing 21 Measures Add All Measures

Adult Primary Rhegmatogenous Retinal Detachment Surgery: No Return to the Operating Room Within 90 Days of Surgery ADD

Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery ADD

Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplements ADD

Selected Measures

5 Measures Added

Download (CSV) Clear All

Closing the Referral Loop: Receipt of Specialist Report

Controlling High Blood Pressure

## MIPS: Quality Scoring

- 50% of Final Score in 2018
  - Maximum score cannot exceed 100%

Total Quality Performance Category Score

=

Points earned on required 6 quality measures

+

Any bonus points

Maximum number of points\*

\*Maximum number of points = # of required measures x 10

## MIPS: Quality Scoring

**Possible Quality Measures:**

- AMD: Counseling on Antioxidant Supplement (claims / registry reporting only)
  - Percentage of patients aged 50 years and older with a diagnosis of AMD or their caregiver(s) who were counseled within 12 months on the benefits and/or risks of the AREDS formulation for preventing progression of AMD
- AMD: Dilated Macular Exam (claims / registry reporting only)
  - Percentage of patients aged 50 years and older with a diagnosis of AMD who had a dilated macular examination performed which included documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity during one or more office visits within 12 months
- Closing the Referral Loop: Receipt of Specialist Report (EHR / registry reporting) \*
  - Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred
- Diabetes: Eye Exam (Claims, EHR, registry reporting)
  - Percentage of patients 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period
- Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care (Claims, EHR, registry reporting) \*
  - Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months

\* High Priority Measures

## MIPS: Quality Scoring

### Possible Quality Measures:

- **Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy (EHR / registry reporting)**
  - Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months
- **Documentation of Current Medications in the Medical Record (Claims, EHR, registry reporting) \***
  - Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration
- **Preventive Care and Screening: Body Mass Index Screening and Follow-Up Plan (Claims, EHR, registry reporting)**
  - Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous six months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter Normal Parameters: Age 18 years and older BMI >= 18.5 and < 25 kg/m2
- **Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (Claims, EHR, registry reporting)**
  - Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user

\*High Priority Measures

## MIPS: Quality Scoring

### Possible Quality Measures:

- **Primary Open-Angle Glaucoma: Optic Nerve Evaluation (Claims, EHR, registry reporting)**
  - Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) who have an optic nerve head evaluation during one or more office visits within 12 months
- **Primary Open-Angle Glaucoma: Reduction of IOP by 15% or documentation of a plan of care (Claims, registry reporting)**
  - Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) whose glaucoma treatment has not failed (the most recent IOP was reduced by at least 15% from the pre-intervention level) OR if the most recent IOP was not reduced by at least 15% from the pre-intervention level, a plan of care was documented within 12 months
- **Use of High-Risk Medications in the Elderly (EHR, registry reporting) \***
  - Percentage of patients 66 years of age and older who were ordered high-risk medications. Two rates are reported, a. Percentage of patients who were ordered at least one high-risk medication. b. Percentage of patients who were ordered at least two different high-risk medications
- **Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (EHR / registry reporting)**
  - Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist (OB/GYN) and who had evidence of the following during the measurement period. Three rates are reported. - Percentage of patients with height, weight, and body mass index (BMI) percentile documentation - Percentage of patients with counseling for nutrition - Percentage of patients with counseling for physical activity

\*High Priority Measures

## MIPS: Quality

### AOA More supported Quality Measures

CMS68	Documentation of Current Medication
CMS131	Diabetes: Eye Exam
CMS50	Closing the Referral Loop: Receipt of Specialist Report
CMS142	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
CMS143	Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation
CMS167	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
CMS 138	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
CMS 165	Controlling High Blood Pressure
CMS 122	Diabetes: Hemoglobin A1c Poor Control

## MIPS: Quality

### Common Measure Benchmarks

#### AMD – Counseling AREDS: Claims Reporting

- **Benchmark: Yes**                      **Topped Out : Yes**

Decile	Benchmark	Points
3	97.33 – 99.99	3 – 3.9
4	-	-
5	-	-
6	-	-
7	-	-
8	-	-
9	-	-
10	100	10

## MIPS: Quality

### Common Measure Benchmarks

#### AMD – Counseling AREDS: Registry Reporting

- **Benchmark: Yes**                      **Topped Out : No**

Decile	Benchmark	Points
3	35.90 – 57.88	3 – 3.9
4	57.89 – 71.75	4 – 4.9
5	71.76 – 86.38	5 – 5.9
6	86.39 – 94.22	6 – 6.9
7	94.23 – 98.31	7 – 7.9
8	98.32 – 99.99	8 – 8.9
9	-	-
10	100	10

## MIPS: Quality

### Common Measure Benchmarks

#### AMD – Dilated Exam: Claims Reporting

- **Benchmark: Yes**                      **Topped Out : Yes**

Decile	Benchmark	Points
3	99.60 – 99.99	3 - 3.9
4	-	-
5	-	-
6	-	-
7	-	-
8	-	-
9	-	-
10	100	10

## MIPS: Quality

Common Measure Benchmarks

### AMD – Dilated Exam: Registry Reporting

- **Benchmark: Yes**                      **Topped Out : Yes**

Decile	Benchmark	Points
3	64.21 - 81.81	3 – 3.9
4	81.82 – 90.85	4 – 4.9
5	90.86 – 95.69	5 – 5.9
6	95.70 – 98.64	6 – 6.9
7	98.65 – 99.99	7 – 7.9
8	-	-
9	-	-
10	100	10

## MIPS: Quality

Common Measure Benchmarks

### Closing the referral loop: EHR Vendor Reporting

- **Benchmark: Yes**                      **Topped Out : No**

Decile	Benchmark	Points
3	14.29 – 24.13	3 – 3.9
4	24.14 – 33.57	4 – 4.9
5	33.58 – 43.65	5 – 5.9
6	43.66 – 54.33	6 – 6.9
7	54.34 – 63.78	7 – 7.9
8	63.79 – 74.99	8 – 8.9
9	75.00 – 88.63	9 – 9.9
10	≥ 88.64	10

## MIPS: Quality

Common Measure Benchmarks

### Closing the referral loop: Registry Reporting

- **Benchmark: Yes**                      **Topped Out : Yes**

Decile	Benchmark	Points
3	65.22 – 99.99	3 – 3.9
4		4 – 4.9
5		5 – 5.9
6		6 – 6.9
7		7 – 7.9
8		8 – 8.9
9		9 – 9.9
10	100	10

## MIPS: Quality

Common Measure Benchmarks

### Diabetes Eye Exam: EHR Vendor Reporting

- **Benchmark: Yes**                      **Topped Out : Yes**

Decile	Benchmark	Points
3	84.83 – 92.85	3 – 3.9
4	92.86 – 95.32	4 – 4.9
5	95.33 – 96.96	5 – 5.9
6	96.97 – 98.19	6 – 6.9
7	98.20 – 99.17	7 – 7.9
8	99.18 – 99.82	8 – 8.9
9	99.83 – 99.99	9 – 9.9
10	100	10

## MIPS: Quality

Common Measure Benchmarks

### Diabetes Eye Exam: Registry Reporting

- **Benchmark: Yes**                      **Topped Out : Yes**

Decile	Benchmark	Points
3	80.91 – 922.85	3 – 3.9
4	92.86 – 96.53	4 – 4.9
5	96.54 – 98.70	5 – 5.9
6	98.71 – 99.99	6 – 6.9
7	-	-
8	-	-
9	-	-
10	100	10

## MIPS: Quality

Common Measure Benchmarks

### Diabetes Eye Exam: Claims Reporting

- **Benchmark: Yes**                      **Topped Out : Yes**

Decile	Benchmark	Points
3	88.98 – 98.44	3 – 3.9
4	98.45 – 99.99	4 – 4.9
5	-	-
6	-	-
7	-	-
8	-	-
9	-	-
10	100	10

## MIPS: Quality

Common Measure Benchmarks

**Diabetic Retinopathy – Communication with Physician managing diabetes: Claims Reporting**

- **Benchmark: Yes**                      **Topped Out : Yes**

Decile	Benchmark	Points
3	-	-
4	-	-
5	-	-
6	-	-
7	-	-
8	-	-
9	-	-
10	100	10

## MIPS: Quality

Common Measure Benchmarks

**Diabetic Retinopathy – Communication with Physician managing diabetes: EHR Reporting**

- **Benchmark: Yes**                      **Topped Out : No**

Decile	Benchmark	Points
3	46.15 – 56.85	3 – 3.9
4	56.86 – 65.13	4 – 4.9
5	65.14 – 72.38	5 – 5.9
6	72.39 – 78.21	6 – 6.9
7	78.22 – 84.27	7 – 7.9
8	84.28 – 89.93	8 – 8.9
9	89.94 – 95.41	9 – 9.9
10	≥ 95.42	10

## MIPS: Quality

Common Measure Benchmarks

**Diabetic Retinopathy – Communication with Physician managing diabetes: Registry Reporting**

- **Benchmark: Yes**                      **Topped Out : Yes**

Decile	Benchmark	Points
3	52 – 72.40	3 – 3.9
4	72.41 – 81.47	4 – 4.9
5	81.48 – 90.76	5 – 5.9
6	90.77 – 96.54	6 – 6.9
7	96.55 – 99.99	7 – 7.9
8	-	-
9	-	-
10	100	10

## MIPS: Quality

Common Measure Benchmarks

**Diabetic Retinopathy – Documentation Presence / absence of Macular Edema: EHR Vendor Reporting**

- **Benchmark: Yes**                      **Topped Out : No**

Decile	Benchmark	Points
3	57.14 – 65.83	3 – 3.9
4	65.84 – 72.72	4 – 4.9
5	72.73 – 78.21	5 – 5.9
6	78.22 – 83.12	6 – 6.9
7	83.13 – 88.17	7 – 7.9
8	88.18 – 92.30	8 – 8.9
9	92.31 – 96.32	9 – 9.9
10	≥ 96.33	10

## MIPS: Quality

Common Measure Benchmarks

**Documentation of current meds: Claims**

- **Benchmark: Yes**                      **Topped Out : Yes**

Decile	Benchmark	Points
3	97.20 – 99.23	3 – 3.9
4	99.24 – 99.79	4 – 4.9
5	99.80 – 99.99	5 – 5.9
6	-	-
7	-	-
8	-	-
9	-	-
10	100	10

## MIPS: Quality

Common Measure Benchmarks

**Documentation of current meds: EHR Vendor Reporting**

- **Benchmark: Yes**                      **Topped Out : Yes**

Decile	Benchmark	Points
3	86.25 – 91.91	3 – 3.9
4	91.92 – 94.85	4 – 4.9
5	94.86 – 96.69	5 – 5.9
6	96.70 – 97.98	6 – 6.9
7	97.99 – 98.87	7 – 7.9
8	98.88 – 99.54	8 – 8.9
9	99.55 – 99.95	9 – 9.9
10	≥ 99.96	10

## MIPS: Quality

Common Measure Benchmarks

**Documentation of current meds: Registry Reporting**

- **Benchmark: Yes**      **Topped Out : Yes**

Decile	Benchmark	Points
3	77.08 – 90.22	3 – 3.9
4	90.23 – 95.97	4 – 4.9
5	95.98 – 98.60	5 – 5.9
6	98.61 – 99.69	6 – 6.9
7	99.70 – 99.99	7 – 7.9
8	-	-
9	-	-
10	100	10

## MIPS: Quality

Common Measure Benchmarks

**BMI screening and follow up: Claims Reporting**

- **Benchmark: Yes**      **Topped Out : No**

Decile	Benchmark	Points
3	43.20 – 48.42	3 – 3.9
4	48.43 – 58.92	4 – 4.9
5	58.93 – 83.56	5 – 5.9
6	83.57 – 96.60	6 – 6.9
7	96.61 – 99.53	7 – 7.9
8	99.54 – 99.99	8 – 8.9
9	-	-
10	100	10

