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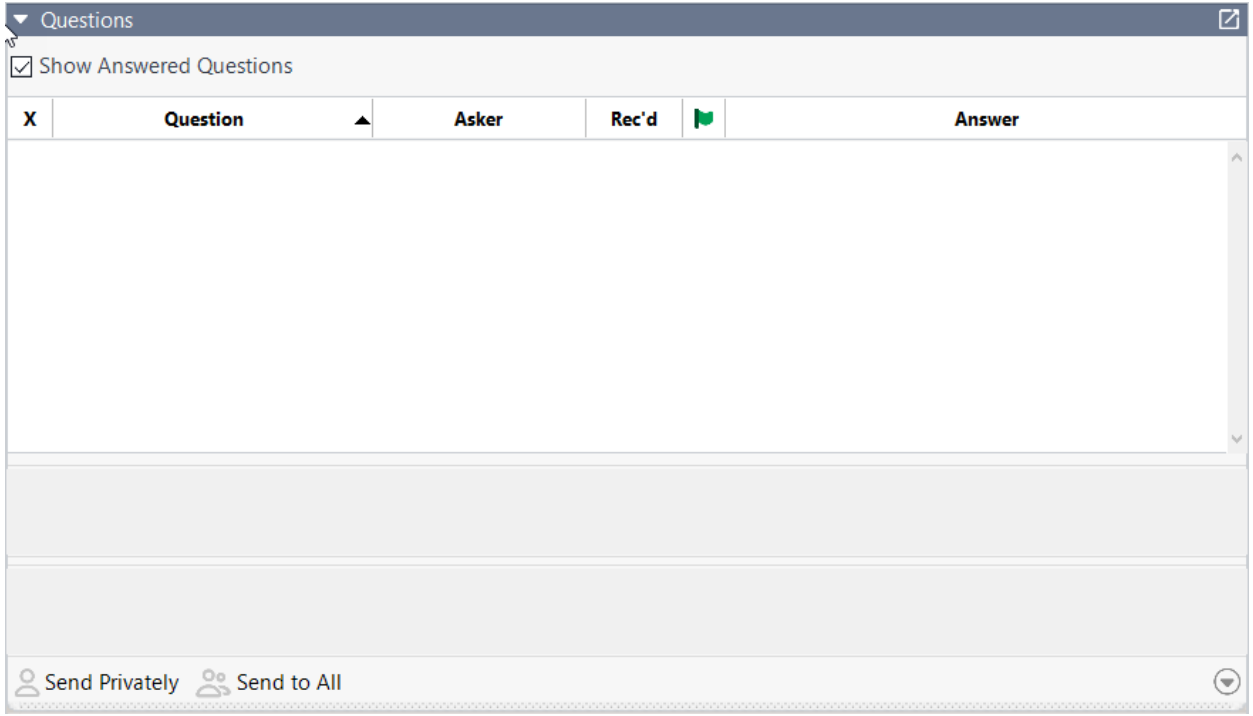
NextGen HQM and MIPS Submission

Inquiries may be submitted using the **Questions** window.



eMedApps - About Us

eMedApps is a Healthcare Information Technology Services company providing practices, clinics and hospitals with a full range of services, as well as a suite of products designed to increase efficiency and facilitate communication.

- Founded in 1999
- Working as partner with NextGen since 2001
- Worked as subcontractor for NextGen
- Serving healthcare clients across USA
- Services and Products for NextGen clients

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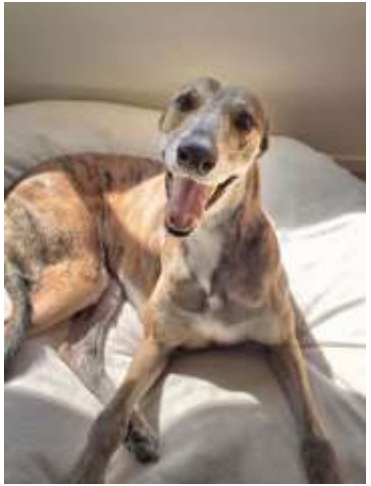
About Our Presenter

About Our Presenter

Christina Ytterock
(pronounced itt-er-ock)

Some of my Favorite Things:

- Greyhounds
- Concerts/Music
- Reading (favorite genre/horror)
- Travel
- New York City



NextGen HQM

Great NextGen HQM Resource Page

NextGen HQM Resources

NextGen HQM Success Community Resource Page:

https://www.community.nextgen.com/nge/kA3330000008V7m?srPos=0&srKp=ka3&lang=en_US

Fantastic page!

Includes, guides, recorded trainings, webinars/classes, troubleshooting tips, links to white papers and additional resources.

What is NextGen HQM

The NextGen HQM Reporting Module is a clinical data repository used for registry reporting of clinical outcomes and quality measure data.

After practices select specific incentive programs and measures, the reporting engine collects & extracts data from the report server to allow the generation of electronic reports.

NextGen HQM is an approved data submission vendor and has the ability to submit data for various performance based incentive programs including:

- MIPS
- Comprehensive Primary Care Plus
- Medicaid Promoting Interoperability
- Accountable Care Organization
- Clinical Quality Measures

Available HQM User Roles

Client Administrator:

Able to perform administration, configuration and reporting tasks. Needed to manage settings across practices

Multi-Client Administrator:

Specialized role with the ability to perform all the tasks of the client administrator for all clients in a group

Practice Administrator:

Able to perform administration, configuration and reporting tasks for a select practice

Report Practice User:

Able to run and manage reports for the selected practices. Unable to modify or configure

Report Provider User:

Able to run and manage reports for a single selected Provider. Unable to modify or configure

Report User:

Able to run and manage reports for all practices/providers. Unable to modify or configure

Basic Navigation

Navigation and Resource/Support Links

Top Menu Bar:

Home – Navigate to the home page display

Admin – Administrative Function Menu

Reports – Menu of available reports for viewing/generation

Config – Configuration Menu

Bottom Menu Bar:

NextGen.com – Launches the NG website

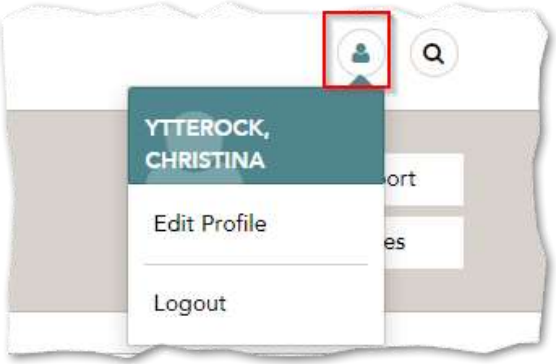
Legal Notices – Displays terms/conditions, privacy policy and other information related to the use of NG software

Client Resources – Launches the success community login page

CMS – Displays the Centers for Medicare and Medicaid Services website

User Profile Access & Options

To access your user profile once you have logged into the HQM, select the profile icon.



Your User Profile includes basic information about you which you can view and access from the profile page. With the exception of your User name, other changes can be made to your profile such as password change.

User Role Email Subscription

Depending on your role, email subscription alerts for various system events are available for configuration. This provides you with the ability to monitor the status of your system.

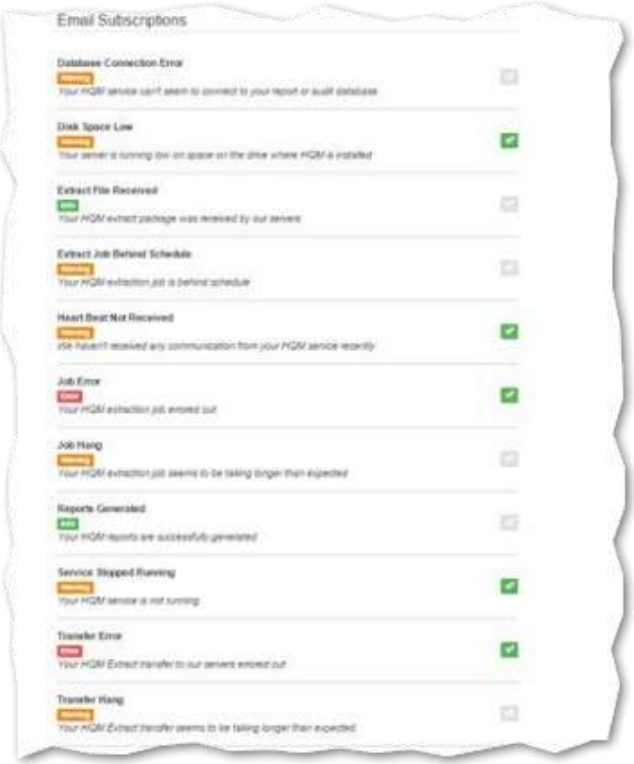
Alerts Include:

Database Connection Error
Disk Space Low
Extract File Received
Extract Job Behind Schedule
Heart Beat Not Received
Job Error
Job Hang
Reports Generated
Service Stopped Running
Transfer Error
Transfer Hang

Subscribe/Unsubscribe to Alerts

Access your user profile and review the available alert types. A green check mark indicates any alerts you currently receive.

To unsubscribe, clear the check box and it will appear grayed out.



Home Page

Once logged in, the home page will appear.

You will see:

- Site name
- Data processing information
- NG system messages, custom messages or alerts
- Latest and favorite reports

Job Status

Viewing your job status is super important as it breaks down your data processing showing when the last time data record extraction and upload was completed, if a job is in progress and also includes your last processed date.

