2019 Quality Payment Program: A Deeper Dive into the Requirements for Success - Transcript from Live Webinar

Wednesday, May 29, 2019

Laurie Fink: Good afternoon, everyone and welcome to today's webinar, 2019 Quality Payment Program, A Deeper Dive into the Requirements for Success. My name is Laurie Fink and I'm the communications specialist with Quality Insights and I will be serving as a host for today's session. We're so glad that you are able to join us today for this live event and for those of you watching a recorded version of this session, welcome. We will get started with the presentation in just a few moments but first, I'd like to go over a few housekeeping items. All participants entered today's webinar in a listen only mode. Should you have any questions during the presentation, we ask that you please type it into the Q&A box to the bottom right of your screen and we will address your questions throughout the presentation and also at the end as time allows.

Laurie Fink: If for some reason your Q and A function isn't currently open, you can just drag your mouse on to the screen, there's some menu circles at the bottom. Just click on the circle with the three dots in it and that will allow you to open your Q&A function on your Webex player. Today's webinar is being recorded. The recording along with the slide deck and a transcript of the webinar will be posted on the Quality Insights website, as well as the Quality Insights QPT Support Center website within the next few days. It is now my pleasure to introduce you to today's speakers. Serving as our moderator today, and that will be Diana Haniak.

Laurie Fink: Also joining her will be Rebecca Dase, Joe Pinto, Amy Weiser, Marvin Nichols, Shirley Sullivan, and rounding out our panel of experts will be Lisa Sagwitz. Without further ado, I will now hand over the presentation to Diana.

Diana Haniak: Thank you so much Laurie. For today's agenda, we're going to look at the eligibility, payment adjustments, reporting options, data submission methods, thresholds and bonuses for the 2019 Merit-based Incentive Payment System or MIPS. We're also going to take a look at the performance category requirements so that's quality, promoting interoperability, improvement activities and cost. We're going to look at 2019 Alternative Payment Models and we'll finish up with questions and answers. Just a brief overview of Quality Insights and the QPP. We're responsible for reaching out to clinicians designated by CMS as eligible to

participate in the Quality Payment Program and we provide customized assistance to help them be successful.

Diana Haniak: We have contracts with CMS to provide QPP assistance to all practices in Delaware, New Jersey, Pennsylvania, West Virginia and to large practices in Louisiana that have 16 or more clinicians. Small practices in Louisiana that have 15 or fewer clinicians are assisted by another contractor, TMF Health Quality Institute. We developed a ton of resources and there's a link to our page right there. Just a very brief overview of the QPP, it's a Medicare pay for performance program initiated in 2017 that rewards value and outcomes. There are two ways to participate. We have MIPS, Merit-based Incentive Payment System and APMs or Alternative Payment Models.

Diana Haniak: If CMS identifies you as a MIPS eligible clinician or EC, you must participate in the QPP or you'll be subject to negative payment adjustment. If you belong to a specific shared risk Accountable Organization or ACO or an Alternative Payment Model, APM, you may earn a Medicare incentive payment if you meet criteria to be a qualifying APM participant or QP in an Advanced APM. We'll look at the timeline for the 2019 Participation. January 1st, 2019, this is when the performance period began. December 31st 2019, this is when the performance period will conclude. January 2nd of 2020, the submission period to report your 2019 data begins. March 31st, 2020, submission period to report your 2019 data ends.

Diana Haniak: In July 2020, you will receive your 2019 MIPS score and feedback reports. On October 1st 2020, this is the final day to request a targeted review, if you believe there's an error in your 2019 feedback report. In late October, early November of 2020, you'll receive your final MIPS scores and feedback reports after all targeted reviews are complete. Then, January 1st, 2021 through December 31st 2021, MIPS payment adjustments applied to all Medicare Part B claims based on our 2019 final MIPS score. Let's get started. Marvin, can you start us out with how do we know how to participate in 2019?

Marvin Nichols: Yes. Thank you. There are a couple of different ways that we could participate for 2019. However, CMS determines the participation criteria by looking at two look-back periods. The first period is October 1st 2017 to September 30 of 2018. The second period is from October 1st 2018 to September 30th 2019. In addition to the five eligible clinician types that participate in 2019, CMS has added six new types for 2019 and they are PT, physical therapist, OT, occupational therapist, speech language pathologist, audiologist, clinical psychologist and registered dietician. In order to participate in the 2019 MIPS program, the clinician must exceed all three low volume threshold criteria.

Marvin Nichols: Those criteria are billing over $90,000 per year in Medicare Part B claims. Providing services to greater than 200 Medicare beneficiaries and new for 2019, providing 200 covered professional services under the physician fee schedule. CMS defines a service as one professional claim line with positive allowed charges to one covered professional service. Clinicians who are newly enrolled

in Medicare fall below all three low volume threshold criteria or are an advanced APM qualified participant, do not have to participate in MIPS for 2019. My colleague Lisa will review the advanced APMs later on in this webinar. In order to confirm your eligibility, simply navigate to the qpp.cms.gov web page and look on the top right hand corner and one of the tabs will be, called MIPS.

Marvin Nichols: Press that tab and another box will open and you will see a check participation status box. Once you press that box, your QPP participation status web page will open up. Simply add your NPI number and you will see three different tabs for 2017, 2018 and 2019 performance years so be mindful of the tab that you're reviewing so if you're looking for 2019, make sure you're viewing 2019 tab. CMS will identify special status of clinicians during the two fiscal year look-back periods that I previously mentioned. Special status indicators include non-patient facing, small practice, that's 15 or fewer clinicians, hospital-based, ASC based, rural-based and HPSAs. MIPS eligible clinicians with special status qualify for special rules but it does not preclude you from participating in the MIPS program.

Diana Haniak: Great. Thank you so much, Marvin. Can clinicians participate even if they don't have to?

Marvin Nichols: Absolutely. There are two different ways that clinicians can participate. What's new for 2019 is what determines, referred to as opt-in reporting so clinicians that meet one or two of the low volume threshold criteria, they can opt-in and participate at the individual group level. If the individual or group decides to opt-in, the data will be scored and that clinician or group will be subject to the payment adjustment, whether it'd be positive or negative. If you are participating in APMs, you would do so at the APM entity level and opt-in capability will be available in upcoming months through the QPP portal. The other way that clinicians can report even if they don't have to is voluntary reporting.

Marvin Nichols: CMS will provide performance feedback based on the data submitted. However, clinicians will not receive a payment adjustment. The difference between opt-in and voluntary reporting is the clinicians that decide to opt-in, they will be subject to the payment adjustment, whether positive or negative and those that voluntarily report will not be subject to that payment adjustment. These are examples of opt-in scenarios. As I previously mentioned, you only need to meet one of the low volume criteria in order to opt-in and if you meet ... and if you don't meet any of the low volume threshold criteria, you cannot opt-in, however you can voluntarily participate.

