Quality Insights
Quality Payment Program Support Center

QPP*Live!* - Q&A from Live Session

Thursday, June 22, 2017

Q: What is the status of the EHR hardship for 2018? (Betty Malone)
A: We won't know details about the 2018 hardship until the proposed rule that was just released the other day is finalized, which will be in the fall. We will learn details by November 1st, which is the deadline for CMS to publish the Final Rule.

Q: When will CMS be publishing clinician status for patient facing versus non-patient facing, as well as hospital based for 2017 evaluation? (Jan Takewell)
A: We do not know when CMS will release specific information about these MIPS eligible clinicians. As soon as we find out, we will notify everyone via our newsletter. Although the letters mailed to practices did not include eligibility for these clinician types, their eligibility status can be checked on the QPP website using the NPI look-up tool.

Q: Do the quality measures have to be a certain performance percentage in order to be counted as a measure? (Missy)
A: No. Three quality points are awarded for each quality measure even if data completeness criteria are not met. More than three quality points will be awarded based on your actual performance rate if there is a benchmark, at least twenty cases are reported, and at least fifty percent of your patients are reported. This consists of reporting patient data for all payors for EHR, registry, and QCDR reporting and just Medicare patients for claims and CMS web interface reporting.

Q: Can you please repeat the quality values again for data completeness? (Paula)
A: In 2017, participants automatically receive three points for submitting a quality measure. More than three points can be awarded if a benchmark exists; if there is sufficient case volume (≥ twenty cases) and data completeness is met (at least fifty percent of possible data is submitted).

Q: Patients with any insurance can be submitted. Is there a minimum percentage of those that need to be Medicare patients? (Karen)
A: This question refers to the data completeness criteria for quality measure reporting and is applicable if you want to earn more than three points for a quality measure. If you are reporting quality measures via your EHR vendor, registry, or a QCDR, then at least fifty percent of data must be reported for all of your patients from all payors. If you are reporting quality measures via claims or the CMS web interface, then only data from Medicare patients should be reported.

Q: If a practice does not elect to participate in group reporting in MIPS, will all clinicians have to report individually? (Eddie)
A: If a practice wants to submit MIPS data at the individual level instead of group reporting, then only MIPS eligible clinicians, identified in the CMS look-up tool as an eligible clinician, will need to participate in QPP in 2017 to avoid the four percent penalty that will be attached to their NPI in 2019.

Q: We were told that if we report on one measure, one time, for one patient, we can avoid the negative adjustment. Is that true or do we also have to report on six quality measures as well? (Sherry)
A: Yes, that is true. By reporting data for just one quality measure for just one patient, you will avoid the four percent penalty in 2019.

Q: How does a practice report by group? (Janet)
A: First you need to decide if you want to report all three categories, or just one or two of them. CMS is allowing flexibility this transition year, so you can report the quality category, ACI category, improvement activity category or a combination of them. You do not have to register or tell CMS what data submission method you will use UNLESS you are a group with at least twenty-five clinicians and you want to report via the CMS web interface or report CAHPS survey as a quality measure. Once you decide which category/categories you want to report, you need to decide how you want to submit data for that category. You do not have to use the same submission method if reporting more than one category. Submitting ACI measures and Improvement Activities via attestation is free, but they can also be reported via registry, QCDR, or EHR vendor for a fee. Quality measures can be submitted via registry, QCDR, EHR vendor, or the CMS web interface.

For the quality category, you can report up to six quality measures. For the advancing care information category, you add everyone's numerators and denominators together and submit only the total of the numerators and the total of the denominators for each measure. For the improvement activity category, only one clinician needs to complete an improvement activity/activities and everyone else in the group receives credit. That is one of the advantages of group reporting, especially with the improvement activity category, that not everybody has to be involved.

Q: How do you register as reporting individually versus reporting as a group? (Betty)
A: You do not need to register if you're going to submit MIPS data as an individual or as group. The only registration required for MIPS is for groups that have at least 25 clinicians and want to submit data via the CMS web interface or groups of two or more clinicians that want to administer the CAHPS survey. Registration in those instances is required and must be completed by June 30th.

Q: How do you obtain all ten points for each measure you are reporting under quality? What factors contribute towards those ten points?" (Mary Anne)
A: It will be very difficult to earn ten points for all six quality measures. Although you may not necessarily need to have a one hundred percent performance rate for each measure, you would have to be in the tenth decile for all measures. There are four requirements to obtain a score of ten points: 1) the measure must have a benchmark, 2) at least twenty cases must be reported, 3) at least fifty percent of patient data must be submitted, and 4) the performance rate must be in the tenth decile.

