# QPP*Live!*
## Transcript from Live Session

Thursday, September 20, 2018

Shanen Wright: Welcome to the September edition of QPPLive!, a production of Quality Insights. If this is your first time joining us, welcome! This will be a fast-paced session where we answer your questions about CMS' Quality Payment Program. You can start submitting your questions using the Q&A feature in your WebEx player at any time. If you're a returning audience member for QPP Live!, welcome back! We're so glad that you've made us part of your life every third Thursday at 9:30 a.m. Eastern and 8:30 a.m. Central. Before we get to the Q&As, which again you can start submitting at any time, I'm pleased to introduce Andrea Phillips who will be delivering today's breaking news and announcements. Andrea.

Andrea: Thank you, Shanen, and good morning everyone. 2017 performance feedback reports have been updated as of 09/13/18, one week ago, the Centers for Medicare & Medicaid Services (CMS) made the revisions to 2017 Feedback reports. Changes were made due to known issues involving the ACI hardship exemption, the extreme and uncontrollable circumstance hardship exemption, awarding credit for participation in the improvement activity, burden reduction study and the addition of the all-cause readmission measure final MIPS score. You may also see a slight change in your payment adjustment as a result of a reapplication of budget neutrality. Quality Insights strongly encourages everyone to re-check their reports as soon as possible.

Andrea: If you believe an error still exists you should submit a Targeted Request. For more information, please read the CMS 2017 MIPS Feedback statement. A link has been included.

Andrea: The time to review deadline has been also extended. Due to issues already identified through targeted review, CMS has extended the deadline to allow clinicians additional time to review their updated 2017 feedback report. Targeted Review requests will now be accepted through October 15, 2018 at 8:00 p.m. Eastern time. 2017 Feedback Reports will probably be updated again after all the targeted review applications have been reviewed. This is necessary to maintain budget neutrality.

Andrea: The CMS Philadelphia Regional Office will be hosting a webinar about the 2017 MIPS Feedback Report on Thursday, October 4th, 2018 from 11:00 a.m. to 12:00 p.m. Eastern time. A link has been included for the registration as well as a link to a resource that provides information about the targeted review of 2019 MIPS adjustment.

Andrea: The key dates for 2018 are quickly approaching.

Andrea: October 2, 2018, the last day to begin a 90-day reporting period for the Promoting Interoperability and Improvement Activities categories.

Andrea: October 15, 2018 is the last to request a 2017 Targeted Review.

Andrea: December 31, 2018 is the last day to complete a Security Risk Analysis to submit for the Promoting Interoperability category. It is also the last day to submit a nomination for the 2018 Virtual Group Reporting, the last day to submit a QPP Hardship Exemption application for the PI category (Promoting Interoperability), and the last day to submit an Extreme Uncontrollable Circumstances Hardship Exemption Application .

Andrea: MIPS audits are here. CMS is currently contacting clinicians and practices to validate 2017 MIP scores. Everyone should prepare for the 2018 audits by using the newly released MIPS data validation criteria. Quality Insights has created tools to highlight the documentation required for the Improvement Activities and the Promoting Interoperability categories. We've included the links for those two categories.

Andrea: We have also included a list of newly released CMS resources, such as the MIPS Data Validation Criteria, Quality Benchmarks, and Measures and Activities for some specialists.

Andrea: CMS has also selected clinical champions from Delaware and Pennsylvania. CMS created a joint Clinical Champions Program to provide perspective for the value of the QPP, identify successes, challenges, and misconceptions and offer insight to reduce administrative burden. Practice staff from two of the practices working with Quality Insights were selected to join the program. Cheryl Mongillo, MBA, Practice Administrator at Family Medicine at Greenhill, in Wilmington, Delaware, and Peggy Hamilton, MSN, RN, Director, Quality Management at Einstein Physicians Montgomery in Norristown, PA.

