QPP*Live!*
Transcript from Live Session

Thursday, August 15, 2019

Quality Insights
Quality Payment Program Support Center

Shanen Wright: Good morning and welcome to QPPLive!, a presentation of the Quality Insights Quality Payment Program Support Center. We're pleased that so many of you have joined us today and are wanting to learn more about CMS's Quality Payment Program. If this is your first time joining us, no worries. We will explain how the process works to submit your questions here in just a moment. If you're a returning guest on QPPLive!, you can start submitting your question using the Q&A box in the Webex player at any time. And we'll get to as many as time will allow for today. But before we get to the Q&A portion of today's show, it's my great pleasure to turn things over to Rabecca Dase, for today's breaking news and announcements. Rabecca?

Rabecca Dase: Hi, good morning everyone. So there is a lot of information to cover today, so bear with me. We're going to kind of jumping from different topics, but there's a lot of good information we want to pass on to you guys.

Rabecca Dase: So first off, CMS has released the 2020 Quality Payment Program proposed rule for the next performance year of 2020. They did this at the end of July. It's very long, but I highly recommend maybe skimming through it to see, because right now they're accepting comments on that. Some key changes that we're seeing for the 2020 performance year include increasing the performance threshold from 30 points to 45 points. So in order to avoid a penalty next year in 2020, you would need to earn a minimum of 45 points. And again, that's proposed, it hasn't been finalized. So again, if you have a problem with that or you think it is okay, they are accepting comments on those things.

Rabecca Dase: Some other things that we're seeing is the decreasing of the Quality category from 45% to 40% of your total MIPS score. And the reason for that is because the Cost category is, in fact, increasing from 15% to 20% of your total MIPS score. And another big change that we're seeing is increasing the data completeness threshold for the quality measures from 60% to 70%. So in the first couple years, you only had to submit 60% of your eligible patients to be considered, you know, your data completeness. But now they're saying you must, or proposing, I should say, that you must submit 70% of all eligible cases in order to meet that data completeness threshold.

Rabecca Dase: So on the next slide, we can see some additional key changes that we wanted to highlight. And one of those being that at least 50% of the clinicians in your group must perform an improvement activity in order for you to receive credit. In the first couple years of the program, it's in fact been if one clinician did the activity, the whole group could get credit for it. But now they're proposing that

at least, if you're reporting as a group, that 50% of the clinicians in that group would need to perform that activity. And some... this could possibly raise an issue for some multi-specialty practices, you know, getting those specialists on board and things like that. So this could be something to keep your eye out for in the coming days.

Rabecca Dase: Another big change is the increasing of the exceptional performance threshold bonus from 75 points to 80 points. The exceptional performance threshold is where, once you meet that threshold, you can get put into an additional pool of money for some additional incentive dollars outside of the MIPS payment adjustment. So they're making the program a little bit harder to avoid the penalty and to earn the extra incentive dollars. So just keep that in mind.

Rabecca Dase: And then, they are proposing to add 10 new episode-based measures and then revising the current Medicare Spending per Beneficiary measure and the Total Per Capita Cost measure.

Rabecca Dase: So on the next slide, one of the big proposals that they're making, and like you could see on slide one, the proposed rule is like 1700 pages long, so 700 of those pages are actually talking about a new proposal which wouldn't take effect until 2021, and it's actually called the MIPS Value Pathways. They're trying to design a new way for clinicians to participate in the MIPS program, and they're trying to united and connect measures and activities across the categories and, in turn, streamline the reporting burden. You know what, CMS is listening, and what they're hearing is it's still cumbersome, it's still confusing, there's a lot of different options. So they're really trying to make it meaningful for the clinicians participating, making specialty-specific conditions and things like that, so these clinicians can actually do something that's going to improve the care in their practice and not feel like they're just running around trying to just scramble to report.

Rabecca Dase: I am actually putting in the chat box right now a CMS resource to the MIPS Value Pathways. It's a zip file. You can open it up and there's a little guide on it, along with some examples which we have here on the next couple slides.

Rabecca Dase: So on the next slide you can see an example for the MIPS Value Pathways for a diabetes condition. On the next slide we included surgery, and again, those are in the files that I did just post in the chat box. So check those out if you'd like.

Rabecca Dase: All right. And then on the next slide, so as I was talking about all the proposals that CMS is putting out, I mentioned they were accepting comments. CMS is accepting comments on this proposed rule until September 27th at 5:00 pm. And we have here listed the ways that you can get them your comments. They have to be submitted in a specific way for CMS to accept them and to hear what you're saying. So we've listed that here. So again, review the final, or proposed rule, and then if you have any comments to submit, you can submit them in one of three ways.

Rabecca Dase: So on the next slide we have listed just some resources to the proposed rule, the press release, and some different things. Those are live links, so you should receive the slides this morning and you can go ahead and click on those links to get some great resources on this proposed rule.