- Green = completed
- Blue = executed (in progress)
- White = not started

This area also provides details on the date that the latest data was extracted and the number of days for the data delay.

Report Data/Information

- Information is pulled from a copy of Production and the data is usually one day behind the last processed date.

- It is important to ensure that your report server is getting refreshed on a daily basis so current clinical data is gathered and reporting is accurate.

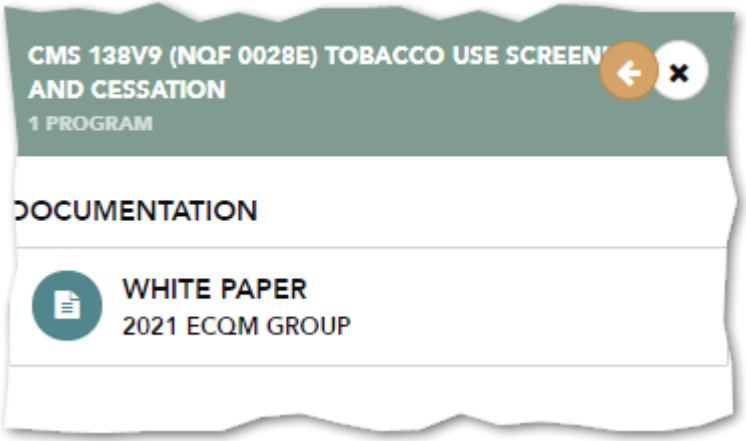
- Typically the data delay is 14 days to allow for encounter completion/closure however, this can be adjusted by requesting the change through your NextGen HQM Analyst or NextGen HQM support ticket.

White Paper Search Feature

Did you know that you can access measure white papers from within the tool?

- White papers provide detailed information about each measure including workflows to meet the measure.
- Click the search button and start typing either a word or measure number to populate the associated white paper.

White Paper Search Feature



Overview

Measure Name

CMS 138 v9: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Description

Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 12 months AND who received tobacco cessation intervention if identified as a tobacco user.

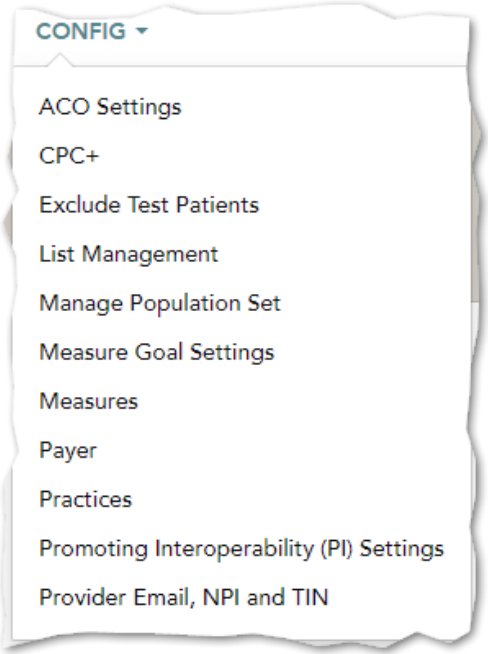
Three rates are reported:

- Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 12 months.
- Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention.
- Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 12 months AND who received tobacco cessation intervention if identified as a tobacco user.

Configuration Overview

Configuration Menu

Configuration options and viewing can be accessed from the Config drop down menu.



HQM Basic Configuration for MIPS Reporting

Correct Configuration Provides Accurate Reports

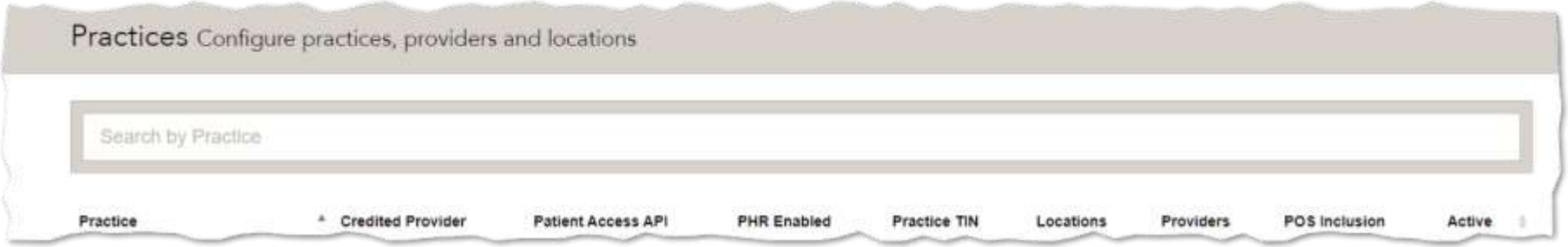
- Practices
- Providers
- Measures
- Promoting Interoperability
- Payer/Medicare Verification
- Test Patients

Practices Configuration

Practices Configuration

Configuration options allow you to:

- Enable/Disable practices
- Set the reporting credit for encounters
- Update the PHR (Personal Health Record) enabled date
- Set the practice TIN (Tax Identification Number)
- Manage locations/providers and places of service (POS)



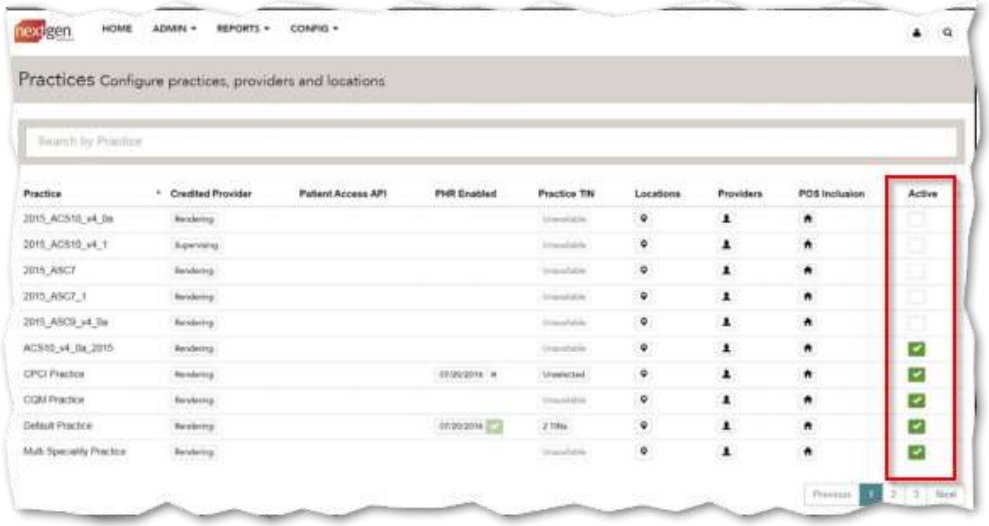
Enable/Disable Practices

Enable:

To enable practice participation select the Active checkbox for the practice

Disable:

To disable practice participation, clear the Active checkbox.



Set the Credited Provider

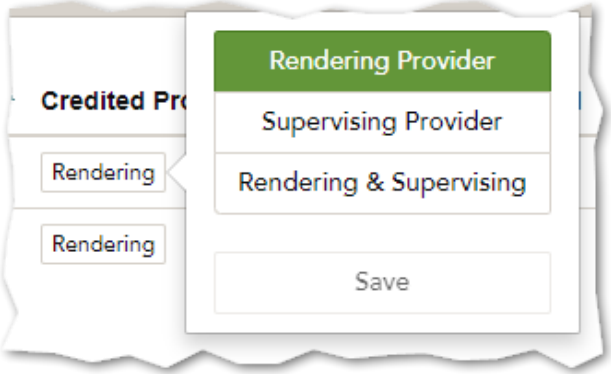
Allows you to select up to 3 options for your practice.

- Rendering – gives credit to rendering Provider on encounter
- Supervising – gives credit to supervising Provider on encounter
- Rendering and Supervising – gives credit to both

Supervising options might be applied/used in educational institutions or practices with supervising providers.

When applied, supervising Providers are given credit for the rendering providers work.

NOTE: If supervising is selected as the default, but no supervising provider has been included on the encounter, the system will revert to rendering.



Update/View Personal Health Record (PHR) Enabled Date

NOTE: If PHR is not enabled, results will be zero for the Patient Electronic Access Measure unless each encounter and lab results are uploaded to the NG patient portal within 4 business days.

A green check mark indicates PHR is currently enabled and provides the date that PHR was enabled for the practice

If you see an X next to the date, this indicates that PHR was enabled previously but has since been disabled.

If the column is blank, PHR has never been enabled.

Set the Practice Taxpayer Identification Number(s) (TIN)

Note: Required for group reporting

TIN column displays one the following:

- Unavailable – TIN is unavailable for selection
- Unselected – TIN is available but has not been selected
- Number of TINS – number of selected practiced TINS

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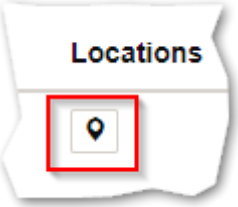
Practice Locations

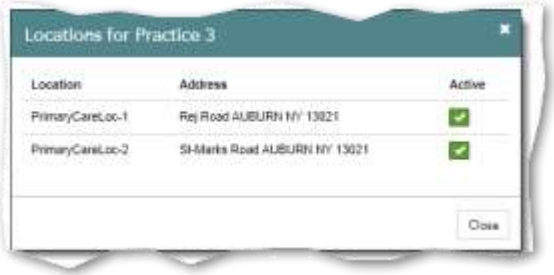
Enable/Disable practice locations by clicking the locations icon

NOTE: This information is pulled from File Maintenance



To Add locations select Active and a green checkbox appears.