Diana Haniak: Okay, so did the payment adjustments increase in 2019?

Marvin Nichols: Yup, they did so clinicians have the potential to earn up to a 7% payment adjustment based on their final scores and how many other eligible clinicians participate nationally. Also, clinicians who are eligible to participate and do not participate, they will receive a negative 7% payment adjustment so that's plus

or minus seven with a caveat that I'll go over here in a little bit. Also, you have the potential to earn an additional positive payment adjustment for exceptional performance if your MIPS score is 75 points or higher. Each year, the minimum MIPS points for a neutral payment adjustment changes. For those who participated last year, that score was 15 points.

Marvin Nichols: This year, the minimum score is 30 points so just remember you have to have at least 30 points to ensure that neutral payment adjustment. This slide just breaks down how the score will work in conjunction with your payment adjustment. Just bear in mind that the final MIPS score that you receive in 2019 will affect your Medicare Part B claims in 2021 and if you score over 75 points, you will receive that exceptional performance bonus. This program is budget neutral so what that means is that a scaling factor is applied to positive payment adjustment based on the distribution of the final scores across all the eligible clinicians that participate in 2019.

Marvin Nichols: For example, in 2017, there are more than 95% of MIPS eligible clinicians that reported data so the plus or minus was four, that was with a caveat because so many other eligible clinicians reported that we didn't reach the maximum potential of 4%. That's why I said in the previous slides that is plus or minus seven with a caveat. So depending on how many other clinicians report their MIPS, that will determine the positive payment adjustments. Now, for 2018, we will not know the final MIPS scores or payment adjustments until fall of 2019.

Diana Haniak: Can you go over what the weights of the MIPS categories are going to be in 2019 for us?

Marvin Nichols: Yes, yes. In order to obtain the highest MIPS score, data should be submitted for the Quality, Promoting Interoperability Improvement categories. Now, there are certain instances where you can get some ... you can get the promote interoperability category, re-weighted to your quality and we will go over that in the webinar as well. Just remember you want to submit for those three categories. You don't have to submit for the cost category because CMS is automatically going to calculate for us so that will be presented in your QPP portal automatically. Now, the difference in weights from last year to this year, quality was worth 50% last year, now it's worth 45 and those ... that 5% went to cost.

Marvin Nichols: Cost is now 15. It was 10%. The promote interoperability category and the improvement activity category stayed the same. Now, what does that look like? So 45, plus 25, plus 15, plus 15, that gives you 100 points. There is 100 possible points that you can score for your final MIPS score. There is an opportunity for bonus points if you can score up to five points for treating complex patients based on their medical complexity. Quality Insights put on a great webinar for HCC coding and if you haven't seen that, I urge you to either view the PowerPoint recording or transcript for that webinar. Finally, if you are a small practice and that's less than 15 clinicians, you will automatically receive five bonus points.

Diana Haniak: Great. Thank you so much Marvin.

Marvin Nichols: No problem.

Diana Haniak: Amy do you mind going over all of the reporting changes, if there are any for 2019?

Amy Weiser: Sure. I'd be happy to. There really are no changes in the reporting periods for 2019. Quality remains a full calendar year, 365 days. Promoting Interoperability, you have a minimum of 90 days to report up to 365 days. I just want to stress here that you must have 2015 CEHRT edition functionality before beginning your 2019 reporting. That's very, very important. Improvement Activities, 90-day minimum up to 365 days, I do want to also stress for Improvement Activities that there are a few that require longer than a 90 day reporting period. In the past, I know that the annual registration for the prescription drug monitoring program was one of the activities that require the six-month reporting period that you were tied to the PDMP for that long.

Amy Weiser: If you have any questions again about Promoting Interoperability, the Improvement Activities and more specifics about what we've just discussed, please reach out to us. We're here to help you. Cost remains a full calendar year also and CMS collects that data for you. There is also no change in reporting options for 2019. There are still three options to report data. Virtual Group reporting is only available if you had already submitted an applications by December 31st of 2018. If you are interested in the virtual group reporting, just bear in mind that that is a decision that you need to make the year before your reporting year. You are not able to select the virtual group unless you already had submitted that application.

Amy Weiser: The three options to report are as an individual, under an NPI and a TIN where individual reassigns benefits. As a group, reported by two or more NPIs who have reassigned billing rights to a single TIN or reported by an APM entity or as I mentioned as a virtual group, which is comprised of solo clinicians and groups of 10 or fewer eligible clinicians, no matter what specialty or location. In 2019, there are some changes to submitting your information. Individuals and groups may use multiple methods to submit data in 2019 which is a new option and if the same measure is submitted via multiple methods, the one with the highest number of points will be scored.

Amy Weiser: Now, this slide has a lot of information on it. This is the new terminology that clarifies submission types, submission data, what quality measure sets to submit. I'm not going to read it line by line. You have it in your slide deck. However, if you do have any questions about any of this, again, we are here to help you understand things a little better. This is a chart that just breaks down, as an individual, what your options are to submit information for the quality payment program. I want to just point out under quality that Medicare Part B claims is only available to small practices now. As an individual in a small practice, you can continue to submit Medicare Part B claims.

Amy Weiser: It is no longer available for large practices so that would be small practices, groups of 15 or fewer clinicians and a large practice is considered a group of 16 or more. If you're an individual in a group with 15 or less clinicians you can still submit Medicare Part B claims for your quality category. Then, this also just goes over information here for the Promoting Interoperability, the Improvement Activities and Cost again. You will not submit any information on Cost. Medicare will calculate that for you. Again, in group data submission, okay so for quality, I want to point out this. This is new for this year.

Amy Weiser: As a group, you can submit Medicare Part B claims but again, only as a small practice so with 15 or fewer clinicians you can submit your quality category measures as a group. Again, there is information here for Promoting Interoperability, Improvement Activities and Cost. There is no data submission required. Medicare will calculate that for you.

Diana Haniak: Thank you so much Amy. Rebecca, can you go over what's new in the quality category?

Rabecca Dase: Absolutely, so for the quality category, I'll cover what's new, what changed and what stayed the same. For 2019, the quality category is worth 45% of your final MIPS score which is the largest category that you'll be assessed on. If you do happen to take that promoting interoperability category re-weight, which Marvin mentioned earlier and which Joe will discuss later, the quality category also actually becomes where 70% of your total score so that's a huge weight. This category is very important to pay attention to and make sure that you have good data to submit to CMS. As Amy had mentioned the reporting period still remains at 365 days or a full calendar year so that's January 1 through December 31st.

Rabecca Dase: Just as the previous years, you are still required to report on six measures or a specialty measure set. If less than six measures apply, you report on the ones that are applicable to you and again, just as the first two years, you still are required to report on at least one outcome measure or high priority measure if the outcome measure is not available. Just like before as well, you are more than welcome to report more than six measures to CMS. CMS will take the highest performing measures to create your final MIPS score and just keep in mind, everything that you do submit to CMS will be published on Physician Compare. For 2019, there are 257 quality measures available against all collection types so EHR, registry claims, things like that.