Rabecca Dase: So switching gears a little bit, obviously clinicians love to have real time information. So CMS is actually launching a pilot program, and it's called “Data at the Point of Care”, and this will enable providers to have information such as diagnosis, medication list, past procedures available at their fingertips, so they know who they're dealing with, what these patients had, and they'll have their complete medical history right there in front of them. And again, it's a pilot program beginning in September. We do have a link here where if you're interested in learning more about the program or what you can do to participate, you can click here and go on and kind of read more about that program.

Rabecca Dase: So we're kind of covering a lot of bases, but again, there's so much good information we didn't want to miss anything. We wanted to share it all with you to make sure you're well informed. The next thing is patient relationship category codes. So the voluntary reporting for these category codes has been available since January 1st of 2018. So we're at almost two years of this being available. Some people are adopting it, some people aren't. But CMS is advising clinicians to start the voluntary reporting on this now, because it may be required for cost measure attribution methodology in the future. And they're actually proposing in the proposed rule that if you are using these relationship category codes in 2020, they can count toward an improvement activity. So that's something to keep in mind. And if you're like, "What are patient relationship category codes?" we did include a link here to the information where you can find more information on these. It's been talked about for a few years, but it's kind of been one of those things that have just been hanging out in the back. But it's really starting to come to the forefront.

Rabecca Dase: On the next slide, we did include the list of the patient relationship category code modifiers that you would typically see on specific encounters for providers. And again, the link on the previous page can kind of take you to some more information on this topic.

Rabecca Dase: So again, moving forward, there have been some updates to the QRDA's III Implementation Guide, and that's been released. Now, a lot of times this doesn't specifically, or I should say directly affect a practice, but we still like to bring it to your attention. A lot of times this applies to the vendors, but in the end, affects you guys, so we want to make sure that you have the information readily available there. You can... There are live links there where you can go in and see what some of the changes are and things like that. And I looked at it briefly this morning, before jumping on the call, and something that I noticed was the proposal for during your out of station for 2019, entering your certification ID number, similar to what we have to do for meaningful use when you're promoting for inter or reporting for promoting interoperability, you

would actually enter the certification number for your EHR. That's something I'd noticed when looking at it.

Rabecca Dase: And then on the next slide, something is worth noting, is we've had conversation come up before. It's also proposed for 2019 to change the Query of Prescription Drug Monitoring Program to a simple yes or no response. Initially, we were thinking it was going to be a numerator and denominator for the bonus measure in the Promoting Interoperability category, but in the proposed rule in the implementation guide, they're showing the proposed change, again, to the yes or no response rather than a numerator and denominator, which I think a lot of people are probably breathing a sigh of relief for.

Rabecca Dase: Next slide. All right, so the 2018 MIPS results have been released. I'm hoping many of you have gone and reviewed your 2018 MIPS feedback, but we just want to cover what the results were looking like from an overall standpoint. So for 2018, it looks like over 98% of people participated in the MIPS program. That's huge. And then over 97% of patients scored above 15 points, making them eligible for the positive payment adjustment. And if you look at your feedback, you're probably thinking, "My feedback's not what I..." or your payment adjustments for 2020 aren't what you expected them to be. Remember, it's a budget neutral program, so when you have over 97% of people participating and being eligible for a positive payment adjustment, they have to spread that money out across several people.

Rabecca Dase: And jumping on the next slide, or the next point, you can see 1.95% will receive a negative payment adjustment. That says a lot. So we had high volumes of clinicians participating, being successful in the program, and just a small, small handful not participating. And a MIPS perfect score of 100 points, at this current time we're seeing a 1.68% payment adjustment in 2020. And that would include the MIPS adjustment along with the exceptional performer bonus. We included a live link here from CMS Administrator, Seema Verma, kind of explaining the progression of the program and the results of the 2018 performance year.

Rabecca Dase: So on the next slide we did want to highlight too that audits have begun. I know that we mentioned it last time on our QPPLive! event, but we have a little bit more information, so we just want to reiterate and share that with you. CMS is contracted with Guidehouse to conduct these data validation audits. They are currently conducting them for the 2017 and 2018 MIPS performance year. You would either receive a request via email or certified mail, or certified letter. If you do, in fact, receive a request to participate in this audit, you have 45 days to comply and provide them with the information that they need. If you don't provide the requested information, CMS may take further action, and one of those could include the possibility that you would be selected for a future audits, and nobody wants that, so if you do happen to get a letter for an audit, please comply. There is some more information we've included.

Rabecca Dase: On the next slide we've included a request letter that one might receive if they in fact did receive the request. This is something that it would look like. And then on the next slide we've included some audit resources that CMS has provided, and I am actually posting in our chat box right now a tool for audit documents that we created here at Quality Insights to help you organize your documentation. We created it last year for the 2018 performance year, but it really kind of just guides you of information to collect what you should have and just gather all of your information so it's in one central place.

