2018 Quality Payment Program Reporting Requirements
Transcript from Live Session

Wednesday, March 21, 2018

Laurie Fink: Good afternoon and welcome to today's webinar, 2018 Quality Payment Program Reporting Requirements. My name is Laurie Fink, and I'm a communications specialist with Quality Insights. I'll be serving as a host for today's session. We will get started with today's program in just a few moments, but first I'd like to review a few housekeeping items. All participants enter today's webinar in a listen only mode. Should you have a question during the presentation, we ask that you please type it in to either the chat or the Q&A box to the right of your screen. We will answer as many questions as we can during the program and then at the end, as well.

Today's webinar is being recorded. The recording will be posted on the Quality Insights website, as well as the Quality Insights QPP support center website later today, and that will be served as an archived event. You should have received a copy of the slide deck for today's webinar earlier this morning via email, but if for some reason you did not, I will send all of you a link to where these resources are posted as soon as they are available.

It is now my pleasure to introduce you to today's speakers, Joe Pinto and Rabecca Dase. Both Joe and Rabecca are practice transformation specialists with Quality Insights, and are helping providers within our network to achieve success within a new quality payment program. Without further ado, I will now hand over the presentation to Joe.

Joe Pinto: Thank you, Laurie. Thank you everyone for taking the time out of your busy day to attend today's presentation. I hope you're hunkered down, and safe from the ravages of winter storm Toby as it continues to make its way up the east coast, some are being affected more than others by the storm. Today, we're going to be reviewing the quality payment program reporting requirements for the 2018 calendar year, which is also known as the 2018 performance year of the Merit-based Incentive Payment System known as MIPS. On the agenda today, we're going to be going over the eligibility criteria, as to who is included, or excluded from the program.

Also, we will be reviewing the performance period for 2018, the reporting and data submission options available to you, the four performance categories (we'll be reviewing each one of them separately), and also the scoring methodology for 2018, as well as the APM scoring standard. For those of you who don't know, APM is the alternative payment models option that is available. Then we will be listening to some of the resources available to you as well as take some time out for any questions and answers at the end of the presentation that you may have to present to us.

Next slide, please. The year two is 2018 and the eligible clinicians requirements. There is no change in the types of clinicians eligible to participate in 2018. The eligible clinicians will include for this year, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists. Now, the definition of physician in the Medicare program includes the following: doctors of medicine, doctors of osteopathy, doctors of dental surgery, doctors of dental medicine, doctors of podiatric medicine, doctors of optometry, and also chiropractors.

There is a low volume threshold, once again, for 2018, and it has increased over the 2017 transition year volume, so more clinicians will be excluded from the program. The excluded clinicians will include clinicians or groups who bill Medicare Part B less than or equal to $90,000.00, and also clinicians or groups who see 200 or fewer Medicare patients. Those included would be clinicians or groups who bill Medicare Part B more than $90,000.00 a year, and also see more than 200 Medicare patients. There also is the voluntary reporting option that still remains in effect for 2018 for those clinicians who are exempt from MIPS, but still want to report.

For the 2018 performance period the four performance categories are still in play, but they have changed a little bit. First off, we have the quality category, and for 2018 that is a 12 month calendar year for the reporting, the 90 day minimum is no longer acceptable, so for 2018 you must report on a full year of data for the quality category. The advancing care information category also known as ACI is still a minimum of 90 days for those who want to take that option. Also, 90 day minimum is still available on the improvement activity category. The cost category is the big change, because this year you will be scored on that. It is a 12 month calendar year, and it is as I said the new category scored for 2018. We'll be talking about that later.

The data submission options have not changed for 2018, so for 2017 if those options that were into play are still going to be available to you as well for this reporting year. The reporting options include, the registry reporting options, also QCDR option, which is the qualified clinical data registry. Also, you have the claim's submission option for individual attesters only. If you are a group, you cannot submit via the claim's submission method, only individuals can. There's also the attestation option still available. EHR vendor reporting is still available, as is for groups of 25 or more. The CMS web interface, and along with that for groups there is also still the CAHPS survey for MIPS that is still available in 2018.

The new reporting option for 2018, include in addition to individual reporting and group reporting, the solo practitioners and small practices with 10 or fewer eligible clinicians, they have an opportunity to report as a virtual group. Now, what is a virtual group? That is a group that is made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together virtually, no matter what specialty or location to participate in MIPS for a performance period for a year. If you need more information on what the virtual group is back in November of 2017 Quality Insights did provide a webinar presentation on virtual group reporting for MIPS, and the slide deck is still available on our website in the resource section, if you are interested in the virtual group option, and you want to learn more about that.