To disable, clear the Active checkbox.



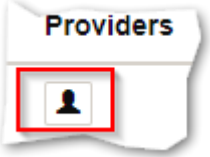
Providers Practice Configuration

NOTE: Provider information is pulled from your File Maintenance set up.

This allows you to see all the Providers that have been configured.

You also have the ability to enable/disable Providers in this area.

- To enable, select the Active checkbox
- To disable, clear the Active checkbox



Places of Service

This area allows you to see all the locations/places of service that have been configured.

You also have the ability to enable/disable Providers in this area.

- To enable, select the Active checkbox
- To disable, clear the Active checkbox

Place of Service	Code	Active
Pharmacy	01	☑
Telehealth	02	☑
School	03	☑
Homeless Shelter	04	☑
Indian Health Service Free-Standing Facility	05	☑
Indian Health Service Provider-Based Facility	06	☑
Tribal 638 Free-Standing Facility	07	☑
Tribal 638 Provider-Based Facility	08	☑
Prison/Jail	09	☑
Office	11	☑

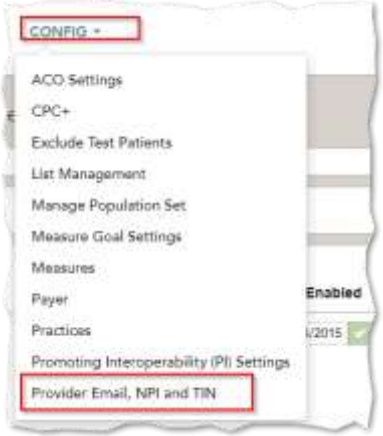
Provider Email, NPI & TIN

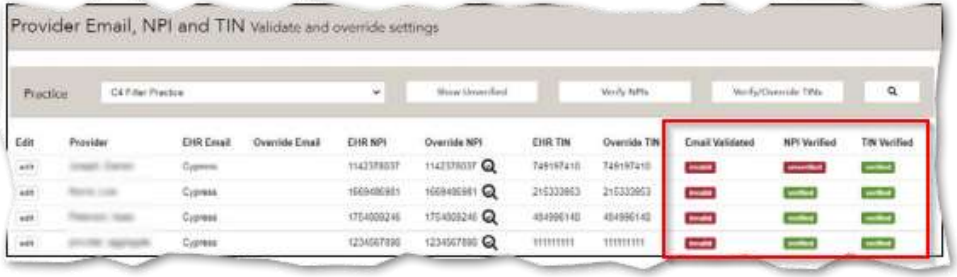
Configure Email, NPI & TIN

View Provider email addresses, NPI information and TIN information.

Review Provider verification status for each

Option to view unverified which will show Providers with unverified information





Verify TIN and NPI Information

Note: Both TIN and NPI information is pulled from your file maintenance set up.

The verify NPI's selection checks the participating Providers against a database of verified NPI's.

The Verify/Override TIN's option allows you to either Verify the practice TIN(s) against a database of verified TIN's.

The Override and Verify option can be used if the information that is pulled from FM is incorrect/missing.

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Check Provider Participation Status

Did you know you can check a Providers MIPS participation status from the HQM tool?

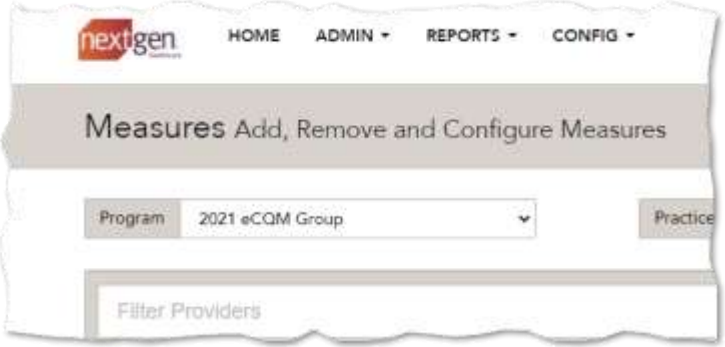
1. To check, select the search link for the Provider
2. Once selected, you will be re-directed to the CMS Participation Lookup Tool.
3. If a Providers participation status has been checked, the search icon populates with a check mark.

Measure Configuration

Measure Configuration

Configuration Options Include:

- Adding/Removing Providers
- Adding/Removing Measures
- Updating/Changing the Reporting Period



The MIPS program has a total of 4 categories that Providers are required to report on. The HQM tool allows submission of 3 out of the 4 including:

- Improvement Activities
- Promoting Interoperability
- Quality

The cost category is based on and calculated using submitted claim information.

Program/Practice Selection

Within the HQM, the 3 categories have programs to configuration based on either individual or group reporting.

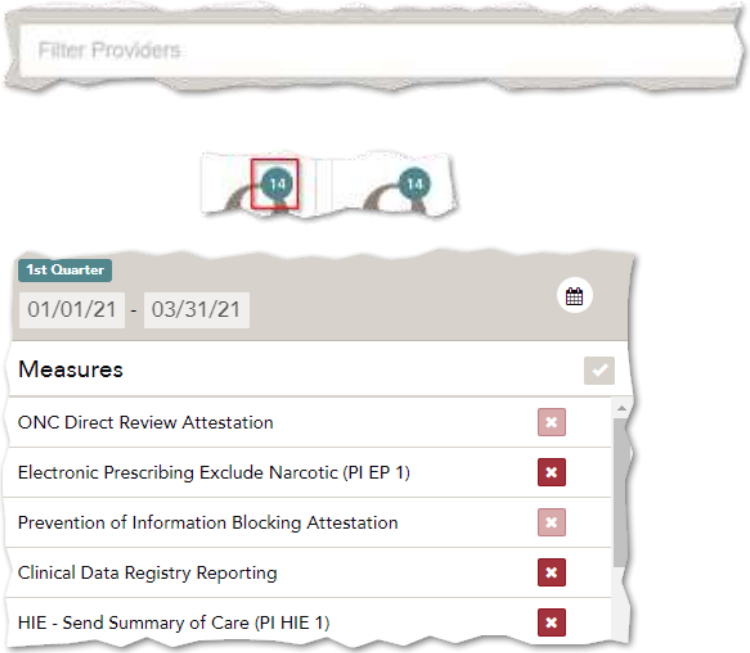
- Select the applicable program from your available options. Programs are listed by year in descending order.

  Note: if you do not see the appropriate year/program, contact your NG HQM specialist or open an HQM ticket to have the updated/correct program(s) added.

- Select a practice from the practice list if applicable. The system does default the practice automatically but if you have more than one practice in file maintenance, you will need to ensure you are configuring correctly

Measure Configuration Features

- When configured, the Provider(s) for the selected practice will display.
- The Filter Providers Field allows you to narrow the list of Providers.
- The blue circle identifies how many measures have been assigned/added to each Provider.
- To view a list of measures, click on the Provider and assigned measures populate along with the configured reporting period.

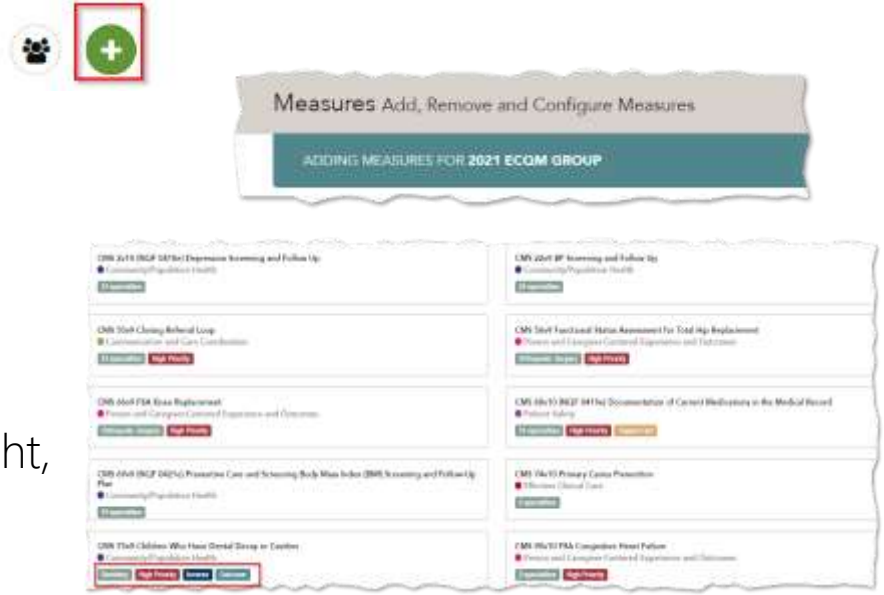


Measure Configuration Features

- NPI status is indicated by the green background/check mark for verified. If unverified the status shows as a red background/X. .. NPI: ✓
- To set/select/change the reporting period, click on the calendar icon. Additional functionality is available to allow your date range selection to be applied to an individual Provider or to the whole Provider group.

