Q&A from 2019 QPP Reporting Requirements Webinar

December 20, 2018

Q: Does this apply to Medicare and Medicare Replacement plans?
A: MIPS eligibility is based only on straight Medicare (Part B fee-for-service).

Q: We are a small practice with only 1 EC. If we hire a part-time PA in the future, would we need to start reporting as a group?
A: No. If both of the clinicians are designated as MIPS eligible at the individual level, you have the option to report their data individually or as a group.

Q: How will we know our cost score for 2018?
A: Your MIPS score and a QPP feedback report will be available by logging into the QPP portal sometime in July 2019.

Q: What's the window of time to "opt-in" if you meet one or two of the low volume threshold criteria?
A: CMS is in the process of finalizing "opt-in" policy guidelines, so we do not have any details at this time or know when the opt-in application period will open and close.

Q: Can someone show me how to do the log in and attest because I don't see it in my web page of QPP?
A: At this time, the reporting portal is not open which is why you are unable to see where to attest. We would be happy to discuss the options with you after the webinar. The portal will open and begin accepting data on January 2, 2019.

Q: Our EMR system still does not have our measures free of defect. Are there repercussions for the EMR system?
A: If you have attempted to work with your EHR vendor and are not getting the response you need, you can complete the feedback form from the ONC which monitors vendor compliance. If you need additional assistance with MIPS, please reach out to us.

Q: Is there a list of the 26 measures that have been removed for 2019?
A: A list of the 26 measures is included below and in Table C on page 2302 of the Final Rule.

26 Quality Measures Removed for 2019	
ID #	**Measure Name**
18	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
43	Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery
99	Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade
100	Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade
122	Adult Kidney Disease: Blood Pressure Management
140	Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement
156	Oncology: Radiation Dose Limits to Normal Tissues
163	Diabetes: Foot Exam
204	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet
224	Melanoma: Overutilization of Imaging Studies in Melanoma
251	Quantitative Immunohistochemical (IHC) Evaluation of Human Epidermal Growth Factor Receptor 2 Testing (HER2) for Breast Cancer Patients
257	Statin Therapy at Discharge after Lower Extremity Bypass (LEB)
263	Preoperative Diagnosis of Breast Cancer
276	Sleep Apnea: Assessment of Sleep Symptoms
278	Sleep Apnea: Positive Airway Pressure Therapy Prescribed
327	Pediatric Kidney Disease: Adequacy of Volume Management
334	Adult Sinusitis: More than One Computerized Tomography (CT) Scan Within 90 Days for Chronic Sinusitis (Overuse)
359	Optimizing Patient Exposure to Ionizing Radiation: Utilization of a Standardized Nomenclature for Computed Tomography (CT) Imaging Description
363	Optimizing Patient Exposure to Ionizing Radiation: Search for Prior CT Studies Through a Secure, Authorized, Media-Free, Shared Archive
367	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use
369	Pregnant women that had HBsAg testing
373	Hypertension: Improvement in Blood Pressure
423	Perioperative Anti-platelet Therapy for Patients Undergoing Carotid Endarterectomy
426	Post-Anesthetic Transfer of Care Measure: Procedure Room to a Post Anesthesia Care Unit (PACU)
427	Post-Anesthetic Transfer of Care: Use of Checklist or Protocol for Direct Transfer of Care from Procedure Room to Intensive Care Unit (ICU)
447	Chlamydia Screening and Follow Up

Q: What about physicians submitting claims where 75% of the encounters are in the hospital? Are they exempt from MIPS reporting?

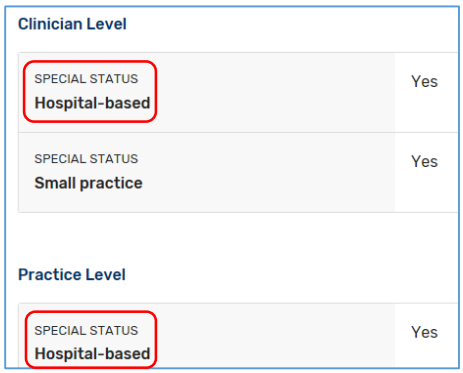
A: No. If clinicians meet the eligibility criteria and are deemed MIPS eligible, they need to participate and report data or they will receive a 7% negative adjustment in 2019. There is a new option available in 2019 for clinicians who are facility-based. Quality and cost category scores will be based on performance of the hospital where they work if the hospital participates in the Hospital Value Based Purchasing Program and the clinician bills at least one service to the hospital (POS code 21) or emergency room (POS 23).

Q: What was the final date to register to report as a group for 2019?

A: There is no registration to report as a group unless you want to report as a VIRTUAL group. The deadline to submit an application for VIRTUAL group reporting is 12/31/18.