Q: I know that we only need to report six quality measures, but will we get any bonus points for reporting more than the six required? (Joan)

A: No, you will not receive bonus points for reporting more than six quality measures. If more than six measures are submitted, CMS will determine which six measures have the highest performance rates and will score those six measures for your MIPS score, but all quality measures submitted will be publicly reported on Physician Compare. Therefore, it is probably advantageous to only submit six quality measures with the highest performance rates.

Q: We should register as a group when we are using the CMS web portal. We are using another registry so I understand we do not need to register as a group with CMS. Is this correct? (Janis)
A: Yes, that is correct. There is no registration required if you are going to use a registry to submit data to CMS. The only registration required, with a deadline of June 30th, is if you want to use the CMS web interface or administer the CAHPS survey.

Q: How will we attest for IA and ACI? (Janet)
A: There are several submission methods for both of these categories which are noted below:

Category	Individual Reporting	Group Reporting
Advancing Care Information	Qualified Registry/Qualified Clinical Data Registry	Qualified Registry/Qualified Clinical Data Registry
	EHR Vendor	EHR Vendor
	Attestation	Attestation
		CMS Web Interface (groups with at least 25 ECs)
Improvement Activities	Qualified Registry/Qualified Clinical Data Registry	Qualified Registry/Qualified Clinical Data Registry
	EHR Vendor	EHR Vendor
	Attestation	Attestation

The only method in which the clinician or practice will not incur a charge is to submit data via attestation. It will be very similar to Meaningful Use attestation that was done for the EHR Incentive program. CMS plans to post a link to the attestation platform on the QPP website. It probably will not be available until January 1, 2018, which is when 2017 MIPS data can begin to be submitted. Numerators and denominators, and possibly measure rates, obtained from EHR vendor reports will be manually entered into the attestation page for the ACI category. For the Improvement Activity category, you will probably only need to check a box next to the improvement activity/activities that you successfully completed for a minimum of ninety days (six months for the Prescription Drug Monitoring Program). At this time, it does not appear that documentation supporting the completion of an activity will need to be uploaded during attestation. Quality Insights will notify everyone when information about the attestation process becomes available.

Q: When is the CMS portal opening up to report our MIPS components not currently enrolled in a registry? (Mary Anne)
The CMS portal to 'attest' will probably not open until January 1, 2018. At this time it does not appear that CMS will accept 2017 data until the year is over.

Q: We don't participate in Meaningful Use or PQRS at this time and are unfamiliar with how to even gather info and report on claims. How can I find very specific information on this process? (Sherry)
A: Please contact Quality Insights so we can provide free assistance and education to help you be successful in the QPP. We have a lot of useful tools and resources on our website and can show you where CMS has posted important resources and webinar recordings on the QPP website. Register here.

Q: Although we have reported individually in the past, is it possible to submit as a group going forward? If reporting to a registry, we do not have the June 30th deadline to meet, correct? (Laurie)
A: You are absolutely correct. You can submit MIPS data this year either individually or as a group - it doesn't matter how you submitted data in previous years for MU or PQRS. You do not have to register unless you want to use the CMS web interface or administer the CAHPS survey and if you do, there is a registration deadline of June 30, 2017. Otherwise, you do not need to notify CMS of the method in which you would like to report any of your categories. Each category can be submitted using a different method if desired.

Q: Is there a minimum number of patients required for each measure? We are a very small practice with only two providers. (Karen Jetter)
A: For the quality category, each measure must have a minimum of twenty cases, at least fifty percent of data submitted, and a benchmark available in order to obtain more than three points. If one of these criteria is not met, then only three points will be awarded. Therefore, there is still the potential to earn 6X3=18 points for the quality category if data completeness criteria is not met. Submitting quality measures via EHR or a registry using end-to-end electronic reporting will add an additional six points for a total of 24 points.

Q: Does it matter how many quality measures or improvement activities you report comparing individual or group reporting? (Maria)
A: The only difference would be if you report as a group and your practice has 16 or more clinicians and more than 200 cases. In that circumstance, CMS will calculate a performance rate for a readmission measure for the quality category. Otherwise, the number of measures or activities reported would be the same. The more data reported, the greater the opportunity to have a higher MIPS score and a larger positive payment adjustment.

Q: How many quality measures need to be reported, and when should improvement activities be started? (Maria)
A: In 2017, CMS is allowing clinicians and groups to decide how many quality measures they want to report because this is the initial year of the QPP. The maximum number of quality measures that can be reported to be scored is six. Improvement activities must be completed for a minimum of ninety days, except one activity involving the Prescription Drug Monitoring Program (PDMP) must be completed for a minimum of six months. The last day to begin an improvement activity (except the PDMP) is October 2nd. Therefore, you can select any date between now and October 2 to begin an activity.

