# 2018 MACRA/MIPS: Practical Applications and Information
# Transcript from Live Session

Tuesday, October 30, 2018

Laurie Fink: Good afternoon everyone, and welcome to today's webinar, 2018 MACRA/MIPS Practical Applications and Information. My name is Laurie Fink, and I am a communication specialist with Quality Insights and will serve as the host for today's session. We will get started with today's program in just a few moments, but I'd like to first review a few housekeeping items. All participants enter today's webinar in a listen only mode. Should you have a question during the presentation, we ask that you please type it into either the chat or the Q&A box to the right of your screen and we'll answer as many questions as we can at the end of the program. Today's webinar is being recorded. The recording will be posted on the Quality Insights website as well as the Quality Insights QPP support center website later this week. And that will be located on the archived events page. I will also be sending out a copy of the PowerPoint slides for today's presentation to all attendees later this afternoon, so you should look for that in your inbox.

Laurie Fink: It is now my pleasure to introduce you to today's guest speaker, Dr. Christian Urrea. Dr Urrea is a specialist in quality and utilization at Mon Valley Hospital and has been in that position for four and a half years. He has worked on MIPS and submitted for 10 TINs in 2017, including a mix of primary care, general surgeons, breast surgeons and nephrologists. In 2018, he will be submitting MIPS reporting data for 7 TINs total. Dr. Urrea has worked on several shared savings programs with major payers in the area as well as PCMH, so he has a very good grasp on value based care. He also has extensive experience with EHRs, which has given him a broad understanding of this technology and allows him to offer sound guidance on how to make your system work to its fullest to support you. Without further ado, I will now hand over the presentation to Dr. Urrea.

Christian Urrea: Thank you, Laurie. I'd also like to thank Kathy Wild for making this presentation happen, and thank you all for tuning in. Now, let's get started. Today, I will not be doing a traditional rehash of the final rule, but rather I would like to share my personal experiences over the past couple of years doing MIPS and MACRA submissions for the Mon Valley PHO. As was mentioned previously, we submitted for 10 TINs in 2017, and I will be submitting for 8 TINs this year with a

mix of primary care and specialty practices. I would like to provide you with a framework for how to maximize your MIPS scoring. And I would also like to provide you with my personal take on where the quality payment program is going in the future, particularly, electronically.

Christian Urrea: The quality category is 50% of your MIPS final score, comprising the biggest portion of the MIPS program. Data must be captured for the full year, but several submission methods can take advantage of the data completeness factor, which I will talk more on later. For full participation, you have to submit six quality measures, one of those measures being outcome. This actually means that you improved a patient's health, i.e. you improved their blood pressure, you improved their A1C score. The other five measures just have you quote "doing something", meaning basically, I just did this hypertension screening, I did this depression screening, outcome not really being any factor there. If you are not able to find any outcomes that are applicable to you, you can submit a high priority measure in its placed. Another key point is that not all quality measures can be submitted via every submission method. I'll talk more about this one later, too. And your best source of quality measures, and for that matter ,all MIPS inflammation, is qpp.cms.gov. This will basically be your MIPS/MACRA bible.

Christian Urrea: More quality facts, bonus points- you can get up to 10% of the category value in bonus points, five bonus points maximum. The simplest way to achieve this is via an electronic submission. This can be done via EHR method, the registry method, qualified clinical data registry, or the CMS Web Interface. If you cannot submit end-to-end, you can submit more outcome measures and/or high priority measures for your bonus points. Data completeness factor, which I personally feel is often overlooked. You actually don't have to report all of your eligible cases, you only have to report 60%, as long as your minimum is 20. Otherwise, your score for that particular measure gets capped out at three points.