Now, one thing I need to remind you on the virtual group requirements, you must notify CMS the year prior to the performance year that you want to report as a virtual group. The election period for the 2018 reporting year has already expired, that was October 1st to December 31st, but if you plan on doing it in future years for 2019, or subsequent years beyond that, you can look at the information, and decide if you want to create a virtual group, and you have plenty of time this year in which to do so for the 2019 reporting year. What you will need to do is first create a written formal agreement between each of the virtual group members before election, and also name an official representative to email the group's election to CMS via the email address that you see listed in the slide deck. The election must also include information about each TIN and NPI, and also include the contact information, and acknowledge that a written formal agreement has been established between each member of the virtual group.

The performance threshold has increased for 2018, over the 2017 volume of three points. It is now at 15 points. Examples of how you can meet that 15 point threshold in 2018 are as follows, you can report improvement activities to earn 40 points, or you can report the advancing care information base measures plus submit one quality measure that meets data completeness, or you can report the advancing care information base measures plus submit one medium weight improvement activity, or report six quality measures that meet data completeness criteria for large practices of greater than 15 clinicians, or finally you can report six quality measures that do not meet data completeness criteria for small practices with 15 or fewer clinicians. There is an exceptional performance bonus threshold and that will stay at the 70 points that it was for 2017. That just carries over for 2018 at the same threshold.

Payment adjustments for 2018 range from negative five percent this year to a positive five percent, multiplied by a scaling factor not to exceed three. The scaling factor is determined in a way to preserve budget neutrality. Additional payment adjustments for 2018 are available for exceptional performance with a MIPS score of 70 or higher. The exceptional performance adjustment starts at 0.5 percent and can go up to 10 percent, multiplied by a scaling factor not to exceed one. The exceptional performance pool, as I mentioned earlier about the budget neutrality is worth $500 million dollars.

The next one you'll see is a graph showing basically the MIPS adjustment schedule, the maximum adjustment to clinicians Medicare Part B payment, starting at the neutral range, and over the next three to four years you'll see the incremental increases, and also penalties that would be incurred if you fail to report on MIPS right up and onward past 2022. There are two changes for 2018 for the MIPS performance categories in weight. The first change is of course to the quality category in 2017, the quality category was worth 60 percent of your overall score, for 2018 that has been decreased, reduced down to 50 percent, because the 10 percent that you lose on quality is being moved over to the cost category. In 2018, you will now be scored on the cost category, where in 2017 that core category held no weight.

The quality category scoring is as follows, there is a three point floor for measures scored against a benchmark. Three points for measures that do not have a benchmark or do not meet case minimum requirements. Also, bonus for additional high priority measures up to 10 percent of the denominator for performance category, and you also can still get the bonus for end-to-end electronic reporting using your certified EHR technology of up to 10 percent of the denominator for the performance category.

Changes to data completeness in 2018 include the following - there is a 60 percent for submission mechanisms, except for CMS web interface, that increased from the 50 percent from 2017. There are also the quality measures that do not meet data completeness criteria that will earn one point, except small practices, which will continue to earn three points as the minimum score, and additional bonus points are available for improvement that you would demonstrate over the data that you submitted for the 2017 reporting period.

Also, for the quality category there are the topped out measures. A topped out measure, for those of you who don't know, is a measure in which the overall performance is so high, near 100 percent, that CMS has determined that the measure is no longer meaningful to collect and report on, so topped out measures will be removed, and scored on a four year timeline for phasing out. There are six topped out measures that have been identified for the 2018 performance period, and for eligible clinicians they will no longer receive a maximum of seven points, or they will, that is receive a maximum of seven points, rather than 10 points for each of those topped out measures. The topped out policies do not apply, however, to the CMS web interface measures, they will be monitored for differences with other submission options. As I mentioned, these are the six topped out measures for 2018. You can refer to those through the presentation later.

Advancing care information scoring, also with that performance category no changes to the base scoring requirements for 2017, there are however two exclusions that are available in 2018 as were written into the final rule that was released back in November of 2017. Those exclusions are as follows, there's an exclusion that's available for the e-prescribing measure for those clinicians who write fewer than 100 prescriptions during the reporting period, and also an

exclusion is available for the Health Information Exchange measure, the HIE measure, for those clinicians who refer or transition fewer than 100 times during the reporting period. Now, for the performance score, MIPS eligible clinicians, and groups will earn 10 percent for reporting to any single public health agency or clinical data registry.

