QPP*Live!*
Transcript from Live Session

Thursday, September 21, 2017

Shanen Wright: Welcome to QPPLive! presented by Quality Insights, the Quality Innovation Network and QPP Support Center for West Virginia Pennsylvania, Delaware, New Jersey, and Louisiana.

We're pleased that so many of you've joined us today for our Q&A session. We'll go over the rules of this session and some of our panelists here in a moment. First, we have some breaking news related to QPP and we're happy to present three of our panelists giving these updates. We'll be hearing from Crystal Welch, Joe Pinto and Lisa Sherman.

First off, with today's QPP updates is Crystal Welch.

Crystal Welch: There are several new QPP resources that CMS has released and we just wanted to let everyone know about those. They recently created some guides for specialists and measures. These resources do not provide a large number of measures, but it is a sample of measures that may apply to specialist groups such as anesthesiologist and CRNAs. There's one for cardiologists, emergency medicine clinicians, ophthalmologists, orthopedists, and also primary care clinicians.

There's also a guide to make sure that you consider your reporting method and your patient mix and then also the performance period to choose for the measures that just best suit you.

Take a look in the chat box and you will see the specific links for those guides for some specialists. They can also be accessed on the qpp.cms.gov website.

Another quick announcement is that CMS has also created a quality category fact sheet that includes how to submit quality measure data and you'll find that fact sheet also listed. Then, there are audit resources that give you documentation of the things that you need to keep. These really fall under security and what you need to keep for your records. CMS is required to conduct data validation and perform those audits annually. If you receive a request for an audit, you have 10 business days to respond but you can learn

what you need to document so you'll be prepared with that validation criteria. It's in a zip folder.

Then, we have the AHA developed MACRA Decision Guide. I think these new resources are very timely considering that we're approaching the last 90-day reporting period. It's coming up on us quickly. As we flip through the calendar, I think tomorrow is the first day of autumn and October 2nd is just a few days away. Those who have not yet decided which measures to report this year to avoid that 4% penalty should contact us so we can help if your practice is located in any of the Quality Insights contract states of Delaware, Louisiana, New Jersey, Pennsylvania, or West Virginia. Again, the website for our quality support is www.qppsupport.org, you can also email us at qpp-surs@qualityinsights.org or call us at 1-877-497-5065. These numbers and links will also be in the chat. With that, I'm going to turn it over to Joe Pinto for another announcement. Joe.

Joe Pinto: Thanks, Crystal. CMS did announce earlier this summer that there are proposed rule changes for the MIPS reporting program. The final rule will be released next month prior to November the 1st. At that time, we will learn if the proposed changes for 2017 will be confirmed such as having exclusions for two of the ACI measures. For the e-prescribe measures, CMS has proposed that if a clinician writes fewer than 100 permissible prescriptions during the reporting period, he or she can be excluded from the measure.

There is also a proposed exclusion for the health information exchange or the HIE measure. If a clinician transfers or refers a patient fewer than 100 times during the performance period, he or she can be excluded from that measure. Therefore, the eligible clinician, or EC, or practice can have a zero in the numerator and still receive credit towards meeting the base measure.

The final rule will also provide guidance for 2018 MIPS reporting. It has also been proposed that practices can continue to utilize a 2014 certified EHR edition in 2018 and the cost category will not be scored in 2018. It has also been proposed that a 90-day reporting period can be used for the ACI and the IA, which is the improvement activities, categories. However, quality measures must be reported for the full calendar year. A new option is that virtual groups can be utilized to report. And bonus points will be available for quality measures that have improved performance rates. With an update on the 2016 PQRS and QRUR reports, I'll now turn it over to my colleague, Lisa Sherman.

Lisa Sherman: Good morning from Louisiana. I wanted to let you all know that the 2016 PQRS and QRUR reports are now available. They were released on September 18th. These reports will show you if you are subject to the 2018 PQRS penalty and what your practice's 2018 value modifier payment adjustment is. It's got valuable information. You can access these reports from the CMS enterprise portal with EIDM account.

After reviewing the reports, if you think an error was made in determining your payment adjustment, you have until the 1st of December to request an informal review.

CMS is hosting a webinar next Tuesday, the 26th. This will be at 12:30 pm Central and 1:30 pm Eastern time about the feedback reports and how to request the informal review. We will post the link on how to register for the webinar.

Again, you need to have an EIDM account, that's an enterprise identity management account, to access these reports and they are accessed on a CMS enterprise portal. If you need any assistance in accessing these reports, please let us know. We'd be glad to help. I'll turn it back over to you, Shanen.

Shanen Wright: Thanks so much, Lisa. Thank you, Joe and thank you, Crystal for today's headlines. They'll be joining us along with our other panelists here at Quality Insights to answer your questions during today's episode of QPPLive! They include Rox Fletcher, Shirley Sullivan, Amy Weiser, Joe Pinto, Lisa Sherman, Lisa Sagwitz, Kathy Wild and Rebecca Dase. We'll be providing you with web links in the chat window so you can follow along and directly link to the resources that we're talking about.

My sincere appreciation to Laurie Fink for producing today's webinar. And me, I'm Shanen Wright.