Christian Urrea: For example, if you have 100 eligible hypertension screenings and you complete 60 of them, you can actually submit for 60 out of 60. Of importance also is that MIPS measures are subjects to benchmarking scoring systems. For example, a performance rate of say 95% for any given measure does not necessarily mean that you will get maximum points on that particular measure. I'll discuss more about this one later as well. And the exclusions, I will have an example coming up, but for cases that are applicable where you are not meeting your numerator, try to exclude that particular patient from your calculation, if you can. Here I am showing a quality measure description from qpp.cms.gov for controlling hypertension. As you can see, it's a high priority measure, and it's also an outcome measure.

Christian Urrea: The bottom left shows you the submission methods that you can use on this particular measure. And the bottom right side shows you links to the detailed measure description from the National Quality Forum as well as the benchmarking information for that particular submission method. QPP has

developed quite nicely over the past 18 months. It has lots of very handy links. You can pretty much get every single piece of info for the whole program on this site. And I encourage you to scour it for every bit of information that it has to offer you. Here is a flow diagram that can aid you in choosing your submission method for your quality measures. The first thing that I want you thinking is, are you electronic or are you not?

Christian Urrea: If you are electronic, then I would want you thinking, does my vendor support the quality measures I have chosen? Because unfortunately, every single vendor is not going to support every single measure, particularly highly specialized measures. If it happens to support your chosen quality measures, you should be submitting via EHR method. If it doesn't though, that will knock you down into the bottom left side of this tree, which is basically where we would be going if you were on paper. We have claims and registry methods available.

Christian Urrea: We also have the CMS Web Interface option, which I'm not going to go into great detail. Just a couple of highlights here are that this is a group submission only with a minimum of 25 providers. You cannot choose your measures, CMS chooses them for you. And there are about 13 measures. You don't have to report on all of your patients, CMS chooses a random sampling for you. And you would be entering information on a secure CMS portal application. As of now, you can only submit quality measures via one submission method, but it has been proposed for 2019 to include more than one submission method, thus giving you more opportunities for maximization of your scoring.

Christian Urrea: Okay. Submitting measures via claims key points. You can only submit via claims as an individual, there will be no groups here. You have to be excellent at coding. The measured descriptions on the National Quality Forum have flow diagrams that tell you precisely how to code all of your measures. Don't be shy about choosing measures solely based on the ease of coding them because for claims, coding means pretty much everything. Only Medicare part B patients are included in your calculation. Many other submission methods look at your whole patient population, not just Medicare part B. Data completeness is applicable, so only 60% of your eligible cases have to count. And for bonus points, you won't be getting the end-to-end bonus, you can choose extra high priority measures or outcome measures to increase your scoring.

Christian Urrea: Here's an example of a coding flow sheet from the National Quality Forum for hemoglobin A1C control measure. I don't necessarily intend to go over every single bubble here in this presentation, but I just want to give you a flavor for the type of a diagram that you would be looking at so that you can choose your proper CPT code. Noticing on the top right though is the example of an exclusion. Now, let's say for instance, we have a patient who has an A1C of 12, and that would normally count against you in this measure. But this particular patient has gotten Hospice services in the measurement year. That particular patient can be taken out of your numerator if you code it properly as it shows you here. That would be G9687. So keep in mind exclusions for every submission method.

Christian Urrea: Next, we will talk about the registry method and the qualified clinical data registry submission methods. These you can submit as an individual or as a group. The data will be captured for all payers, not just only Medicare part B patients. Data completeness is applicable, so you would only have to report 60% of your eligible cases. And you can get your five bonus points here because this would be end-to-end. Now, what is the difference between a qualified registry and a qualified clinical data registry or a QCDR? A qualified registry is a CMS approved registry that collects patient data. Vendor integration is possible, but if it's not, then you would have to log in and log your cases on some external site, sort of like the CMS Web interface site.

Christian Urrea: A qualified clinical data registry is very similar, but the exception being that it can offer unique measures that are CMS approved, but you won't find these particular measures on qpp.cms.gov. This can be very helpful in the case of a highly specialized provider. Here is an example of a QCDR from the American Academy of Breast Surgeons. We have three examples here including unique quality measures only offered by this particular QCDR. And this can help you avoid possible situations where you might have a breast surgeon having to do things like a hypertension screening or primary care based measures.