The ACI bonus score. There's a 5 percent bonus score available for reporting to an additional public health agency or registry not reported under the performance score. Certain Improvement Activities are still eligible, however, for the 10 percent Advancing Care Information, ACI, bonus if your certified EHR technology is used to complete the activity, and the total bonus score available is 25 percent. In 2018, MIPS eligible clinicians can use either their 2014, or 2015 addition of certified EHR technology, or a combination of both. But, in order to receive a 10 percent bonus you must use the 2015 edition only. If you are still using the 2014 certified edition, you would not be eligible for that 10 percent bonus for the 2018 performance year. Only those providers that do report using 2015 certified EHR technology would be eligible for that bonus.

As far as the ACI automatic reweighting, CMS will automatically reweight the ACI category to zero and then reallocate the category weight of 25 percent to the quality performance category for the following list of clinicians, that would include hospital based clinicians, non-patient facing clinicians, Ambulatory Surgical Center based clinicians, and also nurse practitioners, physician assistants, clinical nurse specialists, and certified registered nurse anesthetists.

The ACI application for reweighting. If a hardship application is approved, if you need to submit that, the deadline for submission for the hardship is December 31st of the performance year. Now, there are two new hardship exceptions that you need to be aware of. Number one, for small practice exception, and that would be for 15 or fewer clinicians in a group. Also, for those with decertified EHR technology, the decertification exception is for those that have any EHR system that has been decertified at any point during the performance period, so keep that in mind. Also, CMS will not apply a five year limit to significant hardship exceptions. With that, to continue on with the improvement activities, I'm going to turn things over to my colleague, Rabecca Dase. Rabecca?

Rabecca Dase: Hi, good afternoon. Thanks, Joe. For the improvement activity category, in 2018, there's no change to the percent, it's 15 percent of your total MIPS score, and as Joe mentioned the performance category is a minimum of 90 days for the activity to earn any points. Now, you are absolutely more than welcome to report more than 90 days, but again 90 days is a minimum performance period for your activities. In order to earn full improvement activity category points, you must earn 40 activity points within the category. I'll talk about the activity weighting in a few slides.

As Joe mentioned, as well, the submission methods do remain the same for 2017, you will continue to attest yes for your activities, you can do that via the QPP portal, which I did include a hyperlink here, and I'm sure many of you are

familiar with that as we get ready to close out the first year of reporting. You can use your EHR vendor, your QCDR, a qualified registry, or for groups of 25 or more you have your CMS interface, if you do register for that. As a side note, I will note, the registration for that, I do believe, opens April 1st, so if that's something that you're interested in keep your eyes open for that.

In 2018, CMS actually came out with additional improvement activities, so in 2018 rather than the 92, we actually have a 112 to work with. There was some changes made to the activities in 2018, or from 2017, but again, there's more activities, and some changes made, so I've included the hyperlink, here, for the 2018 activities, and you can go out there and review them and see if anything works for you guys this year. Maybe you didn't like last year, or anything like that. As Joe mentioned in the ACI category, there are some activities that are available for additional bonus points in the ACI category.

In 2017, I believe there were 18 or 19 activities, and now this year they actually came out with 28 activities that do qualify for the bonus. I did include, here, the ACI fact sheet, and you can go out and look there, and they have all the activities listed. Again, you have to do the improvement activity any way, so go out see what's there, maybe you can kill two birds with one stone. Also, in 2017 you had your activities, you can still use those in 2018, if you choose to, or you can use new ones, it's up to you.

What I will recommend though is capturing the new supporting documentation to show what you're doing within your practice in the event of a CMS audit. A lot of time what we hear working with practices is "Our EHR is reporting for us, we don't need that," or "We're using a registry." I still always encourage my practices to capture this documentation, and put it in their own binder, six years is a long time, so if they came out and said, "What were you doing," I'd like to be able to flip to something, and be able to say this is what we were doing for our improvement activities, and then you would have the documentation to back up what you were saying.

For the False Claims Act, they recommend you keep your documentation for 10 years, and as I mentioned CMS can come back and audit you on the missed information for just over six years, so again, keep those binders, put something on them that says, you know, retain until 2028, for the 2018 performance year, but documentation is very important, and CMS has not released the new supporting documentation file, yet, unlike they did for 2017, but I have heard it is in development.

As I mentioned, initially you do need 40 activity points in order to earn all the credit for the improvement activity category. Here you can see in 2018 the activity weight do remain the same. You have your high weighted activities at 20 points, and your medium weighted activities are at 10 points. You want to make sure that you're doing a combination in order to earn the 40 points, so maybe two high, one high, two medium, however you can get those 40 points.

There are some special considerations for small practices, rural practices, and practices located in the HIPSA areas and non-patient facing clinicians. This is a burden reduction aimed that CMS came out with just like they did for 2017. They are giving practices that fall into that umbrella double points for their activities, so they do not have to report on any more than two activities. Your high weighted activities here are 40 points, and your medium weighted activities are at 20.