## MIPS: Quality

Common Measure Benchmarks

**BMI screening and follow up: EHR Reporting**

- **Benchmark: Yes**      **Topped Out : No**

Decile	Benchmark	Points
3	28.22 – 31.92	3 – 3.9
4	31.93 – 35.34	4 – 4.9
5	35.35 – 38.76	5 – 5.9
6	38.77 – 42.88	6 – 6.9
7	42.89 – 49.18	7 – 7.9
8	49.19 – 64.83	8 – 8.9
9	64.84 – 85.93	9 – 9.9
10	≥ 85.94	10

## MIPS: Quality

Common Measure Benchmarks

**BMI screening and follow up: Registry Reporting**

- **Benchmark: Yes**      **Topped Out : No**

Decile	Benchmark	Points
3	45.12 – 52.05	3 – 3.9
4	52.06 – 59.99	4 – 4.9
5	60.00 – 68.74	5 – 5.9
6	68.75 – 77.77	6 – 6.9
7	77.78 – 86.07	7 – 7.9
8	86.08 – 92.85	8 – 8.9
9	95.86 – 99.42	9 – 9.9
10	≥ 99.43	10

## MIPS: Quality

Common Measure Benchmarks

**Tobacco Use Screening and Cessation: Claims Reporting**

- **Benchmark: Yes**      **Topped Out : Yes**

Decile	Benchmark	Points
3	96.65 – 98.59	3 – 3.9
4	98.60 – 99.61	4 – 4.9
5	99.62 – 99.99	5 – 5.9
6	-	-
7	-	-
8	-	-
9	-	-
10	100	10

## MIPS: Quality

Common Measure Benchmarks

**Tobacco Use Screening and Cessation: EHR Vendor Reporting**

- **Benchmark: Yes**      **Topped Out : No**

Decile	Benchmark	Points
3	72.72 – 82.40	3 – 3.9
4	82.41 – 87.55	4 – 4.9
5	87.56 – 90.50	5 – 5.9
6	90.51 – 92.74	6 – 6.9
7	92.75 – 94.63	7 – 7.9
8	94.64 – 96.52	8 – 8.9
9	96.53 – 98.51	9 – 9.9
10	≥ 98.52	10

## MIPS: Quality

Common Measure Benchmarks

**Tobacco Use Screening and Cessation: Registry Reporting**

- **Benchmark: Yes**      **Topped Out : No**

Decile	Benchmark	Points
3	83.72 – 88.38	3 – 3.9
4	88.39 – 91.10	4 – 4.9
5	91.11 – 93.34	5 – 5.9
6	93.35 – 95.44	6 – 6.9
7	95.45 – 97.35	7 – 7.9
8	97.36 – 99.00	8 – 8.9
9	99.01 – 99.99	9 – 9.9
10	100	10

## MIPS: Quality

Common Measure Benchmarks

**POAG – Optic Nerve Evaluation: Claims Reporting**

- **Benchmark: Yes**      **Topped Out : Yes**

Decile	Benchmark	Points
3	98.99 – 99.99	3 – 3.9
4	-	-
5	-	-
6	-	-
7	-	-
8	-	-
9	-	-
10	100	10

## MIPS: Quality

Common Measure Benchmarks

**POAG – Optic Nerve Evaluation: EHR Vendor Reporting**

- **Benchmark: Yes**      **Topped Out : No**

Decile	Benchmark	Points
3	82.75 – 87.40	3 – 3.9
4	87.41 – 90.76	4 – 4.9
5	90.77 – 93.62	5 – 5.9
6	93.63 – 96.16	6 – 6.9
7	96.17 – 97.87	7 – 7.9
8	97.88 – 98.96	8 – 8.9
9	98.97 – 99.99	9 – 9.9
10	100	10

## MIPS: Quality

Common Measure Benchmarks

**POAG – Optic Nerve Evaluation: Registry Reporting**

- **Benchmark: Yes**      **Topped Out : Yes**

Decile	Benchmark	Points
3	94.70 – 98.14	3 – 3.9
4	98.15 – 99.16	4 – 4.9
5	99.17 – 99.99	5 – 5.9
6	-	-
7	-	-
8	-	-
9	-	-
10	100	10

## MIPS: Quality

Common Measure Benchmarks

**POAG – Reduction of IOP by 15% or Plan: Claims Reporting**

- **Benchmark: Yes**      **Topped Out : Yes**

Decile	Benchmark	Points
3	-	-
4	-	-
5	-	-
6	-	-
7	-	-
8	-	-
9	-	-
10	100	10

## MIPS: Quality

Common Measure Benchmarks

**POAG – Reduction of IOP by 15% or Plan: Registry Reporting**

- **Benchmark: Yes**      **Topped Out : Yes**

Decile	Benchmark	Points
3	69.40 – 86.96	3 – 3.9
4	86.97 – 95.04	4 – 4.9
5	95.05 – 97.95	5 – 5.9
6	97.96 – 99.64	6 – 6.9
7	99.65 – 99.99	7 – 7.9
8	-	-
9	-	-
10	100	10

## MIPS: Quality



- Choosing the proper measures is only part of the battle..... Reporting method is just as important in getting the best score
- **Example:** Diabetic Retinopathy – Communication with the Physician managing the Diabetes
  - If you have a performance of 96% you would earn the following score based on your reporting method:
    - Claims: 3
    - Registry: 6.9
    - EHR Direct: 10

## Detailed look



Cost

## MIPS: Cost



- No extra reporting requirement for cost
  - Medicare claims data will be used to calculate score
- Uses measures previously used in the Value-Based Modifier program
- Focuses on resources clinicians use to care for patients and Medicare payments given to a beneficiary during an episode of care
- 10% of final score for 2018

10%  
of final  
score

## MIPS: Cost



### What are the year 2018 cost measures

1. Medicare Spending Per Beneficiary Measure (MSPB) – related to services performed by clinicians immediately before, during, and after a patient's hospital stay
  2. Total Per-Capita Cost Measure – measures all Medicare Part A and Part B costs during the MIPS performance period
- Cost will have a weight of 30% in 2019

## MIPS: Cost



- Score for Cost category
  - Score will be calculated for you or your group's Cost performance if the case minimum of attributed beneficiaries is met
    - 20 cases for total per capita cost measure or
    - 35 cases for MSPB measure
- If case minimums aren't met for either of the two measures Cost category will get reweighted to the Quality category making Quality worth 60% (instead of 50%) of your MIPS score

## Detailed look



Improvement  
Activities

## MIPS: Improvement Activities

- Gauges your participation in activities that improve clinical practice such as:
  - Ongoing care coordination
  - Clinician and patient shared decision making
  - Regularly using patient safety practices
  - Expanding practice access
- 15% of your final score in 2018

15 %  
of final  
score

## MIPS: Improvement Activities

- Attest to participation in activities that improve clinical practice
- Choose from 100+ activities from 9 subcategories to show your performance:
  1. Expanded Practice Access
  2. Population Management
  3. Care Coordination
  4. Beneficiary Engagement
  5. Patient Safety and Practice Assessment
  6. Participation in an APM
  7. Achieving Health Equity
  8. Integrating Behavioral and Mental Health
  9. Emergency Preparedness and Response

15 %  
of final  
score

## MIPS: Improvement Activities Scoring

- 15% Final MIPS score
- Full credit means total points obtaining 40 points in category score

### Activity Weights

- Medium = 10 points
- High = 20 points

### Activity Weights for small practices and rural area shortage areas

- Medium = 20 points
- High = 40 points

## MIPS: Improvement Activities Scoring

- Maximum Score
  - Each improvement activity is all or nothing in score
    - Must satisfy all requirements for 90 days to get credit
  - To get the maximum score you must perform and report 1 to 4 improvement activities
    - The number of activities depends on how they are weighted and on the size and location of your practice

## MIPS: Improvement Activities Scoring

- Pick your reporting mechanism for Improvement Activities
  - You can attest to your improvement activities via:
    - CMS web portal
    - EHR Vendor
- **If you use EHR to report then you may also receive the Advancing Care Information bonus for using CEHRT for improvement activities**
  - **Certain activities not only contribute to your improvement activities score but also can boost your ACI score if performed using a CEHRT**
- Performance Period for Improvement Activities = minimum of 90 consecutive days

## MIPS: Improvement Activities Scoring

- 15% of Final Score in 2018
- Maximum score is 40 points cannot exceed 100%

$$\text{Improvement Activities Performance Category Score} = \left[ \frac{\text{Total number of points scored for completed activities}}{\text{Total maximum number of points (40)}} \right] \times 100$$

- Example if you get 20 points your score would be  $20/40 \times 100 = 50\%$  and your points for the category would be  $50\% \times 15 = 7.5$  points out of the 15 possible points

## Improvement Activities in Detail

## MIPS: Improvement Activities

### Expanded Practice Access: 5 Activities

- High Weight – 20 Points
  - Provide **24/7 access** to MIPS eligible clinicians, groups, or care teams for advice about urgent and emergent care
    - Expanded hours in evenings and weekends with access to the patient medical record (e.g., coordinate with small practices to provide alternate hour office visits and urgent care);
    - Use of alternatives to increase access to care team by MIPS eligible clinicians and groups, such as e-visits, phone visits, group visits, home visits and alternate locations (e.g., senior centers and assisted living centers); and/or
    - Provision of same-day or next-day access to a consistent MIPS eligible clinician, group or care team when needed for urgent care or transition management
- Medium Weight – 10 Points
  - **Collection of patient experience and satisfaction data** on access to care and development of an improvement plan, such as outlining steps for improving communications with patients to help understanding of urgent access needs
  - **Use of telehealth services** and analysis of data for quality improvement, such as participation in remote specialty care consults, or teleaudiology pilots that assess ability to still deliver quality care to patients

## MIPS: Improvement Activities

### Population Management: 20 Activities

- High weight – 20 Points
  - Use of a QCDR to generate regular feedback reports that summarize local practice patterns and treatment outcomes, including for vulnerable populations
- Medium weight – 10 Points
  - Manage medications to maximize efficiency, effectiveness and safety that could include one or more of the following:
    - Reconcile and coordinate medications and provide medication management across transitions of care settings and eligible clinicians or groups;
    - Integrate a pharmacist into the care team; and/or
    - Conduct periodic, structured medication reviews
  - Participation in a QCDR, clinical data registries, or other registries run by other government agencies such as FDA, or private entities such as a hospital or medical or surgical society. Activity must include use of QCDR data for quality improvement (e.g., comparative analysis across specific patient populations for adverse outcomes after an outpatient surgical procedure and corrective steps to address adverse outcome)

## MIPS: Improvement Activities

### Care Coordination: 17 Activities

- High weight – 20 Points
  - Participation in the CMS Transforming Clinical Practice Initiative
- Medium weight – 10 Points
  - Ensure that there is bilateral exchange of necessary patient information to guide patient care that could include one or more of the following:
    - Participate in a Health Information Exchange if available; and/or
    - Use structured referral notes
  - Implementation of regular care coordination training

## MIPS: Improvement Activities

### Beneficiary Engagement: 23 Activities

- High weight – 20 Points
  - Collection and follow-up on patient experience and satisfaction data on beneficiary engagement, including development of improvement plan
- Medium weight – 10 Points
  - Use evidence-based decision aids to support shared decision making
  - Regularly assess the patient experience of care through surveys, advisory councils, and/or other mechanisms

## MIPS: Improvement Activities

### Patient Safety & Practice Assessment: 30 Activities

- High weight – 20 Points
  - Clinicians would attest that 75 percent of time they reviewed and consulted a prescription drug monitoring program prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription that lasts for longer than 3 days
- Medium weight – 10 Points
  - Use decision support and standardized treatment protocols to manage workflow in the team to meet patient needs
  - Use of QCDR data, for ongoing practice assessment and improvements in patient safety
  - Use of tools that assist specialty practices in tracking specific measures that are meaningful to their practice, such as use of the Surgical Risk Calculator