Christian Urrea: Now, switching gears to the key points of the EHR transmission method, similar to the registry method in that you can submit as a group or as an individual. Data is captured for all payers. Data completeness is applicable, and you will get your five bonus points. But what sets this apart is that you will have flexible and customizable documentation in your system. Your vendor will end up providing you with detailed descriptions of how to capture these measures in your system. There will likely be more than one way, such as structured data or a CPT II coder. The EHR method also provides you very favorable benchmarking scoring, which I will have some examples of later. I do have a background in EHR administration and configuration, eClinicalWorks mostly, which has proven to be very, very helpful here.

Christian Urrea: Here are two examples of structured data that we used for a podiatry practice, which are hypertension screening and fall risk screening. Now, for hypertension screening, as a specialist, his plan is always the exact same. See your primary care doctor, dietary changes, so forth. I highlighted a couple of those aspects here. I created this template for him, and with a single button click, he has all of his documentation for hypertension screening satisfied. Similarly, for this screening measure, a negative fall risk will always have answers of no to the highlighted questions here. On a negative fall risk screening, one single button click of the template will satisfy documentation completely for this particular measure also.

Christian Urrea: Next is an example of the CPT II coder from eClinicalWorks that we used to capture the flu shot measure. What the system is looking for is patients in the proper demographic at the proper time of year, proper visit code, such as a 99214, 99213. And that would make this particular patient eligible for the flu shot at this card particular visit. If all of those are satisfied, when your provider

starts coding for the visit, this will pop up. And this will guide you on CPT II coding, thus capturing measures via coding methods. And that will also take away having to memorize every single CPT II code.

Christian Urrea: The final equality factor that I would like to talk about is the benchmarking system, which is arguably the most important. And I feel as if this is also overlooked. This has a pattern of being very favorable for the EHR submission method. First, looking at the cervical cancer screening method, you can see that the EHR method in the 10th decile, you would only need about 72% for your final score. This basically means that if you can get 72% on this particular measure that you can get the maximum 10 points for cervical cancer screening. Compare that to the registry method where you would need almost 90% to get that same exact score..

Christian Urrea: Perhaps even a more glaring example is the next one down, hypertension screening. You would only need 46% to get into the 10th decile via EHR method. Via the other methods listed there, you would need about 100% to get into that 10th decile. That was the single most glaring example I could find, and we have used this one also. Just to show you that it doesn't happen for every single measure though, looking at screening for future fall risk on the bottom there, registry method, you would need about 75% getting you into the ninth decile, whereas as via the EHR method, you would need about 94%. That's one of the fewer cases that the registry method is more beneficial via the benchmarking scoring system.

Christian Urrea: Now moving onto promoting interoperability or PI, this is worth 25% of your final MIPS score. Data must be captured over any consecutive 90-day period. I do encourage you to capture it for the whole year and then just choose your best 90 days. Perhaps most key here is that you do not have to be perfect. You will have 155 total PI points available to you, but you only need 100 of those points to get into your maximum 25% PI score. My general summary of PI, particularly for the future, is transitions of care, and the patient portal, particularly for the future, but also now as well.

Christian Urrea: We do have two PI measure sets that we can choose from in the 2018 year. And these are dependent on the version of the EHR that you have. All that you basically have to know is if you have 2015 or 2014 certified EHR technology, or CEHRT. The first set, the PI objectives and measure set, aligns more closely with Meaningful Use stage 3 and it's more difficult. You can use this particular measure set with a 2015 CEHRT or with a 2015/2014 CEHRT combo. Please note that you must use this particular measure set in year three of the MIPS/MACRA program. However, if you did choose to use it this year and you happen to be on the 2015 CEHRT, you will get 10 PI bonus points.

