AUGUST 22 CMS
QUALITY VENDOR
WORKGROUP

August 22, 2019
12:00 – 1:30 p.m. ET
<table>
<thead>
<tr>
<th>Topic</th>
<th>Speaker</th>
<th>Details</th>
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</table>
| CMS Reporting Document Architecture (QRDA) III Updates: 2020 CMS QRDA III IG, Schematron, and Sample Files and the Updated 2019 CMS QRDA III IG Addendum (10 min) | Yan Heras  
*Healthcare IT and Life Sciences Data Management Solutions Contractor*  
*ESAC, Inc* |         |
| Cypress™ – Cypress Validation Utility + Calculation Check (CVU+) (10 min) | David Czulada  
*MITRE* |         |
| Inpatient Quality Reporting (IQR) Updates (5-10 min) | Artrina Sturges  
*Inpatient Value, Incentives, and Quality Reporting Support Contractor* |         |
| Fiscal Year 2020 Inpatient Prospective Payment System and Long-term Care Hospital Final Rule – Medicare Promoting Interoperability Program Updates (5 min) | Dylan Podson, MPH  
*Division of Health Information Technology, CMS* |         |
| Quality Payment Program Updates (10 min) | Kati Moore  
*Division of Electronic and Clinician Quality, CMS* |         |
| Post- Acute Care Announcements  
• IRF PPS FY 2020 Final Rule  
• IPPS/LTCH PPS FY 2020 Final Rule  
• SNF PPS FY 2020 Final Rule  
• FY 2020 Hospice Final Rule (10 min) | Ariel Adams, MSN, RN, AGCNS-BC  
*Cindy Massuda, JD*  
*Division of Chronic and Post Acute Care, CMS* |         |
| Questions | | |
CMS QRDA III Updates: 2020 CMS QRDA III IG, Schematron, and Sample Files and the Updated 2019 CMS QRDA III IG Addendum

Yan Heras
Healthcare IT and Life Sciences Data Management Solutions Contractor
ESAC, Inc.
CMS QRDA III UPDATES
CMS QRDA III UPDATES

• 2020 CMS QRDA III IG, Schematrons, and Sample Files

• Updated 2019 CMS QRDA III IG Addendum
In July 2019, the Centers for Medicare & Medicaid Services (CMS) released the 2020 CMS QRDA III Implementation Guide (IG), Schematron, and Sample Files.

The 2020 CMS QRDA III IG outlines requirements for eligible clinicians and eligible professionals to report electronic clinical quality measures (eCQMs), improvement activities, and promoting interoperability measures for the calendar year 2020 performance period for:

- Quality Payment Program: Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs)
- Comprehensive Primary Care Plus (CPC+)
- Medicaid Promoting Interoperability
The 2020 CMS QRDA III IG contains several high-level changes as compared with the 2019 CMS QRDA III IG:

- Changes to Performance Period Reporting:
  - Performance period reporting for the Quality and the Improvement Activities performance categories under MIPS is changed from either the individual measure/activity level or performance category level to performance category level only for the 2020 performance period.
  - Performance period reporting for the Promoting Interoperability performance category and for CPC+ for the Quality performance category remain at the performance category level only.

- eCQM Universally Unique Identifiers (UUIDs) have been updated for the 2020 performance period eCQMs that were published on May 13, 2019.

Please note, measures will not be eligible for 2020 reporting unless and until they are proposed and finalized through notice-and-comment rulemaking for the applicable program.
2020 CMS QRDA III IG, SCHEMATRONS, AND SAMPLE FILES

• Changes to the CMS EHR Certification ID requirement:
  o CPC+ participants must include a CMS EHR Certification ID that represents the Certified EHR Technology (CEHRT) used by the CPC+ practice sites during the performance period
  o The CMS EHR Certification ID is optional for the MIPS Quality performance category and remains required for the Promoting Interoperability performance category
In July 2019, CMS has released an updated addendum to the 2019 CMS QRDA Category III IG for Eligible Clinicians and Eligible Professionals Programs to support Calendar Year (CY) 2019 eCQM, Improvement Activity, and Promoting Interoperability reporting.