Q: If a physician is part of an MSSP ACO, but is also in a CPC+ practice, does he have to report through MIPS as well as CPC+ or will CPC+ satisfy reporting requirements? (Allen)
A: It appears that this physician is affiliated with two different TINS, one being the MSSP ACO and the other the CPC+ practice. Since both of these practices must report as a group, the physician's data will be included by both of the practices' data. The CPC+ practice is an Advanced APM and CMS will determine if the physician is a qualifying participant. The MSSP ACO practice will be scored as an APM.

Q: Are there any plans to identify practices or providers that qualify as rural? Many of our practices have multiple locations and providers in multiple locations. I have been previously advised to follow the tax identification number, follow the providers address and use PECOS. I'm still not sure how to identify rural. (Paula)
A: Quality Insights has a user-friendly tool posted on the Quality Insights QIN website that identifies cities in our five state network of DE, LA, NJ, PA, and WV that have a rural zip code. If your practice has

one office and is located in a city that is designated as rural on this list, than you are considered a rural practice and the Improvement Activity weights are worth double the number of points. If your practice has multiple offices, ALL of the offices must be located in a city with a rural zip code in order to be considered 'rural'. The number of clinicians in the practice does not matter, only the location of the practice(s). Improvement Activities Assessment Tool

Q: Regarding the MIPS calculator on the exit report, I received a red statement stating all providers were doing well in this area. How does that affect us? (Bobby)
A: The MIPS Calculator was created by the Great Plains QIN and Quality Insights has adapted it for use by practices in the states we are serving. This disclaimer is being made because the algorithms built into this tool are based on the final rule, but may not be as accurate as CMS calculations. The calculator is meant to guide you in measure selection and track your performance rates throughout the year, and Quality Insights can help you improve them. If the exit report states that you're doing well, you probably have achieved the maximum number of points for that category. Most practices have the possibility of earning sixty points in the quality category, twenty-five points in the advancing care information category, and fifteen points in the improvement activity category.

Q: Will the MIPS Calculator be able to record continuously throughout the year? (Catherine)
A: You can use the MIPS Calculator to monitor measure rates and obtain an estimate of your MIPS score at only one point of time. If you want to check MIPS scores on a monthly basis, you will need to delete the previous month's data and enter new numerators and denominators.

Q: Can you please clarify what is needed in order to meet the public health or clinical data registry reporting measures? (Donna)
A: The public health and clinical data registry reporting measures are not required measures under MIPS. Reporting to a public health registry or clinical data registry awards eligible clinicians a total of five bonus points in the advancing care information category. Reporting to your state immunization registry is one of the performance measures. There are 55 extra points available in the ACI category so clinicians and groups have a great opportunity to earn full credit for the ACI category. If you do not want to pay to report to a specialized registry or you cannot report to your state cancer registry or syndromic surveillance for free, than you should consider completing an improvement activity that requires CEHRT because this will award ten bonus points to your ACI score instead of the five bonus points for specialized registry repoting.

Q: For 2017 reporting, can we opt to do the test track first? Then, if we are comfortable with the test, can we then move onto the ninety day track, or must we choose only one for this year?" (Deanna)
Data cannot be submitted until January 1, 2018, so you have plenty of time to decide what data you want to report. The deadline to submit 2017 MIPS measures is March 31, 2018. It is recommended that you try to submit more than one measure so you have the opportunity to earn a positive payment adjustment instead of avoiding the penalty. The first thing you should do is run a report from your EHR of the Advancing Care Information measures (all were reported last year for 2016 Meaningful Use) and all of the clinical quality measures. Then you will have a baseline to see what your performance rates are and you can enter those rates into the MIPS calculator to obtain an approximate score. You will probably be surprised to see that you will have more than 3 points so it would make sense to report for 90 days. You don't have to decide which 90 days you want to report until next year when you are ready to submit data. That means you will have time to look at different 90 day timeframes and select the one with the highest performance rates. If you have an EHR, and can meet the baseline measures, it is

recommended that you select at least one Improvement Activity that requires CEHRT so you can earn 10 bonus points for the ACI category.

Q: Can only groups report using the CMS interface? If we are reporting as an individual can we still use the CMS interface? If as an individual we do wish to use the CMS interface, must we still register by June 30th? (Deanna)
Yes, the CMS web interface is only for groups of 25 clinicians or more and it commits the group to reporting fifteen specific quality measures instead of six. Registration is required if the CMS Web Interface will be used for quality reporting or a group of two or more clinicians wants to administer the CAHPS survey.