Christian Urrea: But the main focus for the day is on the PI Transition and objective measure set, which aligns more closely with Meaningful Use modified stage 2.You can use this even on a 2014 CEHRT. Before getting into the individual measures, I want to discuss the possible re-weighting of the PI category to 0%, adding an extra

25% to the quality category. The first scenario is for non-MD or DO providers like CRNPs and PAs, and also several others. Of note is that if you are choosing to report as a group, all of the providers must qualify not to have this re-weighted to 0%. The second category is trying to qualify for hardship, which you can possibly do if you are not electronic. Scenarios include de-certified EHR, insufficient internet connectivity and so forth. My goal isn't to review this in detail now, but I want you to keep this in mind if you are not electronic as you might needlessly end up losing out on 25% of your total score.

Christian Urrea: Perhaps the most important of the PI category is your base score of 50 points in which you have to do four simple things. Of note, if you don't get this base score, you will get 0% for the whole category. At the minimum, you should do this. You need your annual security risk analysis. You would have to send one E-prescription. You would have to enable one patient for the patient portal, and one health information exchange or HIE. HIE is essentially sending a referral electronically peer to peer. Exclusions can be applicable if you have fewer than 100 permissible E-prescriptions or less than 100 referrals in your submission period. We actually did get a couple of our surgeons to qualify for exclusions in these two categories based on both of those factors.

Christian Urrea: We've got our base now. Our quickest way to 90 points is the following three measures. Providing patient access, which is just basically signing up patients for the patient portal. This is worth up to 20 points, and is very simple to get 20 points because patients don't have to agree to actually use your patient portal. If they decline it and you document the reason for that in declination, you would still get credit for the measure. Solid check-in, check-out processes get you 20 points easily here. As for medication reconciliation, for transitions of care, I won't spend lots of time on that because most practices get 10 points on this measure pretty simply. But a med rec should be done every single visit anyway. It should be a simple 10 points for you. Lastly, reporting to a public health registry such as your state immunization registry or perhaps doing syndromic surveillance, this will get you 10 points and your vendor will guide you through this connectivity, as well as all of the PI category.

Christian Urrea: Now, we just have to get our final 10 points. And we've got four possible measures that we can get it, and 50 possible points. Just 10 out of 50 here, and we are at the maximum. Patient specific education, this is just handing out patient education to as many patients as you possibly can, up to 10 points. Next is view, download and transmit, or just simply VDT. This is patients merely logging into the patient portal, and this can get you up to 10 points. This doesn't mean patients actually use specific features of the portal, just have to log in, but they will have to in 2019 in the Meaningful Use stage 3 measures. Secure messaging is simply sending messages back and forth via patient portal. We engage our patients as much as we possibly can via patient portal with a reminder system for preventives, physical examinations, and so forth.

Christian Urrea: Lastly, health information exchange, worth up to 20 points. Of key importance is that this is not only the referrals, but this is also any transition of care. We were

able to get 20 points on this for several of our specialists by sending progress notes back to PCPs, peer to peer. That also counts for this particular measure not only sending a referral paper. If you still haven't gotten to 100 points yet, you still have the opportunity for bonus points in the following section, improvement activities. I believe that Improvement Activities is the simplest category to get a maximum score, its worth 15% of your final MIPS score. And you must engage in these activities for a 90-day minimum. There are approximately 113 improvement activities to choose from. You should check this list very, very carefully. And these can be found on qpp.cms.gov. You would have to get 40 points via any combination of high and medium weight activities. High weight activities are worth 20 points, medium weight worth 10 points.