Rabecca Dase: So on the next slide, as I mentioned, I hope that many of you have gone in to look at your 2018 MIPS feedback. It's very important that you do so. There could potentially be errors, and if there are errors, you need to bring that to CMS's attention. You have until September 30th of 2019, so the end of next month, to submit what's called a targeted review if you in fact see errors in your feedback. And we do have a fax sheet here, along with an FAQ document that would kind of help you understand the targeted review process. And again, here at Quality Insights we're more than happy to help you look at that stuff and figure out what we need to do.

Rabecca Dase: And to access your feedback, I just want to highlight, you would log into the Quality Payment Program website where you actually submitted your data initially. You would log in with your HARP account and you could see your feedback there. I'm also putting in the chat box a feedback FAQ document so if you were curious about what you were seeing on the doc, or in your feedback reports, or maybe just wanted some more information, I did just put in the chat box a feedback report frequently asked questions document.

Rabecca Dase: So on the next slide, we also, in addition to some of those resources I was just talking about that Quality Insights had, we also have two new quality resources, and one of those is the MIPS Quality Measures by Submission Method. So this actually takes all of the measures and breaks them down, again, by submission method, so you can see specifically what measures were available for what submission method you were choosing. And then we've talked about this measure, or resource, before was updated, the Topped-Out Quality Measure. This resource, again, kind of groups the measures, and we've sorted them by topped-out measures of what's going to be harder to earn the points on, and we've also highlighted the quality measures that earn a maximum of 7 points because of how they're topped out. So we just wanted to highlight those.

Rabecca Dase: So switching gears a little bit. On the next slide today, we're going to highlight the Cost category. We've been trying to highlight a MIPS category every week just to remind you, maybe get your brain thinking, maybe ask some additional questions. So this week's highlight is on the Cost category. It is worth 15% of your total MIPS score. CMS does not require any additional reporting for this, it's all based on administrative claims that they collect throughout the entire year. Included in this category are the Medicare Spending per Beneficiary measure, the Total Per Capita Cost measure, and the new eight episode-based measures for 2019.

Rabecca Dase: So the scoring for these measures. On the next slide you can see a MIPS eligible clinician, in order to be scored, they must have enough attributed cases to meet the threshold for those measures to be scored. And you're saying, "Well, what if we can't score them all?" So if you can't score them all, when only one cost measure can be scored, the measure... that measure will serve as your Cost category score. When more than one cost measure can be scored, the Cost category is the equally-weighted average of all the scored measures. So for example, if seven of 10 cost measures are scored, this means the score is equally weighted over the average of the seven measures. And then if no cost measures can be scored, the Cost category is re-weighted to zero and those points are re-weighted to the Quality category, making that worth 60 points.

Rabecca Dase: On the next slide. So on the scoring, CMS takes your cost measure performance and they compare them to benchmarks. And the nice part about the benchmarks of the cost is they're actually compared to the performance, the current performance period. The quality measures are usually, the benchmarks are based on historical data where your cost measures are actually, again, compared to benchmarks created for the current performance period. So for 2019, they would be compared to 2019 benchmarks. And just like quality measures too, clinicians can earn between one and 10 achievement points for each measure, and based on their performance in comparison to the benchmark.

Rabecca Dase: So on the next slide we did just include a quick overview of the example of how the Cost category would be scored. So you can just review that. So on the next slide, jumping into the measures a little bit more in detail, the Medicare Spending per Beneficiary measure, this represents the total Medicare Part A and Part B costs incurred by a single beneficiary during an episode. The episode is considered three days prior to an index admission and then 30 days after the hospital discharge. So that's a big window. So three days prior and 30 days post discharge.

Rabecca Dase: So on the next slide, we talk about the attribution. In order to be scored for this measure, you need to have at least 35 episodes attributed to you. And episodes are attributed to the clinician who provides the most Part B physician or supplier services measured by the dollar amount during the period between the index admission, which is three days prior, and the discharge date, which is 30 days post. So, and again, this includes all Medicare Part A and B claims for the items and services during that episode window.

Rabecca Dase: So how is this measure scored? Or how to increase your score, I should say, on this. So know which clinicians your patients are seeing. Care coordination is something that we continue to hear more and more about. Knowing where your patients are going, how to keep them out of the hospital, how to keep them out of the ER, looking at readmission, post-acute care services, and again, care coordination is huge. Some things that we suggest, follow up with your patients that utilize the ER. Educate them on when it's appropriate to go to the ER. Are you doing things in your practice, you know, same day visits, acute visits and

things like that? Are you getting them in after they're in the hospital, maybe to manage them in outpatient setting? Those are all things you can look at, and just a few suggestions of how to keep that cost low.

Rabecca Dase: So on the next slide, we're kind of jumping toward the Total Per Capita Cost measure, and this represents a risk adjusted cost per capita for total Medicare Part A and B for a beneficiary during a performance period. And again, a performance period is the entire year. And beneficiaries are attributed to a single TIN-NPI based on the amount of primary care services a beneficiary receives. So whoever has the majority of the primary care service during a performance period, would in fact have the patient attributed to them.