Rabecca Dase: Moving from 2018 to 2019 they actually removed 26 measures. They have added eight measures and 23 measures, they have listed as having really large changes. On the next slide, you will actually be able to see the eight measures that have been added. Take a peak. These might be ones that you're interested in. On the next slide, slide 41, 42 and 43, we have listed for you the measures that have been removed. I'm not going to go through each measure line by line. We just want to make sure that you have this information available in the event that you wanted to review it. What I do want to point out here on this slide is

two popular measures that I noticed that were removed for 2019 are actually Hypertension, the improvement in blood pressure measure which is quality ID 373 and the Ischemic Vascular Disease use of Aspirin or other antiplatelet measure, quality ID 204.

Rabecca Dase: Those are two measures that I saw a lot of my practice has used in 2018 which have in fact been removed for 2019. If any of those measures on the previous three slides that you've used in the past, you're going to have to go back to the drawing board and re-evaluate what measures you want to submit because they are no longer available. On the next slide, this starts where the measures have been listed with changes. I will note that diabetic eye exam which is quality ID 117, that's a measure that has very large changes. The BMI measure quality ID 128, again, that's another popular measure that did have some changes.

Rabecca Dase: Next slide. Here are some more measure that have changes. Next slide. More changes and then next slide, what we did here again is we also provided each specification links depending on your reporting collection type. If some of your measures have been removed, if you can see some of them there that have been changed, it's always good from your tier to review these specifications to make sure that you're collecting everything appropriately so there's no surprises, come the end of the year and you run your quality report and your numbers aren't what they thought they would be.

Rabecca Dase: Always review your specifications just to be sure. Next slide. New in 2019 as Amy mentioned, and I think this will be very impactful especially for some specialist and things like that. Quality measures can now be reported using multiple submission methods. In the past, it had been, you must use the EHR for six measures or if you choose registry, all six measures had to be reported via the same collection type. Now, they're saying, if you want, you're more than welcome, you can use the EHR for three, the registry for three, things like that. You can mix and match to what best fits your practice. Something I will note is though if you are a CMS web interface reporter, you cannot pick and choose submission methods.

Rabecca Dase: It would strictly be all through the web interface because that is something that you register for and I'll just kind of put in here, you must register for the CMS web interface by 5 PM on June 1st of 2019. The web interface option is available to groups of 25 or more and ACOs of course. Again, you must register by July 1st for that option. As Amy mentioned too on the previous slide, moving to the next bullet point, quality measure via claims is only available to small practices. Again, small practices are 15 or fewer clinicians. If you were in a large practice of 16 or more and claims is something that you've used previously to report your data to CMS, that is no longer available to you so you're going to need to work with a third party vendor or possibly register for the web interface, if that's an option.

Rabecca Dase: Quality Insights is more than happy to help you walk through that because that is a big change and there can be different options for you. I do want to mention,

as we talk about the changes there, unlike the promoting interoperability and improvement activity category, you cannot just log in to the quality payment program portal and manually enter your data. The quality data does have to be entered into the QPP portal in a specific format. Unfortunately, that's where the third party vendor comes in. Next slide.

Diana Haniak: Rebecca, can you go over how practices can maximize their quality scores?

Rabecca Dase: Absolutely, so ultimately like we talked about at the beginning, quality is the largest category that you will be assessed on. It's worth 45%. You want to look at measures that have a benchmark. Measures that meet the data completeness and measures that meet case minimum requirements. Data completeness, you must report on at least 60% of all eligible cases. If you are reporting via claims, that is your Medicare Part B patients only. If you are using another collection type like EHR or registry or QCDR, that's all patients across all pairs. The case minimum is at least 20 patients in your denominator so a 20 case per measure. You want to have at least 20 patients in that denominator that you can be assessed on. We have here, select quality measures with benchmarks advantageous to your submission method.

Rabecca Dase: What's that mean? Benchmarks, each measure is assessed against its benchmark to determine how many points you'll earn for that measure. CMS has actually taken historical data and they created these benchmarks for 2019. The historical data is from two years prior so 2019 benchmarks are actually based on 2017 performance data. I do want to emphasize here that each measure has different benchmarks based on the collection type that you are using. For instance EHR versus registry. EHR measures will have different benchmarks than a registry and I think that's really important to point out as you're trying to determine which way you're going to go and get your data to CMS.

Rabecca Dase: I just want to highlight here before moving to the next slide, the data completeness for the web interface patient or web interface reporters is a little bit different. They actually use sampling requirements. Next slide. We've talked about your measures and things, you will be able to earn between three and 10 points for most measures if your measure can be reliably scored. What does that mean? Reliably scored means that the benchmark exist that we were just talking about. You have your sufficient case volume which is at least 20 cases in your denominator and you've met that data completeness criteria so you have at least 60% of your possible patients that you're submitting your data on.

Rabecca Dase: Again, you'll be able to earn between three and 10 points for most of the measures, if you can be reliably scored and those are the three criteria that they look at when talking about reliably scoring. How are you impacted if you can't be reliably scored? This is a huge and I think really important to point out. If you do not meet data completeness and you aren't a small practice, even if you had perfect performance, you could only earn three points for each measure, three points, that's it and even more importantly, if you're a large practice of more

than 16 clinicians, if you don't meet that data completeness criteria, you will only earn one point for each measure.

Rabecca Dase: If you had 100% for each quality measure that you were reporting and you didn't meet the data completeness, potentially, you would only earn six quality points so you absolutely want to make sure that you are meeting the data completeness for that. Another criteria for that reliable scoring was the benchmarks. If there is not a benchmark available, you could only earn three points. Again, if you had perfect performance on a measure, but there was no benchmark that CMS was able to create, you can only earn three points and I do want to point out here that the preventative care and screening for tobacco measure, quality ID 226, that's a popular measure that we see.

Rabecca Dase: For 2019, as it stands right now, there is no benchmark available for this measure. If you were to submit data for this measure, and there was no benchmark, you can only earn three points. It is sad that if CMS during the data submission period is able to collect enough data for certain measures and no benchmark exist, they will create a benchmark but you almost leave that to a gamble, hoping that they'll get enough data and things like that to create these benchmarks, that's just something to remember. If there's no benchmark, the maximum is three points unless the benchmark can be created.

Diana Haniak: Okay so we talked about the benchmarks and the reliable scoring, can you tell us a little bit more about the topped out measures and how they can really impact your quality score?

Rabecca Dase: Absolutely, so another thing that impacts your quality score in addition to the benchmark data completeness and things like that, a quality measure is considered topped out when the performance on a measure is high as a general rule and they're not seeing any meaningful distinctions and improvement in the performance so everybody does very well at these measures and for lack of better terms, the performance is topped out. A quality measure is considered extremely topped out when the average mean performance is between 98 and 100% and this is CMS's approach to remove process measure. If they're considered extremely topped out, these measures can be proposed to be removed in the next rule making cycle so that's something to note as well.