Christian Urrea: Scoring requirements are cut in half for certain situations listed on the bottom of the slide, but the most common is a small practice which is defined as 15 or fewer providers. When you are choosing these activities, think of it in the following way. Activities that will help you get a PI bonus, activities that will help you in our final MIPS category, cost. Activities that will aid you in other quality incentive programs that you might be in, and activities that help you in the quality category. Activities that can help you in PI include annual registration in a PDMP. Although a PDMP is not a current portion of PI, it is proposed to be for future years. Additionally, PDMP is mandated in several states. Then we have a consultation of the PDMP, which goes beyond merely registering for it, but you actually have to use it to a certain extent.

Christian Urrea: Next activity, engagement of patients through implementation of improvements in patient portal, would also get you 10 PI bonus points. Then we have improved practices that disseminate self-management materials, which is basically the same exact thing as patient education. For activities that can help you in other quality programs, for instance, doing a CAHPS PCMH survey, this can be done via the CMS Web Interface. But as mentioned previously, next year it is proposed to have more than one submission method. Lastly, patient center medical home certification can actually get you full credit for this improvement activities category, and some payers also give incentives for it. Activities that can help you in the quality section include depression screening, which is actually a quality measure as well. Next, we have implementation of formal quality improvement methods. We accomplish this one by having monthly quality check-ins with feedback for our practices. We have formal sign off, and we would give them quality improvement plans. Lastly, participation in a QCDR by itself is an improvement activity.

Christian Urrea: Now, for a couple of activities that can help you in the cost category, we have three transition of care activities at the bottom of the slide that will greatly help you to reduce readmissions. Bottom line here is that improving TOC processes, partnering with your local hospitals and getting your post discharge visits seen by your PCP in a timely manner. These activities can also help you get a jump on PCMH certification, which should that be something that you would choose doing. Now I'll give you my final thoughts on the improvement activities category. Consider becoming a PCMH, but why would you do it? Definitely do

not do it only for the CIA credit. It is not worth it, but you should consider doing it for the final category because this can help you greatly improve costs.

Christian Urrea: Cost comprises 10% of your final score and that will be going up in future years. This is tabulated from Medicare part B claims only. There is no manual submission method necessary, CMS tabulates all of this for you. You will have two cost category measures. One is Medicare spending per beneficiary. This is a risk adjusted average of basically care transitioned out of the hospital. This can basically be summed up as lowering readmissions. Next is the total per capita costs. This is a risk adjusted measure evaluating overall efficiency of your care. How can we tackle the cost category? Utilization reduction is a talk within itself, but becoming a certified PCMH can help you here greatly. I have listed 2 core PCMH concepts that are a key to this category. Patient centered access and continuity. This covers topics like same day appointments, having expanded hours, quick responses via patient portal. The general notion here is that we are funneling as many patients as we possibly can to PCP offices as we possibly can so that you don't have patients going into more expensive care settings like emergency departments and hospitals. The better access your patients have to your facilities, the more likely they are to come to them.

Christian Urrea: Now, for care coordination and care transitions. This covers referral handling and follow-up so that the PCPs get the consult notes back. This can decrease duplication of testing. This also covers transition of care appointment management, and doing such things as partnering with community hospitals to decrease readmissions.

Christian Urrea: Now, for my final MIPS and MACRA thoughts. For the quality category, value based payer models are the future. We all have to get used to being paid for outcomes rather than just purely volume. My personal expectation is that in the future we will have to submit more than one outcome measure, and even perhaps going into all outcome measures in say the next 5 or 10 years. For PI, patient portal is going to be critical, particularly next year. And we don't let any web enabled patients leave our practices until they have had full patient portal training. It takes about 5 or 10 minutes getting all of the core features down. Patients really, really like it. For the future also, CMS will want just about all provider transfer, of clinical information to be electronic. Building a peer-to-peer community will be very key such as we have done in the Mon Valley PHO. And with the improvement activities and the cost categories, focus on those PCMH concepts and highly consider doing an implementation.

Christian Urrea: These guidelines can still be very, very valuable even if you choose not to do a full implementation. And also, in lots of the major shared savings programs that we participate in, to keep in those programs, we are slowly having to integrate PCMH concepts every single year. Any questions?