The 2019 QRDA III IG and addendum provides technical instructions for reporting for:
- Quality Payment Program: MIPS and Advanced APMs
- CPC+
- Medicaid Promoting Interoperability Program
This latest addendum provides an update for the retroactive change to the Query of Prescription Drug Monitoring Program (PDMP) measure based on the newly released FY 2020 Physician Fee Schedule Notice of Proposed Rule Making (NPRM). Based on the Promoting Interoperability category, the addendum reflects the Query of PDMP measure reporting metric change from a Numerator/Denominator measure to a Yes/No response. This change is retroactively applied to the 2019 performance period.
As a reminder, for 2019, MIPS eligible clinicians and groups are required to submit data for a full calendar year for the Quality performance category, a minimum of 90 continuous days for the Improvement Activities performance category, and a minimum of 90 continuous days for the Promoting Interoperability performance category.
RESOURCES AVAILABLE ONLINE

CMS has QRDA-related resources available:

• Additional QRDA-related resources, as well as current and past implementation guides, are found on the Electronic Clinical Quality Improvement (eCQI) Resource Center QRDA page

• For questions related to this guidance, the QRDA IGs, Schematrons, or Sample Files, visit the Office of the National Coordinator (ONC) Project Tracking System (Jira) QRDA project

• For questions related to Quality Payment Program/MIPS data submissions visit the Quality Payment Program website, contact by phone 1-866-288-8292, or email QPP@cms.hhs.gov
Cypress™ – Cypress Validation Utility + Calculation Check (CVU+)

David Czulada

MITRE
CYPRESS™

• Cypress v5.0 with Cypress Validation Utility + Calculation Check (CVU+) is now available
  o Supports 2015 Edition Certification for the Office of the National Coordinator for Health Information Technology Certification Program for electronic clinical quality measures (eCQM)
  o Supports testing the Eligible Hospital/Critical Access Hospital eCQMs and Eligible Professional/Eligible Clinician eCQMs for calendar year 2020 reporting
  o Tool and release notes are available on the Cypress website https://healthit.gov/cypress/
CYPRESS VALIDATION UTILITY + CALCULATION CHECK (CVU+)

• Supports validation with the CMS Implementation Guide for Quality Reporting Document Architecture for 2020

• Supports multi-measure tests, allowing vendors to test eCQM calculations with a single test deck across multiple measures

• Supports code system preference, allowing vendors to choose preferences for the code systems to be used in test patients

• Supports developer-generated test patients, allowing vendors to supplement Cypress test patients with their own test patients to increase eCQM logic/code coverage.
  o Evaluates the rigor of a set of test patients
CVU+ TESTING WITH DEVELOPER-GENERATED TEST PATIENTS

- CVU+ supports developer-generated test patients, allowing vendors to supplement Cypress test patients with their own test patients to increase eCQM logic/code coverage
  - These test patients can be used to augment Cypress generated test patients during pre-certification testing
CVU+ VERIFICATION OF QRDA CONTENT AND ECQM CALCULATIONS

- CVU+ performs and displays eCQM calculation for developer-generated test patients in real time.
  - eCQM calculations are displayed for each eCQM where the developer-generated test patient meets the IPOP requirements.

- CVU+ displays a human readable representation of the data elements parsed from uploaded QRDA documents.
CVU+ ANALYSIS OF RIGOR OF DEVELOPER-GENERATED TEST PATIENTS

• CVU+ performs analysis on uploaded developer-generated test patients

• Statistics include:
  o Measure Coverage
  o Logic Coverage
  o Value sets used
  o Code Systems used
  o Data element types used

<table>
<thead>
<tr>
<th>Data Type</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td># Patients</td>
<td>7</td>
</tr>
<tr>
<td>Measure Coverage</td>
<td>37.3% (22 of 59)</td>
</tr>
<tr>
<td>Population Coverage</td>
<td>44.8% Missing Populations</td>
</tr>
<tr>
<td># Data Element Types</td>
<td>20</td>
</tr>
<tr>
<td># Valuesets Used</td>
<td>61</td>
</tr>
<tr>
<td>Valuesets Coverage</td>
<td>8.3%</td>
</tr>
<tr>
<td>Uncovered Valuesets</td>
<td>677 Uncovered Valuesets</td>
</tr>
<tr>
<td>Code System per Valueset Coverage</td>
<td>8.2%</td>
</tr>
<tr>
<td>Uncovered Code Systems in each Valueset</td>
<td>1076 Uncovered Code Systems</td>
</tr>
<tr>
<td>Average Percent Code Coverage per Valueset</td>
<td>3.0%</td>
</tr>
<tr>
<td>Logic Coverage</td>
<td>Logic Coverage Per Measure</td>
</tr>
<tr>
<td>Least Logic Coverage</td>
<td>CMS190xv8 (9.4%)</td>
</tr>
<tr>
<td>Average Logic Coverage</td>
<td>44.2%</td>
</tr>
</tbody>
</table>
CYPRESS RESOURCES