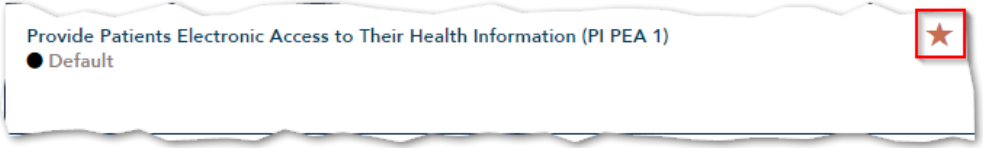
Adding Measures

- To begin, select the green + icon.
- The Adding Measures page appears.
- From here, Practice, Provider and Measure selection is completed.
- Measure descriptions are available by hovering over the measure description.
- Measure details such as high/med weight, inverse/high priority/outcome and specialty are visible as you are making selections.
- Selected measures will populate with a green check mark.

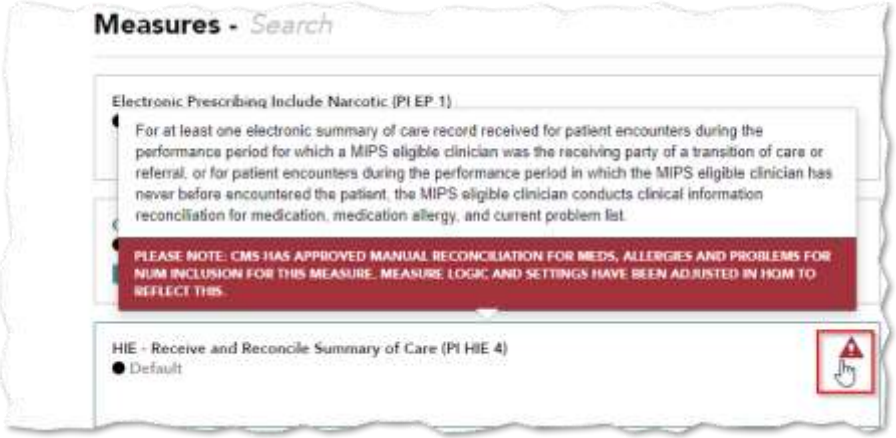


Adding Measures

Mandatory measures including required self attestation measures for the Promoting Interoperability Category will display a star.



NextGen also provides additional information when applicable such as CMS guidelines/notes regarding specific measures.



Adding Measures

- When measure selections are complete, navigate to the Schedule section to select/set your program schedule.

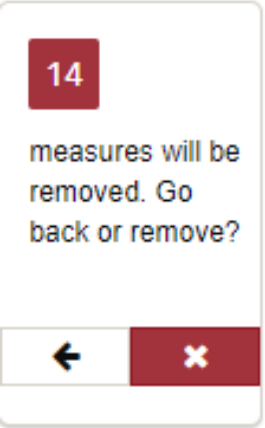
- Click Complete! Add Measures message that appears.

- An additional adding measures message will populate while measures are being added.

Deleting Measures - Individual

- Individual measure removal can be completed by navigating to a Provider and selecting the X below the Provider's name. The X option will remove all measures from the Provider.

- Make sure you really want to delete all measures. The system provides a prompt to confirm before deletion. This gives you the option to go back or move forward.



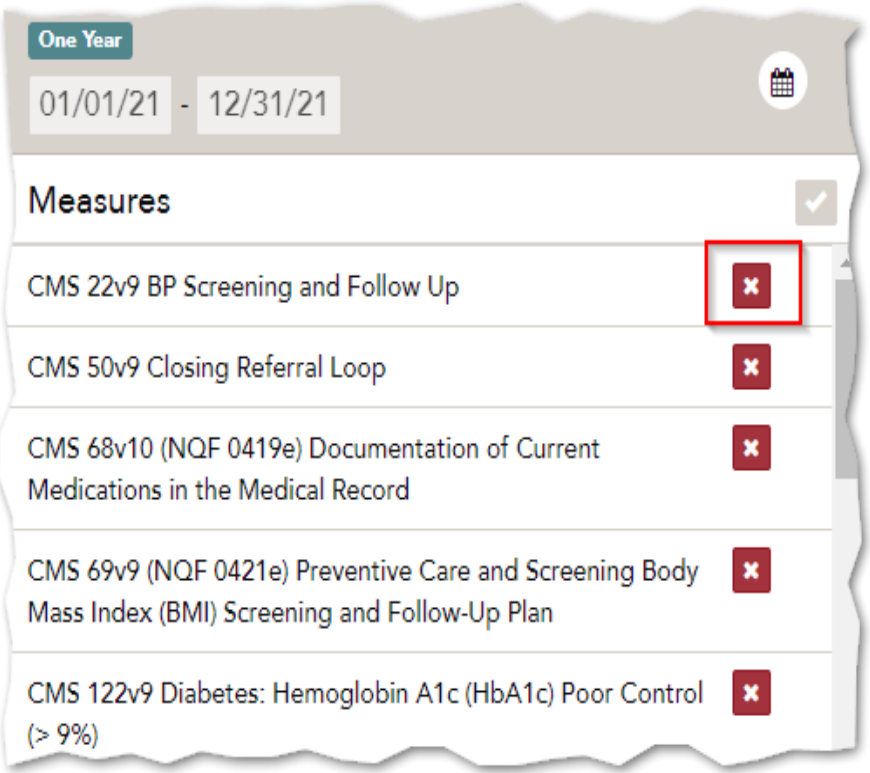
- Selecting the X will remove the measure(s) for the individual Provider.

Deleting Measures - Individual

You also have the option to review and delete specified measures instead of all measures from individual Providers.

Select (click on) a Provider and the list of configured measures populates.

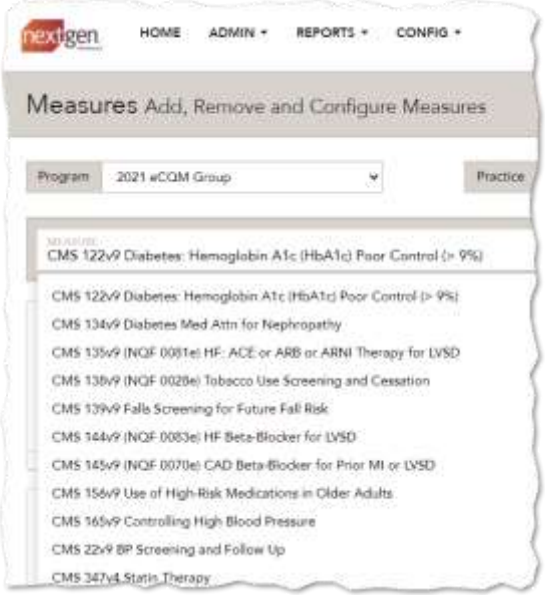
To remove a measure or measures, select the X.



Measure Deletion - Group

When it is necessary to remove specific measures from a group of Providers, the change grouping icon is available.

This feature allows you to view all configured measures and select a measure for removal from the dropdown.



When a measure selection is made, Providers with the selected measure assigned will populate.

The Red X option will remove the selected measure from all Providers.

2021 Quality Category Highlights

2021 Quality Category Highlights

- 40% of your final score
- Full year of measure data
- Over 200 available measures to select from
- Select at least 6 measures for submission
- Include 1 high priority and 1 outcome measure in your selections
- Data must be reported on at least 70% of patients
- Specialty Measure Sets available
- 20 case minimum

2021 Quality Bonus Points

Bonus points are available:

- Submit 2 or more outcome or high priority measures
- Use CEHRT to collect and meet end-to-end electronic reporting
- 6 bonus points are added to the category score for small practices
- 10 additional percentage points can be earned based on your improvement in the quality category from the previous year

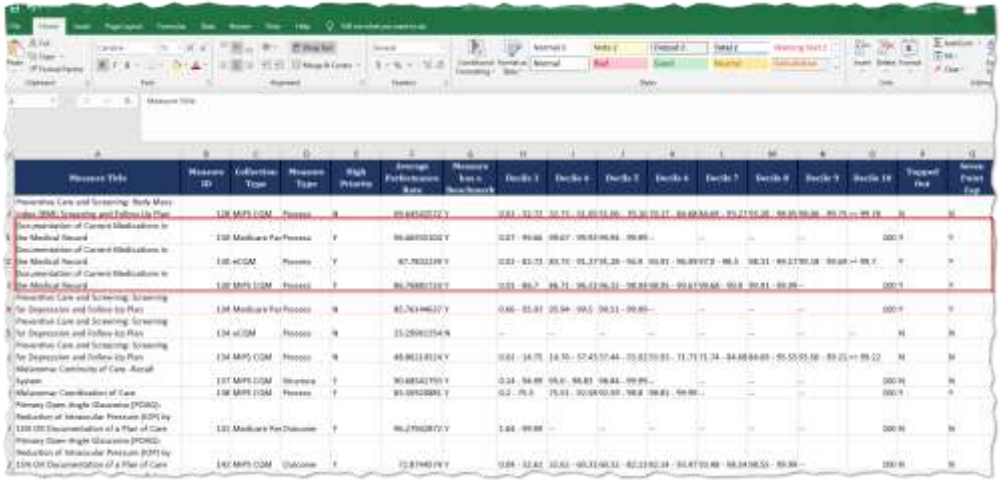
CMS 2021 Quality

Updated 2021 Quality Requirements Page

https://qpp.cms.gov/mips/quality-requirements

Review 2021 CMS Quality fact sheets/resources/details

Review 2021 Quality Measure Benchmarks to aid in your decision making process.