Next slide, please. Some things to consider when you are deciding what activities you're going to do, or how you're going to report. If a group is reporting, and only one MIPS eligible clinician must perform the activity for the TIN to receive credit. If you have a group of say 50 providers, and they are not buying in, they're not interested in what you're doing, but you do have that one chaNPIon clinician that's willing to go above and beyond, and will do the activity, if he or she does the activity, the whole group will get credit, so that could be a way if you're still struggling to adapt to MIPS, and things like that, that you could avoid the penalties, and such.

As those virtual groups that Joe mentioned, as well, this applies to them, as well. In 2018, CMS did come out, and they said that recognized is now equivalent to certified for patients that are in medical homes, which can benefit some, if 50 percent of practice sites within the TIN are recognized as patients that are in medical home, they are eligible to receive full credit in the improvement activity category. Now, CMS does define practice sites as the addresses that are available in [inaudible 00:22:58], so that's something to keep in mind. If you do happen to take full credit for this, you would have to go and attest that you were in fact part of a patient centered medical home.

As for MIPS APM's, MIPS APM's receive at least 20 points in the improvement activity category, and depending on what type of APM model you're in, you are eligible to receive full credit. Now, same thing goes for patients that are in a medical home as it does for MIPS APM's, if you do receive full credit underneath the MIPS APM, or patients that are in medical home, you're not eligible for that, or you're not earning that ACI bonus, so what you can do is you can still choose to go preform a different activity, go to that list on the ACI fact sheet, choose one of those 28 activities, and you can still preform that activity in order to earn the ACI bonus, which in the long run may benefit you. Now, it's not going to give you any additional bonus points in the improvement activity category, but the bonus again in the ACI category could absolutely positively affect your score.

The cost category, something we've all been hearing about, and something that's probably new to a lot of us, it was around in 2017, but it was worth 0 percent, but now in 2018 it is now worth 10 percent of your total MIPS score. Something I will note, initially it was said that the cost category had to be worth 30 percent by 2019, but the bipartisan act that was passed in early February has slowed the growth of the category and the transition of MIPS, so cost does not have to reach that 30 percent threshold until 2022, so it will give us some time

to adapt, to learn the category, understand the attribution, and determine what we can do in our practices to help us be successful in this cost category.

As Joe mentioned earlier, the performance period is in fact a full calendar year. There's nothing additional that you guys will need to do, it's all based on claims. CMS will take these administrative claims and they will determine what your performance score is. Now, something I think is interesting for the cost category, is that performances compared against other MIPS eligible clinicians and groups during the same performance period, they're not compared to benchmarks like we are for the quality category, and things like that. Your performance in 2018 will be directly compared against clinicians and groups within the same performance year, so it's not historical data that they're basing your performance scores on, which I think is good.

What can you do to prepare for the cost category? I will mention that my colleagues from Quality Insights will be hosting a cost webinar in April, I do believe on the cost category alone, so they'll be able to dig deeper into the category, give you more information, more detail of what you can do to prepare, and stuff like that, so keep your eyes out for an invitation coming out on that cost webinar that will be, I think, in April.

To prepare, you can go and review your 2016 QRUR reports, and those are available on the CMS portal, which is portal.cms.gov. You will log in using your EIDM credentials, the same credentials you log in to the QPP portal with, and you can see those reports, and see what your historical cost was, or your cost performances. Yes, they are historical, but you can still use those to identify things that maybe your practice did well at, maybe where you could improve, and start to identify trends within your practice. What change? What are you doing? And things like that.

Also, the 2017 MIPS feedback reports will be out in the late summer of 2018. What you can do then, is you can understand where you were last year, but you can then take the 2016 reports, and compare them to 2017 feedback reports. What changed? What were you guys doing different in your practice? That's something that could help be tools to help identify where you are and where you need to go. Something that I heard on a webinar that I was listening to and I thought was interesting, and they had said, know your patients.

Where are they going? What are they doing, and what do they need? Are they in the hospital all the time? Are they frequent ER visitors? Where are they going for services? Just something to keep in mind, know your patient, and what you're doing within the practice to assist them in the things that they need. I did include, here, the cost fact sheets, so you guys can go up there, and look at that. It is very detailed, like I said, this category is very complex, but it does start giving you an idea of what you guys will be looking at as we, again, transition in the later years with MIPS.

For 2018, they will be evaluating you on two cost measures. They are the total per capita cost, and the medical spending per beneficiary. The total per capital cost takes into account risk adjusted per capital Part A and B costs. The attribution is based on primary care service volume. Simply put, so whoever has the greatest amount of primary care service charges, that's what the patient is going to be attributed to.