Q: I just want to clarify that registration as a group is only for groups that have at least 25 providers. Correct? (Pamela)
A: Correct. You must have a minimum of twenty-five providers to use the CMS web interface, but the registration is only required if you want to report using that submission method. If you're going to report MIPS data using a different submission method (even if your group has more than 25 clinicians) using a registry, EHR, or QCDR, you don't have to do register.

Q: I had asked the question about one the CMS web interface, and I do understand that only groups will be registering for that. Then I think I heard somebody said something about a CAHPS survey. Can you please elaborate on that? (Deanna)
A: If you are a group with two or more clinicians and you want to administer the CAHPS survey as one of your quality measures, then you also must register by June 30. Doing so will obligate your practice to report all MIPS categories as a group.

Q: To clarify, the CAHPS is not for groups of twenty-five or more, but those with less than twenty-five but more than two? (Deanna)
A: The CAHPS survey can be administered by any group with two or more clinicians. There is a fee involved because you have to use a CMS approved CAHPS survey vendor to administer the survey to your patients.

Q: Is it correct that you can report MIPS for any ninety days, rather than a three month quarter? For example, March, April and May instead of January, February March? (Darla)
A: Yes, MIPS data can be reported for any consecutive ninety days. The reporting period can start on any day of the month, such as July 6 or July 18 and can end on day ninety or you can extend it to however many days you want. The time to select the actual reporting period dates is after January 1, 2018 when you can analyze your data to determine what time period you have the highest score.

Q: One of the panelists just said she is working directly with practices. We qualify and are registered as a small practice. Can someone on this panel help us directly? (Janet)
A: Yes, absolutely. Quality Insights is available to provide one-to-one virtual assistance with everyone that wants assistance. All you need to do is login to the website, answer a few questions so we learn about you, and then staff working with practices in that state will contact you. **Register here**

Q: CMS has changed the eligibility threshold for 2018. As a single provider practice, we do not meet the new parameters. Are we still going to be required to report in 2017 or could this be changing as well? (Sherry)

A: The proposed rule that was just released on June 20, 2017 reflects 2018 requirements. Therefore, the low volume threshold for 2017 eligibility will be the same. Clinicians that charge Medicare Part B $30,000 or more and see more than one hundred Medicare patients annually must participate in 2017 to avoid the 4 percent penalty in 2019.

Q: Can we use the MIPS Calculator to track our progress so that we can see how the doctors are doing and if they are progressing, or is it strictly just a one-time use calculator? (Catherine)
A: The MIPS Calculator estimates a score based on data entered. You will need to save a copy of the file for each snapshot period that you are monitoring. It sounds like there is a need to have a spreadsheet that allows MIPS scores to be entered for multiple providers for multiple monitoring periods so practice managers can track progression of improvement. That is an excellent idea and Quality Insights will create a tool that will do this. We will distribute it via a newsletter and post it on our website when it is ready. Quality Insights does have a MIPS tracking sheet for non-APM practices - MIPS Worksheet.

Q: Do I need to start a new spreadsheet every time I want to check the status? (Catherine)
A: If you want to check MIPS scores on a routine basis, which is highly recommended, then you will need to delete the previous month's numerators and denominators to enter the new rates. You can save a copy of the calculator with the quality measures you have selected and then use that version instead of a blank one to save time. You can then save a copy for every month as long as you change the name of the file each time, i.e. June 2017 MIPS, July 2017 MIPS, etc.

Q: I heard mention of the spreadsheet, that you guys already have something in place. Like a template or something? Can we have access to that? (Deanna)
A: Quality Insights developed a MIPS Worksheet to manually record scores for each category, but as requested today, we will create a spreadsheet to track scores on a routine basis.

Q: As an anesthesiologist group, it is hard for us to participate. We are reporting our measures via claims, due to we do not use an EHR because we are hospital based. Will reporting via claims avoid the negative payment? (Tammy)
A: Yes, you are allowed to submit quality measures via claims if you report at the individual clinician level. You will avoid the 4 percent penalty by reporting even one quality measure in 2017.

Q: There are four subset measures under radiation oncology. Do we need to report on those four measures and two others? Can we report on two radiation oncology ones and choose four other measures that are EHR system reports? (Kavita)
A: It is perfectly acceptable to report the 4 measures that are in the radiation oncology measure set because that is all that are available in that measure set. However, if you want to earn more points in the quality category, it is suggested that you report two additional measures.

Q: Only one measure is claim based, which is the sterile technique. How would you pass for anesthesia if you have patient services that fall into other anesthesia measures? (Marcy)
A: Quality Insights needs to obtain more information from Marcy to answer this question.

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-062917