Rabecca Dase: To just point out, QCDR measures are excluded from the topped out measure life cycle and special scoring policies that like an EHR measure regular registry measure or claims measure would be subject to. On the next slide, so ultimately, how does this affect your quality score? If you pay attention, what I said a couple of slides, I said, on most measure you can earn between three and 10 points, that's true but I always want to leave that little caveat because when you're looking at topped out measures, CMS has identified some topped out measures as capped which means those measures can earn no more than seven points. Even if you did, you knocked it out of the park, you got 100% for a measure but it was a capped measure, the most you could earn for that would be seven points so that could affect your score.

Rabecca Dase: Other topped out measures that aren't considered caps, typically require a perfect performance rate to earn those 10 points. You want to look at those different things. Are they topped out? How well do I need to do to earn a lot of points? Are they capped at seven? As I mentioned before, each collection type like EHR registry, they have their own set of benchmarks so EHR is not the same as a registry. A registry is not the same as claims so I think it's really important to point out the different submission methods or collection types to have different benchmarks. We did here include a link to 2019 benchmarks and that's where I got the information on the seven topped out measures or the seven point capped measures and the topped out measures and things like that. I will highlight in column Q.

Rabecca Dase: That is what's listing your measures as topped out. You can go down the column and column Q will say yes or no, if it's topped out and then column Q those are the measures that are capped at seven, it would say yes or no in those columns. Again, very important to review your benchmarks and measures and things and absolutely Quality Insights is more than happy to help you go through those because it does become very complex. On the next slide, we did pull out just a couple of popular topped out measures. There's definitely more than this and Quality Insights is actually working on a tool that separates the topped out measures and capped measures based on submission methods.

Rabecca Dase: You can see here, I just want to point out a topped out measure for claims is BMI, just because it's topped out for claims, does not mean it's topped out for EHR and things like that so just some popular topped out measures here and on the next slide we pulled out a couple measures that were popular that were capped at seven points, even if you had 100% performance rate on these measures, you can earn no more than seven points. The one I want to highlight importantly is the second one down which is quality ID 130, is the documentation of current meds in the medical record. Submission methods will be claims, EHR and registry. This measure is one that we see typically submitted across the board for whether you're specialty, primary care, hospital, things like that.

Rabecca Dase: This is a measure that people typically use. Unfortunately, for 2019, it's capped at seven points so perfect performance would only even earn you a seven point MIPS score on this certain measure. Next slide.

Diana Haniak: Well, Rebecca, are there opportunities to get a bonus, any bonus points in the quality category?

Rabecca Dase: Absolutely, people love bonus points so we'll talk about that for a minute. For bonus points in the quality category which again is your biggest weighted category so it's important to get all those possible points. We talked about initially the outcome measure is required but for each additional outcome measure or patient experience measure that you submit after the required, you can earn additional two points per measure. Same thing for the high priorities, after your required measure, you can earn one point for each additional high

priority measure. Another option for bonus points in this category is going to be that you have the ability to earn one point for each measure that you submit electronically end-to-end to CMS.

Rabecca Dase: You pull it out of your system, you give it to CMS. There's no manual manipulation of your data. There's no playing with the numbers or anything like that. What you pull out is what you're going to give them so ultimately, for both of those options, so the end to end reporting and the potential additional points for high priority or outcome measures, you could earn 12 additional bonus points right there which is huge and just to know unfortunately, CMS web interface reporters are not eligible for those bonus points for additional outcome in high priority measures because CMS already has your measure steps. Another opportunity for bonus points is going to be the improvement scoring bonus.

Rabecca Dase: Groups of clinicians have the ability to earn up to 10 percentage points, when a clinician or groups submits all required quality measures and meets the data completeness. What they do, what CMS does is they actually take your score from 2018 and they compare it to 2019 and see what the improvements are. If you've made improvements, they'll do some calculation to determine what kind of bonus points you can earn. Keep in mind, they do not take into account the bonus points. If you didn't have any bonus points in 2018 and in 2019, you got every bonus point that's available, it doesn't matter. CMS strips away the bonus points and they specifically look at the performance scores that you receive without bonus points.

Rabecca Dase: On the last slide, then I'll give it back to Diana is the small practice bonus and I know Marvin kind of made some reference to this earlier. The small practice bonus has changed for 2019. In 2018, they gave small practices five points on their final MIPS score. That is no longer. It is going to be ... They'll give small practices of 15 or fewer clinicians, if they report at least one quality measure. They'll get six points added to the numerator of their quality category. If your performance was say 30 out of 60, just for being a small practice, those six points, it would actually take you to 36 over 60. Again, so the small practice bonus will be added just to the numerator and not the final MIPS score. That was the change for 2019. Diana, that’s all I have for you so I'll hand it back.

Diana Haniak: Thank you so much, Rebecca. We're actually going to move on to Joe. Joe can you tell us if there's any changes going on in the PI category?

Joe Pinto: Yes, Diana. Actually, there are significant changes to the promoting interoperability category for 2019. CMS has consolidated the measures this year and there is a new scoring process in place. First of all, the base, performance and bonus measures had been eliminated and they've been replaced with performance-based scoring at individual measure level. That's new. Also, if a measure has an exclusion available and the exclusion is claimed, the points for each excluded measure will be reallocated to one of the other PI measures. Also, you must report on all PI measures or take in a claim exclusion if available.

I want to remind you that the scores for the promoting interoperability category, CMS does expect that they could be as much as up to 16% lower in 2019 because of the changes.

Joe Pinto: It is very important that you work closely with your vendor and implement any new workflows that they suggest for you to meet the new measures. Also, the maximum number of points that are going to be allocated for the PI category in 2019 has been reduced to 110. Last year, the total that you could receive was 155 and as Amy had mentioned earlier, very, very important this year, you must use 2015 Certified EHR Technology in order to meet the requirements for the PI category. Now, what stays the same for 2019? Well, the PI category weight is still worth 25% of the overall final MIPS score, unless it has been re-weighted and then it would be worth zero.

Joe Pinto: The reporting period is still a minimum of 90 consecutive days but you are able to report up to full a calendar year if you choose to do so. It is also recommended that you monitor your performance rates throughout the year and then report on the 90 day period that has the highest PI score that you can achieve in order to maximize the final MIPS score.

Diana Haniak: Okay, so Joe, we know that there are new clinician types in the program this year. We went over that earlier. Can you tell us a little bit more about the re-weighting options and how it really affects them?

