2019 Quality Payment Program Reporting Requirements Webinar
Transcript from Live Session

Tuesday, December 20, 2018

Laurie Fink: Good afternoon and welcome to today's webinar, 2019 Quality Payment Program Reporting Requirements. My name is Laurie Fink and I am a Communication Specialist with Quality Insights and will serve as the host for today's session. We will get things started in just a moment, but I'd like to first review a few housekeeping items.

Laurie Fink: All participants entered today's webinar in a listen-only mode. Should you have a question during today's presentation, we ask that you please type it into the Q&A box at the bottom right of your screen. Now we do have a presentation that is jam-packed with information today so we may not have time to verbally answer your questions, but our team is on the line and joining us and they will try and submit some answers to your questions in the chat. If we don't get to all of them, we will compile a list of the questions and pull together a Q&A and get that out to everybody via email.

Laurie Fink: Today's webinar is being recorded. The recording along with the slide deck and a transcript of the webinar will be posted on the Quality Insights website as well as the Quality Insights QPP Support Center website as soon as possible. These resources can be found on the events tab under the archived events page.

Laurie Fink: Now, joining us today to talk about the ins and outs of the 2019 Quality Payment Program (QPP) are several members of the Quality Insights team, including Diana Haniak, Rabecca Dase, Joe Pinto, Amy Weiser, our fearless leader, Kathy Wild, and to round out our panel of speakers is Lisa Sagwitz. So to kick things off, I will now hand over the presentation to Diana.

Diana Haniak: Thanks so much, Laurie, and welcome everybody. For today's agenda, we're going to take a look at the eligibility, the payment adjustments, the reporting options, the data submission methods, thresholds, and bonuses for the 2019 merit based incentive payment system, or MIPS.

Diana Haniak: We're also going to take a look and review the performance category requirements, which are quality, promoting interoperability, improvement activities and costs.

Diana Haniak: Finally, we're going to take a look at the 2019 advanced alternative payment models, or AMPS, and as Laurie said, hopefully we'll have some time for question and answers.

Diana Haniak: So just as an overview, Quality Insights is contracted with CMS to provide QPP assistance to all practices in Delaware, New Jersey, Pennsylvania, and West Virginia, and two large practices in Louisiana that have 16 or more clinicians. Small practices in Louisiana that have 15 or fewer clinicians are assisted by another contractor, which is TMF Health Quality Institute.

Diana Haniak: So Quality Insights is responsible for outreaching clinicians that are designated by CMS as an eligible provider to participate in the Quality Payment Program. We provide customized assistance and support and we want to help them be successful, so we're here to help.

Diana Haniak: So just a brief overview of the QPP, this is a Medicare pay-for-performance program that was initiated in 2017 and rewards value and outcomes. There are two ways to participate. So we have MIPS, which is the Merit-based Incentive Payment System, and we have advanced APMs, the Alternative Payment Models.

Diana Haniak: So with participation in the QPP, CMS identifies if you are a MIPS eligible clinician, or EC, and you must participate in the QPP or you'll be subject to a negative payment adjustment. If you belong to a specific shared risk accountable care organization, or ACO, or an alternative payment model, APM, you may earn a Medicare incentive payment if you meet the criteria to be in a qualifying APM participant, or QP, in an advanced APM.

Diana Haniak: So our timeline for participation in 2019 - January 1st, 2019 is when the performance period is going to begin. December 31st of 2019, that's when our performance period ends. January 2nd of 2020, that's when the submission period will open to get all of our data for 2019 in. March 31st of 2020, that's when the submission period closes. We have to get all of our data in prior to that date. In July of 2020 we're going to receive our 2019 MIPS scores and our feedback reports. October 1st, 2020 is the final day to request a Targeted Review. You would request a Targeted Review if you believe there was an error in your 2019 Feedback Report.

Diana Haniak: In late October to early November of 2020, this is when we'll receive our final MIPS scores and our feedback reports after all of the targeted reviews are completed. Then finally on January 1st of 2021 to December 31st of 2021, this is when we're going to get our MIPS payment adjustments so that will be applied to all of our Medicare Part B claims based on our 2019 final MIPS scores. So Rabecca, how do we know who has to participate in 2019?

