New Jersey Innovation Institute
An NJIT Corporation

2018 MIPS Reporting

Cardiovascular Disease

Quality Reporting Requirements:

- Report on 6 quality measures or a specialty measure set
- Include at least ONE outcome or high-priority measure
- Report on patients of All-Payers (Medicare and Non-Medicare patients)

Specialty Measure Set (0):

There is no specialty measure set for Cardiovascular Disease.

Additional Measures:

- **1:** Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) – **Outcome, High Priority**
- **8:** Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD) **8:** Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- **9:** Anti-Depressant Medication Management
- **12:** Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation
- **110:** Preventive Care and Screening: Influenza Immunization
- **111:** Pneumococcal Vaccination Status for Older Adults
- **112:** Breast Cancer Screening
- **113:** Colorectal Cancer Screening
- **117:** Diabetes: Eye Exam
- **119:** Diabetes: Medical Attention for Nephropathy
- **128:** Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
- **130:** Documentation of Current Medications in the Medical Record - **High Priority**
- **204:** Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic

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2018 MIPS for Cardiovascular Disease

Promoting Interoperability (PI) Reporting Requirements:

- Report on ALL required base measure to earn any credit for PI
- To satisfy base score requirements, clinicians must submit a numerator of at least 1 or answer Yes
- Report on additional performance measures or bonus measure to increase your PI Score

PI Base Score Measures:

PI Objectives and Measure Set (2015 CEHRT)	2018 PI Transition Objectives and Measure Set (2014 or 2015 CEHRT)
○ Security Risk Analysis ○ e-Prescribing* ○ Provide Patient Access ○ Send a Summary of Care* ○ Request/Accept Summary of Care*	○ Security Risk Analysis ○ e-Prescribing* ○ Provide Patient Access ○ Health Information Exchange*

*Exclusion available for measure if denominator is less than 100 patients or occurrences

Improvement Activities (IA) Reporting Requirements:

- Attest to up to 4 activities for a minimum of 90 days
- Choose one of the following combinations:
  - 2 High Weighted Activities
  - 1 High Weighted Activity and 2 Medium Weighted Activates
  - 4 Medium Weighted Activities

Medium Weighted:

- TCPI Participation - **EHR Bonus**
- Implementation of documentation improvements for practice/process improvements
- Collection and use of patient experience and satisfaction data on access
- Implementation of medication management practice improvements - **EHR Bonus**
- Annual registration in the Prescription Drug Monitoring Program
- Engagement of Patients, Family, and Caregivers in Developing a Plan of Care - **EHR Bonus**
- Use of tools to assist patient self-management
- Improved Practices that Disseminate Appropriate Self-Management Materials
- Engagement of patients through implementation of improvements in patient portal - **EHR Bonus**
- Participation in an AHRQ-listed patient safety organization.

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High Weighted:

- Engagement of New Medicaid Patients and Follow-up
- Engage Patients and Families to Guide Improvement in the System of Care – **EHR Bonus**
- Participation in the CMS Transforming Clinical Practice Initiative
- Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient's Medical Record – **EHR Bonus**
- Anticoagulant Management Improvements – **EHR Bonus**
- Consultation of the Prescription Drug Monitoring Program

Cost Reporting:

- CMS calculate Cost measures using administrative claims data if a clinician or group meets the cases minimum for attributed patients
- Individuals and Groups are not required to SUBMIT any additional information for the cost category

Cost Measures:

Medicare Spending Per Beneficiary (MSPB):

- The Medicare Spending Per Beneficiary (MSPB) clinician measure assesses the cost to Medicare of services performed by an individual clinician during an MSPB episode, which comprises the period immediately prior to, during, and following a patient's hospital stay.

Total Per Capita Costs for All Attributed Beneficiaries (TPCC):

- The Total Per Capita Costs for All Attributed Beneficiaries (TPCC) measure is a payment-standardized, annualized, risk-adjusted, and specialty-adjusted measure that evaluates the overall cost of care provided to beneficiaries attributed to clinicians, as identified by a unique Taxpayer Identification Number/National Provider Identifier (TIN-NPI).