## Question & Answer Session

Laurie Fink: All right, thank you very much, Dr. Urrea. At this time we're going to move into the Q&A portion of the session. If you have any questions for Dr. Urrea, please go ahead and type them into the chat or the Q&A box on the right of your screen. And if you have already submitted a question, which we did have a couple rolling in, we will address them now as time permits. I'll go ahead and ask the first question. It asks, **what are some of the common MIPS quality measures your Mon Valley PHO practices report on via the EHR?**

Christian Urrea: Sure. Most commonly are the favorable benchmarking measures, certainly hypertension screening, fall risk screening because primary cares love fall risk screening. We also use flu shot, pneumococcal, hypertension screening, A1C screening. We use depression screening. Those via our particular vendor are very, very easily captured, and we have to jump through very few hurdles to get those ones done.

Laurie Fink: The next question, **for medication reconciliation, is it only on 99, so E&M visit code 99, visits or every visit?**

Christian Urrea: On that particular measure, it is for care transitions only. We are talking about, from the hospital, brand new patient, patient sent to you from a specialist in transitions only. But we just like getting in the habit of having a full medication reconciliation every single visit so we can just always capture it because every single visit, we are always doing it. But for that particular measure, it has only TOCs.

Laurie Fink: Next question, **are the end-to-end reporting points still available in 2018 in the promoting interoperability category?**

Christian Urrea: Promoting interoperability doesn't have end to end bonuses per se. But the bonuses that you can get are reporting to any extra immunization registry or a clinical data registry. You can get like extra five bonus points say if you do immunization registry first. That'll get you your first 10 points, and then you decide to do syndromic surveillance also. That'll get you an extra five bonus points. And the other bonus points are from clinical improvement activities. That will qualify for it. The one that I had mentioned on the slide was the patient portal one. You can also be on a health information exchange, several other measures also, but those are listed in detail on the qpp.cms.gov site.

Laurie Fink: Okay. Our question asks, **do you have any tips on how to increase health information exchange if the practices that you usually refer your patients to don't have the same EHR?**

Christian Urrea: Yes, absolutely. This is a common problem, and there is one unifying product called Direct. Direct basically makes it so you can send a referral from say, an eClinicalWorks practice directly to a Medent practice or even like an Allscripts

practice. You can also have them have a provider who is on paper do it also. It just basically goes into their email box. But you have to pay for Direct on a per provider basis per year. But it is a very much worth it, especially going into 2019.

Laurie Fink: **What recommendations do you have to get patients to use the patient portal and send a secure message?**

Christian Urrea: Sure. We definitely still have trouble in the practices who are heavily Medicare. Some of them might not even have email. But those who we do get using it, the biggest way that we got the improvement is by instead of just simply asking, "Do you want to sign up for the portal?" and then, yes or no, we give them a brochure at the checkout windows, we do brief demonstrations of how it works so that a patient can see first-hand how it will benefit them. And if they actually see it happening, I'm just mainly talking like a five or so minute presentation, they tend to want to use it more if they can actually see how it can work for them.

Laurie Fink: Our next question**, I have 2015 certified EHR technology, can I still report using 2014 CEHRT for 2018 MIPS?**

Christian Urrea: Absolutely, yeah. If you are basically talking about the transition measure set, the answer is yes. Even if you are on 2015 now, it doesn't mean that you have to submit the meaningful use stage three measures. If you did, you would get 10 extra bonus points, but you can still use all the same measures that we went over in detail here today.