## MIPS: Improvement Activities



### Achieving Health Equity: 6 Activities

- High weight – 20 Points
  - Seeing new and follow-up Medicaid patients in a timely manner, including individuals dually eligible for Medicaid and Medicare. Timely is defined as 10 business days
- Medium weight – 10 Points
  - Participation in a QCDR, demonstrating performance of activities for use of standard questionnaires for assessing improvements in health disparities related to functional health status

## MIPS: Improvement Activities



### Emergency Response & Preparedness: 2 Activities

- High weight – 20 Points
  - Participation in domestic or international humanitarian volunteer work. Activities that simply involve registration are not sufficient. MIPS eligible clinicians attest to domestic or international humanitarian volunteer work for a period of a continuous 60 days or greater
- Medium weight – 10 points
  - Participation in Disaster Medical Assistance Teams, or Community Emergency Responder Teams. Activities that simply involve registration are not sufficient. MIPS eligible clinicians and MIPS eligible clinician groups must be registered for a minimum of 6 months as a volunteer for disaster or emergency response

## MIPS: Improvement Activities



### Behavioral & Mental Health: 9 Activities

- High weight – 20 Points
  - Integration facilitation, and promotion of the colocation of mental health services in primary and/or non-primary clinical care settings
- Medium weight – 10 Points
  - Tobacco use: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including tobacco use screening and cessation interventions (refer to NQF #0028) for patients with co-occurring conditions of behavioral or mental health and at risk factors for tobacco dependence
  - Unhealthy alcohol use: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including screening and brief counseling (refer to NQF #2152) for patients with co-occurring conditions of behavioral or mental health condition

## MIPS: Improvement Activities



### How to get the highest score

- Remember 40 points is full score
  - 4 medium weighted activities (4 x 10 points)
  - 2 medium (2 x 10) and 1 high weighted (1 x 20) activity
  - 2 high weighted (2 x 20 points) activities
- If you are in a small practice ≤ 15 providers you get double points for each activity
    - 2 medium weighted activities
    - 1 high weighted activity

## MIPS: Improvement Activities



- Don't forget the ACI bonus for using CEHRT to complete improvement activities
- For example:
  - If you perform the “provide 24/7 access” improvement activity and you use your CEHRT's secure messaging functionality to provide 24/7 access for advice about urgent care by sending or responding to secure messages outside business hours this would qualify you for the 10% CEHRT improvement activities bonus
  - This bonus accrues to your ACI score not your improvement activities score

## MIPS: Improvement Activities



- Document your improvement activities and maintain documentation for 6 years
  - To make sure you are ready for a future audit
  - Maintain documentation that shows you performed the improvement activities that you are claiming credit for
    - For 24/7 access: a patient encounter / medical claim indicating the patient was seen outside normal business hours

## Detailed look



### Advancing Care Information

## MIPS: Advancing Care Information



- Replaces Medicare Meaningful Use
- Contributes 25% to your final score
- Clinicians must use certified EHR technology to report
- Category score is made up of a base score, a performance score, and a possible bonus score

25 %  
of final  
score

## MIPS: Advancing Care Information



Two measure sets for reporting in 2018

- **2018 Advancing Care Information Transition Objectives and Measures**
  - Adopted from Modified stage 2
- **Advancing Care Information Objectives and Measures**
  - Adopted from Stage 3
  - Bonus of 10% if you report exclusively using the Advancing Care Information Objectives and Measures

## MIPS: Advancing Care Information



- The set of measures that you can report depends on whether you have 2014 or 2015 edition certified EHR technology

### Advancing Care Information Objectives and Measures

- If you have EHR technology certified to the **2015 edition**
- If you have a combination of technologies from 2014 and 2015 that support these measures

### 2018 Advancing Care Information Transition Objectives and Measures

- If you have technology certified to the **2015 edition**
- If you have technology certified to the **2014 edition**
- If you have a combination of technologies from 2014 and 2015 that support these measures

## MIPS: Advancing Care Information



### Calculating your ACI Score

**Base Score** 0% or 50%

- Report 4 base score measures from the transition set or 5 base measures from the ACI measures set

+ **Performance Score** 0% - 90%

- Report up to 7 performance score measures from the transition set or up to 9 measures from the ACI set

+ **Bonus Score** Up to 25%

- 5% for additional registry beyond the one identified for the performance score measure
- 10% for using CEHRT for improvement activity
- 10% for using only Advancing Care Information Objectives and Measures

= **ACI Score** 0% - 100%

- Your ACI score is capped at 100%

## MIPS: Advancing Care Information



### Different Levels of ACI Participation

#### Base score and Performance score

- Base score represents a mandatory core level of participation
- Performance score involves a second level of participation where you are rewarded for your performance rate

## MIPS: Advancing Care Information



### Base Score

- You must achieve full marks for the ACI base score which is worth 50% of the maximum ACI score
  - To do this you must report 4 or 5 base measures depending on the measure set you use
  - Base score is all or nothing:
    - You must report all the required measures to earn the full base score (50%)
    - If you fall short even on just 1 measure you will score 0% for both the base score and the overall ACI score

## MIPS: Advancing Care Information



### Base Score

- You must report a Yes / No for the security risk analysis measure
- You must report the numerator and denominator for the other base measures
  - You need a numerator of **at least 1** to successfully report the measure
  - For the base score you don't get any extra points if your numerator is greater than 1

## MIPS: Advancing Care Information Base Score



### Advancing Care Information Measures Base Score

- Security Risk Analysis
- e-Prescribing
- Provide Patient Access
- Send a summary of care
- Request / Accept a summary of care

### 2018 Advancing Care Information Transition Measures Base Score

- Security Risk Analysis
- e-Prescribing
- Provide Patient Access
- Health Information Exchange

- Failure to meet reporting requirements will result in a base score of zero, and an advancing care information category performance score of zero

## MIPS: Advancing Care Information



### Performance Score

- You are eligible for the performance score only if you achieved the base score
- Performance score accounts for up to 90% of your total ACI score
- Report either 7 or 9 performance score measures depending on which measure set you use
  - The transition measure set contains 7 performance score measures
    - 2 mandatory and 5 optional
  - The ACI measure set contains 9 performance score measures
    - 3 mandatory and 6 optional

## MIPS: Advancing Care Information Performance Score



### Advancing Care Information Objectives and Measures Performance Score

Objective	Measure
1. Patient Electronic Access	Provide Patient Access *
2. Patient Electronic Access	Patient-Specific Education
3. Coordination of care through patient engagement	View, Download, and Transmit
4. Coordination of care through patient engagement	Secure Messaging
5. Coordination of care through patient engagement	Patient-generate health data
6. Health Information Exchange	Send a Summary of Care *
7. Health Information Exchange	Request/Accept a Summary of Care *
8. Health Information Exchange	Clinical Information Reconciliation
9. Public Health and Clinical Data Registry Reporting	One of the Public Health and Clinical Data Registry Reporting Measures

### 2018 ACI Transition Objectives and Measures Performance Score

Objective	Measure
1. Patient Electronic Access	Provide Patient Access *
2. Patient Electronic Access	View, Download, and Transmit
3. Patient-Specific Education	Patient-Specific Education
4. Secure Messaging	Secure Messaging
5. Health Information Exchange	Health Information Exchange *
6. Medication Reconciliation	Medication Reconciliation
7. Public Health Reporting	One of the Public Health Reporting Measures

## MIPS: Advancing Care Information



### Performance Score

- Your score for each performance measure will depend on your actual performance rate
  - Most measures are assigned a score of 0-10% using decile based scoring
  - Example you submit a num / den of 85/100 your perf. rate is 85 and your score would be 9%

Performance Rate (Numerator / Denominator)	Your Score
0	0%
1-10	1%
11-20	2%
21-30	3%
31-40	4%
41-50	5%
51-60	6%
61-70	7%
71-80	8%
81-90	9%
91-100	10%

## MIPS: Advancing Care Information Bonus Score

- **5% Bonus** for reporting on one or more of the following public health agencies or clinical data registries not reported for the performance score:
  - Immunization Registry Reporting
  - Syndromic Surveillance Reporting
  - Electronic Case Reporting
  - Public Health Registry Reporting
  - Clinical Data Registry Reporting
- **10% Bonus** for:
  - Using CEHRT to report certain Improvement Activities
- **10% Bonus** for:
  - Report exclusively from the Advancing Care Information Measures

## MIPS: Advancing Care Information Category Score



The overall Advancing Care Information score would be made up of a base score, a performance score, and a bonus score for a maximum score of 100 percentage points

## MIPS: Advancing Care Information

### Several routes to a High ACI Score

- Your ACI score is capped at 100% but a total of 165 percentage points are available
  - 50% from base score
  - 90% from the performance score
  - 5% additional registry bonus
  - 10% CEHRT for improvement activities bonus score
  - 10% reporting using Advancing Care Objectives bonus score
- CMS designed ACI this way to allow you more than 1 way to achieve a high score

## MIPS: Advancing Care Information

### Example Scoring

- You met the requirements for:
  - Base score 50%
  - Extra Registry bonus 5%
  - CEHRT for improvement bonus 10%
  - In this example you now have an ACI score of 65%
    - You only need to accrue a performance score of 35% (from the 90% available) to get a perfect score for ACI
    - You could then either submit all the performance measures and if you do OK not even great on them you will have a high ACI score
    - You might instead choose to focus your efforts on the performance measures where you are most likely to be successful

## Advancing Care Information: Prevention of Information Blocking Attestation

### Prevention of Information Blocking: Making sure EHR Information is Shared

- To receive a score in the ACI category MIPS eligible clinicians are required to **attest to three statements** to show that they have not knowingly and willfully limited or restricted the compatibility or interoperability of their CEHRT
1. A MIPS eligible clinician must attest that they did not did not knowingly and willfully take action (such as to disable functionality) to limit or restrict the compatibility or interoperability of CEHRT

## Prevention of Information Blocking: Making sure EHR Information is Shared

2. A MIPS eligible clinician must attest that they implemented technologies, standards, policies, practices, and agreements reasonably calculated to ensure, to the greatest extent practicable and permitted by law, that the CEHRT was, at all relevant times
  - Connected in accordance with applicable law
  - Compliant with all standards applicable to the exchange of information, including the standards, implementation specifications, and certification criteria adopted at 45 CFR Part 170
  - Implemented in a manner that allowed for timely access by patients to their electronic health information (including the ability to view, download, and transmit this information)
  - Implemented in a manner that allowed for the timely, secure, and trusted bi-directional exchange of structured electronic health information with other health care providers (as defined by 42 U.S.C. 300jj(3)), including unaffiliated providers, and with disparate CEHRT and health IT vendors

## Prevention of Information Blocking: Making sure EHR Information is Shared

3. A MIPS eligible clinician must attest that they responded in good faith and in a timely manner to requests to retrieve or exchange electronic health information, including from patients, health care providers (as defined by 42 U.S.C. 300jj(3)), and other persons, regardless of the requestor's affiliation or technology vendor

## Advancing Care Information: Base Objectives in Detail

## Protect Electronic Health Information

ACI - Base Objective

- Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI data created or maintained by certified EHR technology in accordance with requirements in 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the MIPS eligible clinician's risk management process
- If you don't complete this objective you will receive a **zero score for the entire Advancing Care Information category** of MIPS
- Objective is the same for both ACI Objectives and Measures and the 2018 ACI Transition Objectives and Measures

## Protect electronic health information

- A major goal of the Security Rule is to protect the privacy of individuals' health information while allowing covered entities to adopt new technologies to improve the quality and efficiency of patient care
  - This is similar to the current HIPAA security rules
- **You must document and conduct or review a security risk analysis and implement updates as necessary**
  - Should be done once prior to end of reporting period
- Your software vendor should be able to provide you with tools to complete the risk analysis