• Cypress Bi-Weekly Tech Talks
  o Next session August 27, 2019
  o Check https://healthit.gov/cypress/ for logistics

• Cypress Talk List
  o project-cypress-talk@googlegroups.com

• ONC JIRA Cypress Issue Tracker
  o http://oncprojecttracking.healthit.gov/

• GitHub Source Code Repository
  o https://www.github.com/projectcypress/cypress

• Website
  o https://healthit.gov/cypress

• Demo Server
  o https://cypressdemo.healthit.gov
  o https://cypressvalidator.healthit.gov
Inpatient Quality Reporting (IQR) Updates

Artrina Sturges

Inpatient Value, Incentives, and Quality Reporting Support Contractor
2020 Hospital Inpatient Prospective Payment System and Long-Term Acute Care Hospital Final Rule Update: Medicare Promoting Interoperability Program

Dylan Podson, MPH
Division of Health Information Technology, CMS
The 2020 Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Acute Care Hospital (LTCH) Final Rule for the Medicare Promoting Interoperability Program was released on August 2, 2019.

The final rule (CMS-1716) is available for review on the Federal Register.
MEDICARE PROMOTING INTEROPERABILITY PROGRAM REQUIREMENTS

• Performance-based scoring methodology that requires a minimum total score of 50 points to be considered a meaningful EHR user

• Mandatory use of 2015 Edition CEHRT

• An EHR reporting period for new and returning participants is a minimum of any continuous 90-day period

• Submit a “yes” to the Prevention of Information Blocking Attestation

• Submit a “yes” for the Security Risk Analysis measure
MEDICARE PROMOTING INTEROPERABILITY PROGRAM: FINAL CHANGES FOR CY 2020
## 2019 VS 2020 EHR REPORTING PERIOD

<table>
<thead>
<tr>
<th>2019 EHR Reporting Period</th>
<th>2020 EHR Reporting Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Required to report a minimum of any continuous 90-day period between January 1-December 31, 2019</td>
<td>• Same requirements as 2019</td>
</tr>
<tr>
<td>2019 Objectives and Measures</td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td></td>
</tr>
<tr>
<td>Query of PDMP</td>
<td></td>
</tr>
<tr>
<td>- Optional</td>
<td></td>
</tr>
<tr>
<td>- Up to 5 bonus points</td>
<td></td>
</tr>
<tr>
<td>- Yes/No attestation</td>
<td></td>
</tr>
<tr>
<td>Verify Opioid Treatment Agreement</td>
<td></td>
</tr>
<tr>
<td>- Optional</td>
<td></td>
</tr>
<tr>
<td>- Up to 5 bonus points</td>
<td></td>
</tr>
<tr>
<td>- Will remain optional in 2020</td>
<td></td>
</tr>
<tr>
<td>- Numerator/Denominator</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2020 Objective and Measure Modifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Query of PDMP</td>
</tr>
<tr>
<td>- Will remain optional in 2020</td>
</tr>
<tr>
<td>- 5 bonus points</td>
</tr>
<tr>
<td>- Yes/No attestation (retroactive for 2019)</td>
</tr>
<tr>
<td>Verify Opioid Treatment Agreement</td>
</tr>
<tr>
<td>- Will be removed beginning in 2020</td>
</tr>
</tbody>
</table>
### 2019 VS 2020 CQM CHANGES

#### 2019 CQM Requirements
- No changes to the CQM requirements in CY 2019

#### 2020 CQM Requirements
- Reducing the number of CQMs available from 16 to 8
- Reporting period is one, self-selected calendar quarter of CY 2019
ADDITIONAL RESOURCES

For more information to changes to the Medicare Promoting Interoperability Program:

• Review fact sheet on final rule (CMS-1716)

• View final rule (CMS-1716) on Federal Register

• Visit CMS website and subscribe to CMS Promoting Interoperability listserv
Quality Payment Program Updates