Laurie Fink: Okay. **With the quality measure for tobacco having three parameters for 2018, what have the Mon Valley PHO providers done to get the best percentages on parameter B?**

Christian Urrea: Parameter B. I might have to get back to you on that part of particular one. I don't have that parameter in front of me now. I can tell you that we are very successful in that particular measure, but if maybe I could get some contact information for that particular person, I would be happy to get back to you. *(Answer provided in next section of transcript).*

Laurie Fink: Okay, great. Yeah, I will make sure I send that question to you Dr. Urrea, and we'll get that sent to you, the person who asked the question. Our next question asks, **if we request a medical record from a specialist, and then he sent it to us electronically, does it count as an HIE?**

Christian Urrea: Not if it's being sent to you, this will only count for the outgoing flow. For the particular person sending it to you, that would count for them, but for the receiver, no.

Laurie Fink: All right. Last question is, **if the final rule allows clinicians to submit measures using different mechanisms, what do you suggest we do?**

Christian Urrea: This is where I would go through, we had many different situations where say we had a podiatrist, for instance, and his favorite measures were registry measures. And instead, the scoring worked out so that he could easily maximize it if he didn't use those actual podiatry measures. We had to convince him into more of primary care measures. In that particular case, we could have used his two registry measures that he really, really liked, and that he would get close to 100% on. And then we can also use EHR method measures that would be very simple to document. And then we can kind of blend it together. To fully answer that question, you would have to go over exactly all the measures that your vendor can support for you. Look at the benchmarks, and then perform some analysis with your team to decide what you would choose. But this would be very much a case by case basis here.

Laurie Fink: All right. Well, that brings us to 3 o'clock. I'd like to thank you, Dr. Urrea, and thanks for everyone who was able to join us today. We want you to know that Quality Insights is here to help you navigate MIPS in 2018 and beyond. Our assistance is funded by CMS, there's absolutely no cost to you to take advantage of our services, our huge library of resources and also educational sessions like this one today. We hope you found this to be informative and a beneficial presentation. Now, when you close out of today's session, you will be automatically directed to a very brief evaluation. We ask that you please take just a moment to complete it. We greatly appreciate your feedback and all of your comments. Thanks again, and have a great rest of the day. This session is now concluded.

## Answers to Questions Not Addressed During the Live Session

Q: BillyJo Crawn In reference to the ACI category (formerly Meaningful Use): if I have a 5% score in one of the mandatory categories, say Patient Electronic Access, and the total that can be received is 10% and I received the mandatory one patient for this, do I get a full 10% on this category even though it says 5%? In essence, do we receive a mandatory 10% for each category as long as we have one patient?

1. Security Risk
2. Electronic Prescribing
3. Patient Electronic Access
4. Summary of Care
5. Request/Accept Summary of Care

A: Christian Urrea For a moment, as pertains to the base score, let’s forget about your total score in HIE and Patient Electronic Access. As long as you do one eRX, one Patient electronic access, one HIE, and your security risk assessment, you will get your base score of 50 points.

Now, we will work about overall scoring for HIE and Patient Electronic Access (keep in mind that eRX is not a measure that counts beyond anything besides your base score).

Scoring for each individual PI measure is linearly scaled, and both HIE and Electronic Access are worth 20 points total. If you get between 1 and 10%, you get 2 points. If you get between 11% and 20%, you get 4 points. If you get between 21% and 30%, you get 6 points. And so on down the line.

For argument's sake, let's say you get 55% in both Electronic Access and HIE. You will receive 12 points for both of those categories. Now you would have your base score of 50 + 24 = 74.

The other measures are worth 10 points, maximum. Let's take Patient Education for instance. If you get between 1 and 10%, you get 1 point. If you get between 11% and 20%, you get 2 points. If you get between 21% and 30%, you get 3 points. And so on down the line. Now if you get 66% on patient education, you will we getting 7 more points. That brings your total to 50 + 24 + 7 = 81.

And regarding the very last portion of your question, you do not need a minimum threshold for your score to count. For example, if you are doing HIE, and your final score is 2/2, not only does that help you get your base score, but you get full 20 points for HIE.