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Promoting Interoperability Configuration

Promoting Interoperability Measures

For 2021, the PI category includes 4 required, 1 bonus and additional self attestation required, registry & exclusion measures needing configuration.

In the measure types section of the adding measures page you will see the option for Measures and Self-Attest Measures.

Self-Attest Measures

Any required measures are starred

Exclusion measures provide different options for selection when applicable to your Practice/Provider.

ONC Direct Review Attestation
PI Objectives and Measures
Pre-Attestation

ONC-ACB Surveillance Attestation (Optional)
PI Objectives and Measures
Pre-Attestation

Prevention of Information Blocking Attestation

Any MIPS eligible clinician who does not diagnose or directly treat any disease or condition associated with a clinical data registry in their jurisdiction during the performance period

Clinical Data Registry Reporting
Public Health And Clinical Data Exchange
Self-Attestation

Clinical Data Registry Reporting Exclusion PI PHCDRR 5 EX 1
Public Health And Clinical Data Exchange
Self-Attestation

Clinical Data Registry Reporting ExclusionPI PHCDRR 5 EX 2
Public Health And Clinical Data Exchange
Self-Attestation

Clinical Data Registry Reporting Exclusion PI PHCDRR 5 EX 3
Public Health And Clinical Data Exchange
Self-Attestation

Clinical Data Registry Reporting for Multiple Registry Engagement
Public Health And Clinical Data Exchange
Self-Attestation

Promoting Interoperability Settings

The selection of Promoting Interoperability from the config menu launches PI settings and allows you to configure the following:

Secure message categories – populate the check box for the category(s) you wish to include as part of a secure message.

Business schedule – allows you to indicate the day's your practice is closed/non business days for the Provider to patient exchange objective.

Promoting Interoperability Settings

Practice exclusions are used If PHR is not enabled, this allows you to configure Summary of Care, CPOE, Secure Messaging & Patient electronic access exclusions such as lab results, X-ray etc.

Transition of care is used to specify the external systems and direct messaging addresses.

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2021 Promoting Interoperability Category Highlights

2021 Promoting Interoperability Category Highlights

PI category goal is to promote patient engagement and electronic exchange of information using certified health record technology

- 25% of your Final Score
- Single set of Objectives/Measures
- Required to use EHR that meets the 2015 CEHRT criteria, 2015 Cures Update certification criteria (or combination of both)
- 90 day reporting period
- Must provide your EHR's CMS identification code from the CHPL
- Must submit a yes answer to 3 self attestation measures including:
  - ❖ The Prevention of Information Blocking Attestation
  - ❖ The ONC Direct Review Attestation and
  - ❖ The security risk analysis measure

Promoting Interoperability Category Scoring & Bonus Points

Bonus:

10 points are available for submitting a yes for the optional measure Query of Prescription Drug Monitoring (PDMP)

Scoring:

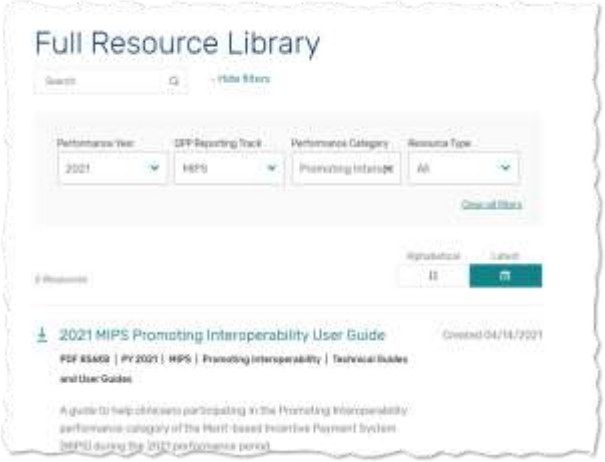
- CMS scores each measure by multiplying the performance rate (calculated from the numerator and denominator you submit) by the available points for the measure.
- The Public Health and Clinical Data Exchange measures are awarded full points if a "yes" is submitted for 2 registries *or* one "yes" and one exclusion.
- Submission is needed for all required measures (submit a "yes"/report at least 1 patient in the numerator, as applicable, or claim an exclusion) or you will earn a zero for the Promoting Interoperability performance category.
- If exclusions are claimed, the points for those measures will be reallocated to other measures.

CMS Promoting Interoperability

Updated 2021 CMS Promoting Interoperability Page:

https://qpp.cms.gov/mips/promoting-interoperability

Check out the full CMS resource library to gain additional knowledge and review information related to categories, measures and objectives.



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CMS Promoting Interoperability

Prepare, gather audit binder necessities & review the PI category criteria for each measure/objective.

Interoperability Measure ID	Interoperability Measure	[illegible]	2021 Promoting Interoperability Measure Required/Optional	Promoting Interoperability Reporting Requirement (Yes/No Statement or Numerator/Denominator)	Promoting Interoperability Validation (during performance period)	Documentation needs to be from certified electronic health record technology (CEHRT) and be inclusive of:
PI_HIE_4	Support Electronic Referral Loops by Receiving and Reconciling Health Information	For at least one electronic summary of care record received for patient encounters during the performance period for which a MIPS eligible clinician was the receiving party of a transition of care or referral, or for patient encounters during the performance period in which the MIPS eligible clinician has never before encountered the patient, the MIPS eligible clinician conducts clinical information reconciliation for medication, medication allergy, and current problem list.	Required	Numerator/Denominator	Receives or retrieves and reconciles an electronic summary care record into the CEHRT when a patient is transitioned or referred to the clinician AND performs review of medication(s), medication allergies, and current problem list and reconciliation for at least one transition of care or referral received, or patient encounter in which the MIPS	A dated report or screenshot that shows the number of times the MIPS eligible clinician: - electronically retrieved or received and reconciled a summary of care document into the CEHRT for a transition of care received, referral received, or patient encounter in which the MIPS eligible clinician has never before encountered the patient during the performance period. - performed clinical reconciliation for 1) medication, including the name, dosage, frequency, and route of each medication, 2) medication allergies, and 3) current problem list for a transition of care or referral received, or patient the MIPS eligible clinician has never before encountered during the
PI_LVHTC_2	Support Electronic Referral Loops by Receiving and Reconciling Health Information Exclusion	Any MIPS eligible clinician who receives transitions of care or referrals or has patient encounters in which the MIPS eligible clinician has never before encountered the patient fewer than 100 times during the performance period.	Required only if submitting an exclusion for the Support Electronic Referral Loops by Receiving and Reconciling Health Information measure.	Yes	The 2020 QRP final rule revised the wording of this exclusion beginning with the 2019 performance period. Any MIPS eligible clinician who receives transitions of care or referrals or has patient encounters in which the MIPS eligible clinician has never before encountered the patient fewer than 100 times during the performance period. The	A dated report or screenshot from the CEHRT that shows the number of times the MIPS eligible clinician receives a transition of care or referral or has patient encounters in which the clinician has never before encountered the patient during the performance period.
PI_HIE_5	Health Information Exchange (HIE) Bi-Directional Exchange	The MIPS eligible clinician or group must establish the technical capacity and workflows to engage in bi-directional exchange via an HIE for all patients seen by the eligible clinician and for any patient record stored or maintained in their EHR, consistent with their attestation statements.	Required only if submitting as an alternative to PI_HIE_1 and PI_HIE_4.	Yes	Must establish the technical capacity and workflows to engage in bi-directional exchange via an HIE for all patients seen by the eligible clinician and for any patient record stored or maintained in their EHR, consistent with their attestation statements.	- A dated report or screenshot that documents successful receipt and transmission of patient data via the entity providing health information exchange services. Should include evidence to support that it was generated for that MIPS eligible clinician's system (e.g., identified by National Provider Identifier (NPI), clinician name, practice name, etc.). AND/OR - Letter, email or other documentation from the entity providing health information exchange services confirming participation of MIPS eligible clinician, the date of on-boarding, a description of services provided, and a description of exchange network participants (e.g. number/type of participating providers). OR - Letter, email or other documentation from the MIPS eligible clinician's CEHRT vendor confirming a connection between the eligible clinician's CEHRT and an entity providing health information exchange services, the date of on-boarding, a description of services provided, and a description of
PI_PEA_1	Provide Patients Electronic Access to Their Health Information	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	Required	Numerator/Denominator	Provide the information necessary to grant access to the patient or their authorized representative in order to view, download, and transmit their health information using any application of the patient's choice meeting the technical specifications of the	A dated report or screenshot that documents the number of times a patient or patient-authorized representative is given access to view, download, or transmit their health information. This could include instructions provided to the patient on how to access their health information, including the website address they must visit, the patient's unique and registered username or password, and a record of the patient logging on to show that the patient can use any application of their choice to access the information and provide API technical

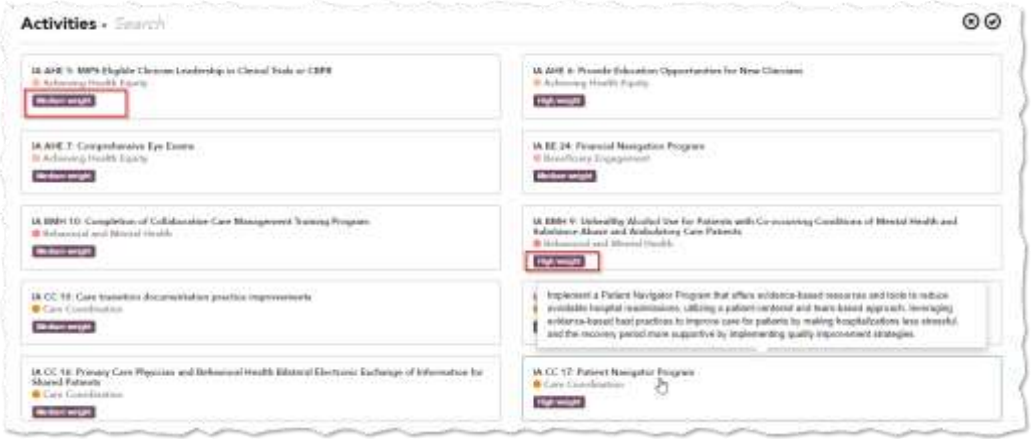
Improvement Activity Configuration

Improvement Activities

NextGen usually releases the activities for selection later in the reporting year

Descriptions of each Activity are available when hovering.