Kati Moore
Division of Electronic and Clinician Quality, CMS
QPP YEAR 4 PROPOSED RULE

• Please submit comments in writing using the formal process; feedback during this presentation will not be considered as formal comments

• See the proposed rule for information on submitting comments by close of 60-day comment period on September 27 (When commenting refer to file code CMS-1715-P)

• Instructions for submitting comments can be found in proposed rule; fax transmissions will not be accepted

• You must officially submit your comments in one of following ways:
  o Electronically through Regulations.gov
  o By regular mail
  o By express or overnight mail
  o By hand or courier
QPP YEAR 4 PROPOSED RULE

• CMS hosted an in-depth webinar, Overview of the Proposed Rule for the Quality Payment Program 2020 Performance Period, on Tuesday, August 6 at 2:00 p.m. ET.

• For more detailed information regarding the proposed rule, please reference the presentation, recording, and transcript from this webinar, which can be found on the QPP Webinar Library

• For additional information, please go to: qpp.cms.gov
MIPS VALUE PATHWAYS

• While there have been incremental changes to the program each year, additional long-term improvements are needed to align with CMS’ goal to develop a meaningful program for every clinician, regardless of practice size or specialty

• CMS is proposing MIPS Value Pathways (MVPs) to create a new participation framework beginning with the 2021 performance year. This new framework would:
  o Unite and connect measures and activities across the Quality, Cost, Promoting Interoperability, and Improvement Activities performance categories of MIPS
  o Incorporate a set of administrative claims-based quality measures that focus on population health/public health priorities
  o Streamline MIPS reporting by limiting the number of required specialty or condition specific measures

• CMS encourages the health care community to review the MIPS Value Pathways Request for Information (RFI) and our [illustrative diagram](#) and submit formal comments. We look forward to working with you to establish this new framework
**MIPS VALUE PATHWAYS**

- **Current Structure of MIPS (In 2020)**
  - Many Choices
  - Not Meaningfully Aligned
  - Higher Reporting Burden

- **New MIPS Value Pathways Framework (In Next 1-2 Years)**
  - Cohesive
  - Lower Reporting Burden
  - Focused Participation around Pathways that are Meaningful to Clinician’s Practice/Specialty or Public Health Priority

- **Future State of MIPS (In Next 3-5 Years)**
  - Simplified
  - Increased Voice of the Patient
  - Increased CMS Provided Data
  - Facilitates Movement to Alternative Payment Models (APMs)

**Building Pathways Framework**

**MIPS Value Pathways**

Clinicians report on fewer measures and activities base on specialty and/or outcome within a MIPS Value Pathway

**Moving to Value**

- **Quality**
- **Improvement Activities**
- **Cost**

**Value**

- **Cost**
- **Quality and IA aligned**

**Fully Implemented Pathways**

Continue to increase CMS provided data and feedback to reduce reporting burden on clinicians

**Population Health Measures**: a set of administrative claims-based quality measures that focus on public health priorities and/or cross-cutting population health issues; CMS provides the data through administrative claims measures, for example, the All-Cause Hospital Readmission measure.

- **Clinician/Group Reported Data**
- **CMS Provided Data**

Goal is for clinicians to report less burdensome data as MIPS evolves and for CMS to provide more data through administrative claims and enhanced performance feedback that is meaningful to clinicians and patients.

We Need Your Feedback on:

- **Pathways**: What should be the structure and focus of the Pathways? What criteria should we use to select measures and activities?
- **Participation**: What policies are needed for small practices and multi-specialty practices? Should there be a choice of measures and activities within Pathways?
- **Public Reporting**: How should information be reported to patients? Should we move toward reporting at the individual clinician level?
MIPS VALUE PATHWAYS: SURGICAL EXAMPLE

MIPS moving towards value; focusing participation on specific meaningful measures/activities or public health priorities; facilitating movement to Advanced APM track

Current Structure of MIPS (In 2020)
- Surgeon chooses from same set of measures as all other clinicians, regardless of specialty or practice area
- Four performance categories feel like four different programs
- Reporting burden higher and population health not addressed