Rabecca Dase: So on the next slide, this measure will be scored if you have 20 beneficiaries attributed to you and 20 beneficiaries must be assigned for individual reporting, so it would be the clinician TIN-NPI level, or if you're reporting as a group, it would be 20 beneficiaries must be assigned to the group of 10 TIN-NPI under the group's TIN.

Rabecca Dase: So how to increase your score. So again, I said it's based on whoever provides the most primary care services. So it's very important. I know specialists are like, "Well, we don't... why do we have these patients? We don't provide primary care services." Sometimes you do, and something to think about is making sure that those patients are getting back to their primary care clinicians. Referring them back, encouraging them to seek that primary care from their primary physician.

Rabecca Dase: Another thing you can do is review your data at the patient level. Know who you're treating, who's attributed to you, making sure your billing services correctly, really working on those wellness appointments. Encouraging patients to get their breast cancer screenings, mammograms, things like that. And be aware of your patient population and their needs. Again, know who you're treating and what their requirements are.

Rabecca Dase: Next slide. So for the episode-based measures, again we said there were eight episode-based measures for 2019, and episode-based measures represent the cost to Medicare for items and service furnished to patients during an episode of care and are calculated using the fee -for-service claims. So the measures reflect the cost of care for an episode and they're looking at acute inpatient medical conditions or a procedure. And these differ from the Total Per Capita Cost measure and Medicare Spending per Beneficiary measure because the costs that they are looking at are only the costs associated with that specific inpatient condition or procedure during that given time frame.

Rabecca Dase: So on the next slide we did highlight what in 2019 eight episode cost based measures were. So you can review those there. And then, so on the next slide, we kind of just highlight the episode groups. Episode groups, or episode measures, are categorized into episode groups, and these groups represent a clinically cohesive set of medical services rendered to treat a given medical

condition or a major procedure. It aggregates all the items and services provided for a defined patient cohort to assess the total cost. So they're taking everything into account and they have their idea of what it should cost to provide or treat an inpatient condition or a procedure.

Rabecca Dase: So on the next slide we're talking about the episode-based case minimums, again. So just like the Medicare Spending per Beneficiary and Total Per Capita Cost measures, these episode-based measures also have case minimum requirements. So for procedural measures, you must have 10 episodes attributed to you to be scored, and for the inpatient medical condition measures, it would be 20, a 20 case minimum. So for procedural episode-based episode groups, these are attributed to a patient who render, or provider who renders the trigger service, and this is identified by the CPT or HCPCS code. So whoever initiates a procedure or, yeah, the procedure, the trigger service, would be the one attributed to that patient. And then for the acute inpatient medical episode group, it's based on E&M claims and that renders the 30% of the inpatient E&M claim lines for that hospital would have that attribution.

Rabecca Dase: So you may be thinking, “That's a lot of information.” I apologize. And so, on the tips for success in the Cost category. What can you do to be successful in this Cost category? So there's different things that you need to take from all of those different things that we just mentioned. Know where your patients are going and things like that. Review your 2018 MIPS feedback report that just came out. See if you were scored on any of these cost measures. Look at the summary of care information from specialties, and again, know where your patients have been. Know where they're going. Track your outpatient care. Encourage the wellness exams. Work with your local hospitals and things to know about discharges and ERs and things like that. And follow your patients. That care coordination we were talking about, ensure that they're going to their specialist referral visits and educate your patients whether it's on ER use, chronic condition management, and things like that. Because really, education is key sometimes and we can only really do so much, but we really need to start educating our patients on what they can do to help as well.

Rabecca Dase: So on the next slide we did include some cost resources, some links to some great resources. Again, all live links. On the next slide, as well, there's some more resources for the QPP website. There were some new resources updated, and some new resources added. Again, on the next slide, again, more resources. The Quality Payment Program website, the qpp.cms.gov, contains a wealth of information. And they're always updating that live, so we're trying to include it there for you.

Rabecca Dase: On the next slide we've highlighted two upcoming educational events for the quality category. One that takes place next Tuesday, and then they'll also re-air that event on Thursday the 22nd, so you have two opportunities to catch that. And it's maximizing your quality score and what you can do for that. So I will turn it back over to you, Shanen, to go ahead and move on. Thank you.

Shanen Wright: Thanks so much, Rabecca. Great information there, and it's my great pleasure to introduce you to our team of experts here on the QPP Team, which include Kathy Wild, who is our Project Manager, Amy Weiser, who's the Lead Project Coordinator of our QPP Support Center. I'm Shanen Wright, the Associate Project Director. Also joining us today we have Rox Fletcher, Andrea Phillips, Shirley Sullivan, Marvin Nichols, Joe Pinto, Julie Williams, Paula Clark, Rabecca, who you just heard from with the news, and Lisa Sagwitz.