Joe Pinto: Sure Diana. First of all as far as the PI automatic re-weighting, as you know CMS automatically re-weights the PI category for the following list of clinicians. The non-patient facing clinician, hospital based clinician, ambulatory surgical center-based clinician and also for certain physician extender such as nurse practitioners, PAs, the CNS and a CRNA. What's new for 2019 is the additional specialties that will be required to report to MIPS if they are eligible and they would include a physical therapist, occupational therapist, speech-language pathologists, audiologists, clinical psychologist and also, certain registered dietician or nutritional professionals, all new for 2019.

Joe Pinto: If the Promoting Interoperability data is not submitted, then the quality category will get re-weighted and that score will be increased to 70% of your overall score. If PI data is submitted, it will automatically be scored. If you are going to submit data under the PI category, keep in mind that whatever data you do submit is going to be scored. There's also the PI Hardship Exception for Re-weighting. Certain clinicians are eligible to submit a PI Hardship Exception application and that will get the PI category re-weighted down to zero. The deadline, keep in mind to submit a hardship application is December the 31st of later this year and sometime in the fall, the applications will be made available to those that do intend to submit for the hardship exception for PI.

Joe Pinto: There are acceptable reasons in which you can submit the hardship application and they would include, for clinicians in a practice with 15 or fewer clinicians that would be a small practice. Also, if the EHR has been decertified during the

performance period. If you have insufficient internet activity where you live or practice from rather. Also, for extreme and uncontrollable circumstances and that would include like a lack of control over the availability of certified EHR technology. That would be obviously a significant hardship. If the hardship application was approved then the quality category as I mentioned will increase up to 70% and once again, keep in mind that if any PI data is submitted, the category will be scored.

Diana Haniak: Thanks, Joe. You also mentioned that 2015 Certified EHR was required for 2019 performance year, can you tell us a little more about that requirement?

Joe Pinto: I sure can Diana. Certified EHR Technology is a requirement in 2019 so everyone must have 2015 EHR functionality in place for the entire PI reporting period. That also means that software must be certified by the last day of the reporting period. For example, if you choose to report on the final 90 days of the year, you would have to begin your reporting period by October the 2nd, and you must have your EHR certified no later than the final day of the year, the 31st of December in order for the PI category to count. It is not possible to earn any points in the category unless the EHR is 2015 edition during the complete reporting period.

Joe Pinto: Check with your vendor, your EHR vendor if you are unclear or unsure if you have EHR, a 2015 EHR edition in place and they will be able to provide you more directives on that. Also, you can ask your vendor for the certification number and you can check by going to the website, the certified health IT product list, also known as the CHPL website. I have the link provided to you in the slide deck. There are also promoting interoperability submission options that you need to be aware of for individual and group reporting, you can submit via your EHR vendor. Also, you can sign up and use a registry or a qualified clinical data registry, also known as a QCDR or you can attest via the QPP portal.

Joe Pinto: Submission types for the category would include direct being by the EHR vendor or registry, also by log in and upload as well as log in and attest. For the submitter type that would include individual, third party intermediary which should be your EHR vendor, registry, billing company, et cetera.

Diana Haniak: Okay, so we know there were some changes for this category in 2019, can you go over which measures, practices we'll need to report on?

Joe Pinto: I sure can Diana. There are changes in 2019 and they are significant as I mentioned earlier. In front of you, you have the list of all of the PI measures that will be scored for 2019 so for the E-prescribing measure, it is actually a three part. You have E-prescribing worth 10 points. Also, new for 2019 is the query of the prescription drug monitoring program also known as the PDMP and also the Verify Opioid Treatment Agreement which is also new and those are bonus point categories but I also want to make you aware, especially for those of you who practice in Pennsylvania, electronic prescribing of controlled substances

will become mandatory in the Commonwealth beginning later this year in October.

Joe Pinto: That means that the querying of the PDMP and the Verify Opioid Treatment agreement becomes very important especially for those who are practicing in Pennsylvania. The health information exchange is also very important. This year, there are two separate categories of that worth 20 points each. You have the support electronic referral loops by sending health information, that is formally known as send a summary of care and also new is the support electronic referral loops by receiving and incorporating health information. I want to remind you too, that supporting the electronic referral loops is a new measure for 2019 and there are no exclusions that can be taken for that measure.

Joe Pinto: Also, we have the provider to patient exchange and that would be your ... formerly known as the provide patient access, that has been provide patients electronic access to their health information. Also no exclusions can be taken for that measure and finally, is the public health and clinical data exchange and that would include the immunization registry reporting, electronic case reporting, public health registry reporting or syndromic surveillance reporting, all worth 10 points each and if you need more information on any of the measures specifications, we've included a link to the specifications list in your slide deck for this particular slide.

Joe Pinto: Now, I did not mention earlier about the security risk analysis because it is although not a standalone measure anymore, it still must be completed in order for you to earn any points under the promoting interoperability category. The security risk assessment analysis must be completed when 2015 edition CEHRT is implemented or upon installation and upgrade to a new system. The security risk assessment analysis can be conducted outside the performance period but keep in mind that the analysis must be unique for each performance period and must include the full MIPS performance period and it must be conducted within the current calendar year. Again, even though the security risk assessment analysis is not listed among those initial PI measures, you still must complete it for 2019.

Joe Pinto: The two new PI bonus measures that I mentioned earlier, worth five points each are the query of prescription drug monitoring program, that is the PDMP and also the Verify Opioid Treatment Agreement, worth five points as well and as I mentioned earlier, electronic prescribing if it's controlled substances, it's going to become mandatory in PA later this year so those of you practicing in Pennsylvania, you definitely want to get in touch with your Quality Insights Practice Transformation Specialist Representative to help you through this process. The public health reporting PI measure is also in play and there are a number of requirements in the PI category for 2019 to report the two different public health agencies or clinical data registries.

Joe Pinto: The options include first of all would be the immunization registry reporting and we've listed the links to the individual registry in the state that you practice in,

in the slide deck there. Also, the links for public health registries under the clinical data reporting, the public health registry reporting and we have them listed by the states for you to click on as well. Syndromic Surveillance Reporting and also Electronic Case Reporting. Now there is a promoting interoperability measure highlights, which is the support electronic referral loops as I mentioned earlier. The measure description for this particular measure is as follows.

Joe Pinto: For at least one electronic summary of care record received for patient encounters during the performance period for which a MIPS eligible clinician was the receiving party of a transition of care or referral, or for patient encounters during the performance period in which the MIPS eligible clinician has never before encountered the patient, the MIPS eligible clinician conducts a clinical information reconciliation for medication, medication allergy and current problem list. The second part of that measure would be that provide patients electronic access to their health information, formerly known as provide patient access.

Joe Pinto: There are two points to this that I want to make you aware of for at least one unique patient seen by the MIPS eligible clinician, the patient or the patient authorized representative is provided timely access to view online, download and transmit his or her health information and the MIPS eligible clinician is to ensure the patient's health information as available for the patient or the patient authorized representative to access using any application of their choice that is configured to meet the technical specifications of the application programming interface also known as the API in the MIPS EC's Certified EHR Technology.