Measure selections are populated with a green check mark



Activities are classified with High & Medium weight for guidance as you are making your selection(s)

CMS Validation

Did you know that in 2020 CMS required Qualified Registries (NextGen) to "validate" that clients met specific IA's by validating the suggested documentation.

NextGen/HQM was able to auto validate some of the activities

Other information needed to be provided on company letterhead for review/validation.

Start preparing this documentation now!

Improvement Activity ID	Subcategory Name	Activity Name	Auto-validated by HQM Information
IA_PM_3	Population Management	RHC, IHS or FQHC quality improvement activities	Clients who are FQHC's and are configured for quality measure programs and are regularly running reports for review will qualify for this measure.
IA_PM_16	Population Management	Implementation of medication management practice improvements	Configures and has NUM for the MIPS CQM 130 or eCQM CMS 68v9 measure Documentation of Current Medications in the Medical Record
IA_CC_1	Care Coordination	Implementation of use of specialist reports back to referring clinician or group to close referral loop	Configures and has NUM for the eCQM CMS 50v8 measure Closing the Referral Loop
IA_CC_13	Care Coordination	Practice improvements for bilateral exchange of patient information	The use of NGShare and the sending of CCDA's as a structured referral document - could allow having a NUM/DEN for the Send Summary of Care measure to technically meet this. Ideal if also receiving CCDA's. Having and using CareQuality (which functions as an HIE) will meet this measure as well.
IA_BE_4	Beneficiary Engagement	Engagement of patients through implementation of improvements in patient portal	Configures and has NUM results for 2020 Medicaid PI Secure Messaging Measure meets the ***and/or bidirectional communication about medication changes and adherence.***

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CMS 2021 Improvement Activity Category Highlights

CMS 2021 Improvement Activity Category Highlights

- 15% of your Final Score
- 90 day reporting period
- High-weighted activities receive 20 points and medium-weighted activities receive 10 points.
- To earn full credit you must submit one of the following combinations:
  - ❖ 2 high-weighted activities
  - ❖ 1 high-weighted activity and 2 medium-weighted activities *or*
  - ❖ 4 medium-weighted activities
- If Special Status is applicable this allows you to receive double points for each high or medium weighted activity you submit.

CMS Improvement Activity

Updated 2021 Improvement Activity page:

https://qpp.cms.gov/mips/improvement-activities

Quality Payment PROGRAM

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Home / Traditional MIPS

Improvement Activities: Traditional MIPS Requirements

Traditional MIPS is the original framework available to MIPS eligible clinicians for collecting and reporting data to MIPS. The improvement activities performance category measures participation in activities that improve clinical practice.

Requirements may change each Performance Year (PY) due to policy changes.

Performance Year
Select your performance year.

Performance Year 2021

2021 Improvement Activities Requirements

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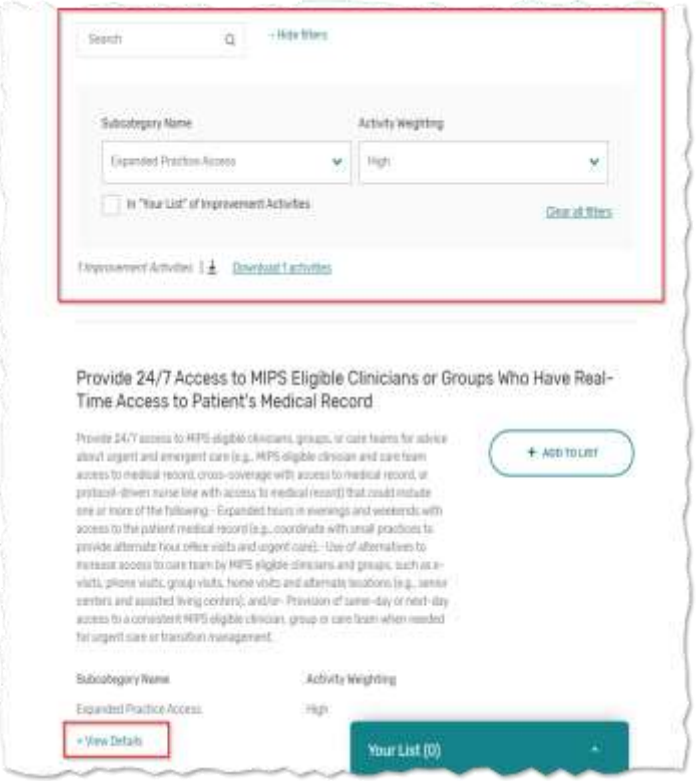
Explore and View Details

Utilize qpp.cms.gov to explore, download and view details about each activity as you prepare to make/update improvement activity selections for 2021.

ACTIVITY NAME	ACTIVITY DESCRIPTION	ACTIVITY ID	SUBCATEGORY NAME	ACTIVITY WEIGHTING
Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient's Medical Record	Provide 24/7 access to MIPS eligible clinicians, groups, or care teams for advice about urgent and emergent care (e.g., MIPS 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 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	IA_EPA_1	Expanded Practice Access	High



CMS Improvement Activity

Prepare, gather audit binder necessities & review policies/procedures and the 2021 improvement activity category criteria for your selection(s)