## Protect electronic health information

- HIPAA protects the privacy of individually identifiable health information, called **protected health information (PHI)**
- Security Rule protects a subset of information covered by the Privacy Rule, which is all individually identifiable health information a covered entity creates, receives, maintains or transmits in electronic form. The Security Rule calls this information "**electronic protected health information**" (e-PHI)

## Annual Security Risk Assessment Cycle



## Protect electronic health information

Where to get more help:

<http://www.healthit.gov/providers-professionals/security-risk-assessment>

## Electronic Prescribing

- At least one permissible prescription written by the MIPS eligible clinician is queried for a drug formulary and transmitted electronically using certified EHR technology

– May report a null value if write fewer than 100 permissible prescriptions for the performance period

- Objective is the same for both ACI Objectives and Measures and 2018 ACI Transition Objectives and Measures

ACI - Base Objective

## E-Prescribing (eRx)

### Clinical Significance?

- Improves medication safety
- Better management of medication costs
- Improved prescribing accuracy and efficiency
- Increase practice efficiency
- Reducing health care costs
- Reduction of adverse drug events



## Patient Electronic Access

ACI – Base and Performance Objective

- **Provide Patient Access:** For at least one unique patient seen by the MIPS eligible clinician:
  - (1) The patient (or the patient authorized representative) is provided timely access to view online, download, and transmit his or her health information; and
  - (2) The MIPS eligible clinician ensures the patient's health information is available for the patient (or 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 MIPS eligible clinician's certified EHR technology
- **Part (2) does not apply to clinicians using the 2018 ACI Transition Objectives and Measures**
- **Also a performance score objective so numerator and denominator are important**
  - Performance Score Weight: Up to 10%
  - Weight for 2018 Transition Objectives & Measures: Up to 20%

## Patient Electronic Access: API

- Application Programming Interface (API)
- API is a set of programming protocols
- Enables access to data via third-party applications
- More flexible than a patient portal
- If API provides view, download, transmit than a patient portal is not needed separately

## Health Information Exchange

### ACI – Base and Performance Objective

- **Send a Summary of Care:** For at least one transition of care or referral, the MIPS eligible clinician that transitions or refers their patient to another setting of care or health care provider
  - (1) creates a summary of care record using certified EHR technology **and**
  - (2) electronically exchanges the summary of care record
- Objective is the same for both ACI Objectives and Measures and 2018 ACI Transition Objectives and Measures
- Also a performance score objective so numerator and denominator are important under both ACI Objectives and Measures and 2018 ACI Transition Objectives and Measures
- Performance Score Weight: Up to 10%
  - Weight for 2018 Transition Objectives & Measures: Up to 20%

## Summary of Care Record for Transitions of Care

### Clinical Significance?

- You must provide a summary of care record to the provider you are referring the patient to
  - This is important because it allows the next provider of care to understand your clinical findings which may impact the patients care
  - You could use the clinical summary or your electronic copy
- You must have 10% of the summaries transmitted electronically
  - This is why secure (direct) messaging is so important!
  - Eventually you will be able to look up a doctors direct email address on the NPPES website

**eHealth Info**  
Created On: April 23, 2015

**Patient:** Sphert S, Test      **Patient ID:** 133911 (Medical Record Number)  
**Sex:** Female      **DOB:** April 16, 1995  
**Preferred Language:** English      **Ethnicity:**      **Race:**      **Emergency Contact:**      **Insurance Providers:**

**Table of Contents**

- Encounter
- Chief Complaint and Reason for Visit Section
- Past Surgeries
- Medications
- Allergies and Reactions
- Problem List
- Social History
- Insurance Providers

**Properties**

File Name: 133911\_Test\_Subset       Link to Patient Encounter      Reviewer: [Select User]      Reviewed?

Category: CCR or CCR      Description:      Review Notes:     

Source: [Select]      Edit List      Report Type: [Select]

Referring Physician: [Select]

**Clinical Summary**  
Created On: May 15, 2014

**Patient:** Patient Demo      Tel: (555) 555-555

**Sex:** Male      **Preferred Language:** English

**Guardian:**      **Organize:** New Folder

**Table of Contents**

- Encounter
- Allergies and Reactions
- Diagnostic Results
- Vital Signs
- Medications
- Problem List
- Social History
- Insurance Providers
- Family History
- Immunizations
- Past Surgeries
- Procedures
- Labs
- Functional and Cognitive Status
- Encounter Diagnoses
- Reason for Referral
- Instructions

File name: 2015-Clinical Summary      Save as type: CCA\*.xml     

**Compose**      Send From: Myself     

Attachments (drag pages to change order)     

pgross@vqeyecare.eyeclinicdirect.net      X

Secure Msg      Fax      Direct

**direct** pgross@vqeyecare.eyeclinicdirect.net

Sharing patient health information to this address is HIPAA compliant

Subject: Copy of Patient Summary of Care      No options

Message: Please find attached the CCA for patient Test Record

## Health Information Exchange

### ACI – Base and Performance Objective

- **Request/Accept Summary of Care:** For at least one transition of care or referral received or patient encounter in which the MIPS eligible clinician has never before encountered the patient, the MIPS eligible clinician receives or retrieves and incorporates into the patient's record an electronic summary of care document
- Does not apply to clinicians using 2018 ACI Transition Objectives and Measures for base or performance
- Also a performance score objective so numerator and denominator are important if using ACI Objectives and Measures
- Performance Score Weight: Up to 10%

## Request/Accept Summary of Care

Initial Information Reconciliation for Patient Data

Current/Reconciled Medications

Date	Drug	Qty	Status	Stop Date	Source
05/15/2014	Avapro tablet 75 mg	Take 1 tablet by mouth once a day	Active		Patient
05/15/2014	Lipitor tablet 10 mg	Take 10 mg by mouth once a day	Active		EHR
05/15/2014	Xalatan drops 0.005 %	Apply 1 drop in both eyes at bedtime for 30 days	Active		Transition of Care

Current/Reconciled Allergies

Reaction Date	Allergy	Reaction	Allergy Type	Status	Source
	Penicillin Group	Urticaria (hives)	Drug allergy	Active	EHR

Current/Reconciled Problems

Date Disposed	Date Created	Date Modified	Date of Onset	Code	Description	Type	Status	Source
	05/15/2014	05/15/2014		1201005	Benign essential hypertension		Active	EHR
	05/15/2014	05/15/2014		13644009	Hypercholesterolemia		Active	Patient

TDC Medications

Date	Drug	Sig	Status	Stop Date
05/15/2014	Avapro tablet 75 mg	Take 1 tablet by mouth once a day	Active	
05/15/2014	Lipitor tablet 10 mg	Take 10 mg by mouth once a day	Active	
05/15/2014	Xalatan drops 0.005 %	Apply 1 drop in both eyes at bedtime for 30 days	Active	

TDC Medications Allergies

Reaction Date	Allergy	Reaction	Allergy Type	Status
	Penicillin Group	Urticaria (hives)	Drug allergy	Active

TDC Problems

Date Disposed	Code	Description	Status
	1201005	Benign essential hypertension	Active
	13644009	Hypercholesterolemia	Active

Current/Reconciled Medications

Date	Drug	Sig	Qty	Status	Stop Date	Source
5/15/2014	Avapro (irbesartan) tablet 75 mg	Take 1 tablet by mouth once a day	75 mg	Active		Patient
5/15/2014	Lipitor (atorvastatin) tablet 10 mg	Take 10 mg by mouth once a day	10 mg	Active		EHR
05/15/2014	Xalatan drops 0.005 %	1 drop at bedtime		Active		Transition of Care

Current/Reconciled Allergies

Reaction Date	Allergy	Reaction	Allergy Type	Status	Source
	Penicillin Group	Urticaria (hives)	Drug allergy	Active	EHR

Current/Reconciled Problems

Date Disposed	Date Created	Date Modified	Date of Onset	Code	Description	Type	Status	Source
	05/15/2014	05/15/2014		1201005	Benign essential hypertension		Active	EHR
	05/15/2014	05/15/2014		13644009	Hypercholesterolemia		Active	Patient

## Advancing Care Information: Performance Objectives in Detail

## Patient Electronic Access

ACI - Performance Objective

- Patient-Specific Education:** The MIPS eligible clinician must use clinically relevant information from certified EHR technology to identify patient-specific educational resources and provide **electronic access** to those materials to at least one unique patient seen by the MIPS eligible clinician
- Performance Score Weight: Up to 10%
- Objective applies to both ACI Objectives and Measures and 2018 ACI Transition Objectives and Measures
  - The electronic access does not apply to the 2018 Transition Objectives and Measures

## Patient specific education resources

### Clinical Significance?

- It is our job as a doctor to properly educate our patients on all of their clinical findings and diagnosis as well as risks and benefits of each treatment option
- Certified EHRs have the ability to identify patient specific educational resources based on the problem list, medication list, or lab test results
- The EHR technology must identify the patient educational material or resources
  - The resources do not have to be stored within or generated by the EHR

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Text F Record (1900-01-01, 100001)  
Send Message | My Profile | Sign Out

Home Messages Records Appointments

Inbox Sent Deleted

Education material for Myopia, bilateral

Morgan Murphy on 03/20/2017 12:34 PM UTC

**Title:** Refractive Errors  
**Link:** <http://www.medicines.gov.au/hack/eyecare.html>

**Summary:**  
Also called: Farsightedness, Hyperopia, Myopia, Nearsightedness

The cornea and lens of your eye helps you focus. Refractive errors are vision problems that happen when the shape of the eye keeps you from focusing well. The cause could be the length of the eyeball (longer or shorter), changes in the shape of the cornea, or aging of the lens.

Four common refractive errors are

- Myopia, or nearsightedness - clear vision close up but blurry in the distance
- Hyperopia, or farsightedness - clear vision in the distance but blurry close up
- Presbyopia - inability to focus close up as a result of aging
- Astigmatism - focus problems caused by the cornea

The most common symptom is blurred vision. Other symptoms may include double vision, haziness, glare or halos around bright lights, squinting, headaches, or eye strain.

Glasses or contact lenses can usually correct refractive errors. Laser eye surgery may also be a possibility.

NH: National Eye Institute  
• [Astigmatism](#) (Medical Encyclopedia)

**Patient Education**

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SPELL CHECK DOCUMENT

**Blepharitis**

**Overview**

Blepharitis is a common inflammatory condition that affects the **eyelids**. It usually causes burning, itching and irritation of the lids. In severe cases, it may also cause **styes**, irritation and inflammation of the **cornea** (keratitis) and **conjunctiva** (**conjunctivitis**). Some patients have no symptoms at all.

Blepharitis is usually a chronic problem that can be controlled with extra attention to lid hygiene. However, it is sometimes caused by an infection and may require medication.

**Signs and Symptoms**

- Sandy, itchy eyes
- Red and/or swollen eyelids
- Crusty, flaky skin on the eyelids
- Dandruff

**Detection and Diagnosis**

**Coordination of Care Through Patient Engagement**

**ACI - Performance Objective**

- **View Download and Transmit (VDT):** During the performance period, at least one unique patient (or patient-authorized representatives) seen by the MIPS eligible clinician actively engages with the EHR made accessible by the MIPS eligible clinician and either:
  - (1) view, download or transmit to a third party their health information
  - (2) Access their health information through the use of an API
  - (3) Uses a combination of (1) and (2) above
- Performance Score Weight: Up to 10%
- Only part (1) above applies to both ACI Objectives and Measures and 2018 ACI Transition Objectives and Measures

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Home

**Hermann & Henry Eyecare, Inc.**

**Address** 650 Hill Road North  
650 Hill Road North  
Pickerington, OH 43147  
phone: 614-633-2400  
fax: 614-633-6559  
email: info@hheyecare.com

**Hours**  
Mon 8:30 am - 5:30 pm  
Tue 8:30 am - 5:30 pm  
Wed 8:30 am - 8:00 pm  
Thu Closed  
Fri 8:30 am - 5:30 pm  
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Home Messages Records

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fax: 614-633-6559  
email: info@hheyecare.com

**Hours**  
Mon 8:30 am - 5:30 pm  
Tue 8:30 am - 5:30 pm  
Wed 8:30 am - 8:00 pm  
Thu Closed  
Fri 8:30 am - 5:30 pm  
Sat Closed  
Sun Closed

Pickerington's First Optometry Practice

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Home Messages Records

**My Records**

Continuity of Care Documents (CCD) and Continuity of Care Records (CCR) are two different file formats for representing patient health data. They are often used when transferring patient information from one computer system to another.