Here's how it'll work for those of you who haven't been on an episode of QPPLive! before. You'll ask questions using the Q&A feature in your WebEx player. I see folks are already asking questions and that's great. You can be typing them in at any time. Just use the ask dropdown menu and choose all panelists, type in your question and hit Send. We'll answer all the questions that we can as time will allow for during today's session.

Please note that we'll be using the chat feature for the web links so if you could use Q&A for that, that would be very helpful for us as well. Some of you have also called in on the telephone. You'll have your chance to ask questions verbally. Periodically, we will pause from the Q&A window and I'll give you a heads up and I will be unmuting all lines so you can ask your questions. If everybody starts stepping on one another, we may go by state so that way we can organize it. Please, if you're not going to have an individual question, we ask that you mute your phone on your end so that we're not hearing any background noise, barking dogs, crying babies, whatever may be in the background. We would really, really appreciate that.

Please keep in mind that we at Quality Insights are here to help anytime not just during QPPLive! You may not realize who your contact is at Quality Insights. If so, you can always use the general QPP inbox for inquiries. Know that we'll do our best to answer all questions today but we may need to follow up at a later

time. Some of the questions you have are very, very good ones and very complicated and therefore, require a little bit more analysis and follow up. Also, keep in mind that rules and interpretations change over time but most of all, we want to establish a relationship with you so you can succeed in the Quality Payment Program.

With that being said, let's get started with today's episode of QPPLive! Go ahead and type in your questions now in the Q&A box and we'll start out with one from Teresa who asks, "This year our provider wishes to only report on one measure for one patient to avoid the penalty. Can this be done via a claim and if so, how."

Kathy Wild: Hi Teresa, this is Kathy. The quick answer for you is yes, you can certainly submit one quality measure for one patient and that would ensure that you do not receive the 4% penalty in 2019. The way to do this is for each quality measure CMS has specification sheets and on those sheets it lists what's called a G code. On the claim, you will need to submit the applicable G code for that measure.

What I'd like to recommend is that you contact one of us from the state that you practice in and we can walk you through that process, help you select which quality measure would probably be most applicable and that you might have a large percentage of people in that to ensure that you do definitely have one for that measure and what code to put on it. I hope that answers your question.

Shanen Wright: Thanks so much, Kathy. We go back out to the Q&A box. You guys are typing some great questions in. We really appreciate that. This one comes from Shanty. She says, "For practitioners who are not hospitalists who do have to report quality for the part B claims but they cannot report quality on hospital patients since they use the hospital EHR. Do you know what CMS recommends for these practitioners?

Kathy Wild: I can take that one too. For MIPS claims reporting, it involves Medicare part B claims and Medicare part B patients. Chances are that patients in the hospital, you're probably not going to be billing under Medicare part B for them. If you are going to report quality measures using claims as the submission method you are correct that those patients would not be captured but hopefully, you are also seeing patients in the outpatient setting and those are the claims that you would be putting the G codes on. I hope that answers your question and once again, please feel free to contact us and/or when Shanen opens the phone line maybe we can speak further and get some more details to see if that addresses your question.

Shanen Wright: Next up is Terry who asks, "What is the difference between stage three and MIPS?"

Kathy Wild: This is Kathy again. I'll respond to that because I started typing in an answer to that question. Stage three actually refers to the CMS EHR incentive program

that started back in 2011. CMS implemented that not only for clinicians but also for hospitals. What has happened is through the years, legislation has changed and the EHR incentive program actually ended for clinicians last year, but they now report some of the measures from that program under MIPS.

Hospitals have different quality reporting requirements so they are still dealing with the stages that CMS developed when they started the meaningful use program. The MU measures and the advancing care information category measures that are applicable under MIPS are almost identical to those in the EHR incentive program. They match but there are not threshold under MIPS. Under the EHR incentive program, there are thresholds and different criteria but basically, like I said, that is for the hospital setting or if you are participating in the Medicaid EHR incentive program whereas the MIPS measures that are pulled out from there are applicable to clinicians now.

Shanen Wright: Excellent, Kathy. Thank you so much. We go back out to the Q&A box next for Patrick who says, "We are a multispecialty practice. As such we do most of our referrals internally between our specialties. Question is then for the HIE proposed exclusion for providers who refer less than 100 patients, is that for external referral only?

Kathy Wild: Joe, you are our ACI specialist. Do you want to answer that one?

Joe Pinto: I'll give it a shot, Kathy. As far as the proposed rule on that, Patrick, until CMS announces what the proposed rule may or may not be, we can't really define one way or another, so I'd rather not even make a calculated guess on whether or not that proposed rule is going to take place.

What I advise is that for the time being what the rule currently states for that particular measure practices should follow. In order to meet the requirements of that particular measure on the referral, you just need to have one case during your reporting period in order to meet that measure.

Shanen Wright: All right. Thank you, Joe. Next up we hear from Deborah who says, "We are finding choosing IA difficult. It is hard to decipher the verbiage for documentation to meet the activity." She provides an example, IA 24/7 access. "I am assuming that if this is something you cannot improve on you should not pick it, correct? I believe we are already doing as much as possible to meet this IA. However, it is a high-weighted activity."