New MIPS Value Pathways Framework (In Next 1-2 Years)
- Surgeon reports same “foundation” of PI and population health measures as all other clinicians but now has a MIPS Value Pathway with surgical measures and activities aligned with specialty
- Surgeon reports on fewer measures overall in a pathway that is meaningful to their practice
- CMS provides more data, reporting burden on surgeon reduced
- Surveys indicate surgeon reports on fewer measures overall in a pathway that is meaningful to their practice
- CMS provides more data, reporting burden on surgeon reduced

Future State of MIPS (In Next 3-5 Years)
- Surgeon reports on same foundation of measures with patient-reported outcomes also included
- Performance category measures in Surgical Pathway are even more meaningful to the practice
- CMS provides even more data (e.g. comparative analytics) using claims data and surgeon’s reporting burden even further reduced

MIPS Value Pathways for Surgeons

**QUALITY MEASURES**
- Unplanned Readmission within the 30-Day Postoperative Period (Quality ID: 355)
- Surgical Site Infection [SI] (Quality ID: 357)
- Patient-Centered Surgical Risk Assessment and Communication [Quality ID: 358]

**IMPROVEMENT ACTIVITIES**
- Use of Patient Safety Tools (IA_PSPA_8)
- Implementing the line of Specialist Reports back to Referring Clinician or Group to Close Referral Loop (IA_CE_1)
- Completion of an Accredited Safety or Quality Improvement Program (IA_PSPA_28)

**COST MEASURES**
- Medicare Spending Per Beneficiary (MSPB_1)
- Renovascularization for Lower Extremity Chronic Critical Limb Ischemia (COST_CLI_1)
- Knee Arthroplasty (COST_KA_1)

*Measures and activities selected for illustrative purposes and subject to change.

Population Health Measures: a set of administrative claims-based quality measures that focus on public health priorities and/or cross-cutting population health issues; CMS provides the data through administrative claims measures, for example, the All-Cause Hospital Readmission measure.
MIPS moving towards value; focusing participation on specific meaningful measures/activities or public health priorities; facilitating movement to Advanced APMtrack

Endocrinologist chooses from same set of measures as all other clinicians, regardless of specialty or practice area

Four performance categories feel like four different programs

Reporting burden higher and population health not addressed

Endocrinologist reports same “foundation” of PI and population health measures as all other clinicians but now has a MIPS Value Pathway with measures and activities that focus on diabetes prevention and treatment

Endocrinologist reports on fewer measures overall in a pathway that is meaningful to their practice

CMS provides more data; reporting burden on endocrinologist reduced

Endocrinologist reports same foundation of measures with patient-reported outcomes also included

Performance category measures in endocrinologist’s Diabetes Pathway are more meaningful to their practice

CMS provides even more data (e.g. comparative analytics) using claims data and endocrinologist’s reporting burden even further reduced

MIPS Value Pathways for Diabetes

QUALITY MEASURES
- Hemoglobin A1c (HbA1c) Poor Care Control (<7%) (Quality ID: 001)
- Diabetes: Medical Attention for Nephropathy (Quality ID: 119)
- Evaluation Controlling High Blood Pressure (Quality ID: 236)

IMPROVEMENT ACTIVITIES
- Chronic Care and Preventative Care Management for Empaneled Patients (IA_PM_13)
- Electronic Submission of Patient Centered Medical Home Accreditation (IA_PM_4)
- Total Per Capita Cost (TPCC_1)
- HbA1c Poor Care Control (>9%) (Quality ID: 001)

COST MEASURES
- Total Per Capita Cost (TPCC_1)
- Medicare Spending Per Beneficiary (MSPB_1)

Future State of MIPS (In Next 3-5 Years)

Clinician/Group CMS

Current Structure of MIPS (In 2020)

New MIPS Value Pathways Framework (In Next 1-2 Years)

Future State of MIPS (In Next 3-5 Years)

Population Health Measures: a set of administrative claims-based quality measures that focus on public health priorities and/or cross-cutting population health issues; CMS provides the data through administrative claims measures, for example, the All-Cause Hospital Readmission measure.
QUALITY PAYMENT PROGRAM
PROMOTING INTEROPERABILITY
HARDSHIP EXCEPTIONS AND
EXTREME AND UNCONTROLLABLE
CIRCUMSTANCES
PROMOTING INTEROPERABILITY HARDSHIP EXCEPTIONS

• The 2019 Quality Payment Program (QPP) Exception Applications for the Promoting Interoperability performance category and Extreme and Uncontrollable Circumstances for the Merit-based Incentive Payment System (MIPS) are now available on the QPP website.