Your records are typically available in 2 formats:

- as a data file (in XML format), which you can download and provide to other practices or upload to a personal health record (such as Microsoft HealthVault)
- as a human readable report (in HTML format), which you can read yourself

**Continuity of Care Document (CCD)** [View](#) [Download text](#) [Download data](#) [Transmit](#)

**Continuity of Care Record (CCR)** Hermann & Henry Eyecare, Inc. has not yet provided a CCR record for you.

**Consolidated Clinical Document Architecture (CCDA)** Hermann & Henry Eyecare, Inc. has not yet provided a CCDA record for you.

**Continuity of Care Document - C32 Standard (C32)** Hermann & Henry Eyecare, Inc. has not yet provided a C32 record for you.

## Coordination of Care Through Patient Engagement



ACI - Performance Objective

- **Secure Messaging:** For at least one unique patient seen by the MIPS eligible clinician during the performance period, a secure message was sent using the electronic messaging function of certified EHR technology to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative)
- Performance Score Weight: Up to 10%
- Objective is the same for both ACI Objectives and Measures and 2018 ACI Transition Objectives and Measures

## Secure Messaging

## Coordination of Care Through Patient Engagement



ACI - Performance Objective

- **Patient-Generated Health Data:** Patient-generated health data or data from a non-clinical setting is incorporated into the certified EHR technology for at least one unique patient seen by the MIPS eligible clinician during the performance period
- Performance Score Weight: Up to 10%
- Objective does not apply to clinicians using the 2018 ACI Transition Objectives and Measures

## Information From Patient or Non-Clinical Setting

- Information from patient
  - Patient generates the data on their own
  - Recording own vital signs, activity and exercise, medication intake, nutrition
- Information from non-clinical setting
- Non-EP or non-hospital provider who doesn't have access to the EPs EHR
  - Nutritionists, physical therapists, occupational therapists, psychologists, home health providers
- Could include:
  - Social service data, advanced directives, medical device data, fitness monitoring, etc.

## Health Information Reconciliation



ACI - Performance Objective

- **Clinical Information Reconciliation:** For at least one transition of care or referral received or patient encounter in which the MIPS eligible clinician has never before encountered the patient, the MIPS eligible clinician performs clinical information reconciliation
  - The MIPS eligible clinician must implement clinical information reconciliation for the following three information sets:
    - (1) Medication: Review of the patient's medication, including the name, dosage, frequency, and route of each medication
    - (2) Medication allergy: Review of the patient's known medication allergies
    - (3) Current Problem List: Review of the patient's current and active diagnoses
- Performance Score Weight: Up to 10%
- Objective applies to both ACI Objectives and Measures and 2018 ACI Transition Objectives and Measures
  - Parts (2) and (3) do not apply to the 2018 Transition Objectives and Measures

# Clinical Information Reconciliation

**Clinical Information Reconciliation for Patient Davis**

**Current Medications**

Date	Drug	Sig	Qty	Status	Stop Date	Source
5/15/2014	Avapro (irbesartan) tablet 75 mg	Take 1 tablet by mouth once a day	75 mg	Active		Patient
5/15/2014	Lipitor (atorvastatin) tablet 10 mg	Take 10 mg by mouth once a day	10 mg	Active		EMR
5/15/2014	Xalatan drops 0.005 %	1 drop at bedtime		Active		Transition of Care

**Current Allergies**

Reaction Date	Allergy	Reaction	Allergy Type	Status	Source
	Penicillin Group	Urticaria (hives)	Drug allergy	Active	EMR

**Current Problems**

Date Disposed	Date Created	Date Modified	Date of Onset	Code	Description	Type	Status	Source
	05/15/2014	05/15/2014	05/15/2014	1201005	Benign essential hypertension		Active	EMR
	05/15/2014	05/15/2014	05/15/2014	13644009	Hypercholesterolemia		Active	Patient

**TDC Medications**

Date	Drug	Sig	Status	Stop Date
05/15/2014	Avapro tablet 75 mg	Take 1 tablet by mouth once a day	Active	
05/15/2014	Lipitor tablet 10 mg	Take 10 mg by mouth once a day	Active	
05/15/2014	Xalatan drops 0.005 %	Apply 1 drop in both eyes at bedtime for 30 days	Active	

**TDC Medications Allergies**

Reaction Date	Allergy	Reaction	Allergy Type	Status
	Penicillin Group	Urticaria (hives)	Drug allergy	Active

**TDC Problems**

Date Disposed	Code	Description	Status
	1201005	Benign essential hypertension	Active
	13644009	Hypercholesterolemia	Active

**Current/Reconciled Medications**

Date	Drug	Sig	Qty	Status	Stop Date	Source
5/15/2014	Avapro (irbesartan) tablet 75 mg	Take 1 tablet by mouth once a day	75 mg	Active		Patient
5/15/2014	Lipitor (atorvastatin) tablet 10 mg	Take 10 mg by mouth once a day	10 mg	Active		EMR
5/15/2014	Xalatan drops 0.005 %	1 drop at bedtime		Active		Transition of Care

**Current/Reconciled Allergies**

Reaction Date	Allergy	Reaction	Allergy Type	Status	Source
	Penicillin Group	Urticaria (hives)	Drug allergy	Active	EMR

**Current/Reconciled Problems**

Date Disposed	Date Created	Date Modified	Date of Onset	Code	Description	Type	Status	Source
	05/15/2014	05/15/2014	05/15/2014	1201005	Benign essential hypertension		Active	EMR
	05/15/2014	05/15/2014	05/15/2014	13644009	Hypercholesterolemia		Active	Patient

# Public Health and Clinical Data Registry Reporting

- Immunization Registry Reporting:** The MIPS eligible clinician is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS)
- Performance Score Weight:** 0 or 10%
- Objective applies to both ACI Objectives and Measures and 2018 ACI Transition Objectives and Measures**

ACI - Performance Objective

# Public Health Reporting: Active Engagement

- Active engagement is defined as:**
  - Option 1: Completed registration to submit data:** Registration was completed within 60 days after the start of the EHR reporting period and the EP is awaiting an invitation from the PHA or CDR to begin testing
  - Option 2: Testing and Validation:** EP is in the process of testing and validation of the electronic submission of data. EPs must respond to requests from the PHA within 30 days; failure to respond twice within a reporting period would result in failure to meet this objective
  - Option 3: Production:** EP has completed testing and validation and is electronically submitting production data to PHA or CDR

**Immunization Info**

Filter by: Patient Johnson Esther

Start Date of Administration: 02/28/2011

End Date of Administration: 02/28/2011

Administered Vaccine: Chelera vaccine, 0.5 ml

Vaccine Manufacturer: Novartis

Vaccine Expiration Date: 02/28/2011

Vaccine Lot Number: 1111

Administered Notes: [Empty]

Immunization Records Table:

Select	Date	Patient ID	Patient Name	Provider	Vaccine	Vaccine Lot No.	Exp. Date	Submitted	View	Edit	Delete
<input type="checkbox"/>	02/28/2011	101008	Johnson Esther	Mary Kurtz	Chelera vaccine, 0.5 ml	1111	02/28/2011	No			

## Public Health and Clinical Data Registry Reporting

ACI - Performance Objective

- **Syndromic Surveillance Reporting:** The MIPS eligible clinician is in active engagement with a public health agency to submit syndromic surveillance data from a urgent care ambulatory setting where the jurisdiction accepts syndromic data from such settings and the standards are clearly defined. Earn a 5% bonus in the advancing care information performance category score for submitting to one or more public health or clinical data registries
- Performance Score Weight: 0 or 5% Bonus
- Objective is the same for both ACI Objectives and Measures and 2018 ACI Transition Objectives and Measures

## Public Health and Clinical Data Registry Reporting

ACI - Performance Objective

- **Electronic Case Reporting:** The MIPS eligible clinician is in active engagement with a public health agency to electronically submit case reporting of reportable conditions. Earn a 5% bonus in the advancing care information performance category score for submitting to one or more public health or clinical data registries
- Performance Score Weight: 0 or 5% Bonus
- Objective does not apply to clinicians using the 2018 ACI Transition Objectives and Measures

## Public Health and Clinical Data Registry Reporting

ACI - Performance Objective

- **Public Health Registry Reporting:** The MIPS eligible clinician is in active engagement with a public health agency to submit data to public health registries. Earn a 5% bonus in the advancing care information performance category score for submitting to one or more public health or clinical data registries
- Performance Score Weight: 0 or 5% Bonus
- Objective does not apply to clinicians using the 2018 ACI Transition Objectives and Measures

## Public Health and Clinical Data Registry Reporting

ACI - Performance Objective

- **Clinical Data Registry Reporting:** The MIPS eligible clinician is in active engagement to submit data to a clinical data registry. Earn a 5% bonus in the advancing care information performance category score for submitting to one or more public health or clinical data registries
- Performance Score Weight: 0 or 5% Bonus
- Objective does not apply to clinicians using the 2018 ACI Transition Objectives and Measures

## Public Health Reporting

ACI - Performance Objective

- **Specialized Registry Reporting:** The MIPS eligible clinician is in active engagement to submit data to specialized registry. Earn a 5% bonus in the advancing care information performance category score for submitting to one or more public health or clinical data registries
- Performance Score Weight: 0 or 5% Bonus
- Objective only applies to clinicians using the 2018 ACI Transition Objectives and Measures

## MIPS: Advancing Care Information Category Score

### Example of Base Scoring:

Measure	Result
Security Risk Analysis	Yes
e-Prescribing	30/150
Provide Patient Access*	250/500
Send Summary of Care*	100/150
Request/Accept Summary of Care*	25/50

Fulfilled base score = 50%

\* Also a performance objective

## MIPS: Advancing Care Information Category Score

### Example of Performance Scoring:

Measure	Num/ Den	Perf Rate	% Score
Provide Patient Access	250/500	50	5%
Patient-Specific Education	15/500	3	1%
View, Download, or Transmit	300/500	60	6%
Send Summary of Care	140/150	93	9%
Request/Accept Summary of Care	25/50	50	5%
Immunization Registry Reporting	No		0%
<b>Total Performance</b>			<b>26%</b>

## MIPS: Advancing Care Information Category Score

### Example of Bonus Scoring:

Measure	Result	Score
Specialized Registry Reporting Bonus	Yes	5%
Improvement Activities Bonus for Providing 24/7 access to eligible clinicians via real time access to patient's medical record in EHR	Yes	10%
<b>Total bonus score</b>		<b>15%</b>

## MIPS: Advancing Care Information Category Score

### Example of Scoring Total for Advancing Care Information:

Base Score	50%
Performance Score	26%
Bonus Score	15%
<b>Total Score</b>	<b>91%</b>
<b>Final Score</b>	<b>91% x 25 = 22.75 points out of 25 total</b>

## Calculating the Final Score Under MIPS

Final Score =



## MIPS Data Submission Methods

	Individual <small>(Self-Reporting)</small>	Group
Quality	<ul style="list-style-type: none"> <li>✓ QCDR (Qualified Clinical Data Registry)</li> <li>✓ Qualified Registry</li> <li>✓ EHR</li> <li>✓ Claims</li> </ul>	<ul style="list-style-type: none"> <li>✓ QCDR (Qualified Clinical Data Registry)</li> <li>✓ Qualified Registry</li> <li>✓ EHR</li> <li>✓ Administrative Claims</li> <li>✓ CMS Web Interface (groups of 25 or more)</li> <li>✓ CAHPS for MIPS Survey</li> </ul>
Improvement Activities	<ul style="list-style-type: none"> <li>✓ Attestation</li> <li>✓ QCDR</li> <li>✓ Qualified Registry</li> <li>✓ EHR Vendor</li> </ul>	<ul style="list-style-type: none"> <li>✓ Attestation</li> <li>✓ QCDR</li> <li>✓ Qualified Registry</li> <li>✓ EHR Vendor</li> <li>✓ CMS Web Interface (groups of 25 or more)</li> </ul>
Advancing Care Information	<ul style="list-style-type: none"> <li>✓ Attestation</li> <li>✓ QCDR</li> <li>✓ Qualified Registry</li> <li>✓ EHR Vendor</li> </ul>	<ul style="list-style-type: none"> <li>✓ Attestation</li> <li>✓ QCDR</li> <li>✓ Qualified Registry</li> <li>✓ EHR Vendor</li> </ul>

## MIPS Data Submission

Quality Payment Program

MIPS - [Help](#) [About](#) [APHS](#) [About](#) [Sign In](#)

Modernizing Medicare to provide better care and smarter spending for a healthier America.