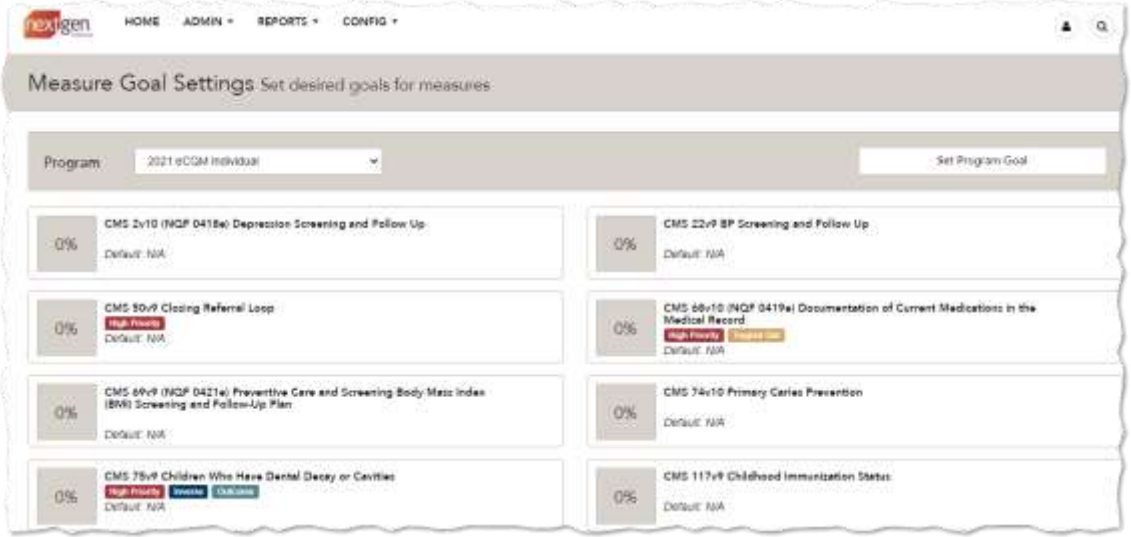
ID	Subcategory	Activity Name	Activity Description	Activity Weight	Objective & Validation Documentation
IA_EPA_1	Expanded Practice Access	Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient's Medical Record	Provide 24/7 access to MIPS eligible clinicians, groups, or care teams for advice about urgent and emergent care (For example, 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 (For example, 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 telehealth, phone visits, group visits, home visits and alternate locations (For example, 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	High	Objective: Increase patient access to eligible clinicians who work in an outpatient setting with the goal of reducing unnecessary emergency room visits. Validation Documentation: Evidence of demonstrated patient care provided outside of normal business hours through expanded practice hours and by eligible clinicians with real-time access to patient's electronic health record (EHR), so that patients received needed urgent or transitional care in a timely way. Expanded Business Hours are defined as hours that are outside of a practice's standard business hours of operation. Include at least one of the following elements: 1) Patient record from EHR – A patient record from an EHR with date and timestamp indicating services provided outside of the practice's normal business hours for that eligible clinician (a certified EHR may be used for documentation purposes, but is not required unless attesting for the Promoting Interoperability bonus); OR 2) Patient encounter/medical recordkeeping – Patient encounter/medical recordkeeping indicating patient visit care or services provided outside of the practice's normal business hours for that eligible clinician.
IA_EPA_2	Expanded Practice Access	Use of telehealth services that expand practice access	Use of telehealth services and analysis of data for quality improvement, such as participation in remote specialty care consults or teleradiology pilots that access ability to still deliver quality care to patients.	Medium	Objective: Increase use of telehealth services, thus removing geographic and time barriers to access, and use data from these services to implement quality improvement initiatives. Validation Documentation: Evidence of documented use of telehealth services. For purposes of this activity, telehealth services are defined as "real-time" interaction between eligible clinician and patient. Include the following element: 1) Use of telehealth services – Demonstration of a standardized and routine approach to the use of telehealth. Telehealth services may include care provided over the phone, online, etc., and are not limited to the Medicare reimbursed telehealth service subset. Examples of documentation include at least
IA_EPA_3	Expanded Practice Access	Collection and use of patient experience and satisfaction data on access	Collection of patient experience and satisfaction data on access to care and development of an improvement plan, such as outlining steps for improving communication with patients to help understanding of urgent access needs.	Medium	Objective: Develop an improvement plan structured by patient experience and satisfaction data, including any differences across demographic groups, so that eligible clinicians can use data driven approaches to improve patient access and quality of care. Validation Documentation: Evidence of documented improvement plan for access to care and quality based on collected and stratified patient experience and satisfaction data. The goals for improvement can be defined broadly or within certain population strata. CMS examples of stratification may include patient demographics such as race/ethnicity, disability status, sexual orientation, sex, gender identity, or geography. (It is acknowledged that some stratification data may not be available). Include both of the following elements: 1) Patient experience and satisfaction data on access to care – Data collected through a patient experience survey for a population defined by the eligible clinician. For example, eligible clinicians could give the survey to all patients seen within a defined study period. Data can be prepared in any useful format, or as they were collected; AND 2) Improvement plan – Documentation of an improvement plan, which should include specific activities, goals, and outcomes for addressing access to care. (For example, an eligible clinician may choose that
IA_EPA_4	Expanded Practice Access	Additional improvements in access as a result of QIN/QIO TA	As a result of Quality Innovation Network-Quality Improvement Organization technical assistance, performance of additional activities that improve access to services or improve care coordination (for example, management of on-site diabetes education).	Medium	Objective: Use learnings from engagement with Quality Innovation Network-Quality Improvement Organization (QIN-QIO) technical assistance to design, plan, and initiate implementation of new activities, ultimately improving access to services or care coordination. Validation Documentation: Evidence of implementation of newly added processes, practices, resources, or technology to improve access to services or improve care coordination as a result of receiving QIN-QIO technical assistance. Include both of the following elements: 1) Relationship with QIN-QIO technical assistance – Confirmation of technical assistance and documentation of relationship with QIN-QIO (e.g., signed letter of agreement, email exchange); AND 2) Activities – Documentation of planned and/or tested activities that improve access or improve care coordination, including cancel/no-show rates
IA_EPA_5	Expanded Practice Access	Participation in User Testing of the Quality Payment Program Website	User participation in the Quality Payment Program website testing is an activity for eligible clinicians who have worked with CMS to provide substantive, timely, and responsive input to improve the CMS Quality Payment Program website through product user-testing that enhances system and program accessibility, readability and responsiveness as well	Medium	Objective: Help CMS improve the content provided on the Quality Payment Program (QPP) website. Validation Documentation: Evidence of user participation and implementation of website testing for the QPP. Eligible clinicians must be invited on CMS' Beta Tester list and be able to share at least one of the following elements:

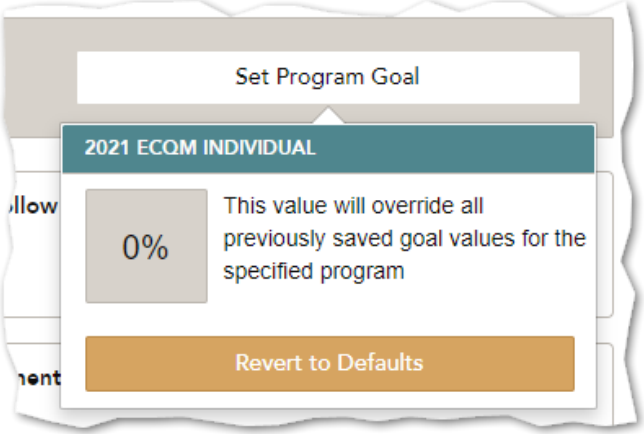
Additional Configuration

Edit Measure Goal Settings

This page allows you to set goals for measures and these goals appear on the Measure Goal report and Summary report.

You can set measure goals for a program or for individual measures in a program.





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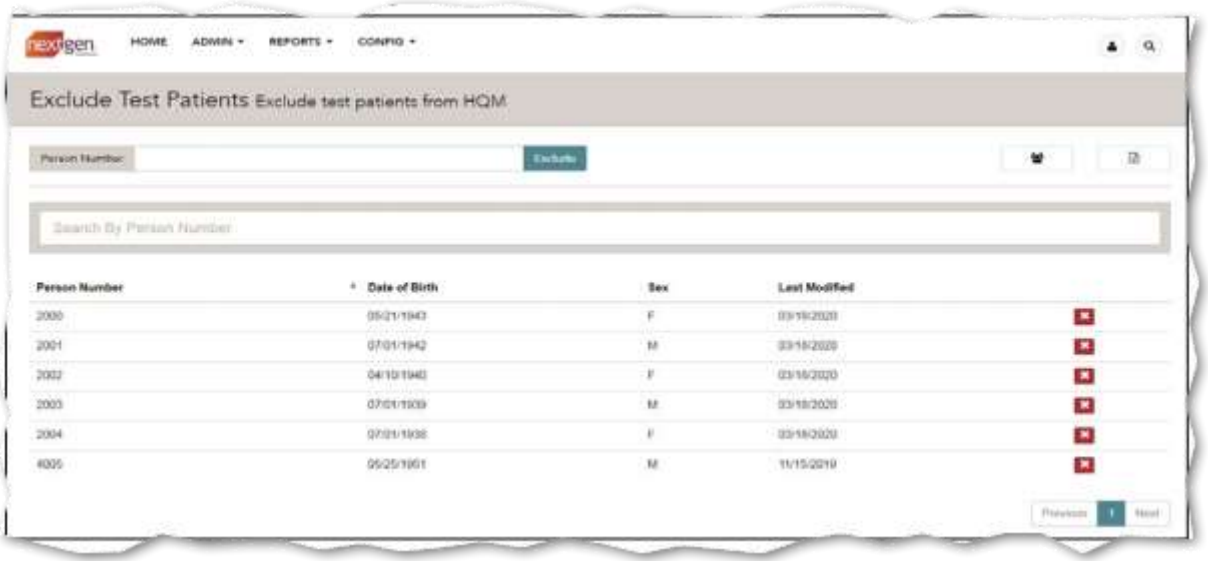
Medicare Verification Configuration

For reporting, you must identify payer IDs as Medicare Part B or Railroad transmitter. Payer information is pulled from File Maintenance set up.

Note: An alert will appear on your home page if you have not verified your Medicare B or Railroad payers.

Test Patient Exclusions

The feature allows you to exclude test patients that you have created in your production database. The configured patients will not be counted in the results for reporting.



Submission Overview

NextGen MIPS Submission Checklist

NextGen has submission readiness Deadlines, checklist's & guides available for review as you prepare for attestations/submissions.

2020 Program Deadlines

Below are the deadlines to Request HQM Set-up & Approve Submission Files for CMS 2020 Programs. Follow the below guidelines for requesting HQM set-up and approving your files for submission for your CMS 2020 programs.

Program Name	Approve submission file by...	CMS or State reporting deadline
CPC+ 2020	February 19, 2021	Extended 3/12/2021 by 8pm EST
ACO 2020	No Submission Approval required however request for XML Data Files should be made March 19, 2021	3/31/2021 by 8pm EST
Medicaid PI 2020	No Submission Approval required, however, request for HQM QRDA III Files should be made 5 days in advance of the state deadline	Varies by state
MIPS 2020	March 19, 2021	3/31/2021 by 8pm EST

Overview

Use the following checklist as guidance to help you plan, prepare, and submit quality program data for the Merit- based Incentive Payment System (MIPS) 2020 reporting year.

Items that Impact all MIPS Performance Categories:

- ☐ Determine if your organization will use Group or Individual reporting.
- ☐ Confirm that you have upgraded to 2015 CEHRT (5.9 or higher) to comply with PI reporting requirements for 2020. If you were not on the 2015 CEHRT, confirm that you were upgraded in Production before 10/3/2020.
- ☐ ONC Patch updates applied prior to Promoting Interoperability 90-day period beginning
- ☐ Patient Electronic Access installed prior to Promoting Interoperability 90-day period beginning
- ☐ The CMS reporting deadline for MIPS performance in 2020 is 3/31/2021. NextGen Healthcare urges clients to approve all submission files by 3/19/2021 to meet the CMS deadline.

HQM Set-up

Verify the following in HQM (see the 2020 MIPS Configuration Guide for NextGen HQM for further assistance).