Joe Pinto: I want to make a note of this that the measure is worth 40 points of the overall total for the PI category and there is not an eligible exclusion for this measure for 2019.

Diana Haniak: How exactly are these measures scored?

Joe Pinto: The scoring for the PI measure Diana, well, each measure is going to be scored on performance based on a numerator and a denominator or a yes or a no during the time of attestation. You must submit a numerator of at least one or answer yes to fulfill the measure requirement. If there is an exclusion for a measure that is going to be claimed by the clinician and the points for that measure will be allocated to another PI measure. The measure specifications for the 2019 measures list are available here at this link. You can click on that and it will take you to the specifications for each of the measures that are listed for 2019.

Joe Pinto: Also, there are steps to calculate the PI category measure and there are five steps included here. First of all, you can calculate the performance rate by dividing the numerator by the denominator then you would multiple the performance rate by the maximum number of points for that particular measure and then add all of the individual measure scores together. You would then add

the applicable bonus points to the total number of measure points and then multiple the total points by the PI category weight of 0.25. I do want to make everybody aware that I know many of you have used in the past MIPS calculators to help you calculate your score.

Joe Pinto: The MIPS calculators will be available at a later date this year, generally later this summer and Quality Insights will be hosting a webinar on the promoting interoperability category in the near future, so just keep that in mind. In terms of calculating the PI score if you take a look at the chart that we've provided to you, I'm just going to go over the first one just to show you an example of how these scores are calculated so if you take the e-prescribing measure for example, the maximum points that are awarded for that particular measure are 10 points. If you look at, for example the numerator and denominator that would have been provided for that particular measure, you have a numerator of 200 and a denominator of 250.

Joe Pinto: The performance rate for that measure, for this individual clinician was 80% so the measure score in terms of the points would be taking the total maximum number of points which is 10 and then times it by 0.8 which represents the performance rate and you would come out with eight points out of a possible 10. If you calculate the same for the rest of the measures in the category, you will get a final PI category score. Now, looking at this example, you will see that the total number of points that were awarded to this individual clinician was 83 points out of a possible 110 so the total final points for the category are calculated out to 20.75 out of a possible 25 maximum points for the category so that actually is a very good score for this individual clinician.

Joe Pinto: Again, the MIPS calculators will be out later this summer and they will help you calculate the score a little bit more detailed in this and we're more than happy to help you through that process. Finally, the PI attestation statements for clinicians and groups, they will be prompted to answer yes, as I indicated earlier to the following statements in order to report data for the PI category. Those questions are number one, that you used 2015 Certified EHR Technology for the performance period. That you've attested to the prevention of information blocking. Also that you attest to ONC direct review. Attest to completing your security risk assessment analysis and finally, that you must complete the security risk assessment analysis after the 2015 edition of your EHR technology is in place.

Diana Haniak: Great. Thank you so much Joe. Shirley, can you give us a little insight on to how the improvement activities category has changed?

Laurie Fink: I think the speaker might be muted. Do you want kind of unmute yourself? We're not hearing you. Diana, who is covering this section?

Diana Haniak: I can go over it. This is Diana.

Laurie Fink: Okay, thanks.

Diana Haniak: Got it. The Improvement Activities are worth 15% of the final MIPS score. You must earn 40 points to earn full credit. You must complete most activities for a minimum of 90 consecutive days. You can complete the same activities reported in the previous year or select new ones. We removed the PI category bonus for completing the activity using CEHRT. The total number of activities available in 2019 is 118. There were six activities that were added, five activities were modified and one activity was removed. The new improvement activities in 2019, there are six new improvement activities. We have the comprehensive eye exams. We have the financial navigation program.

Diana Haniak: We have the completion of collaborative care management training. We have the relationship centered communication. We have patient medication risk education and we also have the use of CDC guidelines for clinical decision support to prescribe opioids for chronic pain via clinical decision support. The 2019 modified and removed activities. There were five modified improvement activities. We have the care transition documentation practice improvements. We have the chronic care and preventable care management for empaneled patients. We have the participation in an MOC part four. We have the use of patient safety tools and we also have the implementation of analytic capabilities to manage total cost of care for practice population. The one removed improvement activity is the participation in population health research.

Diana Haniak: There's been no change in submission methods for the improvement activities. There's either attestation via the QPP portal. You can go through your EHR vendor, through our QCDR or a qualified registry. Supporting documentation should always be kept for a minimum of six years. You can review the 2019 MIPS data validation criteria down at this link. The improvement activity scoring. The activity weights remain the same and the number of points awarded are based on the size and/or location of your practice. A high weight is 40 points and a medium weight is 20 points, when a practice has less than 15 clinicians, a practice is located in a rural zip code.

Diana Haniak: A practice is located in the health professional shortage area or HPSA or you're a non-facing eligible clinician. A high weight or 20 points and a medium weight, 10 points is when a practice has over 15 clinicians. The considerations for the improvement activities. If you're reporting as a group or a virtual group, only one MIPS clinician must perform the activity for the TIN to receive credit. For a TIN to receive credit, at least 50% of the practice sites within the TIN must be recognized or certified as PCMH to receive full credit for the improvement activity category. MIPS APMs receive at least 20 improvement activity points and are eligible to receive more points based on their model.

Diana Haniak: There are some changes here in the cost category that we'll review. What stays the same in 2019? The performance period is for the full calendar year. We have no manual submission of data necessary because cost measures are calculated by CMS based on administrative claims. The performance is compared against

other MIPS eligible clinicians and groups during the same calendar year and it's not compared to benchmarks from a previous year. The changes to the cost category in 2019. The weight was increased to 15% of total MIPS score. There are eight new episode based cost measures that will be scored in addition to the total per capita cost, so the TPCC and the Medicare Spending Per Beneficiary Measure.

Diana Haniak: Case Minimums to score a measure include a case minimum of 20 for the total per capita cost. A case minimum of 35 for the Medicare spending per beneficiary. We have a case minimum for 10 procedural episodes and we have a case minimum of 20 for acute inpatient medical condition episodes. The eight new episode based cost measures are as follows. We have the elective outpatient coronary intervention. We have the knee arthroplasty. We have the revascularization for lower extremity chronic critical limb ischemia. We have the routine cataract removal for intraocular lens implantation. We have screening surveillance for colonoscopy. We have intracranial hemorrhage or cerebral infarction.

Diana Haniak: We have simple pneumonia with hospitalization and we have ST elevation myocardial infarction with PCI. Lisa, I'm going to give it to you to tell us what the new facility based measurements are.

Lisa Sagwitz: Thanks, Diana. You may remember at the beginning of today's presentation Marvin talked about special statuses. Things like small practices, rural, non-patient facing providers. A new term for 2019 is facility-based. If you have providers who perform many of their services in a hospital setting, this might be applicable to you and it would impact quality and cost categories potentially. If you have an individual or group that furnishes 75% or more of covered services, in inpatient hospital settings, on campus outpatient hospitals or an emergency room, they might be facility-based. That would be point of service codes 21, 22 and 23.