Andrea: CMS is also looking for volunteers to serve on the Improvement Activities panel. CMS is seeking feedback from stakeholders, consumers, patients and experts who can contribute direction and thoughtful input on the Improvement Activities. 10 to 12 people are being sought to form a new Technical Expert Panel. The nomination period closes at 5.00 p.m. Pacific Standard Time on September 22, 2018. We provided a link to the nomination form below.

Andrea: Two 2018 MIPS Calculators are available. The Great Plains QIN released another updated version of its 2018 MIPS Calculator for non-advanced APM's and non-CMS Web Interface reporters on 9/11/18. This version includes the updated benchmarks CMS published on 9/11/18.

Andrea: Stratis Health enhanced their 2018 MIPS Estimator by including specialty quality measure sets, an improved score the quality category, the small practice bonus, and a self-rated score for the complex patient bonus.

Andrea: We've also included some examples of how you can your MIPS scores on the next few slides. You can see how different categories and measures relate to each other. For more assistance with improving your MIPS scores, please reach out to us and we will be happy to assist you.

Andrea: As for upcoming events, join us for the 'Why Health and Health Care Disparities Matter', webinar scheduled for Wednesday, September 26 2018, from noon to 12:30 p.m. Racial, ethnic, and socioeconomic disparities in clinical practices demonstrate that health care is not equitable. Disparities affect us all, not just the groups facing them. Quality Insights invites you to join us for this live webinar, featuring our guest speaker Knitasha Washington. Dr. Washington will discuss potential barriers to equality, and how diversity and inclusion within the person & family engagement infrastructure improves the collection of values, beliefs and preferences that shape decision making. A link has been included for the registration here.

Andrea: And that concludes our news and announcements. Now back to you Shanen.

Shanen Wright: Thanks so much, Andrea, and thank you again to everyone for joining us today for QPPLive!, where we've assembled our panel of experts yet again to answer your questions about the CMS Quality Payment Program. These experts include Kathy Wild, who's our project director, and Amy Weiser, our lead project coordinator. Serving the state of Delaware we have Rabecca Dase and Rox Fletcher. For Louisiana, we have Lisa Sherman. And from New Jersey we have Maureen Kelsey, Diana Haniak and Andrea Phillips.

Shanen Wright: Looking ahead to our other states, we also have, give me one moment please. I wonder if you could help me advance this slide real quickly, we'll continue on with the process. There we go, thank you so much for your help. For Pennsylvania we have Rabecca Dase and Joe Pinto, Lisa Sagwitz, Shirley Sullivan and Marvin Nichols, and for West Virginia we have Julie Williams and Debbie Hennen, all with us today to help answer your questions about CMS' Quality Payment Program.

Shanen Wright: You can ask questions at any time using the Q&A feature in your WebEx player. All you have to do, if you're not seeing that you can go up to 'View' at the top, and that will come up for you, and you can submit those questions using the Q&A feature by dragging your mouse to the bottom of the screen and clicking

on the gray icon with the three dots in the middle of it, and then select 'Q&A' from the drop down menu. You can type in your question in the Q&A feature and then hit 'Send' and we will address as many as we can.

Shanen Wright: If you're not seeing the chat feature you can also look, like we have here on the image at the bottom of the screen, to be able to bring that up as well, and you will be able to view Chat, but we ask that you not submit your questions using the chat feature. We'll be sending web links to the resources that we're talking about directly using the chat feature.

Shanen Wright: We'll also have an opportunity to ask question verbally. You can do that if you've called in on the telephone, so periodically we will do unmute the phone lines and allow you to talk with our panelists, ask questions or provide your feedback.

Shanen Wright: Keep in mind that we here at Quality Insights are here to help you any time, not just during QPPLive! on the 3rd Thursday of every month. You may not realize who your contact is at Quality Insights. If so, you can use the general QPP inbox for inquiries, or reach out to any member of our team, and we'll be happy to pass along this information. We'll do the best we can to answer all the questions today, but know that we may need to follow up at a later time. Sometimes your questions require a little more research, and we'll be happy to do that.