Check your participation status

Enter your National Provider Identifier (NPI) number

NPI Number

Check NPI

What's the Quality Payment Program?

The Quality Payment Program improves Medicare by helping you focus on care quality and the one thing that matters most – making patients healthier.

# MIPS Data Submission

Quality Payment PROGRAM

MIPS - Merit-based Incentive Payment System | APFs - Alternative Payment Models | About - The Quality Payment Program | Sign In - My Account | Manage Data

Before we submit data to the physician quality reporting system (QRS),

ENTER EDH USER ID

ENTER EDH PASSWORD

STATEMENT OF TRUTH

In order to sign in, you must agree to this. I certify, to the best of my knowledge that all of the information that will be submitted will be true, accurate, and complete. If I become aware that any submitted information is not true, accurate, and complete, I will correct such information promptly. I understand that the knowing omission, misrepresentation, or falsification of any submitted information may be punished by criminal, civil, or administrative penalties, including fines, civil damages, and/or imprisonment.

Yes, I agree

Sign In

Forgot your username? Go to the CMS Enterprise Portal to reset your user ID. Or password?

# MIPS Data Submission

Quality Payment PROGRAM

MIPS - Merit-based Incentive Payment System | APFs - Alternative Payment Models | About - The Quality Payment Program | Sign In - My Account | Manage Data

## Verify Code

Enter the code sent via text message to \*\*\*\*-\*\*\*-3100.

ONE-TIME CODE

Submit Code

Quality Payment PROGRAM

Developer Tools | Resource Library | Help and Support | Subscribe to Updates

CMS Privacy Notice | Accessibility | Contact Us | 1-844-288-6270 | TTY 1-877-761-4222

# MIPS Data Submission

Jay Henry

Account Dashboard

Performance Year 2017 submission window

You can update your data anytime the submission window is open:

- January 2 - March 31, 2018 for standard reporting
- January 22 - March 16, 2018 for CMS web interface reporting

Once the submission window is closed, CMS will begin calculating payment adjustments.

**The CMS Web Interface submission window is closed. You can review but not edit your data in the CMS Web Interface.**

PRACTICES (1)

HERMANN & HENRY EYECARE INC  
The HERMANN & HENRY EYECARE INC, 10000 WOODMONT, PROCESSIONAL, OH-45127

SPECIAL SERVICES  
Health Professional Shortage Area (HPSA) Small Practice

Special activities are not currently featured into arbitrary codes.

Read more about special activities

GROUP REPORTING

Report

All groups

All individuals

# MIPS Data Submission

Quality Payment PROGRAM

MIPS - Merit-based Incentive Payment System | APFs - Alternative Payment Models | About - The Quality Payment Program | Jay - My Account

Account Dashboard

HERMANN & HENRY EYECARE INC  
Tax ID: 31705867

## Group Reporting Dashboard

Report data for the group

You can report for your practice as a group here. If you'd rather, you can go to this practice's Connected Clinicians section to report for clinicians as individuals.

Quality Measures  
Start reporting

Advancing Care Information  
Start reporting

Improvement Activities  
Start reporting

Quality Payment PROGRAM

# MIPS Data Submission

Quality Payment PROGRAM

MIPS - Merit-based Incentive Payment System | APFs - Alternative Payment Models | About - The Quality Payment Program | Jay - My Account

Account Dashboard

HERMANN & HENRY EYECARE INC  
Tax ID: 31705867

## Quality

The Quality score is based on the highest score among all submission method scores. [Read full instructions](#)

FILE UPLOAD

DELETE CATEGORY DATA

# MIPS Data Submission

Quality Payment PROGRAM

MIPS - Merit-based Incentive Payment System | APFs - Alternative Payment Models | About - The Quality Payment Program | Jay - My Account

Account Dashboard

HERMANN & HENRY EYECARE INC  
Tax ID: 31705867

## Measures that count toward Quality Performance Score (Q)

Your Measure Score includes both performance points and bonus points.

Measure Name	Performance Rate	Measure Score	Bonus Points
Primary Care and Specialty (PC/S) Split-Rate Evaluation	100%	11.0	±
Preventive Care and Screening Body Mass Index (BMI) Screening and Follow-up Plan	78.59%	11.0	±
Recognition of Patient Medications in the Medical Record	99.88%	12.0	±
Preventive Care and Screening Tobacco Use: Counseling and Cessation Support	98.51%	10.9	±
Controlling High Blood Pressure	55.56%	4.0	±
Use of High-Risk Medications in the Elderly	0%	12.0	±
<b>Sub-Total</b>		<b>60.90</b>	

# MIPS Data Submission

Quality Payment PROGRAM

MIPS - Most Used Qualitative Payment System | APMs - Alternative Payment Models | About - The Quality Payment Program | Jay - My Account

Account Dashboard

HERMANN & HENRY EYECARE INC  
TIN 31705867

Connected Clinicians

Group Reporting

Quality Measures

Advancing Care Information

Improvement Activities

ONLY include those bonus points:

**Measures submitted but do not count towards quality (4)**  
These measures were submitted and earned either performance or bonus points. They either fall outside the top six measures or exceed the maximum bonus points however they do not contribute to the submission.

Measure Name	Performance Rate	Measure Score	Max Bonus Points
Historic Orthopedic (the combination of Presence or Absence of Chronic Disease and Level of Severity of Measurement)	56.25%	3	1
Historic Postoperative Communication with the Physician (Managing Ongoing Diabetes Care)	90.91%	3	1
Choosing the Referral/Loop Receipt of Specialist Report	0%	0	1
Diabetic Eye Exam	97.3%	8.33	1

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

# MIPS Data Submission

Quality Payment PROGRAM

MIPS - Most Used Qualitative Payment System | APMs - Alternative Payment Models | About - The Quality Payment Program | Jay - My Account

Account Dashboard

HERMANN & HENRY EYECARE INC  
TIN 31705867

Connected Clinicians

Group Reporting

Quality Measures

Advancing Care Information

Improvement Activities

Choosing the Referral/Loop Receipt of Specialist Report: 0% 0

Diabetic Eye Exam: 97.3% 8.33

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

Category Score: 52  
Points from Quality Measures that count towards Quality Score: 8  
Additional Bonus Points: 0  
**60**  
Maximum number of points (if of required measures = 10)

# MIPS Data Submission

Quality Payment PROGRAM

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Account Dashboard

HERMANN & HENRY EYECARE INC  
TIN 31705867

Connected Clinicians

Group Reporting

Quality Measures

Advancing Care Information

Improvement Activities

**Quality**  
The Quality score is based on the highest score among all submission method scores. [Base Full Instructions](#)

**Your Scores by Submission Methods**

Your highest score is:

**60**  
100%

**EHR Submission Summary**

**MAXIMUM 60 QUALITY POINTS ACHIEVED!**  
This submission achieved a performance score higher than all 60 Quality points allowed for the program. The maximum quality performance score is 60 points.

# MIPS Data Submission

Quality Payment PROGRAM

MIPS - Most Used Qualitative Payment System | APMs - Alternative Payment Models | About - The Quality Payment Program | Jay - My Account

Account Dashboard

HERMANN & HENRY EYECARE INC  
TIN 31705867

Connected Clinicians

Group Reporting

Quality Measures

Advancing Care Information

Improvement Activities

**Advancing Care Information**  
Review the advancing care information measures available. Remember, in order to get credit for advancing care information, you must submit information for the required measures. [Read Full Instructions](#)

Start by selecting your performance period: 01/01/2017 To 12/31/2017

**CHOOSING THE CORRECT ADVANCING CARE INFORMATION MEASURE SET**

In 2017, there are two measure set options for reporting:

- 2017 Advancing Care Information Transition Measures
- Advancing Care Information Measures

The option you will use to send in data is based on your Certified EHR Technology status.

- In 2017, MIPS eligible clinicians can alternatively report the **2017 Advancing Care Information Transition Measures** if they have:
  - Technology certified to the 2015 edition; or
  - Technology certified to the 2014 edition; or
  - A combination of technologies certified to the 2014 and 2015 Editions
- MIPS Eligible clinicians can report the **Advancing Care Information Measures** if they have:
  - Technology certified to the 2015 edition; or

# MIPS Data Submission

Quality Payment PROGRAM

MIPS - Most Used Qualitative Payment System | APMs - Alternative Payment Models | About - The Quality Payment Program | Jay - My Account

Account Dashboard

HERMANN & HENRY EYECARE INC  
TIN 31705867

Connected Clinicians

Group Reporting

Quality Measures

Advancing Care Information

Improvement Activities

Review the advancing care information measures available. Remember, in order to get credit for advancing care information, you must submit information for the required measures. [Read Full Instructions](#)

Start by selecting your performance period: 01/01/2017 To 12/31/2017

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In 2017, there are two measure set options for reporting:

- 2017 Advancing Care Information Transition Measures
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The option you will use to send in data is based on your Certified EHR Technology status.

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  - Technology certified to the 2015 edition; or
  - Technology certified to the 2014 edition; or
  - A combination of technologies certified to the 2014 and 2015 Editions
- MIPS Eligible clinicians can report the **Advancing Care Information Measures** if they have:
  - Technology certified to the 2015 edition; or

# MIPS Data Submission

Quality Payment PROGRAM

MIPS - Most Used Qualitative Payment System | APMs - Alternative Payment Models | About - The Quality Payment Program | Jay - My Account

Account Dashboard

HERMANN & HENRY EYECARE INC  
TIN 31705867

Connected Clinicians

Group Reporting

Quality Measures

Advancing Care Information

Improvement Activities

**Certified EHR Technology Lookup Tool (Optional)**  
Need help verifying your EHR technology vendor's status with the EHR Lookup Tool to pinpoint the measure set option most applicable to your practice. [Go to EHR Lookup](#)

NOTE: This tool is maintained by a third party. OHSU is not responsible for the accuracy of data.

When choosing the combination of technologies path, you may not submit a measure from the ACI measure set that corresponds to a 2015 ACI transition measure. For example, if you submit the Provider Patient Access 2017 ACI transition measure (worth up to 30%), you may not submit the corresponding ACI measure Provider Patient Access (worth up to 10%) or Patient-Generated Health Data (worth up to 10%).