Amy Weiser: Hi, this is Amy. I'll be happy to address this. Thank you for your question. Yes. The IA activities for 2017 are designed to be relatively easy, user-friendly, et cetera. You don't need to show improvement even though they're called improvement activities for 2017. You don't actually need to show improvement. I believe that Rabecca has also just posted some information to give you more guidance as well the data validation information for each of the improvement

activities. Because each improvement activity has a specific data validation that CMS would expect you to have on in case of an audit.

When you are submitting your information in 2018 for the IA category, you're going to say yes, that you're meeting that; however, you will just need to provide what is in the data validation file as proof if you are audited. If that particular improvement activity is cumbersome for you, there are many others to choose from on the QPP website and we'd be happy to work with you individually as well to find something that is maybe better suited for you. As a small, underserved, or rural practice, you need two improvement activities which are medium weighted or as you stated you could use just one high-weighted activity.

There are a couple that comes to mind that are relatively not as difficult. One is the prescription drug monitoring program for your state. The requirement for that though is that you're registered and using the prescription drug monitoring program for a minimum of six months. Then, there's another one called engaging Medicaid patients. If you accept Medicaid patients into your practice, that's also an improvement activity, medium weighted like thePDMP is also medium weighted that is relatively simple for practices to list as IA activity.

Again, I hope that answers your question. If you want to call in the line or when we open up the lines we can talk to you more about it or you can reach out to us at qppsupport.org. Thank you.

Shanen Wright: Thank you, Amy. Great answer. Next up we hear from Marsha who asks, "Can you do two additional measures after you have submitted one patient, one claim if you change your mind?"

Amy Weiser: This is Amy, I'll take that one. Yes. Actually, the more that you can submit in any of the categories, the higher your MIPS score will potentially be. Yes, absolutely. In fact, we encourage practices to do more than just one measure for one patient, one time. If you're able to do more, absolutely, do as much as you can.

Shanen Wright: Okay. Next up from Deborah, she asks, "How important is direct messaging for the 2017 year?"

Amy Weiser: I'll take this one also. This is Amy. Thank you for your question. As Joe mentioned, I'm sorry Joe, I'm probably stepping on your toes. As Joe mentioned for the Health Information Exchange measure for 2017 all you need is one case or one instance reported. If you aren't able to do that they are proposing an exclusion for that measure as Joe had previously mentioned. Joe, if I neglected to say anything please go ahead.

Joe Pinto: No, you covered it. Until CMS actually announces the final rule, we pretty much advise the practices don't assume that any of the proposal rules that were listed as being looked at are actually going to go true. Better to be safe than sorry

because some of the rules may not be changed and some may change dramatically. Pretty much go by what's currently in place so that way you're prepared one way or another. If the rule changes and it benefits you then we can address that at that time. Always assume that the rule that is in place is what the rule will be moving forward.

Shanen Wright: Next up we hear from Terry who asks do individual reporting providers need to register before October 2nd?

Kathy Wild: I can take that one. This is Kathy. No, there is actually no registration involved for MIPS reporting this year. The only registration already ended and that was for large groups that have over 25 clinicians that wanted to use the CMS web interface. The October 2nd date is strictly referring to the fact that it is the beginning of the last 90-day reporting period so we're just trying to make you aware that if you haven't started anything yet or haven't looked at any of your data retrospectively from the beginning of this year until now, October 2 through December 31 is the last 90-day reporting period if you choose to report for 90 days.

Once again, CMS is offering that test option this year so you can report one quality measure for one patient one time and you would avoid the penalty. If you do report for 90 days, you have a better chance of having a higher MIPS score, which means that you have the possibility of getting a positive payment adjustment instead of just avoiding the penalty.

Shanen Wright: Next we hear from Rachel who says, "I joined my practice in March and began running our reports at that time. We are reporting using our EHR. Am I still able to successfully report for the full year even though we had a little bit of a late start?" I'll add a follow-up with that. Rachel also says, "I feel as if I should be doing more than I am at this time. If reporting via EHR and I'm monitoring my report, is there anything else I should be doing at this time?"

Kathy Wild: I can take that. Rachel, I'm not sure if you are a clinician or an office manager, but if data was collected and is available in the EHR beginning January then you most certainly can go ahead and report data for the full calendar year. If you want to report for the full calendar year and you're with a previous practice then what you would need to do and it all depends if you're going to report individually or as a group. There are a lot of nuances that we'd probably have to discuss in detail to clarify your question here. If you are going to report as an individual and you were with a previous practice, you would have to obtain the data from that EHR and add the measures from that practice to the measures from March through the end of the year, then just submit the totals from both practices. We can certainly walk you through how to do this.

As far as just sitting back and monitoring your measure rates, I imagine you're thinking of advancing care information and possibly quality measures. The thing to do is look at your rates to see what you can do to improve the rates. We would be more than happy to talk with you and explain what the workflow

issues are to increase the measure rates with the goal ultimately of increasing your MIPS score for all of those measures. Thank you.

Shanen Wright: Thank you, Kathy. Next up we hear from Shao Ping who says, "I work in my practice but also cover hospital patients one week per month. I plan to do MIPS for office patients. Do I have to do anything for patients seen in the hospital since these patients are inpatient encounters and in the EHR but I do billing for hospital patients?"