Shanen Wright: Now, if you're wondering how QPPLive! works, maybe this is the first time you've been with us, all you have to do is type your questions using the chat, or using, rather the Q&A feature you see there on your screen. You see the little button, if you hover over your WebEx player? It will pop up. There are three little dots on it. You click on that and Q&A comes right up. Very easy to do so. We ask you to please use the chat, or Q&A button, rather than the chat button, for your questions, because we will be sending you direct links to the resources that we're talking about. Actually already have. Rabecca's got them in there in the chat box that way it's a one-click solution to get to the resources you need that we are talking about on QPPLive! today.

Shanen Wright: Now, I know most of you are listening on your computer speakers, but some of you may have called in on your phone. If so, you'll have the opportunity to ask questions verbally. Once we've gotten to that point in today's show, we will unmute the phone lines and you can start asking your questions. We do ask that if you don't have any questions or comments for our panelists, that you please mute your phone on your end so that way we won't hear what's going on in your office, home, wherever you may be tuned into us from today.

Shanen Wright: We've also got some special polling questions coming up. Some are going to be asking you about your progress with the Quality Payment Program and how you're doing, and we've got some fun ones as well. So a lot of great things coming up. You can go ahead and start submitting your questions now, and keep in mind that we are here to help you any time, not just on the third Thursday of each month at 9:30 am, during QPP Live!. If you don't realize who your contact is at Quality Insights, you can always use our general QPP inbox for inquiries, or reach out to any member of the Quality Insights team. We'll make sure that you get the help you need.

Shanen Wright: We'll do the best we can to answer all the questions today, but know that sometimes you guys have really good questions that we need to do a little bit more research on. If that's the case, we'll be happy to follow up with you directly. Please also keep in mind that rules and interpretations change over time, especially if you're viewing this as a recording and not on August 15, 2019, so keep that in mind.

Shanen Wright: Most of all, we here at Quality Insights, want to establish a relationship with you so you can succeed in the Quality Payment Program. We're going to ask you about whether you've reviewed your 2018 feedback report coming up, but first,

let's go out to the Q&A box for a question here. This one asks, "What are the 2019 improvement activities performance category reporting requirements?"

Shirley Sullivan: Hi Shanen, and I can take that one.

Shirley Sullivan: The Improvement Activities category is worth 15% of your total MIPS score and needs to be completed for 90 continuous days, so the maximum number of points available for the improvement activity category is 40. If you achieve 40 points in this category, then it will translate into being 15 points of your total MIPS score.

Shirley Sullivan: So how do you get to those 40 points? Now most, generally most eligible commissions will get 10 points for a medium-weighted activity, and 20 points for a high-weighted activity, except if you're a clinician with a special status. Now if you have a special status, you receive double points, so you'll receive 20 points for a medium activity and 40 points for a high-weighted activity. And some of the special statuses are if you're a small practice with a TIN consistent of 15 or fewer clinicians, if you practice in a rural area or in a HIPSA, if you're non-patient [inaudible 00:30:00], if you're participating in an APM or a MIPS APM, or you're a practice certified as a PCMH, a patient-centered medical home or comparable specialty practice.

Shirley Sullivan: So if you're, for instance, for example, small practice, you need to achieve 40 points, you could do that by doing two medium-weighted activities or one high-weighted activity for 90 continuous days to achieve the 40 points in that category, which will then translate to 15 points in your total MIPS score. And that 15 points will get you halfway to the 30 points you need to avoid the penalty, so this is definitely a good category to do.

Shanen Wright: Thanks, Shirley. We're going to ask you a question now, so get ready to answer this. It will pop up on your screen. We want to know, have you reviewed your 2018 feedback report? Yes; no, haven't had time; no, I don't know how to access it; or, what's a feedback report? You've got time to enter your answers now and we'll see what you had to say about that.

Shanen Wright: But in the meantime, let's go out and get another question here from our audience. This one asks, "What are the reporting requirements for individual MIPS eligible clinicians and groups that participate in a recognized or certified PCMH or comparable specialty practice?"

Amy Weiser: Hi, Shanen. This is Amy. I can take that one, thanks. A MIPS eligible clinician who is in a practice that is certified or recognized as a patient-centered medical home, including a Medicaid medical home model, medical home model, or comparable specialty practice, will receive 100% for the improvement activities performance category. So that would be the full 15 points. For the 2019 MIPS payment year, at least one practice site within the group's TIN must be certified or recognized as a patient-centered medical home or comparable specialty

practice. For the 2020 MIPS payment year and future years, at least 50% of the practice sites within a group's TIN must be recognized as a patient-centered medical home or comparable specialty practice. A MIPS eligible clinician or group must attest to their status as a patient-centered medical home or comparable specialty practice in order to receive the full credit.

Amy Weiser: Reporting requirements for individual MIPS eligible clinicians in groups that participate in the APM or MIPS APM, MIPS eligible clinicians participating are scored under the APM scoring standard are assigned an improvement activities performance category score, and this score will be at least 50% of the highest potential score, and may be higher. So I think that's all I have for that question. Thank you.

Shanen Wright: Thanks, Amy. Let's take a look at your polling results, and it looks like the vast majority of you have reviewed your 2018 feedback report. We've got 82% indicating that. Only 6% said they hadn't had time, and 6% said they don't know how to access it, and it appears everybody knows what a feedback report is.