Shanen Wright: Please also keep in mind that rules and interpretations change over time, especially if you are viewing QPP live as a recording. Most of all, we here at Quality Insights want to establish a relationship with you and help you succeed in CMS' Quality Payment Program. With that being said, let's jump right into the questions today on QPP live.

Shanen Wright: First question we have. How do we meet the measure for health information exchange?

Joe Pinto: Shanen, this is Joe, I can take that one. So if you're going to be reporting the Promoting Interoperability transition objectives and measures set for 2018, you can meet the Help Information Exchange measure requirements basically by transitioning or referring a patient to another practice setting, or care, or healthcare clinician. And you can do that by either using your certified EHR technology to create a summary of care record, and also to electronically transmit the summary of care to a receiving clinician for at least one transition of care or referral done during the reporting period. If you'd like to know more information about that, you can see the CMS QPP website for their tool. It's under the 'Explore Measures' tool to find the Promoting Interoperability 2018 measures.

Shanen Wright: Thanks so much, Joe. Next we have a question from Fran who says, "For an exception for the PI for hospital-based providers, is POS31 and 32 considered for meeting the 75% billing requirement?"

Julie Williams: This is Julie. We may want to get back with her on that. We want to make sure that we're looking at the correct place of service there.

Lisa Sagwitz: Oh hi, this is Lisa. I just took myself off mute. I might be able to help with that question. 32 is definitely a point of service that would be for hospital based. I believe 31 is as well, and how the person who asks that question would know for sure, if you go to the website qpp.cms.gov, then use the 'Lookup' tool, and put in the providers NPI number, you'll get some detail listed, and there will be a section that says 'Hospital Based Clinician', and it will say 'Yes' or 'No', and that will confirm that there was enough billing, the 75% that that provider would be considered hospital based.

Shanen Wright: Thank you, Lisa. Next question we have coming in, “What is the minimum number of transaction for health information exchange?”

Lisa Sagwitz: Hi, it's Lisa, I can take that question. The minimum number is 1 for your numerator, so the denominator for the period of time, which would need to be 90 days or more, is 100. You must have at least 1 in your numerator. I might also add, while it's not necessary, you might want to print off that transaction, that direct email that's sent, and just keep it with you 2018 MIPS binder documentation as proof that that was sent, as well as the actual EHR report.

Shanen Wright: Thank you, Lisa. If you're not looking at the Chat window, per the earlier instructions you bring it up, because Rabecca has provided direct links to these fact sheets and tools on CMS' website, so you can access those directly.

Shanen Wright: Let's go out and get another question right now, this next one asks, "When do I report to MIPS?"

Julie Williams: Hi, this is Julie, I can take that. Oh, go ahead Joe if you'd like.

Joe Pinto: No Julie, you can take it if you want, go ahead.

Julie Williams: Okay, so the MIPS reporting period is January 1 through December 31st of each year, but you will report your data when the window opens after January 2nd through March 2019.

Shanen Wright: Thank you, Julie. Next question we have, “Do we need to report Nurse Practitioners?”

Joe Pinto: Shanen, I can take this one. Nurse Practitioners are eligible to participate in the MIPS program if they meet the low volume threshold for 2018. If you need more information regarding the participation eligibility, you can check whether your specific Nurse Practitioners are eligible by going to the Look-up Tool on QPP website. I will tell you that as far as the low volume threshold for the 2018 reporting period year would be if they were to see at least 200 Medicare patients during the calendar year, and including $90,000 in billed services for

Medicare. So those are the low volume thresholds for 2018, but I would definitely refer you to the 'Lookup' tool to ensure whether or not that Nurse Practitioner is eligible.

Shanen Wright: Thank you, Joe. Next question comes in from Janet who asks, "Are Nurse Practitioners required to report?"

Lisa Sagwitz: Hi, it's Lisa. Just adding to what Joe had mentioned, if you would be doing group reporting, if there are multiple providers in your practice, you may want to include the Nurse Practitioners data in there, but if you're individually reporting, then you definitely want to look and see if that Nurse Practitioner is eligible or not, meeting the threshold.