Again, like I said it does get very complex, and there are different steps that you have to take for attribution, but in a nut shell, that's how patients are going to be attributed. This measure specifically requires a 20 case minimum to be scored. If you do not meet that 20 case minimum, CMS will not evaluate you on this measure. The second measure, again, is the MSPB measure of Medicare Spending Per Beneficiary. This in fact is risk adjusted Part A and B costs per inpatient admission, and the attribution is based on service volume during a hospitalization. CMS actually identifies its episode window as three days prior to admission, while the patient is in the hospital and 30 days post discharge, so that is a very large window, but they will be evaluating all those costs.

Again, three days prior to admission, while the patient is an inpatient, and 30 days post discharge. A lot of times you hear, "Well, we don't admit patients," and things like that, but keep in mind this is not necessarily attributed to the provider who admits the patient to the hospital. This measure specifically does require a 35 case minimum to be scored. Again, if you guys do not have a 35 case minimum, CMS will not look at this measure for your practice. I did include the cost measures, here, so you can go out, and they're broken down into the TPCC, or MSPB, and it does get very detailed into the cost measures, and again you can see the attribution, what they're taking into account for the measures specifically. Again, look at those, and keep an eye out, again, for the webinar that's coming, so you guys can get more details on those measures, specifically.

How are these measures scored? Each of those measures that we just discussed, they're both worth up to 10 points, and the cost category score is an average of the two measures. If only one measure can be scored, remember you have those case minimums, so if only one can be scored, that will be your performance score for that category. Something important to note, if neither measure can be scored, the cost category will be reweighted to the quality category, so your quality category would then become worth 60 percent and cost would go to zero, but that's only if they cannot evaluate you on both measures.

New bonus points opportunities. We're always looking for bonus points on things that we're already doing, so CMS did come out with a couple things for 2018 to help you guys earn some extra bonus points. For the quality category there are up to 10 percentage points available, so in 2017 if you submitted a quality score at the category level of a 30 and in 2018 you submit a quality category score of 50, you guys obviously had some improvement and CMS will actually assign bonus points based on your improvement. How the bonus points will be distributed I'm not exactly sure, but do know that if you guys improve in

your quality category, and again this is at the quality category, not the measure level, if you guys improve, you will be eligible to earn some bonus points, so that's good.

Another opportunity that's available is for the treatment of complex patients. Providers who treat complex patients are eligible for five bonus points in this category for this, and this is based on the HCC coding, and that's the model that identifies individuals with serious, or chronic illnesses, and assigned a risk and assigned a risk factor score to the patients based on the combination of the individual's health conditions and demographic details. Again, people are always like, well, my patients are maybe sicker than another provider, or things like that, so CMS is going to take into account the complex patients that you're treating, and award bonus points for that.

This is based on the risk score from the previous year, so from 2017, and then the patient attribution is overlapping, and it's September 2017 to August of 2018. Another bonus opportunity is another reduction, burden reduction from CMS, they're actually giving five bonus points to clinicians, or small groups of 15 or fewer clinicians who do submit data on at least one category. Again, it's kind of helping those smaller practices out that maybe don't have as much resources as larger practices. Again, small practice bonus, if you were poor on at least one category, you can get five bonus points.

We will now touch on a special status considerations that Joe and I both have been mentioning throughout the presentation. You can see, here, rural and HIPSA areas, the improvement activity points are doubled, which I mentioned. The non-patient facing clinicians they also have the double points for the improvement activities, and they can qualify for an automatic reweighting of the ACI category. Again, if they do submit the score, CMS will score it. Same goes for hospital-based, their ACI's can be automatically reweighted, but if they do submit it, they will score. CMS will never turn down any data. Same thing goes for the ambulatory surgical centers, again the automatic reweight for the ACI category. Not included in this list, I will mention, again, are the nurse practitioners, physician assistants, clinical nurse specialists, CRNA's, they can too qualify for that automatic reweighting, but again if you do submit their scores, that they will be scored.

MIPS hardship exceptions, there is the application available. The deadline is going to be December 31st, and a lot of times you see this applied to the ACI category, and it rewrite it to quality. Again, deadline for the application will be December 31st. Next slide, please. We did include, here, some reasons that one may be approved for the hardship, and I won't read through them all, but you can see here there are several such as significant hardship for a small practice or an extreme or uncontrollable circumstances. For instance in 2017 the hurricanes that came through, people were allowed to get the hardship based on those. Lack of control over availability of certified EHR, and things like that. Those are valid reasons that you'll probably be approved for your hardship application.