Shanen Wright: Regional trivia time is coming up. Let's test your knowledge about how much you know about the states we serve with the Quality Payment Program from Quality Insights, but first, another question. This one asks, "What are the 2019 performance period cost performance category measure?"

Amy Weiser: Shanen, I can take that one.

Shirley Sullivan: Hi Shanen, I'll take that.

Amy Weiser: Go ahead, Shirley.

Shirley Sullivan: Oh gosh, sorry about that. I didn't get myself unmuted. Okay, so there are, as Rabecca had reviewed in the slides, there are 10 cost measures used to evaluate you for this year for 2019. Both the TPCC and the MSPB were measures that were evaluated in 2017, 2018, and again for 2019. Now, there are those new eight episode-based cost measures new for 2019, and again, if they don't apply to you, any of these measures, you won't be evaluated on them. You have to meet the case minimums. And I would recommend that you look at the 2019 cost fact sheet, it really goes into great detail regarding these measures. And I think we included the link of the new eight based measures on our slide. Thank you.

Shanen Wright: Thanks, Shirley. Let's play trivia time right now. We serve many states with our Quality Payment Program, so we want to know, do you know what the state bug of New Jersey is, the official state bug? Is it the butterfly, the honeybee, the ladybug, or that nasty thing squashed on my windshield? We'll have the answer coming up. Let's see if you know that.

Shanen Wright: But next, another question in the meantime. This one asks, "Is it still possible to be classified as a patient-centered medical home?"

Amy Weiser: Hello, this is Amy. I'm not entirely sure of the context of your question, but yes. If you mean in terms of getting credit for the improvement activities, absolutely. You can get improvement activity points actually if you get the full points for patient-centered medical home in 2019 as long as at least 50% of the sites in your group, if you have more than one site, are PCMH recognized.

Shanen Wright: Thanks, Amy. Let's take a look. Oh, it appears we have stumped you on this edition of QPP Live! We usually don't. 43% indicated it was the ladybug. It's not. It's actually, what 29% of you said, the honeybee. 10% indicated a butterfly and 14, ugh, I don't know what that thing is but it was hard to scrape off my windshield.

Shanen Wright: All right. Let's go out to our questions again and see what we've got on the list here from our audience. This next one asks, "What is facility-based measurement?"

Amy Weiser: I can take that Shanen. Our goal for CMS, this is coming from CMS, for measuring performance at the facility level is to reduce reporting burdens for MIPS eligible clinicians who are facility based. During the 2019 MIPS performance year, we will give the MIPS eligible clinicians, meaning CMS, who are facility based and working primarily in hospital settings, an opportunity for their quality and cost performance category scores to be based on a hospital's performance under the hospital's value-based purchasing, or VBP program. As value-based programs across different healthcare settings become more widespread, we will consider expanding this opportunity to other facility types and programs as appropriate in the future. Thank you.

Shanen Wright: Thanks, Amy. Another question for you about your security risk analysis, next. But another question first. This one asks, "How will CMS determine who is facility-based?"

Shirley Sullivan: I can take this one Shanen. For 2019, the determination period for facility-based is based on Medicare Part B claims billed by clinicians between October 1, 2017, and September 30, 2018, including a 30-day claims run-out. You will be identified as facility-based when you go to the QPP participation look-up tool and put in your NPI. It will list whether you are eligible for facility-based or not. And the way they determine that, is if you billed at least 75% of your covered professional services in a hospital setting, and those settings would be inpatient point of service, 21, on-campus outpatient hospital point of service, 22, or emergency room point of service, 23. So 75% of your covered services have to be in these three point of services. And then, also at least one claim has to be billed to the inpatient hospital, which is the point of service, 21, or the point of service, 23.

Shirley Sullivan: And then also, in order to be attributed to a facility, to be considered facility-based, you have to be attributed to a facility that has a hospital VBP score. So if you're not sure if you're facility-based, I would recommend that you go to the qpp.cms.gov website, look at your participation lookup tool, put in your NPI number, and it will list for you whether you're facility-based or not. Thanks, Shanen.

Shanen Wright: Thanks, Shirley. Sure. We want to know from you right now, have you completed your 2019 security risk analysis? The options are: yes, we did it last year so we're all set; we have it scheduled to be completed at a later date in 2019; or what the heck is an SRA? We want to hear that from you. But while you are sharing that, let's go back out for another question from our audience here.

Shanen Wright: This one says, "If we got a small practice hardship exception last year, do I need to reapply again? We are a two-doc radiation oncology practice and almost everything is outpatient. So how does the cost category apply? Seems mostly related to inpatient admission."

Amy Weiser: Hi Shanen. Thank you for the question. So it sounds like there's two parts to your question. The first is about the hardship exception. The hardship exception, you have to apply for that every year if you are interested in applying for that, and as of today, I looked this morning, there is no application yet available on the QPP website for the hardship exception application. So be looking for that. It should be coming out soon, they said in the summer. It's mid-August now, so hopefully that'll be coming out soon. And again, if you need any assistance at all with that, please reach out to us and we will help you with that.