Lisa Sagwitz: I also wanted to mention that that status will be shown so when you go to the QPP look up with the NPI number, the special status would say facility based and you can also see on the QPP portal preliminary scoring if you might be eligible. Next slide. Clinicians are attributed to a hospital where they provide services to the most patients and groups are attributed to the hospital where the most facility-based clinicians are attributed. If unable to identify facility with the hospital value based purchasing score, then that clinician would not be eligible for facility-based measures. Next slide. CMS automatically applies this measure to MIPS clinicians and groups who are eligible and the benefit would be, you may have a higher quality and cost score.

Lisa Sagwitz: Now, for those providers, they still need to submit improvement activities and promoting interoperability and the link that's shown in blue is an eight page document and it includes a few graphs on cost and quality and shows a potential conversion there. Next slide. The quality and cost scores are based on how well the hospital performs in comparison to other hospitals in the hospital

value based purchasing program. If a hospital does not receive a total performance score for this year, then CMS cannot calculate a facility-based score for a clinician. The new measure of this facility-based is not applicable to ACO participant, the accountable care organizations.

Lisa Sagwitz: The blue link there has a nice fact sheet. The important message I want to mention on this is if you're not sure, you need to research a little more, please reach out to us. At the end of the presentation, we'll have our contact information and we will help you research and put you on the right path for reporting if you do have facility-based individuals.

Diana Haniak: Okay, Lisa. Do you mind going through the changes for alternative payment models or APMs in 2019?

Lisa Sagwitz: Definitely. ACOs are alternative payment models, accountable care organizations and what are they? They're a different payment model that a group of physicians gets added incentives to provide high quality and cost efficient care. In the large blue circle, that's the umbrella for APMs and then you'll see two smaller circles. The green one represents the MIPS APMs. Those are generally the non-risk bearing models. Then, the smaller blue circle represents advanced APMs. Advanced APMs do have two-sided financial risk. They have skin in the game to perform well and get incentives. Most advanced APMs are MIPS APMs. As we go through the next couple of slides, I'll talk about, there's some crossover between them and point it out.

Lisa Sagwitz: If you're in an ACO, scoring is a little bit different. Quality is worth 50%. Promoting interoperability, 30% and improvement activity, 20%. There's a link there for a little bit more information. You may hear about Snapshot dates. March 31st, June 30th, August 31st. If you're an ACO, you want to see that you're a QP or a qualifying participant by one of those first three snapshot dates. That means that you've got full ownership in your ACO for the reporting purposes. CMS is going to have a fourth snapshot date of December 31st but if a provider would come late to a group in the ACO, they're likely not going to be able to participate in the ACO and the APM for this year so a little bit one off scenario.

Lisa Sagwitz: Do you remember I talked about some crossover between the little green MIPS circle and then the little blue advanced APM. This is a list of some potential MIPS APMs but what I want to mention is the one that I really see the most of with no financial MIPS risk. It's probably like the six or seventh one down. Medicare shared savings program or MSSP as it's called, accountable care organization track one. The plain track one. I called that the plain vanilla model. That's the one that has no financial risk and I see the most of those for MIPS APMs.

Diana Haniak: Lisa, can you tell us what makes some APM an advanced APM?

Lisa Sagwitz: Excellent question. The difference between the green circle of the MIPS APMs and the advanced APMs, the smaller blue one, are three things. In an advanced APM, that's when there's financial risk, you've got skin in the game to perform well, at least 75% of the eligible clinicians must be on an EHR that's 2015 certified. Also, the APM must provide payment for covered professional services based on quality measures comparable to those used in the MIPS category. For this year, there are 10 quality measures that the ACOs will be looking for data on and reporting on. Then, the third requirement require participants to bear a more than nominal amount of financial risk.

Lisa Sagwitz: Here is a list of advanced APMs. This would be if you're a qualifying participant or you want to be a qualifying participant. Again, there's crossover with what you saw a few slides ago for MIPS APMs. I'm going to point out the ones that I see the most of and work the most with. The fifth one down, Medicare Accountable Care Organization track one plus. That plus is significant. That distinguishes it from the plain vanilla track one model. They became available in 2018. Also, the shared savings program track two and three. Those are the advanced APMs. I wanted to mention the fourth one down, comprehensive primary care model. We often call it the CPC plus. That's a geographic ACO. In Pennsylvania, you'll see that predominantly in the Philadelphia area.

Lisa Sagwitz: Generally when you're an ACO, all the clinicians in your ACO or all the clinicians in your practice are part of the ACO. If you can go back Diana just to that slide before, but there's one exception. The second one down, that comprehensive care for joint replacement or we call it, CJR for short, the orthopedic groups that I work with, because it only has to deal with joints, the hips, the knees, only those doctors are in the ACO. If you have a hand specialist or a back specialist, they're not included, such as the one off to mention. Go ahead. Next, we'll talk about what are the benefits for being in the advanced APM, the two-sided risk model that you want to do well. There are extra incentives for a sufficient degree of participation.

Lisa Sagwitz: You get greater rewards for taking on a risk related to patient outcomes. You want the patients to do well and show that. Then, there's the financial reward of a 5% lump sum bonus for Medicare that's paid to the practices.

Diana Haniak: Lisa, how exactly does a clinician become a qualifying participant in an Advanced APM?

Lisa Sagwitz: Another good question. For Medicare, there are a certain number of patients, certain number of revenue for the services that are provided that make a provider a qualifying participant. You also may hear the term partial qualifying participant. For Medicare, that's what I predominantly see with the groups that I work with. You want your people to show up on the NPI lookup as a qualifying participant based on those different Snapshot dates. Now, when we move on to number two, the all-payer combination, this is something brand new this year and I don't work with any of those groups yet but again, Medicare, straight Medicare with the current ACOs are.

Lisa Sagwitz: Now, there can be an additional contract between an ACO and CMS to also include Medicare advantage or Medicaid patients or commercial or private payers. That's something I think we're going to see more of moving forward and something that's important for you to know if you're thinking about joining an ACO. Next slide. With that new all-payer combination, same three requirements. The only difference is that only 50% of the eligible clinicians need to be on the 2015 CEHRT. I also wanted to mention as we conclude the APM section, there are going to be some significant changes with ACOs and APMs this summer. Definitely keep your ears open. Talk with the people who you're involved with so that you know what's happening moving forward.

Diana Haniak: Great. Thank you, Lisa. Can you tell us what practices and clinicians should be doing now?