Amy Weiser: This is Amy. Thank you for the question. I would say that for the purpose of MIPS as long as you have the information in your EHR for the patient that you see in your practice in the ambulatory setting, those would be the ones that you would be basing your reporting on. I don't know that there's anything additional you would need to do on the hospital side. I'll let someone else chime in if they have any other suggestions or you can of course, always talk to us individually as well.

Kathy Wild: This is Kathy. I would just add to that for the quality measures, CMS will determine which patients are in the denominator based on claims. I'm not sure if when you work in the hospital if some of those charges are submitted as Medicare part B claims. If so, then those patients could possibly qualify in one of the quality measures that you're reporting. However, they may not be applicable to the patient population for some of the quality measures.As far as the advancing care information category, those would not be included. The improvement activity is really based on the patients you're seeing in the office setting also.

Shanen Wright: Thank you, Kathy and Amy. This time I know a lot of folks have been patiently waiting and they want to ask questions verbally. Please keep typing your questions in the Q&A box. We'll get back to those. We'd like to open up the phone lines now to see if anybody would like to provide a question, comment, maybe a follow up, additional information from any of the questions before.

Please if you don't have a verbal question to ask, mute your phone on your end so we do not hear a lot of background noise. Let's see how many callers. We have quite a few.

Laurie, if you could unmute our callers at this time. I won't go by state. We'll just see if more than one person has a question at any time. As soon as the lines are unmated you can jump in, which they are now, and provide your questions or comments for our panel of experts here on QPPLive!

Bobbie: Shanen?

Shanen Wright: Yes?

Bobbie: This is Bobbie from Pennsylvania. I'd actually just typed the question but I was just wondering if I could ask it because there might be some additional questions you might have.

Shanen Wright: Sure.

Bobbie: My question is we're aiming for 70% for the whole year and we have one doctor who has it. We've been monitoring since the beginning of the year and we had one doctor that has had two months where it was in the 67-69 range, but other months, there's 84 or 77 and I want to know if it's the average of the whole year or is it each month individually that you would be counted for. Does that make sense?

Kathy Wild: Okay, so you get to select your reporting period. This is a transition year so you will get to select what reporting period you want to use. You don't have to really make that decision until you submit the data which can't be until at least January and you have until March 31 of 2018. CMS feels that the longer the reporting period is, at least for the quality measures, the more likely you are to meet the data completeness criteria. You have to have enough patients reported. Remember the reporting period that you pick for each category can differ. Just because you want to pick 90-days or 100-days or the full year for quality, you do not have to do that for the advancing care information and improvement activity. Now I will note that the minimum time for the improvement activity to get credit for one of those is 90 days if you will report for that category.

What I suggest is, keep monitoring, but you do not need to make a decision yet. Your score will be based on whichever reporting period you pick for that category. Then you'll be adding the three different category scores together.

Bobbie: Okay.

Kathy Wild: Does that answer your question?

Bobbie: Yeah. This is going to be my first time reporting. I've never done this before so I guess I didn't realize that you report quality separate from advancing care. How does that happen?

Kathy Wild: This is the first year for everybody so we're all learning this together but there's three categories that can be reported and like you said, the goal, if you want to try to get at least 70 points so you're part of that exceptional bonus pool to get the additional money, then we recommend you participate in all three categories. The advancing care information, quality and IA categories can each be submitted using a different method and each one can be submitted for a different reporting period.

The only thing you have to do consistently for the whole year is decide whether you want to report at the individual clinician level or at the group level. If you want to do it at the individual clinician level, once again, you pick whichever submission method you want for each category and then whatever reporting period you want but yes those are two different things. It's six quality measures, then for advancing care information there are some base measures that must be met in order to get any points for that category. You have to meet the base measures and then you would also report the performance measures to add to your ACI score. If you're doing well with your EHR, it should be pretty easy to get full credit for the advancing care information and improvement activity categories. Most people really need to focus on improving their quality scores. Feel free to reach out to your practice coordinator in your state and we can certainly go through this with you in more details.

Bobbie: Okay. Thank you.

Kathy Wild: You're welcome.

Lisa Sagwitz: Hi, it's Lisa Sagwitz and I can just add one other little comment to what Kathy said. As the year has gone on, many of the practices already have some tentative scores. They've been monitoring and looking, so when you find good scores for quality and advancing care information, just dot down those time periods. As an example, one practice I worked with that has multiple providers has one provider that has 100 points already we know from January first until mid-June.

I said mark that off to the side and now, let's work on the other providers to try to get them up as close to 100 points as possible. Just bottom line, when you know you've got a good set of numbers, jot off to the side on a little post-it note so it's a reminder as you're working on this at your end.

Bobbie: Can you tell me, like a good number, so like for quality, it's 60 points, right? Like a good number is that like 46, 50, 59. What would be considered a good number?

Kathy Wild: Well, it all depends. To get full credit, there are 25 MIPS points for the advancing care information category, 15 MIPS points for the improvement activities so that's 40 MIPS points so far. If you aim to get at least 70 points, if that is your ultimate goal, then you know you need 30 points for the quality category.

Bobbie: Okay.

Kathy Wild: I'd say, have a goal of at least 31 points in your quality category. That would put you in that exceptional bonus pool of $500 million.

Bobbie: Yeah. That's what we have basically. Some of them.

Kathy Wild: Okay. Good.