NOTE: The 2015 Edition has the reporting capability to support either the 2017 Advancing Care Information Transition Measures or the Advancing Care Information Measures. We encourage clinicians and vendors that collect and combine data from the 2014 and 2015 Editions during a performance period to aggregate their numerators and denominators for the 2017 Advancing Care Information Transition Measures.

For additional information in questions, contact the QIP Service Center.

**Select Measure Set:**  
You will be unable to choose a track until a performance period date range is entered above.

2017 ADVANCING CARE INFORMATION TRANSITION MEASURES | ADVANCING CARE INFORMATION MEASURES | COMBINATION OF BOTH MEASURE SETS

# MIPS Data Submission

Quality Payment PROGRAM

HERMANN & HENRY EYECARE INC  
The 3170382

Group Reporting

Quality Payment Program

2017 Advancing Care Information Transition Measures

NOTE: The 2019 Edition has the reporting capability to support either the 2017 Advancing Care Information Transition Measures or the Advancing Care Information Measures. We encourage clinicians and vendors that collect and combine data from the 2014 and 2015 Editions during a performance period to aggregate their numerators and denominators for the 2017 Advancing Care Information Transition Measures.

For additional information or questions, contact the QIP Service Center

Select Measure Set:

- 2017 ADVANCING CARE INFORMATION TRANSITION MEASURES
- ADVANCING CARE INFORMATION MEASURES
- COMBINATION OF BOTH MEASURE SETS

# MIPS Data Submission

Quality Payment PROGRAM

HERMANN & HENRY EYECARE INC  
The 3170382

Group Reporting

Select Measure Set:

- 2017 ADVANCING CARE INFORMATION TRANSITION MEASURES
- ADVANCING CARE INFORMATION MEASURES
- COMBINATION OF BOTH MEASURE SETS

ATTESTATION STATEMENTS FOR THE ADVANCING CARE INFORMATION PERFORMANCE CATEGORY

- Prevention of Information Blocking Attestation: Yes No
- ONC Direct Review Attestation: Yes No
- ONC-ACB Surveillance Attestation (Optional): Yes No

ADVANCING CARE INFORMATION SCORE: 0 / 100

2017 Advancing Care Information Transition Measures

REQUIRED FOR BASE SCORE

e-Prescribing

At least one permissible prescription written by the MIPS eligible clinician is queried for a drug formulary and transmitted electronically using certified EHR technology.

ACL\_TRANS\_EP\_1 PERFORMANCE SCORE: N/A

Security Risk Analysis

Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308 (a)(1), including addressing the security (to include encryption) of ePHI data created or maintained by certified EHR technology in accordance with requirements in 45 CFR 164.312(a)(2) (v) and 45 CFR 164.306(a)(3), and implement security updates as necessary and correct identified security deficiencies as part of the MIPS eligible clinician's risk management process.

ACL\_TRANS\_PPHI\_1 PERFORMANCE SCORE: N/A

Provide Patient Access

At least one patient seen by the MIPS eligible clinician during the performance period is provided timely access to view online, download, and transmit to a third party their health information.

# MIPS Data Submission

ATTESTATION STATEMENTS FOR THE ADVANCING CARE INFORMATION PERFORMANCE CATEGORY

- Prevention of Information Blocking Attestation: Yes No
- ONC Direct Review Attestation: Yes No
- ONC-ACB Surveillance Attestation (Optional): Yes No

ADVANCING CARE INFORMATION SCORE: 0 / 100

2017 Advancing Care Information Transition Measures

REQUIRED FOR BASE SCORE

e-Prescribing

At least one permissible prescription written by the MIPS eligible clinician is queried for a drug formulary and transmitted electronically using certified EHR technology.

ACL\_TRANS\_EP\_1 PERFORMANCE SCORE: N/A

# MIPS Data Submission

ADVANCING CARE INFORMATION SCORE: 0 / 100

2017 Advancing Care Information Transition Measures

REQUIRED FOR BASE SCORE

e-Prescribing

At least one permissible prescription written by the MIPS eligible clinician is queried for a drug formulary and transmitted electronically using certified EHR technology.

ACL\_TRANS\_EP\_1 PERFORMANCE SCORE: N/A

Security Risk Analysis

Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308 (a)(1), including addressing the security (to include encryption) of ePHI data created or maintained by certified EHR technology in accordance with requirements in 45 CFR 164.312(a)(2) (v) and 45 CFR 164.306(a)(3), and implement security updates as necessary and correct identified security deficiencies as part of the MIPS eligible clinician's risk management process.

ACL\_TRANS\_PPHI\_1 PERFORMANCE SCORE: N/A

Provide Patient Access

At least one patient seen by the MIPS eligible clinician during the performance period is provided timely access to view online, download, and transmit to a third party their health information.

# MIPS Data Submission

ADVANCING CARE INFORMATION SCORE: 0 / 100

2017 Advancing Care Information Transition Measures

REQUIRED FOR BASE SCORE

e-Prescribing

At least one permissible prescription written by the MIPS eligible clinician is queried for a drug formulary and transmitted electronically using certified EHR technology.

ACL\_TRANS\_EP\_1 PERFORMANCE SCORE: N/A

Security Risk Analysis

Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308 (a)(1), including addressing the security (to include encryption) of ePHI data created or maintained by certified EHR technology in accordance with requirements in 45 CFR 164.312(a)(2) (v) and 45 CFR 164.306(a)(3), and implement security updates as necessary and correct identified security deficiencies as part of the MIPS eligible clinician's risk management process.

ACL\_TRANS\_PPHI\_1 PERFORMANCE SCORE: N/A

# MIPS Data Submission

ADVANCING CARE INFORMATION SCORE: 100 / 100 Category Success!

2017 Advancing Care Information Transition Measures

REQUIRED FOR BASE SCORE

Provide Patient Access

At least one patient seen by the MIPS eligible clinician during the performance period is provided timely access to view online, download, and transmit to a third party their health information subject to the MIPS eligible clinician's discretion to withhold certain information.

ACL\_TRANS\_PEA\_1 PERFORMANCE SCORE: 20 / 20

Health Information Exchange

The MIPS eligible clinician that transitions or refers their patient to another setting of care or health care clinician (1) uses CDERT to create a summary of care record; and (2) electronically transmits such summary to a receiving health care clinician for at least one transition of care or referral.

ACL\_TRANS\_HI\_1 PERFORMANCE SCORE: 20 / 20

## MIPS Data Submission

ADVANCING CARE INFORMATION SCORE: 100 / 100 Category Success!

2017 Advancing Care Information Transition Measures

REQUIRED FOR BASE SCORE

OPTIONAL PERFORMANCE MEASURES

**Immunization Registry Reporting**  Yes

The MIPS eligible clinician is in active engagement with a public health agency to submit immunization data.

ACI\_TRANS\_PHICDRR\_1 PERFORMANCE SCORE: N/A

**Patient-Specific Education**  No

The MIPS eligible clinician must use clinically relevant information from CEHRT to identify patient-specific educational resources and provide access to those materials to at least one unique patient seen by the MIPS eligible clinician.

ACI\_TRANS\_PSE\_1 PERFORMANCE SCORE: 10 / 10

Numerator: 7167  
Denominator: 7254

## MIPS Data Submission

ADVANCING CARE INFORMATION SCORE: 100 / 100 Category Success!

2017 Advancing Care Information Transition Measures

OPTIONAL PERFORMANCE MEASURES

**Secure Messaging**  No

For at least one unique patient seen by the MIPS eligible clinician during the performance period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient's authorized representative), or in response to a secure message sent by the patient (or the patient's authorized representative) during the performance period.

ACI\_TRANS\_SM\_1 PERFORMANCE SCORE: 10 / 10

Numerator: 6878  
Denominator: 7254

**View, Download, or Transmit (VDT)**  No

At least one patient seen by the MIPS eligible clinician during the performance period (or patient-authorized representative) views, downloads or transmits their health information to a third party during the performance period.

ACI\_TRANS\_PDL\_2 PERFORMANCE SCORE: 17 / 50

Numerator: 236  
Denominator: 7254

**Medication Reconciliation**  No

The MIPS eligible clinician performs medication reconciliation for at least one transition of care in which the patient is transferred into the care of the MIPS eligible clinician.

ACI\_TRANS\_MR\_1 PERFORMANCE SCORE: N/A

Numerator: 0  
Denominator: 1

## MIPS Data Submission

ADVANCING CARE INFORMATION SCORE: 100 / 100 Category Success!

2017 Advancing Care Information Transition Measures

OPTIONAL PERFORMANCE MEASURES

ADDITIONAL REGISTRY BONUS

**Syndromic Surveillance Reporting**  No

The MIPS eligible clinician is in active engagement with a public health agency to submit syndromic surveillance data. Earn a 5% bonus in the advancing care information performance category score for submitting to one or more public health or clinical data registries.

ACI\_TRANS\_PHICDRR\_2 BONUS SCORE: N/A

**Specialized Registry Reporting**  Yes

The MIPS eligible clinician is in active engagement to submit data to specialized registry. Earn a 5% bonus in the advancing care information performance category score for submitting to one or more public health or clinical data registries.

ACI\_TRANS\_PHICDRR\_3 BONUS SCORE: 5 / 5

## MIPS Data Submission

ADVANCING CARE INFORMATION SCORE: 100 / 100 Category Success!

2017 Advancing Care Information Transition Measures

ADDITIONAL REGISTRY BONUS

ACI\_TRANS\_PHICDRR\_3 BONUS SCORE: 5 / 5

ADVANCING CARE INFORMATION IMPROVEMENT ACTIVITIES BONUS

**CEHRT Used**  Yes

I attest that I have submitted an eligible Improvement Activity using Certified Electronic Health Record Technology (CEHRT).

ACI\_IACEHRT\_1 BONUS SCORE: 10 / 10

## MIPS Data Submission

IMPROVEMENT ACTIVITIES SCORE: 20 / 40

Showing 92 Activities FILTERS All Search Activities

EXPANDED PRACTICE ACCESS 1 / 4

**Provide 24/7 access to eligible clinicians or groups who have real-time access to patient's medical record**  Yes

Provide 24/7 access to MIPS eligible clinicians, groups, or care teams for advice about urgent and emergent care (e.g., eligible clinician and care team access to medical record, cross-coverage with access to medical record, or protocol-driven nurse line with access to medical record) that could include one or more of the following: Expanded hours in evenings and weekends with access to the patient medical record (e.g., coordinate with small practices to provide alternate hour off-hour visits and urgent care); Use of alternatives to increase access to care team by MIPS eligible clinicians and groups, such as e-visits, phone visits, group visits, home visits and alternate locations (e.g., senior centers and assisted living centers); and/or Provision of same-day or next-day access to a consistent MIPS eligible clinician, group or care team when needed for urgent care or transition management.

IL\_EPA\_1 BONUS: 20 CEHRT Eligible

**Use of telehealth services that expand practice access**  No

Use of telehealth services and analysis of data for quality improvement, such as participation in remote specialty care consults or telemonitoring pilots that assess ability to still deliver quality care to patients.

IL\_EPA\_2 BONUS: 10

## MIPS Data Submission

Quality Payment PROGRAM

MIPS: Most Qualified Provider Payment System APIS: Alternative Payment Model About: The Quality Payment Program My Account

Account Dashboard

HERMANN & HENRY EYECARE INC New 31753867

Connected Clinicians

Group Reporting

Quality Measures

Advancing Care Information

Improvement Activities

Your Scores by Submission Methods

Your highest score is:

EHR 60 out of 60

EHR Submission Summary

MAXIMUM 60 QUALITY POINTS ACHIEVED! The submission amount is Performance level 1 (100%) from the 60 Quality points allowed for the program. The maximum Quality performance score is 60 points.