Amy Weiser: And then your next question about the cost and your specialty. If you submitted for the Quality Payment Program in the past, I would suggest, you know, if you submitted for 2018, you can go into the QPP portal and look at your feedback information currently to see how you scored on the past measures. And if you would want more assistance related to that, please reach out to one of us directly and we will help walk you through that as well.

Shanen Wright: Thanks, Amy. Let's see if you have completed your 2019 security risk analysis. It's pretty evenly split with our responses here: 30% said yes; 30% said we have it scheduled to be completed later in 2019; 20% indicated that we did it last year, so we're all set; and 20% are still wondering what an SRA is. We've got at least one more polling question coming up for you. If you've got a question, make sure you get it in before we run out of time on today's QPP Live!

Shanen Wright: Our next question asks, "What are the data submission requirements for clinicians who are determined to be facility-based?"

Shirley Sullivan: Hi Shanen, I can take this one. CMS will automatically apply facility-based measurement to the quality and cost category scores if you were determined to be facility-based, either as an individual or as a group. So you don't need to opt

in or submit data for quality performance category to be considered facility-based measurement. Now, if you are considered a facility-based clinician and you decide, well, you do want to submit quality data anyway, you can and CMS will look at both ways, so they will look at your quality and cost under facility-based and score that, and then they will also look at the quality data you submitted and the cost outside of the facility and score that, and they will give you the highest of the two scores. But you don't, if you're facility-based, you do not have to submit any data on the quality category.

Shanen Wright: Thanks, Shirley. Another fun polling question next. But first, another question. "How does this impact quality and cost performance category scores?"

Amy Weiser: Hi, this is Amy. I can take that one. So, for individual MIPS eligible clinicians groups and virtual groups who are determined to be facility-based, CMS will incorporate all the measures used into the hospital VBP program for the program year specified to calculate the quality and cost performance category scores. Specifically for the 2019 MIPS performance year, CMS will calculate the facility-based quality and cost performance category scores based on the total performance score calculated under the hospital value or VBP program, excuse me, during fiscal year 2020. And there is a list of measures that we can include, but they weight, excuse me, CMS will include to calculate the total PPS during fiscal year 2020. And if you would like more information about this, it is on the QPP website under the resources. You can look there or you can reach out to us and we will help you with that as well.

Shanen Wright: Thank you, Amy. Now we've got another polling question for you. This one has to do with something that happened on this day in 1972, the actor Ben Affleck was born in Berkeley, California. Which superhero has Ben not played in a Hollywood movie? Is it Daredevil, Batman, Superman, or MIPS Man?

Shanen Wright: We'll be looking forward to getting your responses to that, and while we do, here's another question. Make sure and get them in, we've only got about five more minutes to go today on QPP Live!. This next question asks, "Will there be an opportunity to preview what facility-based measurement looks like?"

Shirley S.: Hi Shanen, I can take that. CMS does say that they will give a preview period using data available from the fiscal year 2019. So from this year, their hospital value based purchasing program. And this preview period will be... you'll be able to see both the MIPS eligible commission groups who are eligible for facility-based for the 2019 MIPS performance period, so you will be able to look at what your scores... I don't believe they have that available now. I don't know if anyone else knows that. But they also do, and tend to display the hospital that you're attributed to. I know many providers might go to different hospitals, so they're not sure which one they may be attributed to, so CMS's intention is they're going to also allow you to know what hospital you're attributed to as that facility-based.

Shanen Wright: Thanks, Shirley. Oh, I'm sorry. You have something to add?

Shirley Sullivan: I was just going to say, if you have more questions regarding facility-based, there's a great fact sheet, the 2019 Facility-based Measures Fact Sheet that I would recommend that you review for that. And that's available on the CMS website, and we can put the link for that in the chat also. Thank you.

Rabecca Dase: This is Rabecca. I did post the Facility-based Fact Sheet and the preview FAQ in the chat box, but I do believe that there is a preview available in the QPP portal, or it was toward the beginning of the year unless they removed it for some reason, but I do believe there was something available based on last year's data where you could see where you could potentially end up if you did choose that route this year.

Shirley Sullivan: Okay. Do you know if this year's, for the 2019's are available yet? Or no.

Rabecca Dase: No. I don't believe so. It's probably too early considering how the years run. But it did say it was based on 2018 data based on what I could see. And again, I did share the preview, FAQ preview, which kind of walks you through that, so that is available.

Shirley Sullivan: Perfect. Thank you.

Shanen Wright: All right, looking at those survey results, 80% of you got it right. Not yet is there a MIPS-man, but it is probably on the horizon. One person said Daredevil. I don't know about that. That was a pretty easy one, Daredevil. Batman and Superman were a little more difficult though. He never starred as Superman, but he did play actor George Reeve, the star of the 1950's TV series, Adventures of Superman, in the 2006 movie Hollywoodland. So a little bit of Ben Affleck trivia for you today. If you happen to bump into Ben on the street, make sure and tell him happy birthday from QPPLive!.