Bobbie: All right.

Kathy Wild: I just want to note, Rebecca just sent a link for a paper worksheet we developed. To kind of piggy back on what Lisa said, you can print the worksheet and write down your reporting period, which quality measures you've been tracking, and your score. Then you will have that handy, so when January comes it'll be like, "Oh, wow! That doctor had 100 points and what were the dates again?" Feel free to use the worksheet. It's available on our website.

Bobbie: Got it. Thank you very much.

Kathy Wild: You're welcome.

Shanen Wright: Thanks so much for the question Bobbie. Other folks on the telephone line, anyone have a question or comment for our panelists? All right, hearing none. We'll go back to the Q&A box right now. Laurie, if you wouldn't mind muting the lines. If time allows, we'll open up the phones one more time before the end of today's session.

As we go back to the Q&A box, we hear from Shao Ping again. He says, "For messaged patients, could office staff answer the message back with the guidance of doctors? Thank you."

Amy Weiser: Hi, this is Amy. I'll take this one. Great question. It is my understanding that yes, anyone in the practice under the physician's guidance can answer a secure electronic message for a patient. If anyone else has a different thought on that, please add your comments. Thank you.

Shanen Wright: Next up, we'll hear from Regina. She says, "We are an anesthesia group with 21 CRNAs and part of an ACO MSSP track one. The ACO is not reporting any quality measures to the CMS web interface for us. Should we report quality measures via the registry to avoid a penalty?"

Kathy Wild: That's interesting because part of the requirements of being an ACO is that they are required to submit quality measures on behalf of all of the participants especially if they're a Medicare Shared Savings Program ACO. Regina, I'd like to have you reach out to us so we can discuss that and see. It's possible, that this could be incorrect, but absolutely, if for some reason they are not reporting your quality measures for you, then we would definitely suggest that you go ahead and report.

Like I said, that is one of the ACO requirements, that an ACO must report the quality measures on behalf of all the participants. You automatically get full credit for the improvement activity being in an ACO. You are definitely covered for not receiving a penalty just because you are in an ACO because of the

improvement activity category but yes, please reach out to us and I'm curious to see which ACO that is and what the particulars are.

Shanen Wright: Thank you, Kathy. As a reminder, we mentioned earlier, we are here to help you anytime not just during the third Thursday of the month at 9:30 am Eastern on QPPLive! so we are happy to help you and answer your questions electronically via the phone, anyway we can. We can even conduct one-on-one go to meetings if we need to share our computer screen. Most of all, we just want to help you succeed in the Quality Payment Program here at Quality Insights.

Keep in mind that Rebecca is still providing great links in the chat window. You can access those web links at any time for more information. Also note that we are recording today's QPPLive! session and we'll provide a link to the recording and a transcript as well, so you can follow up on any questions and answers that you heard. We will email that to you within a matter of a couple of weeks or so following the conclusion of today's episode of QPPLive!

We'll go back out to the Q&A box to hear from Melissa right now. She says, "For ACI, I reviewed the data validation document, for the base measures, if we report as a group, do we only submit one example to satisfy the measure or do we need to submit all occurrences in order to receive more points in that category?"

Lisa Sagwitz: Hi, it's Lisa. I can take that question. The nice thing about reporting as a group is you would only need one of your providers to satisfy one of the base measures. An example of that would be the direct messaging with the HIE. If just one doctor in the group did it, it would take care of the whole group. Now certainly, if you have higher numbers, you're going to get a better score, so it's in your benefit to do the best you can in each category but for the group reporting, just one thing takes care of the whole group.

Shanen Wright: Thank you, Lisa. Next up, a question from Paula who asked, "When is the deadline for submitting the QPP so the doctor is not penalized?"

Amy Weiser: Hi, this is Amy. Thank you for the question. Submission for 2017 will be open January first and the deadline is March 31st of 2018 so that is your reporting window for 2017.

Shanen Wright: Okay. Next up, we have a question from Shanty. She says, "As a follow up to my previous question, dual reporting via claims and via EHR is not permitted because of this, for 2017, we chose to report quality via claims to include all patients." Then she continues on and says, "For 2018, is dual reporting permitted claims and EHRs?"

Kathy Wild: I can take that, thank you Shanty. The final rule for 2018 has not been released yet, but it should be some time in the next six weeks. CMS has a deadline that it has to be published prior to November first. At this time, we are unable to

answer that question, but we will certainly know that sometime in the next month.

Shanen Wright: Next up, we hear from Melissa again. She says, "Does that mean, submit an example for each eligible clinician in the group. Wouldn't that be the same as submitting individually?" I imagine that's a follow up to her earlier question.

Lisa Sagwitz: It's Lisa. If that's for group reporting, you would take a cumulative total of everyone's numerators and denominators for your MIPS reporting.

Shanen Wright: Thank you Lisa. Next, we have our first question from Eric. Welcome Eric to QPPLive! He says, "Hi! We are located in Wilmington, Delaware. We are a single doctor's office. How do I initiate a request to QPP to help us with quality measure reporting? Could you give contact info. Thank you for your info."

Kathy Wild: Shanen, do we have a slide that we can show that has all the contact info and links and Rebecca can probably put it in the chat box also. There we go.