Lisa Sagwitz: Most of the time, with the practices that I work with, the Nurse Practitioners do not have to report – they are under that threshold of $90,000 and 200 Medicare Part B patients.

Shanen Wright: Looks like we have another Nurse Practitioner related question coming in. This question asks, "If we have a part time Nurse Practitioner, do we need to report her information as not enough volume for her?"

Lisa Sagwitz: It's Lisa. No, if the part time Nurse Practitioner's under the threshold of $90,000 or the 200 Medicare Part B patients, you would not be required to attest for that Nurse Practitioner, and again you'd be able to confirm that on the 'Lookup' tool on qpp.cms.gov.

Shanen Wright: And another follow-up Nurse Practitioner question. Janet asks, "Even if she is eligible, does she need to report?"

Rabecca Dase: This is Rabecca, I can answer that. So ultimately, if the Nurse Practitioner is eligible to report, they would in fact need to submit data to CMS. It's my interpretation that they do, again if reporting is individual, they could choose to either report the Promoting Interoperability category, or take the automatic category weight to the Quality category. But again, if reporting as a group, you would want to include their data in that, but ultimately, yes they would have to report if they are eligible, but you could, if reporting as an individual, choose to either report the PI category or take a category weight to Quality.

Shanen Wright: Thank you, Rabecca. We also have other web links up in the chat window right now so you can check those out. Coming up we're going to unmute the phone lines so those of you who have dialed in on your telephone will have an opportunity to ask your questions verbally. But next let's get another question in. This one asks, "Will audiologists need to report in 2019?"

Amy Weiser: Hi, this is Amy.

Lisa Sagwitz: Hi, this is Lisa.

Amy Weiser: Sorry.

Lisa Sagwitz: Go ahead Amy.

Amy Weiser: Okay. Hi, this Amy. As far as we know, audiologists are not going to be included, or they're not proposed to be included in the rule for 2019, although we are waiting for the final rule to be announced, which should be around November 1st. They have proposed to consider clinical psychologists, licensed social workers, physical therapists, and occupational therapists, I believe, for 2019. Again, it's all proposed at this point, we don't have the final rule. Thank you for the question.

Shanen Wright: And thank you for the answer, Amy. This time we are going to unmute the phone lines. If you have a question, please jump in and ask it. If you do not, we ask that you mute the phone lines on your end so we don't hear any background noise. All lines are now unmuted so please feel free to jump in with any comments or questions for our experts.

Shanen Wright: Okay, hearing no verbal questions, we will re-mute the lines and go back to the Q&A. The next question asks, “Do we have to report on the entire year or for 90 days?"

Joe Pinto: Hi Shanen, I'll take that one. Basically, there's a two-part answer to that question. For the Quality Performance category, you must report for the entire year, so the reporting period would start on January 1st and run through December 31st for your Quality Performance category. You can report on a minimum of 90 days for both the Improvement Activities and the Promoting Interoperability categories. The Promoting Interoperability, just a reminder, is the new name for the old Advancing Care Information, or ACI, category. The requirement is a full year for the Quality and a minimum of 90 days, consecutive 90 days, for both Improvement Activities and Promoting Interoperability.

Shanen Wright: Thank you, Joe. The next question asks, "If you're using a registry or EHR, do 60% of all patients need to be reported?"

Julie Williams: This is Julie, I can answer that. The data completeness requirement is 60% for the Quality Performance in 2018 across the submission mechanisms that are applicable to small practices. However, small practices can continue to receive 3 points for quality measures for incomplete reporting.

Shanen Wright: Thank you, Julie. The next questions asks, "If we have providers that are exempt from attesting this year, are they still exempt even if we decide to attest as a group instead of individuals?"

Joe Pinto: Shanen, I can take that one. Basically if you were going to report as a group then you must include the information from all of the providers that are in the group

working under that tax identification number under your TIP and that would include those providers that are exempt at the individual level.

Shanen Wright: Thank you, Joe. Next question comes to us from Janet who asks, "What is considered a small practice?"

Julie Williams: This is Julie, I'll be glad to answer that. A small practice is 15 or less providers.