• If you are participating in MIPS during the 2019 performance year as an individual, group, or virtual group – or participating in a MIPS Alternative Payment Model (APM) – you can submit a QPP Hardship Exception Application for the Promoting Interoperability performance category, citing one of the following specified reasons for review and approval:
  o You’re a small practice
  o You have de-certified EHR technology
  o You have insufficient internet connectivity
  o You face extreme and uncontrollable circumstances such as disaster, practice closure, severe financial distress, or vendor issues
  o You lack control over the availability of certified electronic health record technology (CEHRT)
PROMOTING INTEROPERABILITY HARDSHIP EXCEPTIONS (CONT.)

• An approved Promoting Interoperability Hardship Exception will:
  o Reweight your Promoting Interoperability performance category score to 0 percent of the final score
  o Reallocation of the 25 percent weighting of the Promoting Interoperability performance category to the Quality performance category

• Please note that simply lacking CEHRT does not qualify you for reweighting of your Promoting Interoperability performance category

• If you’re already exempt from Promoting Interoperability reporting, you do not need to apply for this exception

• You must submit a hardship exception application by December 31, 2019 for CMS to reweight the Promoting Interoperability performance category to 0 percent. You will be notified by email if your request was approved or denied. Approval will be added to your eligibility profile in the QPP Participation Status Tool.
EXTREME AND UNCONTROLLABLE CIRCUMSTANCES

• MIPS eligible clinicians who are impacted by extreme and uncontrollable circumstances may submit a request for reweighting the Quality, Cost, and Improvement Activities performance categories.

• These extreme and uncontrollable circumstances would cause you to either be:
  o Unable to collect information necessary to submit for a performance category, OR
  o Unable to submit information that would be used to score a performance category for an extended period (for example, if you were unable to collect data for the Quality performance category for 3 months).

• The application for extreme and uncontrollable circumstances must be submitted by December 31, 2019 for the 2019 MIPS performance year. You will be notified by email if your request was approved or denied. Approval will be added to your eligibility profile in the QPP Participation Status Tool but may not appear until the submission window opens in 2020.
2018 MIPS PERFORMANCE FEEDBACK AND FINAL SCORE
REVIEW PERFORMANCE FEEDBACK

• If you submitted 2018 Merit-based Incentive Payment System (MIPS) data, you can now view your performance feedback and MIPS final score on the Quality Payment Program website.

• You can access your 2018 MIPS performance feedback and final score by:
  o Going to cms.gov/login
  o Logging in using your HCQIS Access Roles and Profile (HARP) system credentials; these are the same credentials that allowed you to submit your 2018 MIPS data.

• If you don’t have a HARP account, refer to the QPP Access User Guide and start the process now.
MIPS Eligible Clinicians Participating in MIPS Alternative Payment Model (APM) Entities

• If you participated in one of the models below in 2018, your MIPS performance feedback is now available via the Quality Payment Program website:
  o Medicare Shared Savings Program Accountable Care Organization (ACO)
  o Next Generation ACO
  o Comprehensive Primary Care Plus
  o Oncology Care Model
  o Comprehensive ESRD Care

• Under the MIPS APM Scoring Standard, the performance feedback will be based on the APM Entity score, and is applicable to all MIPS eligible clinicians within the APM Entity. This feedback and score does not have any impact on assessments performed by the specific model.
New Access for Individual Clinicians

• We’ve created a new QPP role that lets individual clinicians access MIPS performance feedback for all of their practices, virtual groups, and APM Entities. For more information please review the Connect as a Clinician document in the QPP Access User Guide.

• Watch this demo video for a step-by-step overview of adding the new clinician role in the QPP portal.
REVIEW PERFORMANCE FEEDBACK (CONT.)

Questions?

• If you have questions about your performance feedback or MIPS final score, please contact the Quality Payment Program by:
  o Phone: 1-866-288-8292/TTY: 1-877-715-6222 or
  o Email: QPP@cms.hhs.gov
2018 TARGETED REVIEW
TARGETED REVIEW PROCESS

• The targeted review period opened on July 3, 2019. MIPS eligible clinicians, groups, and virtual groups who believe an error has been made to their 2020 MIPS payment adjustment may request a targeted review until September 30, 2019.