- ☐ Verify in HQM CONFIG – Practices:
  - All reporting practices are selected as active
  - If reporting as Group or ACO confirm Practice TIN(s) are set as the appropriate Group TIN(s)
  - Confirm Patient Access API installed and Promoting Interoperability (PI) report starting date begins after or starts on this date if in 2020.
  - Locations and Places of Service needed for reporting are selected as active
  - All 2020 reporting providers are selected as active under Providers
- ☐ Verify in HQM CONFIG – Provider Email, NPI and TIN
  - Confirm NPIs and TINs are verified in HQM and correct for reporting. If reporting as a Group, verify all providers have the Group TIN
  - All configured providers are MIPS-eligible clinicians, use magnifying glass in HQM to pull up provider in the QPP Participation Status Tool)

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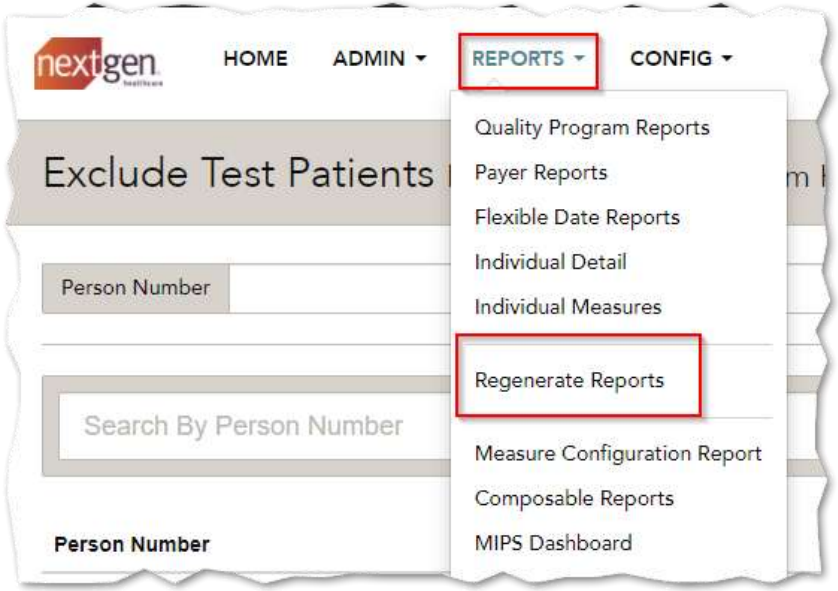
Regenerating Reports

As you are preparing for submission, configuration/modifications may be needed. When one of the following is completed, report regeneration is necessary.

- Measures are Added to a Provider
- Measure Periods are Modified
- Locations are Modified
- Provider Email/NPI/TIN are Modified
- Test Patients are Added/Removed
- List Descriptions are Modified
- Business Schedule is Modified
- Message Categories are Modified



Regenerating Reports

The following listing is what makes a program available for regeneration.

Validation Report

When generating reports, the validation report option will allow you to verify the completeness and accuracy of your reporting data before it is submitted.

Submission Process

MIPS Submission for all 3 Categories is identical using NextGen HQM

1. Complete, Verify & Finalize measure and reporting period configuration for PI, IA, and Quality
2. Regenerate the reports

   Reminder: if any configuration updates, the job run must be completed to pull data
3. Generate program submission file
4. Correct Errors/Warnings
5. Re-generate submission file
6. Approve

Program Submissions

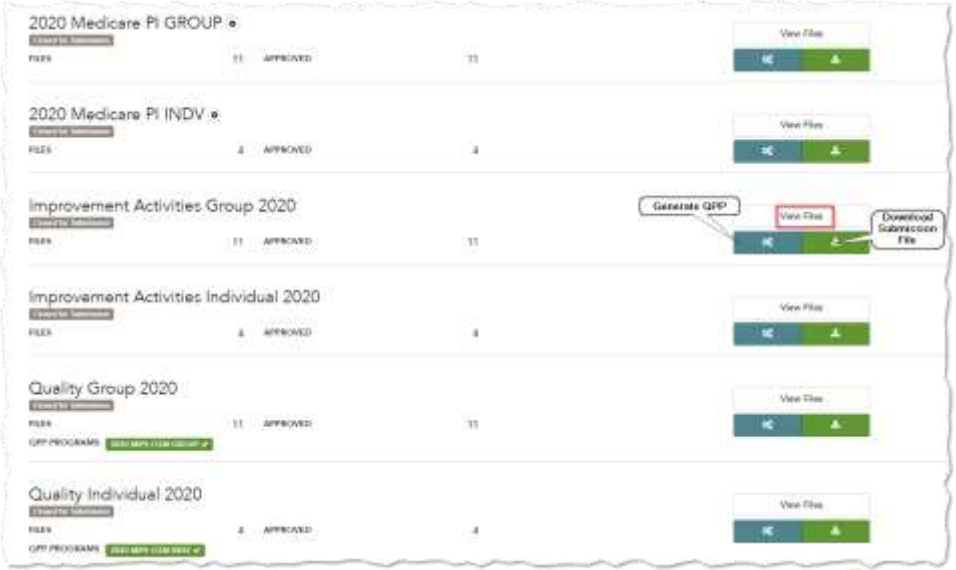
In order to generate files for submission select Admin>Program Submissions.

You will then select Generate Medicare QPP for the program you are reviewing.

Note: if reports are not available for the program then Evaluation Required displays instead

The file(s) generate and become visible after a few minutes and the page is refreshed.

- The # of files generated display
- Warnings and Errors display in color if items are listed
- Warnings and Errors display in white if none
- Total # of Warnings and errors for all files are displayed



Review Files

Review each program category's file by clicking View Files.

- All files for the category display the file name, status, option for viewing and if alerts/warnings exist.
- This is the same for all categories.

On the file view page, the review is completed to confirm that all file contents are correct.

- Above the content/file display, a download/print option is provided
- To the right of the report, any errors and/or warnings are listed
- Error corrections must be made before file can be submitted
- Beneath the errors and warnings list is the option to approve the file

Errors & Warnings

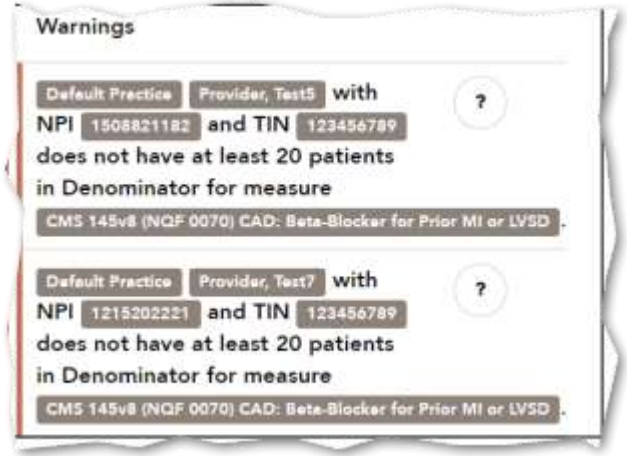
Errors populate due to invalid or missing measure data. (Red L side border)

- Errors will prevent utilization of preview data in the MIPS dashboard and approval of submission file(s)
- To resolve errors, click the wrench icon to view and see instructions for correction
- Once corrected, mark as resolved

Warnings populate due to issues with your data that can cause possible rejections and are displayed beneath any errors. (Orange L side border)

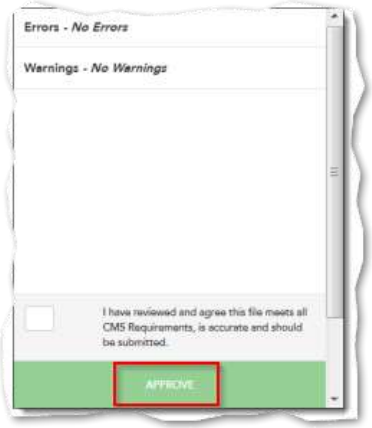
Some common warnings include:

- Provider has less than 100 summary of care: HIE or ePrescribing
- Provider has less then 20 in denominator



Approve/Submit

Once you have confirmed the data in the file and are ready to submit, review the agreement and then select the check box at the bottom of the page.
The *APPROVE* option is available.



Click to submit the file to CMS.

Once selected, the label changes to *APPROVING* while processing is underway.

When processing is completed, a message displays the name of the approver and the date of approval.

The label changes to *APPROVED* followed by a check mark.

MIPS Dashboard

The MIPS Dashboard is a tool that allows you to monitor Provider performance for 3 categories, IA, PI, and Quality.

The Dashboard displays provider performance data for generated submission files prior to and after submission.

The MIPS score for each category is also available to view.

Provider Name	NPI	TIN	Status	IA	PI	Quality		Total	Evaluation Date
Provider, Test1	1730106477	000010777	OK	0.00	0.00	0.00		0.00	2021-02-17
Provider, Test3	1255477790	110111111	OK	3.75	0.00	0.00		3.75	2021-02-17
Provider, Test2	1164788455	111111111	OK	0.00	0.00	0.00		0.00	2021-02-17
Provider, Test3	1255477790	111111111	OK	0.00	0.00	0.00		0.00	2021-02-17
Provider, Test1	1730106477	111111111	OK	0.00	0.00	18.00		18.00	2021-02-17
Z, Provider	1255910327	111333333	OK	3.75	0.00	16.50		3.75	2021-02-17

Next Steps

Unsure/Overwhelmed or Need Help?

eMedApps can help:

- Assess your current readiness
- Provide recommendations
- New process and procedure implementation
- Workflow Adjustments
- Support you throughout the year
- Troubleshoot and Identify Issues

Questions?

Contact Us

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Thank you!