Shanen Wright: Excellent, thank you Julie, and as we noted in our introduction of our experts, we have individual experts who serve the small practices and the large practices here in Quality Insights, so that we can provide the best possible service for you to help you succeed in the QPP program.

Shanen Wright: Next question asks, "Is there a certain number of Medicare that our practice is required to have?"

Amy Weiser: Hi, this is Amy, I'll take that one. For the 2018 QPP program year, CMS requires eligible clinicians to report to MIPS if they have greater than 200 Medicare patients, and greater than $90,000 in Medicare allowed charges, and Part B claims.

Shanen Wright: Thank you, Amy. The next question comes from Janine who asks, "Is there a way to verify what has been received by CMS if we submit Q codes on claims, since we do not have an EMR, to make sure we met our requirements for 2018?"

Julie Williams: This is Julie, I'll take that. Your explanation of benefits that come back on your claims will actually have a code. You can reference the claims, submission fact sheet and it will actually give you the codes. Those codes will tell you that they have been submitted, and those are things that you would want to keep in your audit file.

Shanen Wright: Thank you, Julie. The next question asks, "If CMS says we are not required to report for MIPS or APMs, can we still be penalized?"

Joe Pinto: Shanen, I can take that one. Basically, you're not required to report for MIPS if you are not listed as eligible, so you will not be penalized. The only way that you're going to know for sure, though, is by using the QPP participation status lookup tool on CMS' qpp.gov website. It's in the resource section. You definitely want to go to that to double check to make sure about whether or not you have been deemed eligible for MIPS for 2018. Then you can log in with your EIDM credentials at qpp.cms.gov just to double check and make sure that you are listed or not listed, so you know whether or not you're going to be penalized.

Shanen Wright: Thank you, Joe. The next question comes from Candice who asks, "We are a small practice, how would we contact the two individuals you indicated for the state of Delaware should we need help?"

Julie Williams: This is Julie. You can call the 1877-497-5065 and they'll send that person the message. Or you can literally email us at qpp-surs@qualityinsights.org.

Shanen Wright: Thank you, Julie. The next question we have up here asks, "How do we avoid a penalty if we do not use an EHR?"

Lisa Sagwitz: Hi, it's Lisa. I'll take that question. For practices that do not have an EHR yet, or they're not using it, there are two ways that you can avoid a penalty, and this year you must get at least 15 points, one five, to avoid that penalty. So one would be by going to the Improvement Activities category, and there are about 112 to choose from. Several of those you will probably be able to select an attest that you are doing without an EHR, and that would give 15 points. The other thing that you can do is for your Medicare Part B claims, include a G code on certain Quality Measures. Now, technically that should have been done the full year, so if you don't have an EHR that's something you definitely want to work with your biller, make sure that you have a way for those G codes to be entered, and it says 0 or 1 sent line item, and they would also count towards MIPS.

Shanen Wright: Thank you, Lisa. The next question we have here asks, "What MIPS changes should we expect for year 3?"

Joe Pinto: Shanen, this is Joe, I can take that one. Basically, and I think it was mentioned earlier during the session, the proposed rule is out right now for year 3, which would be the 2019 reporting year, however the rule has not been finalized yet, we don't expect the final rule to be announced until sometime around November 1st. But you can take a look at what the proposed changes for year 3. There is a proposed rule fact sheet that is available through the resource section of the QPP website. I'm not even sure, Rabecca do you have a copy of that, that you could post a link to it? If not, they can get it directly from the resource section, which will give you an idea of what the proposed rule changes will be, but again, none of it is finalized yet. Until the final rule is announced, we won't know for sure exactly which of the proposed rules will be put into effect for year 3.

Lisa Sagwitz: And it's Lisa, just to add to what Joe's said. What we're looking for is probably you to have 2015 CEHRT for your EHR, so if you have not upgraded, or your EHR vendor isn't offering that, you'll want to ask and see when that's available. They'll be some additional things you need to do under Promoting Interoperability. We also know that there are going to be changes to the Quality Measures, so some Quality Measures will be deleted, we don't know which ones yet. Some of them will probably have higher benchmarks, so you'll need to be aware what you do for Quality right, what capabilities your EHR has, and then do some planning for what's going to work for your practice. And I'm sure we're going to have some webinars once that final rule is released, to let you know what's going to be impact you and help you.