Shanen Wright: We are going to open up those phone lines in just one second if anybody has a question. But first, one more question here from the box. "Can you share information on the cost data we should expect in the 2018 MIPS performance feedback reports?"

Amy Weiser: Hi Shanen, this is Amy. Thanks for the question. The 2018 MIPS performance feedback is now available. To view the performance feedback, you need to visit the QPP portal and sign in. Again, like you would sign in to the MIPS data. Your performance feedback includes the beneficiary level cost data reports for viewing and download by clinicians and groups who were scored on the MIPS Total Per Capita Cost for all attributed beneficiaries, or the TPCC measure. Excuse me. And the MIPS Medicare Spending per Beneficiary cost measure in 2018. Individuals and groups can compare their cost for each measure with the benchmark provided in the performance feedback user interface, or UI, to better understand their performance relative to their peers, which includes TINS or TIN-NPIs that had at least 20 eligible cases for TPCC and for all TINS or TIN-NPIs that had at least 35 eligible cases for MSPB. These data may be used to

identify care coordination opportunities for your beneficiaries and streamline resource use.

Amy Weiser: For more information, you can see the 2018 Performance Feedback FAQs on the QPP website, which has detailed information about how to understand your cost category performance feedback. Thank you.

Shanen Wright: Thanks, Amy. Let's go and unmute those phone lines and see if anybody has a question or comment for our panelists. If you don't, please make sure and mute your phone on your end.

Shanen Wright: Okay, hearing nothing, we will re-mute those phone lines and we'll squeeze in a few more questions. We'll be wrapping up at 10:25 today on QPPLive!. This next one I'll take on myself. "Are the resources you referred to today in the link that went with this seminar link?" And yes, the slide deck includes live links to all the resources that were discussed today. That was emailed to everyone who registered to attend the QPPLive! session. Please be sure to check your email inbox. You should find the email with the slides attached. If not, feel free to reach out to any of us, or specifically, Marvin Nichols at mnichols@qualityinsights.org or 1-800-642-8686.

Shanen Wright: All right, another question for you. "Are we responsible for all of the costs during a hospital admission, even if our provider is not directly involved with the patient?"

Shirley Sullivan: I can take this one, Shanen. So this goes back to the process for attributing measures to a clinician, and it varies by measure type. So for the Medicare Spending per Beneficiary measure, the MSPB, the eligible clinician who provided the most Part B physician supplier services during the period between index admission date that Rabecca talked and so on, and the discharge date, is attributed the episode of care. So it's that provider who provides the most Medicare Part B supplier and physician services.

Shirley Sullivan.: Now all Medicare Part A and B claims for items provided during that time period is attributed to that eligible provider. Now, if you... for procedural episode groups, episodes are attributed to each MIPS eligible clinician who renders that trigger service, as identified again but the CPT HCPCS procedure codes defined in the measure specifications.

Shirley Sullivan: And then on to the acute inpatient Medicaid medical condition episode groups. These are attributed to each MIPS eligible commission who bills the ENM claim lines during that trigger hospitalization under a TIN that renders at least 30% of the inpatient ENM claims lines in the hospitalization. That's a lot, but it really depends, again, on each one of those different measures how a physician is attributed to that. And I would really recommend reading over each of the measures to see what all goes into them. Thank you.

Shanen Wright: Thank you, Shirley.

Lisa Sagwitz: Hi Shanen, it's Lisa.

Shanen Wright: Go ahead, Lisa.

Lisa Sagwitz: I'd like to clarify something we talked about a little earlier so there's no confusion. One of our polling questions had to do with the security risk assessment, or an SRA, and we gave a couple different possible answers. The correct answer is you must do it every year. So if you had it done last year, great, but you need to do it again this year. I just wanted to make sure there was no confusion on that.

Shanen Wright: Thank you for that, Lisa. Appreciate that. And we appreciate everybody joining us for today's edition of QPPLive! for August 2019. Please reach out to any member of the Quality Insights team with your questions or comments, or you can always contact the Quality Insights QPP Support Center, which is at qpp-surs@qualityinsights.org, or you can call the phone number, 1-877-497-5065.

Shanen Wright: Mark your calendars, because next month we'll be doing it again on the third Thursday. I believe that equates to September 20th for the next edition of QPPLive!, but we're here to help you anytime, not just during this session. Please reach out to us, because most of all, we want to establish a relationship with you so you can succeed in the Quality Payment Program.

Shanen Wright: Please take a second to fill out the evaluation after you exit this Webex. We appreciate it, and look forward to talking again with you in September. Have a great day.

This material was prepared by Quality Insights, the Quality Payment Program-Small Underserved and Rural Support Center for Delaware, New Jersey, Pennsylvania and West Virginia under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication number QPP-082019A