## MIPS Data Submission

Quality Payment PROGRAM

MIPS - High-Quality Incentive Payment System | APMs - Alternative Payment Models | About - The Quality Payment Program | Jay - My Account

HERMANN & HENRY EYECARE INC  
TIN# 31705867

**Select Measure Set:**

- 2017 ADVANCING CARE INFORMATION TRANSITION MEASURES
- ADVANCING CARE INFORMATION MEASURES
- COMBINATION OF BOTH MEASURE SETS

**ATTestation Statements for the Advancing Care Information Performance Category**

Statement	Yes	No
Prevention of Information Blocking Attestation	<input checked="" type="checkbox"/>	<input type="checkbox"/>
ONC Direct Review Attestation	<input checked="" type="checkbox"/>	<input type="checkbox"/>
ONC-ACB Surveillance Attestation (Optional)	<input checked="" type="checkbox"/>	<input type="checkbox"/>

ADVANCING CARE INFORMATION SCORE: 100 / 100 Category Success!

## MIPS Data Submission

Quality Payment PROGRAM

MIPS - High-Quality Incentive Payment System | APMs - Alternative Payment Models | About - The Quality Payment Program | Jay - My Account

HERMANN & HENRY EYECARE INC  
TIN# 31705867

**Improvement Activities**

Review and select activities that best fit your practice. [Read full instructions](#)

Start by selecting your performance period: 01/01/2017 To 12/31/2017

**IMPROVEMENT ACTIVITIES SCORE: 20 / 40**

Showing 92 Activities | FILTERS | All | Search Activities

## MIPS Data Submission

You are about to be signed out

You can sign back in to update your data any time the submission window is open

Performance Year 2017 Submission Window Dates

- Advancing Care Information
  - January 2 - March 31, 2018 for standard reporting
  - January 22 - March 16, 2018 for CMS Web Interface quality reporting

[SIGN OUT](#)

[Keep me signed in](#)

## MIPS: Public Reporting

Quality + Cost + Improvement Activities + Advancing Care Information

- Your MIPS final score is available for public reporting
- All MIPS data are available for public reporting on Physician Compare Website

## MIPS Score

- MIPS scoring will be made public at: <https://www.medicare.gov/physiciancompare>

Medicare.gov Physician Compare

Home About Resources MyMedicare.gov

Find physicians & other clinicians

Enter your location | Search for a name, specialty, group, body part, or condition | Search

Examples: Dr. Smith, heart, allergen, cardiology, Baltimore Family Practice

## MIPS Score

Back to Physician Compare home | Share | Print

General information | Locations | **Performance scores**

These performance scores are based on information this clinician reported to Medicare using a set of specific criteria and guidelines developed to show whether this doctor provided patients the best recommended care. Performance scores are included on Physician Compare to help you make informed decisions about your health care and to encourage all clinicians to improve the care they provide. It's important to understand that not all clinicians report the same information to Medicare, and the types of care available to report on are different depending on the types of services they provide to patients. Reporting more or less information is not a reflection of this clinician's quality. And, the performance scores are not a complete picture of the types of services this clinician provides. This is just a snapshot of some of the care this clinician provided to people with Medicare in 2015. [Get more information.](#)

**More stars are better.** Select "Show +\*" to read more information.

**Preventive care: General health**

Some clinicians do a better job than others providing care that keeps patients healthy. Medicare gave this clinician a performance score based on how well the clinician did on each measure. The scores are presented as stars and as a percent.

Screening for an unhealthy body weight and developing a follow-up plan. **★★★★★ 51%** Show +

## MIPS Score

General information
Locations
% Performance scores

**Patient safety**

Some clinicians do a better job than others preventing harm to patients by reducing risk of accidents and medical error. Medicare gave this clinician a performance score on each measure based on how well the clinician followed recommended care to keep patients safe. The scores are presented as stars and as a percent.

Recording current medicines.
★★★★★ 100% [Show +](#)

**Behavioral health**

Some clinicians do a better job than others screening and providing care for patients with mental health or substance use disorders. Medicare gave this clinician a score on each measure based on how well the clinician provided the recommended care for mental health or substance use disorders. The scores are presented as stars and as a percent.

Screening for tobacco use and providing help quitting when needed.
★★★★★ 98% [Show +](#)

## MIPS Score

**Eye care**

Some clinicians do a better job than others providing care to protect patients' eyes and vision. Medicare gave this clinician a performance score based on how well the clinician provided care to maintain patients' eyesight. The scores are presented as stars and as a percent.

Optic nerve evaluations on patients with primary open-angle glaucoma.
★★★★★ 100% [Show +](#)

Treating patients with primary open-angle glaucoma.
★★★★★ 100% [Show +](#)

## MACRA / MIPS Audits

## MIPS Audits

- CMS will conduct data validation and audits to ensure that the QPP operates on accurate and useful data
- If selected for data validation or an audit providers will have 45 calendar days to complete the data sharing as requested
- In accordance with the False Claims Act, you should keep documentation up to **6 years**

## MIPS Audits

- You will always use your CEHRT MIPS report for your primary documentation during an audit
- CMS also states that this report will need to include:
  - The time period the report covers (reporting period)
  - The clinician identification (NPI / Name)
  - Evidence to support that the report was generated by the CEHRT (take a screen shot of the report before it is printed)
- You should also acquire screen shots of certain objectives and activities to help validate that you accomplished them as required

## How to get Screen Shots

- Window's free – "Snipping Tool"
  - Start, Accessories, and find Snipping Tool
- PrtScn** on keyboard which copies to clipboard, holding area, and then past in to Word
- Techsmith's advanced tool called "Snagit"
 

## MIPS Audits

- **Quality category**

- You may be audited to validate that you submitted all applicable measures and encounters
  - Especially if you submit fewer than 6 measures
  - Also if you do not submit the required outcome measure or other high priority measure
- An audit may also look to be certain that proper age ranges were used in calculating numerators and denominators

Select	Quality ID	eCQM	NQF	Domain	Measure	Info	Num	Den	Excl	Excp	Perf. Rate	Not Met	Medicare Num	Medicare Den
<input type="checkbox"/>	236	185v5	0018	Effective Clinical Care	Controlling High Blood Pressure		11	27	0	0	40.7%	16	3	5
<input type="checkbox"/>	238	156v5	0022	Patient Safety	High Risk Meds (1+) in the Elderly		0	25	0	0	*0%	25	0	14
<input type="checkbox"/>	238	156v5	0022	Patient Safety	High Risk Meds (2+) in the Elderly		0	25	0	0	-	25	0	14
<input type="checkbox"/>	226	138v5	0028	Community, Population and Public Health	Tobacco use: Screening & Cessation/Intervention		25	25	0	0	100%	0	0	0
<input type="checkbox"/>	117	131v5	0055	Effective Clinical Care	Diabetes: Eye Exam		50	50	0	0	100%	0	6	6
<input type="checkbox"/>	12	143v5	0086	Effective Clinical Care	POAG: Optic nerve Eval		13	16	0	0	81.2%	3	4	4
<input type="checkbox"/>	18	167v5	0088	Effective Clinical Care	Diabetic Retinopathy: Documentation		49	49	0	0	100%	0	6	6
<input type="checkbox"/>	19	142v5	0089	Effective Clinical Care	Diabetic Retinopathy: Communication		49	49	0	0	100%	0	6	6
<input type="checkbox"/>	130	68v5	0419	Patient Safety	Documentation of current Meds in Medical Record		716	722	0	0	99.2%	6	41	41
<input type="checkbox"/>	128	69v5	0421	Community, Population and Public Health	BMI Screening & Follow-Up Plan		131	146	0	0	90.3%	14	15	19
<input type="checkbox"/>	374	55v5	3000	Community & Care Coordination	Closing Referral Loop: Receipt of Specialist Report		0	0	0	0	N/A	0	0	0

## MIPS Audits

- **Advancing Care Information category**

- You should retain documentation to support submissions for each objective
  - EHR Report
  - Screenshots

## Electronic Prescribing

- At least one permissible prescription written by the MIPS eligible clinician is queried for a drug formulary and transmitted electronically using certified EHR technology

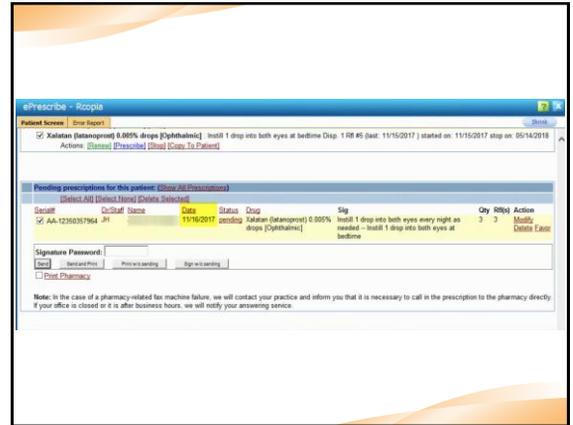
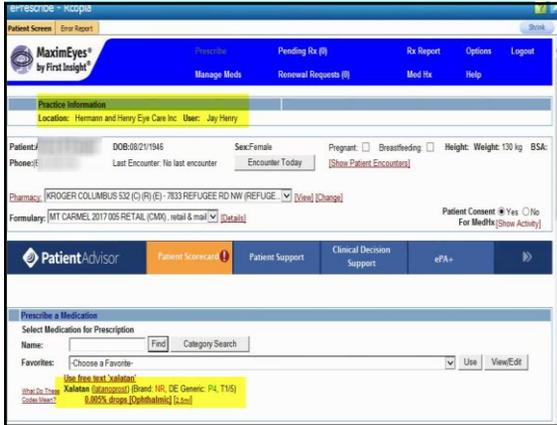
ACI - Base Objective

## Suggested Documentation

- Report from the EHR system showing numerator, denominator, and percentage are valid for this measure
- You should have a **screen shot** showing eRx for a patient for you as provider in the date range attesting for

ACI - Base Objective

Measure Type	Measure	Info	Numerator	Denominator	Performance Rate	Met for Base Point?
Base	ePrescribing: Option 1 - excludes controlled substances		401	402	100%	Yes
Base	ePrescribing: Option 2 - includes controlled substances		401	402	100%	Yes
Base	Patient Electronic Access (VDT): Provide Timely Online Access		3051	3138	97%	N/A
Performance	Patient Electronic Access (VDT): Patient Engagement		84	3138	3%	N/A
Performance	Patient Specific Education		3111	3138	99%	N/A
Base	Health Information Exchange		1	1	100%	Yes
Performance	Medication Reconciliation		0	0	N/A	N/A
Performance	Secure Messaging		3055	3138	97%	N/A



## MIPS Audits

- **Improvement Activities category**
  - You should retain documentation that validates your activities
  - Documentation should demonstrate consistent and meaningful engagement within the period for which you attested



## Provide 24/7 access

- Provide 24/7 access to MIPS eligible clinicians, groups, or care teams for advice about urgent and emergent care
  - Expanded hours in evenings and weekends with access to the patient medical record (e.g., coordinate with small practices to provide alternate hour office visits and urgent care);
  - Use of alternatives to increase access to care team by MIPS eligible clinicians and groups, such as e-visits, phone visits, group visits, home visits and alternate locations (e.g., senior centers and assisted living centers); and/or
  - Provision of same-day or next-day access to a consistent MIPS eligible clinician, group or care team when needed for urgent care or transition management

## Suggested Documentation

- Patient record from EHR
  - With date and timestamp indicating services provided outside of normal business hours for that clinician
- Patient encounter / claim
  - Patient encounter / claim indicating patient was seen or services provided outside of normal business hours

## MIPS Audits

- **Cost category**
  - Since the cost data is captured based on your Medicare claims data your claims could be audited for accuracy

**YOU HAVE BEEN  
SELECTED!**



MAY THE ODDS BE EVER IN YOUR FAVOR

Questions?

Jay W. Henry, O.D., M.S.