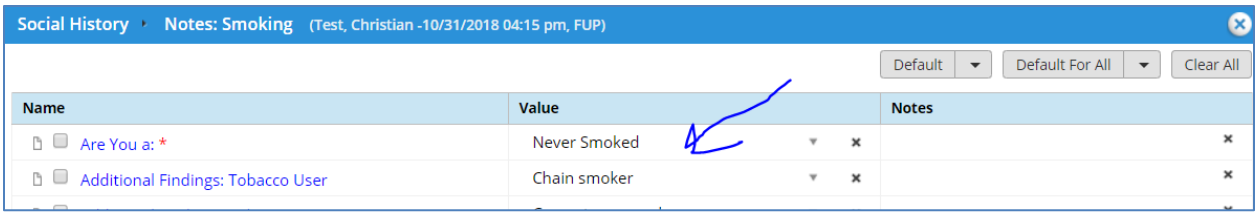
Q: Lisa Sagwitz

With the Quality measure for Tobacco having 3 parameters for 2018, what have the Mon Valley PHO providers done to get the best percentages on parameter "B?

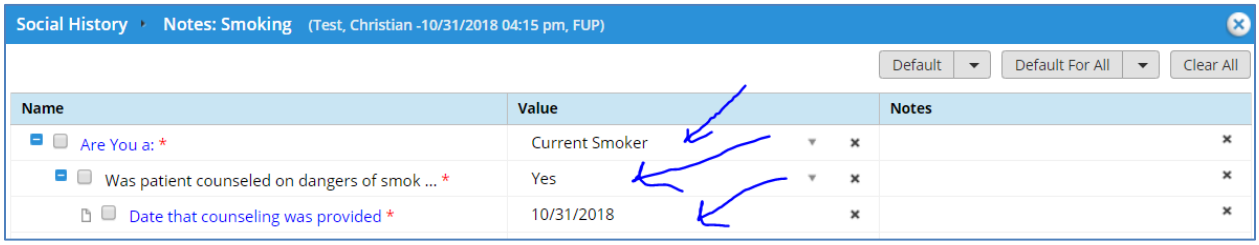
Parameter B:
a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months
b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco

A: Christian Urrea

Below is step-by-step with screenshots for how we accomplish this. We use our Social History for this, and we address smoking on EVERY single visit no matter what. The easiest scenario is if the patient is a non-smoker, we document it structured like so:



If we have a patient who is a former smoker or a current smoker, the following is applicable for both. You must document the smoking status, if counseling was provided, and the date of the counseling. It looks like this when complete:




You are free to document more if you want to, but at a minimum, if you capture this, you will be good to go for the entirety of the measure. The description of the measure is convoluted in my opinion, so it's a little difficult to decipher.

Q: Lisa Keeney — Is there a percentage of providers or sites within a group that need to be PCMH recognized in order to claim that credit?

A: Christian Urrea — First let's take a single PCMH site. For the time being, and proposed 2019 also, if you are a provider associated with a TIN that is a PCMH, even if that provider's name isn't on the official PCMH certification (i.e. perhaps that provider wasn't there during the certification), that provider still gets full IA credit. Now if that same TIN has multiple practices, at least 50% of those practice sites must be PCMH recognized in order to get the credit needed for IA.

Q: Cindi Musselman — Is there any way to see our progress throughout the rest of the year?

A: Christian Urrea — This question is difficult to answer without more information. If I am provided with more, I will expand and tailor the answer to you. That said, I will do my best here.

If you are not electronic, you can still track your quality measures via claims on qpp.cms.gov. When you sign in at the top right to "submit and manage data", this will take you to the practices you are linked to via their TIN. This requires you to have an EIDM account linkage and likely be the security official for that TIN. This will show you claims progress throughout the year.

If you are electronic and submitting via the EHR method, your vendor will have a dashboard for you that tabulates all of your quality measures, PI numbers, as well as your cost estimates. If you are submitting via QR/QCDR, the website you are logging into to log your cases will have tabulated score reports as well for your quality measures.



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