Rabecca Dase: All right, so eligibility is determined on an annual basis and it's actually based on criteria and regulations that are passed by Congress every November. So this

past year, or November when the final rule came out, they actually took the look-back periods and aligned them now with the fiscal year. So the first look back for the 2019 performance year will be October 1st, 2017 through September 30th of 2018. And the second period is going to be October 1st, 2018 through September 30th of 2019. Next slide please.

Rabecca Dase: So in 2019, we have maintained the five clinician types that we've known for the first two years of the performance. But what CMS has done now is that they have actually added six clinician types. We have physical therapists, which is new, occupational therapist, speech language pathologist, audiologist, clinical psychologist, and registered dietitian or nutritional professionals. So if you have any of those clinician types within your group, you will be required to report on them for MIPS if they are considered eligible for the 2019 performance year. Failure to report on those new clinician types will actually result in a negative payment adjustment in 2021. Next slide please.

Rabecca Dase: The eligibility criteria for 2019 is the same as what we've known for the previous couple of years but they have added one new criteria. In order to be eligible at the individual level or group level, you need to have $90,000 or more in Medicare Part B allowable charges. You have also provided care to 200 or more Medicare beneficiaries and then the new one for 2019 is you have provided 200 covered professional services under the physician fee schedule. They're defining a service as one professional claim line with a positive allowable charge to one covered professional service. Now again, in order to be eligible, you must meet all three of those low volume threshold criteria set by CMS. Next slide.

Rabecca Dase: All right. So who doesn't have to participate? If you are in fact newly enrolled in Medicare, you do not have to participate if you do not meet all three of those criteria that I just mentioned on the previous slide of the $90,000 or more in charges, 200 or more Medicare patients, or if you don't have 200 covered professional services, you don't have to participate. Then the third way that you wouldn't have to participate is, in fact, if you are a qualifying participant in one of those advanced APMs. Next slide.

Rabecca Dase: So to confirm your 2019 eligibility, you can actually go to the same place that you've gone the past two years and that's the qpp.CMS.gov website. You can see here we've actually kind of highlighted where you'll go to check your eligibility. So you'll go under MIPS and then you'll hit the check participation status. Next slide.

Rabecca Dase: And what it'll do is going to enter your individual clinician NPI number. You're not going to enter your group NPI number, that'll come up and say data not found information not available. Again, you want to make sure it's your individual clinician, NPI number and that'll actually bring up all the information that you would need for your group as well. Next slide.

Rabecca Dase: So when you do check the participation eligibility of your clinicians, it's actually going to, again, like I said, show you the information for your group and that

clinician. It will show you your special statuses, which is very important to note because with special statuses come special rules and scoring and things like that. So when you do log in to check your participation, which is for eligibility just like you have for the previous years, you'll be able to see if you have special statuses like non patient based clinician. If CMS deems you as small practice of 15 or fewer clinicians, whether you are hospital-based, and things like that.

Rabecca Dase: So if you need any help looking up their eligibility within the QPP Lookup Tool, feel free to reach out. If you're not sure what your special statuses mean, we can absolutely provide you more assistance to help you understand that. So Diana, I will turn it back over to you.

Diana Haniak: Thanks so much, Rabecca. We're going to move on. Joe, can clinicians participate even if they don't have to?

Joe Pinto: That's a great question, Diana, and the answer is absolutely. New for 2019 CMS has added an opt-in reporting option for MIPS. As Rabecca had mentioned earlier, there was a third of low volume threshold criteria that was added now for the 2019 performance period. So clinicians who meet one or two of the low volume threshold criteria, but not all three can opt in and participate in MIPS in 2019. If the opt in is selected the data will be scored and the clinician will be subject to the payment adjustment.