Alternative payment models. I'll briefly touch on these, and I just wanted to mention some changes that happened with the scoring, which I thought were interesting, and worth bringing to our attention. Next slide, please. In 2017, CMS actually had two different scoring standards based on what type of APM you were at. You can see here that the quality was worth 50 for some, zero for others. ACI was worth 30 percent for some, and 75 percent for others, so a burden reduction aim at CMS took for 2018, they took the standardization approach, and what they did was they actually made year two for all MIPS APM's regardless of what type, all worth the same. You can see here it's now worth 50 for all. The cost remains at zero because there are assessed within the APM on the cost. Improvement activities is at 20 percent. The ACI is at 30 percent for all APM's.

I did include, here, I went to the comprehensive list of APM's and that is current as of February 2018. For the APM's that have their quality weighted to zero in 2017, CMS did come out with how they will score their quality for 2018, for the non-ACO models, so they'll actually take the quality measures that they're responsible for reporting in within their APM to give them a quality score in MIPS. CMS also for APM's did add a fourth snapshot date of December 31st, and I think this is great, because there's a lot of times where practices in 2017 thought they had everything in line, and then a practice would join after the August 31st deadline, and then they would have to then figure out how they were going to report for them, as well.

When you're involved in APM, you're obviously reporting as a group, so if anybody joins your practice after that, and they weren't on captured on other snapshot dates they were considered what they say, not on your roster, your APM roster, so you would have to report on them individually. That became confusing and complex, and again added burden, so they're adding that fourth snapshot date to help elevate that. If you are a clinician, and you're an APM, if you have a clinician that joined say September 4th, they will be considered part of your APM, and they will absolutely benefit from the APM scoring, so you will not have to report on them individually, as well. I will note, too, that the fourth snapshot they did add will not be factored into the qualifying participation, or participant status, and what that is, is that's for advanced APM's, certain percentage of claims, and patients, and all that stuff have to go through their APM, so that fourth snapshot date will not apply to that status, the last snapshot date is August 31st.

On this slide we listed a bunch of 2018 resources that are available for you, and there are some repeat hyperlinks that were throughout the presentation, but keep in mind the CMS resource library, that is where you can find all of your QPP resources from 2017, to 2018, and anything you might be looking for will be there. Yeah. Go ahead, next slide, please. That's it for today. We'll go ahead and open it up for questions. If you guys have any questions, or need assistance, please reach out to your Quality Insights specialist. We also have our contact information here on the slide. Please reach out, we are here to help the

assistance is at no cost, and we work to just help your practices be successful in the program. Now, I will turn it over to Laurie for questions.

Laurie Fink: Thanks, Rabecca. At this time we will move into the Q&A portion of this session. If you have any questions for our team, please type them into the chat or the Q&A box to the right of your screen. If you have already submitted a question during the presentation it will be addressed now as time permits. We do have Kathy Wild on the line, she's been answering some of the questions as we go through the presentation to get you the answers as soon as possible. I will try and look through these questions and see which ones have not been addressed already. I do know we had two questions about the 2018 MIPS calculator tool, people are curious if that tool will be updated for 2018. Kathy, you did provide an answer to that down in the Q&A but I'm wondering if maybe you might want to let everybody know the update on that?

Kathy Wild: Sure. I'd more than happy to. The 2018 MIPS Calculators were actually developed by some other organizations, kind of like our peers, and we have recently contacted them, and they are still in the process of updating them. That is because the low volume threshold did change over the last year, so the calculations have to be changed as well as adding the cost category. They had been working on that, but then on February 9th, CMS passed another long congress, which changed that a little bit more to not include Part D drugs. Once again, the calculations had to be changed, so they are not ready yet, they are working on them franticly, and as soon as they do become available we will certainly share that with all of you. They will be posted on our website, and we will definitely highlight that in a newsletter as soon as we get them.

Laurie Fink: All right. Thanks, Kathy. Another question that just came in, when will hardship exemption applications for ACI be available for 2018?

Kathy Wild: That is a good question, as of right now, we do not know. We will certainly notify you as soon as CMS makes them available. We do know that the deadline will be December 31st. I know sometimes in the past with different programs the application deadline was sometime in the summer June, July, and this year it will be through the end of the year. There will be plenty of time to do that, but once again as soon as we find out we will definitely inform you of that, also.

Laurie Fink: All right. Next question asks, how do you define complex patients?

Rabecca Dase: All right. This is Rabecca. That is based on your HCC coding, so I'm not a coding expert or anything like that, but it is based on the HCC coding model that is available, so I don't know if you have billers, and things that you can talk to about that, but it is in fact based on the HCC coding model. I hope that answers your question.