Q: The quality for hospital encounters cannot be submitted by the physician for hospital encounters. How will this quality score be evaluated for these physicians?
A: CMS identifies clinicians who are facility-based on the QPP participation status look-up tool. Scores for the quality category and cost category will be based on performance of the hospital where the clinician works if the clinician has at least one service billed to an inpatient hospital (POS code 21) or emergency room (POS 23) and the hospital participates in the Hospital Value Based Purchasing Program (VBP). If CMS is unable to identify a hospital with a Hospital VBP score to attribute to the clinician's performance, then that clinician is not eligible for facility-based measurement and will have to report quality measures on their own via claims, registry, or EHR for their patients they see in an outpatient setting.

Q: Is there a place to check if an EC is eligible for the Facility-based Measurement Priority?
A: The QPP Participation Status look-up tool identifies if a clinician is hospital-based, at both the clinician and practice level, as noted below.



Q: We are a small practice that has been participating for a year, however we do not have an EHR (we do but don't use it because we serve nursing homes exclusively and don't often have access to Wi-Fi/ internet service). Is joining an APM or reporting as a group an option for us or can we just carry on as we have in the past, simply reporting QR codes upon entering billing information for each consult?
A: You do not need to have an EHR to participate in MIPS. You can report Quality measures via codes again in 2019 (because you are a small practice), but you will need to earn more MIPS points to avoid a penalty. For 2018, you need a total of 15 points to avoid a negative payment adjustment, but for 2019, you need 30 points. Since you don't have an EHR, you will not earn any points in the Promoting Interoperability (PI) category. Because your clinicians work in a small practice, they can submit an application to have the PI category reweighted. This will result in having your Quality category worth 75 points in 2018 and 70 points in 2019. The Improvement Activity category is worth 15 points both years and the Cost category is worth 10 points in 2018 and 15 points in 2019.

Please contact us so we can help you select measures and activities that best suit your practice. Reporting one high weight or two medium weight improvement activities will result in 15 MIPS points. This is enough to avoid the penalty in 2018, but not in 2019. You will also need to report quality measures. We suggest that you submit 6 quality measures via claims using G codes/CPT codes as you did in the past. Make sure one quality measure is an outcome or high priority measure. Because you are a small practice, you will also earn 6 bonus points that will be added to the numerator of the quality

category which will help improve your quality score. Joining an ACO is an option and CMS is encouraging practices to move in that direction. There is information about APMs on the QPP website. Group reporting is also an option for practices that have at least two clinicians and at least one is MIPS eligible.

Q: Does treating non-English speaking patients in their own language (Spanish) qualify for patient complexity?
A: From the CMS QPP Help Desk: Treating a patient who does not speak English would not qualify for patient complexity. Below is the definition of "complex patients" as it pertains to the Quality Payment Program, specifically the Cost category, which is scored by CMS based on administrative claims.

CMS will award providers between one and five bonus points based on their treatment of Complex Patients. The determination of a Complex Patient is based on the dual eligible ratio and the Hierarchical Conditions Category (HCC) risk score. The overall goal when considering a bonus for complex patients is two-fold: (1) to protect access to care for complex patients and provide them with excellent care; and (2) to avoid placing MIPS eligible clinicians who care for complex patients at a potential disadvantage while we review the completed studies and research to address the underlying issues.

CMS uses the term "patient complexity" to take into account a multitude of factors that describe and have an impact on patient health outcomes; such factors include the health status and medical conditions of patients, as well as social risk factors. CMS believes that as the number and intensity of these factors increase for a single patient, the patient may require more services, more clinician focus, and more resources in order to achieve health outcomes that are similar to those who have fewer factors. In developing the policy for the complex patient bonus, CMS assessed whether there was a MIPS performance discrepancy by patient complexity using two well-established indicators in the Medicare program. The proposal was intended to address any discrepancy, without masking performance. Because this bonus is intended to be a short-term strategy, CMS proposed the bonus only for the 2018 MIPS performance period (2020 MIPS payment year) and noted that it will be reassessed annually.

Q: I do the billing for a large ER group and we submit our quality measure via claims to CMS. Are you saying for 2019 we can no longer do this?
A: That is correct. If the TIN has 16 or more clinicians, you can no longer submit claims with G codes to meet the Quality Category requirement for MIPS in 2019. Your options include reporting quality measures via your EHR, a registry, a QCDR, or CMS web interface (if your practice has 25 or more clinicians. You are allowed to submit quality measures using more than one method in 2019 and CMS will score the one with the greatest number of measure achievement points. The exception is that the CMS Web Interface measures cannot be scored with other collection types. Review the 2019 Quality Category Fact Sheet to learn more.

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