Joe Pinto: Also keep in mind that after a clinician notifies CMS of their election to opt-in, the clinician cannot change his or her decision and it is not revocable. Also APM entities interested in opting in can do so with the APM entity level and one thing to keep in mind that CMS is currently developing the opt-in election process so we don't have all the details on it yet. We will know sometime after the first of the year, so you can contact your Quality Insights Practice Transformation Specialist for more information on that when it is released. Next slide.

Joe Pinto: There is voluntary reporting for 2019 non-MIPS ECs which are the eligible clinicians also have an option to participate in MIPS via voluntary reporting. What this means is that CMS will provide performance feedback based on the data that is submitted, but clinicians will not be eligible to receive a payment adjustment if they are reporting voluntarily. The difference between the opt-in and the voluntary reporting is that clinicians who opt-in are subject to a payment adjustment while those who voluntarily report are not. Next slide.

Joe Pinto: In the next slide, you'll see a chart of a breakdown of some of the opt-in scenarios. There are seven scenarios listed here, the first six of which include that at least one or more of the three low volume criteria are met with a yes. If you meet one or more of the criteria, then you are required to participate and you have the three options. You can either opt-in, you can voluntarily report, or you can choose not to participate at all. The only options that can't opt-in would be those providers that do not meet even one of the three low volume criteria. If they answer no to the more than $90,000 billed to Medicare, no to more than

200 Medicare patients seen, and no to more than 200 Medicare services provided, they cannot opt-in to the MIPS program in 2019. Next slide.

Joe Pinto: And with that I'll turn it back over to you Diana.

Diana Haniak: Thanks, Joe, we're going to move on. So Amy, did the payment adjustments increase or change in 2019? What's going on?

Amy Weiser: Hi Diana. So yes, the financial implications for the QPP for 2019 have changed. Practices will receive a negative 7% payment adjustment if they are a MIPS eligible clinician and do not report any data in 2019. It is also possible for practices and clinicians to receive up to a positive 7% payment adjustment based on their final MIPS score, how many eligible clinicians report nationally and their MIPS scores, which we'll talk a little bit more about in the coming slides. Eligible clinicians can also receive an additional positive payment adjustment for exceptional performance if their MIPS score is 75 points or more. Next slide please.

Amy Weiser: So each year the performance threshold, the MIPS score that must be achieved to avoid a penalty, increases. So as you'll recall in 2017, the MIPS score to avoid a penalty was three points and for 2018 the MIPS score to avoid a penalty is 15 points. Now for 2019, the MIPS score to avoid a penalty is 30 points. Next slide please.

Amy Weiser: This gives you just an idea of how CMS will break down the MIPS payment adjustments based on your final MIPS score for 2019. So as an example, if you score 0 to 7.5 points in 2019, your payment adjustment would be a negative adjustment of 7%. And if this would occur in 2021, if you scored between 7.51 and 29.99 points, you would also receive a negative payment adjustment between zero and negative seven. 30 points would be the neutral payment adjustment. You would receive neither a positive or negative payment adjustment.

Amy Weiser: 30.01 to 74.99 points is a positive payment adjustment between zero and 7% and greater or equal to 75 points would mean a positive payment adjustment between zero and 7% and then exceptional performance payment adjustment with a minimum additional 0.5%. Next slide please.

Amy Weiser: So the payment adjustments are tied to what's called budget neutrality. To ensure that budget neutrality is a scaling factor, it is applied to the positive payment adjustments based on the distribution of final scores across all MIPS eligible clinicians. In 2017, more than 93% of MIPS eligible clinicians reported data. So the positive payment adjustment did not reach the maximum potential of 4%. A perfect MIPS score of 100 points earned a total positive payment adjustment of only 1.88%. So there's really no way for us to tell you how much you could potentially earn in MIPS based on the budget neutrality, but we will

do everything we can as we assist you to score as high as you can and hope that you can receive that positive 7%. Next slide.

Diana Haniak: Great. Thank you so much, Amy. Rabecca, can you tell us what are the weights with the MIPS categories that are coming in 2019?