Shanen Wright: Thanks Joe and Lisa. Let's get another question in here. Keep in mind we've still got about 12 more minutes to go here at QPPLive!, so if you've got your questions, don't miss out. Make sure and enter them in the Q&A box now.

Shanen Wright: Next questions ask, "What should we do if the staff we are communicating with do not know their HISP address?"

Amy Weiser: Hi, this is Amy, I can take that. The Health Information Service Provider, or HISP, is an entity that facilitates the electronic exchange of health information among individuals or entities. If a HISP address or direct email address is unknown, the EHR vendor that the staff uses may have a provider directory with addresses for providers or facilities using their products. If this is not an option, and if the staff of the receiving site does not know their address, another option may be identify the vendor they are using, and reaching out to that vendor for the direct exchange address.

Shanen Wright: Thank you, Amy. Next question we have asks "what are some suggestions for using patient-generated health data, and communicating with other offices to reconcile the medications, allergies and problems?".

Joe Pinto: Hi Shanen, I can take that one. That's a pretty good question. Incorporating patient-generated health data into an EHR is an option. It's actually an optional Promoting Interoperability that the clinicians can choose to report on in order to improve their performance score for MIPS. According to CMS, the measure supports the objective of increased care coordination through patient engagement, so incorporating the data could potentially lead to better health outcomes for patients, since all the providers with access to the patients EHR could be better informed about the patient's health status, current meds, allergies, etc., so it's kind of complex but that's basically where we stand.

Shanen Wright: Thank you, Joe. We have a question coming in from Fran right now who asks, "Can you please explain again for 2018 Quality, if you do not have six measures with 20 cases, do they still just count as three, or are they excluded, and change the denominator i.e. 50 instead of 60?"

Lisa Sagwitz: Hi, it's Lisa. I'll try to start answering that question and Fran, if I'm not, or there's more detail, please type it in or dial in and we can have a conversation.

Lisa Sagwitz: You do need to have six Quality measures that you're reporting on for the most part. One needs to be either an outcome or a high priority measure. Now with that said, we know that there are certain specialties that cannot meet that, so if you're practice falls within one of those specialties, again we can have a conversation or an email exchange offline. So we're going to say that you're reporting the 6 Quality Measures for a full year. Now, Quality is for a full year of reporting. The denominator needs to have a minimum of 20 cases to match up what your percentage is on the MIPS benchmark. If you don't have 20 cases, what will happen is you will just get three decile points for that particular

measure. So you would want to try to choose Quality Measures that have more than 20 in the denominator. And 50% is what the Quality is, unless it would re-scored.

Lisa Sagwitz: And I-

Shanen Wright: Okay, go ahead Lisa, I didn't know if you saw that.

Lisa Sagwitz: I was going to say. Specialty hospital-based rural MIPS is small.

Lisa Sagwitz: What I would want to do would be to look at some of your providers to see how they are categorized under the qpp.cms.gov lookup site. Fran, if you want to type in what state you're in, and maybe your contact information, it would be a good idea if one of us would contact you, or if you want to call in to 1877-497-5065, let us know what state you're in, and we can have a 1 on 1 conversation to be sure that-

Shanen Wright: All right, I believe we've got the contact information there for follow-up on that. Let's go out and get some other questions that are coming in. Here's another one we have that asks, "Some of the Quality measures like mammograms and colon screenings are yearly. How would it reflect if we want to report for 90 days? It would probably not be part of a certified EHR report?"

Rabecca Dase: This is Rabecca, I can answer that one. So ultimately, Quality for 2018 is 365 days or a full year, so you wouldn't be able to choose to report for 90 days because you would want to report the whole year for the Quality measures.