• CMS strongly recommends targeted review requests be submitted as soon as possible to ensure that payment adjustments are applied correctly at beginning of 2020.

• Each request for targeted review is reviewed and either approved or denied based upon information provided - include as much documentation as necessary to detail circumstances of your request.

• If targeted review request is approved, final score and/or associated MIPS payment adjustment will be updated, if applicable.
NEW RESOURCES
RESOURCES NOW AVAILABLE ONLINE

CMS has posted following new resources to Quality Payment Program Resource Library:

• 2020 QPP Proposed Rule Overview Factsheet
• 2018 Performance Feedback FAQs
• 2018 Targeted Review Fact Sheet
• 2018 Targeted Review User Guide
• 2018 Targeted Review FAQs
• 2018 QPP Participation Results Infographic
• 2018 MIPS Eligibility Redetermination Fact Sheet
• Quality Payment Program Access User Guide
• Participating in QPP in 2019 Infographic
• 2019 CAHPS for MIPS Approved Survey Vendors
• 2020 Self-Nomination Toolkit for QCDRs and Registries

• 2019 MIPS User Guides
  • MIPS 101
  • Eligibility and Participation
  • MIPS APMs
  • Cost
  • Quality
  • Improvement Activities
  • Promoting Interoperability

• 2019 MIPS Specialty Guides
  • Cardiologists
  • Chiropractors
  • Dentists
  • Emergency Medicine Clinicians
  • Nurse Practitioners
  • Ophthalmologists
  • Optometrists
  • Orthopedists
  • Pathologists
  • Physician Assistants
  • Podiatrists
  • Radiologists
Post-Acute Care Announcements:
IRF PPS FY 2020 Final Rule;
IPPS/LTCH PPS FY 2020 Final Rule;
SNF PPS FY 2020 Final Rule;
FY 2020 Hospice Final Rule

Ariel Adams, MSN, RN, AGCNS-BC
Cindy Massuda, JD

Division of Chronic and Post Acute Care, CMS
FY 2020 IRF PPS FINAL RULE UPDATE

• FY 2019 IRF Prospective Payment System Final Rule

• IRF Help Desks
  o CMS IRF Quality Questions:
    • IRF.questions@cms.hhs.gov
  o CMS IRF QRP Reconsiderations
    • IRFQRPReconsiderations@cms.hhs.gov
  o CMS Public Reporting/IRF Compare Questions:
    • IRFPRquestions@cms.hhs.gov
FY 2020 IPPS/LTCH PPS FINAL RULE UPDATE

• FY 2020 IPPS/LTCH PPS Final Rule

• LTCH Help Desks
  o CMS LTCH Quality Questions:
    • LTCHQualityQuestions@cms.hhs.gov
  o CMS LTCH QRP Reconsiderations Questions:
    • LTCHQRPReconsiderations@cms.hhs.gov
  o CMS Public Reporting/LTCH Compare Questions:
    • LTCHPRquestions@cms.hhs.gov
FY 2020 SNF PPS FINAL RULE UPDATE

• FY 2020 SNF PPS Final Rule

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  o CMS SNF QRP Reconsiderations Questions:
    • SNFQRPReconsiderations@cms.hhs.gov
  o CMS Public Reporting/SNF Compare Questions:
    • SNFQRPPRQuestions@cms.hhs.gov
FY 2020 HOSPICE FINAL RULE UPDATE

• FY 2020 Hospice Final Rule

• General HQRP or HIS-specific Inquiries
  o Hospice Quality Help Desk: HospiceQualityQuestions@cms.hhs.gov

• CAHPS®-specific Inquiries
  o hospicecahpssurvey@HCQIS.org or 1-844-472-4621
  o CMS staff about implementation issues: hospicesurvey@cms.hhs.gov

• For Technical Assistance (QTSO, QIES, HART, or CASPER)
  o QTSO Help Desk:
    • Email: help@qtso.com
    • Phone: 1-877-201-4721 (M-F, 7AM-7PM CT)
Questions?

cmsqualityteam@ketchum.com
Topics?

Do you have a topic that you would like CMS to discuss on the next Vendor Workgroup? CMS is listening! Please email cmsqualityteam@Ketchum.com with your suggestions.
Thank you!
The next CMS Quality Vendor Workgroup will tentatively be held in October 2019. CMS will share more information when it becomes available.