Shanen Wright: Yes. This is our contact information that we have. We are not wrapping up, so don't be confused but thank you for joining us today. In addition, Rox Fletcher has also replied to Eric and she is our contact representative for small practices in the State of Delaware and she replied with a link and you will also see the QPP support link here on the screen, so you can fill it out, complete the assessment and that will give you, access to Rox's assistant and a ton of tools on the QPP support center website.

We look forward to seeing you sign up and working with you moving forward. Thanks so much for the question, Eric. Anyone who wants to add anything else for this question?

All right, moving on. Next, we hear from Marianne who asks, "Will CMS add our scores together for us if we are using a registry for quality in the CMS portal for ACI and activities or somehow, do we have to get a total to CMS?

Amy Weiser: Hi, this is Amy. Thank you for the question. Oh, sorry.

Kathy Wild: No, go ahead, Amy.

Amy Weiser: Okay. The way that we understand it is CMS will create a score for you. You will not have to submit a score. They will score you based on what has been submitted and then sometime in 2018, I'm not exactly sure when, after March 31st of course, when everyone has submitted and they have sent their work on their end, clinicians who have participated will get a MIPS score.

Kathy Wild: This is Kathy. I'll just add from previous experience with PQRS reporting that it will take several months for CMS to analyze the data and send reports out. A prime example is the PQRS data from 2016 was just loaded this past week and

here is September 21st. My guess is that it will be late summer or early fall before anyone knows their MIPS scores for this year. Just so that you know it probably won't be before that.

Shanen Wright: Thank you, Kathy and Amy. Next up in the Q&A box, we have a request for a follow up by Teresa Wilson who would like someone from Quality Insights to contact her today regarding her question. I believe we'll be able to access her contact information from your registration form or if not, you can certainly, to ensure, we can contact you, chat with our panelists privately with your contact info and we'll be happy to follow up with you today and help you with your questions regarding the Quality Payment Program.

Next up we hear from Regina. She says, "We are a gastroenterology practice with 24 clinicians and two pathologists. The pathologists have been reporting on Barrett's esophagus via claims. This measure is topped out and there are no other measures relevant to our practice. Does anyone have any recommendation?"

Lisa Sagwitz: Hi, it's Lisa. There's a brand new resource out. It's called the Quality Payment Program 2017 MIPS Quality Performance Category Fact Sheet. At the bottom of page seven, you'll see specifically it talks about eligible clinicians submitting via claims or qualified registry who submit less than six measures or no outcome or high priority measures. CMS will use what's called an eligibility measure applicability process to determine if additional clinically relevant measures could have been submitted. If CMS finds that there are no applicable measures for the clinician, they won't be held accountable for not submitting those measures.

That's right there in writing at the bottom of page seven and that's one of the brand new resources that just came out this week or the end of last week.

Shanen Wright: Thank you, Lisa. Next up we hear from Melanie. She asks, "What is the most affordable way to meet the measure for the security assessment? Most companies offering the service charge $2,000 and up for this assessment."

Kathy Wild: This is Kathy. Unfortunately, our organization no longer offers that service to any practices. We did do a Google search and we came up with a list of six organizations that do perform the SRA and I'm not sure if you've contacted any of the six that we found or not. We are not sure about the pricing. We don't have that kind of experience or haven't talked to them. Unfortunately, it's out of our hands.

We did have a privacy and security risk assessment webinar on August 8th, and the recording and transcript and the slides or available on our website. At that time, we did go over the security risk analysis form that is available on the healthit.com website where you can complete it on your own. It's very thorough and complex but you can, if you want to save money, try to do that on your

own. The only disclaimer we did want to say is that previously, in the Meaningful Use Program when CMS conducted an audit, they did look at that security risk assessment at great detail and a lot of times, they found that it was not acceptable when the practice did it.

We would just want to give you that head's up and you would need to make the decision whether or not you would want to attempt to do that on your own or hire somebody. We can certainly share the links when we publish the transcript of the six organizations that we have found that do offer that service.

Online Business Systems (Obsglobal)
https://www.obsglobal.com/security-consulting/

nControl, LLC
http://www.ncontrolsec.com/about.html

ClearDATA
https://www.cleardata.com/solutions/hipaa-security-risk-assessment-sra/

E Security Solutions, LLC
http://www.esecuritysolutions.com/security-risk-assesments/

Precision Practice Management
http://www.precisionpractice.com/precisions-security-risk-assessment-offering

Trustwave
https://www.trustwave.com/Services/Compliance-and-Risk/Risk-Assessment-Services/

Amy Weiser: Kathy, I just want to add to your great comment too that this does need to be completed by December 31st of 2017. If you do not yet have a security risk analysis in place and you want to report the advancing care information category, you must have your security risk analysis completed. That doesn't mean that all your risks need to be mitigated. However, you need to be definitely showing that you're working towards mitigating those risks by December 31st.

Shanen Wright: Thank you, Amy and Kathy. Further comments?

Lisa Sagwitz: Yeah, it's Lisa. It's great that you're asking about that now because I think as the year comes to an end, those organizations are going to be swamped with requests, so it's better to get that moving now.