Laurie Fink: Okay. Another question is for those EC's who are part of the PCP Plus Program, will they be required to report MIPS for performance year 2018?

Kathy Wild: Joe, or Rabecca, do you know the answer to that one off the top of your head? I'm not sure, but it's something we can definitely look up, and get back to you.

Joe Pinto: On that, I just don't know what the definitive answer is. I do have documentation for PCP Plus, but I'd rather look into that, and provide the answer than to just speculate.

Rabecca Dase: What we are planning is we will be taking all the questions that were submitted in the chat box, and writing a document, and share all the Q&A's with everyone that attended the webinar, we'll also post them on our websites. We will make sure we have an accurate answer for you when that gets done.

Laurie Fink: Okay. Great. Our next question is does the base measure portion of the ACI require practice management data?

Kathy Wild: I'm not sure what the practice management data means so could the person who asked that question please clarify?

Joe Pinto: I think the practice management system, and the EHR are two separate systems, I think that's what the question is referring to.

Kathy Wild: Okay.

Joe Pinto: If that is what the question is, then no. It's coming from your certified EHR technology, not from the practice management system alone.

Laurie Fink: Okay, let’s move on to the next question. It asks, what application and enterprise portal do I need to access to see the QRUR in 2017 performance report?

Rabecca Dase: I do believe if you do have access to, I think, it's PV Quality, I think that's the application, if you were able to get in and do stuff within the QPP portal that came out this year, you should have certain access. A lot of times group representatives will for the PVPQRS quality, I think, but again, we can follow up on this to make sure you do have the correct application, and you do request a correct application to see this, but again, if you were able to do stuff within the QPP portal this year, I bet that you do already have the correct access and application to view the report.

Laurie Fink: All right. Thanks, Rabecca. Another question is if we reported on a topped out measure in 2017, and were planning on continuing for 2018, would you suggest we select the different measure instead to maximize the point potential, or should we just add an additional measure to help make up the max point differential?

Kathy Wild: That is a decision you will have to make on your own. Knowing that the topped out measures, the maximum score you can get is seven points, instead of the

10, but if you report another measure, once again CMS is only going to score the top six, so if you want to report another measure, and you think you can score higher than a seven. Then by all means you probably should do that, but that will be something you'll have to discuss internally. Also, please reach out to us, and work with your practice transformation specialist, and maybe they can guide you better, once we have a picture of what the other quality measure scores would be.

Laurie Fink: Thanks, Kathy. Next question asks, how do we know if the cost category will be reweighted or not? Is there any way to know beforehand?

Rabecca Dase: This is Rabecca, and that is not something that I'm aware of. I don't know if the cost category is based on a full year. I don't think that you would know until after December 31st of the current year, 2018, but I am not aware of practices being notified to say, hey, look, you are exempt from this, or if they're just going to find out when the feedback reports come out. Joe, or Kathy, are either of you familiar with that?

Kathy Wild: No.

Joe Pinto: I'm not aware of this being an option for reweighting at this time.

Rabecca Dase: I was thinking cost. I apologize. I thought they were asking about cost.

Kathy Wild: I think they were, but I think the cost category, you wouldn't have access to that data ahead of time, they won't know until after the fact.

Rabecca Dase: Correct.

Kathy Wild: If there isn't enough data then they would have a score of zero for that category. That is my understanding.

Rabecca Dase: Yes. If they can, for the cost category, you have the two measures. If they can score one measure, they will still give you the performance score, but if they can score neither, then they would in fact reweight that to the quality category. Again, because it's a full performance year they won't even know if you met the case minimums or not until after the year has already completed. Like I said, I do not think people will be notified that they are reweighting, or anything like that. Maybe they would put it in the portal to show that you were reweighted, but again, I do not have a date of how you will know that.

Kathy Wild: Thank you, Rabecca. Yeah. You're completely right on that.

Rabecca Dase: Thank you.

Laurie Fink: All right. The next question comes from a new quality coordinator at a clinic. She has a few questions, she's wondering if all clinics are required to report for

MIPS. Is it mandatory or optional? The second part of that question is, are we reporting for individual providers or the clinic as a whole?

Kathy Wild: Okay. This is Kathy. I can try to take that. The first thing I want to point out is that every year CMS will determine who is MIPS-eligible for the current reporting program. For 2018, which began on January 1st, CMS has not released that list of clinicians, yet. However, we know for a fact that the list will be available very, very soon. We have been informed that we should be getting access to that list by the end of next week, which will be the end of March, and then CMS is hoping to update the NPI lookup tool on the QPP website very early April.