Lisa Sagwitz: Sure. Quality Insights is here to help be successful. Again, any questions you have, you're welcome to put them in the Q and A box and we'll address them, as well as contact us. Just some tips, number one, go to the website, qpp.cms.gov. Look for the box that says, check participation status and put in the NPI numbers. Do your providers need to attest or are they part of a special status group or part of an ACO? Know what you're dealing with upfront. We've mentioned before, the second point. For your EHR, make sure you're on the 2015 certified edition. If you're not, check with your EHR vendor. When are they going to offer it? When can you implement it? This is important to know.

Lisa Sagwitz: Third point, your audit documentation binder. Many of the practices I work with keep both a paper binder and an electronic file. It's never too soon to start printing those back up documents, put a post it note on them, what they represent, which measure, which provider they cover and it really makes your job a lot easier at the end of the year, when you're trying to put all that data together. On the HARP account, you'll remember in 2017, everyone needed something called an EIDM account, with a username and a password to do your attesting. Then, in 2018, that was changed to a HARP account. Make sure someone in your practice has a HARP account with a username and an active password. Then, security risk assessments, you must do those every year.

Lisa Sagwitz: You want to be sure that's being performed once you have your 2015 CEHRT on your EHR. Next to last bullet point, through MLN LMS, there are some resources that you can access once you sign up. Then, the last point, Quality Insights has a nice resource library, that's how to get to it. If you are one of the new provider types like a physical therapist or occupational therapist, we have individual flyers on each of those to help guide you. This is how to get a hold of us. The top section is for small practices of 15 or fewer providers. There's the phone number, the email, the website. If you're in a group with 16 or more, Kathy Wild's information is there and phone number.

Lisa Sagwitz: She'll get the referral to us and we generally will get back to you within 24 hours but the important message is we're here to help you and help you be successful

with this program. We'll turn the presentation back over to Laurie to start our question and answer session now.

Laurie Fink: All right, thanks so much, Lisa. Yes, we still have some time left so if anyone has any questions, please go ahead and submit them via the Q&A feature in Webex, that's at the bottom right of your screen. I noticed we did have a couple of questions submitted throughout the presentation and thank you Rebecca and Amy for addressing all of those questions. The first one was how do I register for the CMS web interface? Rebecca replied with a link to where you can find that information as well as where do you find the benchmarks, there's also a link that you can access there if anyone else has a similar concern. You can use that link that she inserted in the answer portion under that question.

Laurie Fink: We will just kind of pause here for a minute or two. Feel free to send in your questions and we'll address them now. Two questions just came in about accessing these slides. I did email the slide deck to everyone who registered for today's session, probably around 11 so check your inbox for that. You should have the slides. If for some reason you did not get them, please send me an email at lfink@qualityinsights.org and I will make sure to get them to you. We will also be posting them on both of our websites and you will see the web address up on your screen now. You just need to go to the events and archived events section and all of the resources from today's presentation will be there.

Lisa Sagwitz: Laurie, it is Lisa. One thing I can mention for the group and the person who asked about this CMS interface registration, the website, qpp.cms.gov, when you log on, that screen that pops up has the link for the registration. For anyone who's not familiar with that, ACOs report that way and groups of 25 or more have that option. If you're a group of less than 25, it wouldn't even apply to you.

Laurie Fink: All right, here's a question that just came through. Did I hear correctly that voluntary reporting, either exempt small practices will provide for the bonus points?

Lisa Sagwitz: Hi. It's Lisa.

Amy Weiser: Hi. This is Amy.

Marvin Nichols: Hi. Lisa this is ... Go ahead Amy.

Amy Weiser: Go ahead. Okay, just to clarify, okay, if you voluntarily report for MIPS, meaning that you are not eligible to report but you want to report anyway, you can neither receive a negative payment adjustment nor a positive payment adjustment. You are simply reporting your information. I hope that answers your question and so if you're voluntarily reporting, I don't believe you would be eligible for bonus points but I would refer to my colleagues on that, thank you.

Marvin Nichols: Yes, Amy you are correct. What CMS will do, CMS will provide you a performance feedback, based off the data that you submitted. However, you will not be subject to that adjustment, either positive or negative. They will just show you ... They will show you, say, "Hey, this is what you would have received as your MIPS score if you are participating in the program."

Lisa Sagwitz: Correct and there's a difference between voluntary reporting and the term opt-in. Opt-in is when you make the commitment to report and then you have to fall within certain guidelines and you would get a potential payment adjustment.

Laurie Fink: All right. Thanks Lisa, Marvin and Amy for addressing that question. We did have another one, asking will you have a similar web seminar later. We tend to have these webinars monthly or every other month as new information comes out on the QPP program. I'm not sure if we've determined the topic for our next session yet but we definitely will let everyone know as we put our schedule together for the rest of the year, what we will be offering. Amy, do you know if we have any other upcoming webinars and what the topics will be?

Amy Weiser: Thanks, Laurie. Great question. We actually will be planning a promoting interoperability webinar so it will be focused solely on that category in the near future, probably within the next month or so. I don't have a firm date on that but I just wanted to just remind everyone that on the third Thursday of every month, at 9:30 AM Eastern Standard Time, we do have QPPLive! and that is a great opportunity for you to ask us any questions about the quality payment program. As time progresses and we come up with a plan, we will of course make sure that you know about it but at QPP Live you can ask us questions there as well so thank you.

Lisa Sagwitz: I think another comment that might be nice to add is we do record these webinars so we covered a lot of information today and like Laurie said, in a few days, this will be posted to our website and you could go back and listen to it or print the slides that are applicable to you and put notes on it and that resource will be there for the entire year.

Marvin Nichols: As always, if you have any questions or concerns, please reach out to the brightest transformation specialist that are working in your area or send an email to one of those email address to the inbox for the QIN or the small practice and we usually respond within 24 hours.

Laurie Fink: I think we have time for one last question. This one comes to us from Jeanne Pollard. She said my doctors only see inpatient, will Medicare make them automatically facility based or is there something I must do on our end?

Lisa Sagwitz: Inpatient hospitals or inpatient at hospitals only. I'm assuming that's what she's asking. If her doctors are only seeing hospital inpatients, I would expect that the special status would say facility-based so how to determine that? You want to go to the website, qpp.cms.gov. Find the check participation status box, enter

each of your doctor's NPI numbers and look for the special status box and see what it reflects. Then, again, if you need help and want to work with us, definitely reach out and we can go through that with you.

Laurie Fink: All right. Well, we are quickly approaching the 1:30 mark so I'll take this time to thank our great panel of experts and speakers today and also thank everyone who was able to join us for this session. Just a quick reminder that when you close out of today's session, you will be automatically directed to a very brief evaluation. We ask that you please take a moment to complete it. We really do appreciate your feedback and all of your comments. Thanks again for joining us today. Have a great rest of the day and this session has now concluded. Thank you.

This material was prepared by Quality Insights, the Medicare Quality Innovation Network-Quality Improvement Organization for West Virginia, Pennsylvania, Delaware, New Jersey and Louisiana 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 QI-D1M-053019