Shanen Wright: Great comment, Lisa. Next up we have a question from Sarah where she asks, "Where can we find the data validation for IA measures?" Sarah, if you look in your Q&A player, you'll see a direct link that you can copy and paste provided by Lisa Sherman. I won't even attempt to read it out loud or that would take the rest of the time. Very long link but great that it's in there for you, Sarah. We hope that helps.

Next question's from Rachel. She says, "I have seven physicians currently in my practice; however, only four met the qualification for reporting. We previously reported to Meaningful Use as individuals. How can I determine if I would benefit more from reporting as a group or as individual?"

Amy Weiser: This is Amy. I can take this. You could report as a group because what you do is you use the cumulative data for all of your clinicians so that all of the clinicians could be included in MIPS and you could help to avoid the penalty for them as individual. It probably would be worth it to go ahead, I think as Lisa Sagwitz had mentioned earlier, that reporting as a group would benefit you as long as you're under the same tax ID.

If anyone else wants to add to that, please feel free. Thank you.

Kathy Wild: This is Kathy. I'll just say that it is a personal business decision that each practice has to make. We've heard that there are pros and cons to reporting both individually and as a group. Of course, as a group it's administratively more simple that you'd only be collecting the data and submitting it at the group level. The other good thing is if one of your clinicians is a high performer and one is a low performer, that it would make your score in the middle.

The other thing to consider is that the MIPS score follows the clinician wherever he goes. If one of the clinicians left your practice, remember his score and his part B reimbursement would follow him to where he goes two years down the road. It will be a decision that you should have a discussion with your clinicians to decide what they want to do.

Shanen Wright: Next up, we hear from our friend, Bobbie in PA. She says, "When we run our MIPS calculator each month under quality, we get a note that states, submitting three topped out measures. What does this mean?"

Kathy Wild: I can take that one. A topped out measure is one where the measure has been around for several years and your peers are all doing well with that measure. What it means is it's more difficult to earn points unless you get the full 100%. If you look at the quality benchmark document on the QPP website, you'll see that you start with a minimum score of three and your goal is to get 10 points. With the topped out measures, you will find that it's very difficult to be in the 90s. You still might only get four or five points because all of the other clinicians are doing well. It doesn't mean that you cannot report it. Once again, you want to look at the measures. Your ultimate goal is to get the most MIPS points as you can. If you want to report a topped out measure but you have a MIPS score of 10 or 9, then certainly, go ahead and report it.

Shanen Wright: Thank you, Kathy. Next up, first time question from this person right here in the Mountain State, Mitchell, he says, "If I report PQRS by claims this year, can I report by EHR next year?"

Kathy Wild: Just to clarify, there is no more PQRS reporting. Once again, everything is in MIPS, so the equivalent of PQRS would be reporting the quality category, but yes, there is absolutely no problem changing your submission method between years and once again, even between categories you can change your submission method. If you want to do submit one category using a registry and one using claims and one using an EHR, you can do so, if the measures are available to be reported that way for that category.

Shanen Wright: Next, Sarah asks, "Can I use registry reporting for quality for our group and then EHR reporting for ACI and IA for 2017?"

Joe Pinto: Shanen, this is Joe. I can take that one since I did post a response to Sarah's question. Yes Sarah, you do have the option to do that. If you're going to report your quality measures using either a certified registry or a QCDR and then you can also report your ACI and your IA measures using the other options that are available such your EHR if you want to go through that or your claims submission process. Also, we're expecting that CMS is going to make a portal available through the QPP website, so that you'll be able to submit your ACI and IA performance measure results directly through the website.

Shanen Wright: Thank you, Joe. We are at one hour but luckily, we have so many great questions. We're going to give you some bonus coverage of QPPLive! today, and keep the questions coming. Next up, we hear from Lisa, "Who says we are planning to report ACI measures using our EHR vendor. They have yet to release new reports for us to run based on MIPS. I have been running monthly reports and our numbers are good, but I'm worried our numbers may look different in the new report."

Kathy Wild: I can take that one. No, the measures that were under the meaningful use program are the same as the ones that you've been reporting for MIPS if you are going to report the ACI transitional measures which most providers probably will if they have a 2014 certified edition EHR. Remember, this year you are allowed to use either 2014 or 2015 version and the only way you can report the other measures, the newer measures, is if you have 2015 certified edition. But if you pick the advancing care information transitional 2017 measures, then know that they are exactly the same as what you reported last year. The dashboard you're looking at now should truly reflect the same as what you'll be reporting for 2017.

Shanen Wright: Next, we hear from Marianne. She says, "We have always done the risk assessment on our own and most recently did the QPP RA tool, and we were able to add some things that were missing from our RA. It is a very helpful tool. If someone did not ever do it, you will have a lot of work to do."

Kathy Wild: That is excellent feedback. Great and I'm glad that somebody did use the tool. We did say in our privacy and security webinar last month that it is a lot of work. It's something that you definitely don't want to wait until December 1st to get

started but yes, you can do it on your own, but it is time consuming and complex.

Lisa Sagwitz: It's Lisa. I've one other thought on that. While we can provide you with some of the consulting groups that can help with that, some practices that I work with have IT people that are good in that area too. If you have IT support, that would be another resource for you to go to if this is something you need to work on, either for your initial one or to update it for this year.