To answer the question, at this point no one is really aware of who has to participate, yet, for 2018, because that information, that data, has not been released, yet. The first step I would take is wait until that NPI lookup tool is released, and then what you will need to do is look up the NPI numbers for all of the clinicians in your practice, and you will find out whether they need to report either individually as a group, or as a group. If you want to report them individually, you can do that. Your second option is to go ahead and do group reporting, and then I think as Joe went over there's also an option that started this year where you could join a virtual group.

However, actually that won't be applicable for you, because you had to have applied for that prior to the end of last year. You can determine whether you want to go ahead and aggregate all of your data together for all the clinicians, or submit it individually. There are pros and cons to doing both ways, and we can certainly take a look at that with you, and kind of explain based on the specifics in your practice. Once again, we have the slide, please look at that, and send an email out to one of us. We have staff that are dedicated for each state to work with practices based on the size of the practice, whether you're considered small, having 15 or fewer clinicians or large, and therefore they are more of an expert in dealing with specifics there. I hope that answers your questions, and like I said, please reach out to us, and email the QPP surs at Qualityinsights.org, and we will get someone working with you right away.

Laurie Fink: All right. Our next question asks if reporting MIPS data through the QPP website is the correct way to do it?

Rabecca Dase: The QPP portal is a way that you can upload MIPS data. Now for quality, you can't just go in there and enter your numerators and denominators. You would actually have to have a specific file type, which they call a QRDA three file, and you would get that out of your certified EHR, and then you could take that file and upload it. For the MIPS, or the ACI category, you could in fact enter your numerators and denominators manually, or you could then take another file out of your EHR and upload it. Then for the improvement activities, you would go through, and you can either upload a file out of your EHR, if you have that capability, and/or you can go through and check, yes, we've done it, or no, we

haven't. Yes, it is an option to report MIPS data, but there are different specifications for each category within MIPS.

Joe Pinto: This is Joe, let me just add one little snippet to that, too. As far as the report that you would be uploading to the QPP web portal, if you do not have the report in an XML, which is an Excel file, or a JSON file, which is what CMS and the government uses, down at the bottom of the homepage of the QPP website in the left hand corner there is the developer tools option. If you click on that, it will take you to the developer tool section of the QPP website and it has conversion file tools that you can use in which you can convert a file to the appropriate file in order to upload. Just keep that in mind, as well.

Kathy Wild: This is Kathy. I'll add one more thing to that. Just to clarify for each of the different categories, whether its quality measures, or the advancing care information, or improvement activities. You can actually submit the data for each category a different way. Each category has to be the same, but you could submit your quality measures using a registry, or your EHR, but you can go ahead, and use the QPP portal, which would be no cost to you to go ahead and manually enter those numerators, and denominators, and then go ahead, and manually attest to which improvement activities you did. Once again, or if you want a registry to report all of them, you have that option, too. There are different options available to you.

Laurie Fink: Okay. We are looking for recommendations. What to do if you do not have an EHR in regards to the advanced category, besides going through an EHR?

Kathy Wild: For MIPS, you do not have to have one. You could report for the other categories. CMS did create a hardship exception for especially small practices where they would be able to ask for a reweighting of the advancing care information category, because they do not have a certified EHR, so I'm not sure if you qualify in that, and that your practice has 15 or fewer clinicians you would have that possibility of applying for that. If it is granted, then your API category would be reweighted to the quality category. It is my understanding that CMS would allow that hardship application for not having any EHR for five years, but at this point we don't know that it would be extended beyond that. Do you have any other suggestions, Rabecca and Joe?

Rabecca Dase: Yeah. I'll just add that even if you don't have an EHR, you can still report quality as an individual via claims, and you can absolutely do your improvement activities, so the ACI category would be the only category that you couldn't perform without having any HR, so you do still have quality. You can use your claims submission for individuals, and then improvement activities that's just a simple attestation of yes with your supporting documentation, so again, no EHR's would be needed for the cost category, the improvement activity category, or the quality category if you did it that way.

Laurie Fink: All right. I think we have touched on all the questions that have been submitted. Thank you everyone for joining us today, you really asked some great questions.

Moving forward we hope to be a great resource for you to help you with the quality payment program and you're reporting efforts. We want you to know that Quality Insights is here to help you navigate MIPS and the QPP. Our assistance is funded by CMS, so there's absolutely no cost to you to take advantage of our services.

We have a huge library of resources, and we'll also host educational sessions like this one, coming up throughout our contract, so we are here to help you. We hope you found the information we provided today beneficial to your practice. We ask that when you close out of today's session you will be directed to a very brief evaluation, we ask that you please take just a moment to complete it, we greatly appreciate your feedback and all of your comments. Thanks again for joining us, today. I hope you have a great rest of the day. This session is now concluded. Thank you.

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