Shanen Wright: Thank you, Rabecca. Coming up we'll unmute the phone lines one last time just in case maybe a question or comment has arisen in the course of today's QPPLive! that you'd like to share, but next we're going to have another question addressed. This one asks, "What should I do if I can’t communicate through my EHR with other doctors because I have to use fax?"

Lisa Sagwitz: Hi, it's Lisa. Julie, if you wanted to take it, go ahead.

Julie Williams: Okay Lisa, I'll let you get it.

Lisa Sagwitz: Okay. I assume that you're referring to the Health Information Exchange, or HIE measure? If you have more than 100 in your denominator for the 90-day period, or whatever period you're attesting to, you absolutely must have one, so you would need to find someone else with a direct email that you would refer to, and there's no getting out of that unfortunately. I know that can be challenging sometimes, so what you might do, just a suggestion, would be to contact your EHR vendor if you don't know any doctors that you refer with that have a direct email that it would go through to. Ask your vendor, tell them the scenario that you're in, and say who locally to me does have direct emails, and maybe you could back into getting a direct email that way. But again, to answer your

question, if your denominator is 100 or greater, you must have 1 in the numerator.

Shanen Wright: Thank you, Lisa. Laurie let's go ahead and unmute the phone lines one more time just in case anybody has a question or comment that they'd like to share with our panelists. Any questions or comments?

Shanen Wright: Okay, hearing none, we'll re-mute the lines and squeeze in a few more questions. If you've got one we've got a few more minutes left so do submit those in the Q&A box right now.

Shanen Wright: Next question we have asks, "Where can I find information on how to verify my bonus if received an unexpected score?"

Julie Williams: This is Julie, and you should be able to get that data on your feedback report in your EIDM account.

Shanen Wright: Okay, and how does the score correlate with the bonus?

Joe Pinto: Shanen, I can take this one. Basically, clinicians in groups do have the option of receiving the bonus points based on meeting certain performance criteria thresholds in the performance category areas. There is an additional adjustment for exceptional performance for clinicians in groups that receive a final score of 70 points or above. If you need more information on this you can take a look at the CMS 2018 Merit Based Incentive Payment System Bonus Overview Factsheet. I don't if, Rabecca, if you can post that direct link in the chat box and they can take a look at that.

Joe Pinto: One quick note that CMS does provide the ability for a Targeted Review for those who may not agree with their total score or related information, so you're definitely going to want to log into your EIDM account, check the feedback report, especially the most current feedback report because there was the adjustment made recently, and you'll see whether or not your bonus was applied to your overall payment adjustment, which will begin for your practice or clinicians on January 1st of 2019.

Lisa Sagwitz: It's Lisa, I can add to what Joe just said with an example. Those who attained 100 MIPS points in 2017, originally you would have seen your payment adjustment is 2.02%. But with that recent change, it's now at 1.88%, and that's for a perfect 100 MIPS score, and on your feedback report you'll see 2 different parameters. So the actual payment adjustment number for 100 points is 0.29%, and the exceptional performance adjustment is now 1.59% for a total of that 1.88%. And again, depending if your score was less, those numbers will be changing, but on your MIPS feedback report you can see that data.

Shanen Wright: Thank you so much, Lisa and Joe. And with that, we are going to wrap up today's edition of QPPLive!. We'd like to thank you for joining us today. If you need to

get in touch with us, for practices with 15 or fewer eligible providers, you can contact us at qpp-surs@qualityinsights.org, or 1877-4975-065. For practices with 16 or more eligible providers, you can reach out to Kathy Wild, and she will assist with that. We look forward to seeing you again next month. Our next episode will be Thursday October 18th at 9.30 a.m. Eastern, 8.30 a.m. Central.

On behalf of the entire Quality Insights team, I'd like to thank you again for joining us, and hope that you have a great day.

Quality Insights
Quality Payment Program Support Center

This material was prepared by Quality Insights, the Quality Payment Program-Small Underserved and Rural Support (QPP-SURS) Contractor for Delaware, New Jersey, Pennsylvania and West Virginia under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication number QPP-092318