Shanen Wright: Thank you, Lisa. Everybody must have security on their mind today because Rachel next asks, "When we do our security risk assessment, do we have to submit it or just have it on hand in the event of an audit."

Amy Weiser: This is Amy. Great question. You will just need to have it on hand for an audit at this point.

Shanen Wright: All right, and the final question we have in the queue right now for Q&A, but we will open up the phone lines one last time just in case anybody has a question. Marcia asks, "Is it too late to register to submit as a group?"

Amy Weiser: Hi! This is Amy.

Kathy Wild: I can take that one. Oh, go ahead, Amy.

Amy Weiser: I'll start Kathy and then you can fill in. Thank you. As long as you want to submit as a group, if you have, I think it's between 2 and 25 clinicians in your practice, you can still report as a group. You would've had to sign up with the group reporting option using the web interface by June 30th, if you have 25 or more clinicians, but if you have less than that number and you want to submit as a group, you did not need to do that. You can still submit as a group and you don’t need to register.

Kathy, please correct me if I said anything amiss. Thank you.

Kathy Wild: No, Amy. You've got it perfectly. Yeah, there's no registration required if you still want to submit as a group. The only thing is you can't use CMS web interface as a submission method, but you can certainly report as a group using any other submission method.

Lisa Sagwitz: Can I add to that too because I know that's a confusing thing, for us that do it every day, we know, but for many of you probably on the call, there's two types of group reporting. There's just the regular group reporting that you put your numbers together cumulatively, and then that CMS web-based interface is a special one that you would've registered by June 30th and then CMS gives you specific things to report on. You go into a certain portal to do that. There's two different types of group reporting.

Shanen Wright: Another question's come in. This is another first time inquirer. Welcome to QPPLive! Vicky. Thanks so much for your question. She asks, "Is attestation for IA simply yes or no?"

Lisa Sagwitz: Hi! It's Lisa, I can …

Amy Weiser: This is Amy. Oh sorry, go ahead Lisa.

Lisa Sagwitz: Okay. I was going to say, yes. Now, we have not actually seen the attestation screens because they're not available yet. Yes, you'll probably say yes or no. There was one thing that I learned yesterday on one of the EHR vendor's MIPS dashboard, and they looked for dates for IA. One's called a plan date to enter, one is called in progress and one is called completed date. Whenever you're doing your improvement activities, maybe just jot down when you started something how long it took place.

Most of them, you need at least 90 days, but the prescription drug monitoring program one you will need to be enrolled for six months or 60% of the year, which would be about seven or eight months of the year. Just jot down in case that's something you need to know when it's actually time to attest.

Shanen Wright: A follow-up from Vicky as well. She says, "We are non-patient facing so do not need to attest to ACI just IA. Do we get extra points for doing one high weight and one medium weight? We are only required to attest to one high weight and one at medium weight, correct?"

Kathy Wild: Vicky, this is Kathy. The total number of points you want for the improvement activity category is 40 points. The number of points awarded, whether it's a high weight or medium weight, are based on how many clinicians are in your practice or if your practice is located in a rural or health professional shortage area. If you have less than 16 clinicians in your practice, then to get full credit for that category, you would do one high weight because you'd get 40 points or you could do two medium weight which would be 20 plus 20.

If you did one high weight and one medium weight, you could do that also, but you wouldn't have to really do the medium weight. On the other hand, if you have a practice that has 16 or more clinicians, then the high weight is only worth 20 points and the medium weight is worth 10, so you would have to do two high weights or four medium weights. I know it sounds confusing, but it's all based on how many clinicians are in the practice or where you're located.

Shanen Wright: Thank you, Kathy. If anyone else has questions for the Q&A box, please type them now. At this time, we are still in bonus coverage of QPPLive! today. I'm going to ask that if you do not have a telephonic question, please mute your line on your end. Laurie, if you could unmute our lines and see if anyone else on the telephone has a question or comment for our panel of experts today.

Okay. Well, hearing no questions and no more questions in the Q&A, I would like to thank each and every one of you for joining us for today's episode of QPPLive! We appreciate all the great questions from Shao Ping, Rachel, Teresa, Shanty, Eric, some of our first-time people like Mitchell. Thanks so much for joining us and keep in mind that you can contact Quality Insights anytime for assistance with the Quality Payment Program. You see here on your slide the contact information for practices with 15 or fewer eligible clinicians and for 16 or more eligible providers. We have Kathy's direct contact information there on the screen for you.

Please note that you will receive an evaluation for today's QPPLive! We appreciate your feedback and we do take it into account for each and every session, so we appreciate if you would fill out your evaluation as well. Please make sure and register now. We have the link on our website for our next episode of QPPLive! It will be taking place October 19th, that's the third Thursday of the month at 9:30 am Eastern.

On behalf of everyone at Quality Insights, including Kathy Wild, Rox Fletcher, Shirley Sullivan, Amy Weiser, Joe Pinto, Lisa Sherman, Lisa Sagwitz, Rebecca Dase and Laurie Fink, I'm Shanen Wright asking you to have a great day. We look forward to seeing you next month on QPPLive!

This material was prepared by Quality Insights, the Quality Payment Program-Small Underserved and Rural Support (QPP-SURS) Contractor for Delaware, New Jersey, Pennsylvania and West Virginia under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication number QPP-092517