Rabecca Dase: Yeah, absolutely. So ultimately for the MIPS program, in order to receive the highest possible score, you want to make sure that you're submitting data on all of the categories. You have your Quality, Promoting Interoperability and Improvement Activities categories that you would be responsible for submitting data to CMS or making sure it gets there. And then for the Cost category, it's based on claims so there's nothing you have to do for that one. CMS does that all on the back end. Next slide.

Rabecca Dase: So when you're reporting on these categories you have to think about how much they are worth to you. So your Quality category from 2018 to 2019 has changed by 5%. So in 2019 it's worth 45% of your total MIPS score and then for cost, cost is going up. It went from 10% in 2018 to actually 15% in 2019. Then your Promoting Interoperability has remained consistent or constant at 25% and the Improvement Activities remains the same at 15% as well. So just a little bit of change there. Next slide.

Rabecca Dase: So what CMS does is they actually take the total points earned in each category and add them together to determine your final MIPS score. There's worth up to 100 points for your final MIPS score, so whatever you earn out of that, out of that 100 would be your final MIPS score for performance 2019 performance. And next slide.

Rabecca Dase: In 2019 they are continuing with the complex patient bonus. So what this is saying is you have your four categories and then based on the complexity of the patients that you treat, you can receive up to five extra points. Obviously you can't go over 100 but you can earn up to five extra points based on the complexity of your patients and how CMS determines this, it's based on the HCC codes and the risk scores and stuff that are assigned to your patients, which they receive based on the codes and stuff that are submitted to them.

Rabecca Dase: I will note too that Quality Insights will actually be hosting a webinar earlier in 2019 about the HCC coding and how it can impact your MIPS score and such. So this complex patient bonus is actually for 2019 and will be based on a look-back period of October 1, 2018 through September 30 of 2019. So it's very important that you guys are coding to the highest level that you can and things like that. But again, we will also be providing more information in early 2019.

Rabecca Dase: So Diana, I will turn it back to you.

Diana Haniak: Thanks, Rabecca. There's a lot of changing going out there. So Kathy, are there any reporting changes for 2019?

Kathy Wild: Thanks, Diana. So first of all, for the reporting periods there is actually no change. CMS is leaving that where the quality category and the cost category will be measured for the full calendar year, 365 days and both the promoting interoperability and improvement activity categories will remain a 90-day minimum up to 365 days. I did just want to note there are some Improvement Activities when you look at the actual specs that do require more than 90 days. So you would have to fulfill the minimum for them. Next slide.

Kathy Wild: For the reporting options, there's no change from this year either. The clinicians and practices have three options to report data. They can show data at the individual NPI level, they can show data at the group level which is comprised of two or more clinicians together, or they can report via a virtual group. One thing I do want to note is that if you are thinking of doing virtual group reporting next year, there is a deadline where you need to notify CMS that you're going to do so and that deadline is December 31. There are materials on the QPP website about the virtual group election process. Next slide.

Kathy Wild: Okay. So the big thing, and this is a big benefit to everybody, is the submission change that they have put in place. So this year, or rather in 2019, individuals and groups may start to use multiple methods to submit data. What that means is if you submit one measure using different methods, the one with the highest number of points will be scored. This is really good for the Quality category where you had to, in previous years you had to select whether you wanted to report via claims, or via your EHR vendor, or a registry and then all of your measures had to be submitted that way, the same way.

Kathy Wild: Next year you will be able to report some Quality measures maybe via your specialized registry and maybe some through your EHR vendor, and you can submit all of them together. Once again, CMS will go ahead, score them and then take the ones with the highest scores. Next slide.

Kathy Wild: Something else that's new this year is CMS wanted to kind of clarify some terminology. They thought there might be some confusion so they came up with some new terms and I just am throwing them out there in case you see it in any of the documentation and resources they create. So basically, to submit data they are now calling the term direct submission. So what that would be, is like a third party would be reporting that data specifically from that third party straight to CMS and you wouldn't be involved. That would be your EHR vendor, your registry, your QCDR.

Kathy Wild: Another option is the login and upload. So the log in part is logging into the QPP portal and then you would go ahead and upload the files that are necessary for the category or categories that you want to report. Another one is the log in and attest and that would be logging into the portal again and the attest station simply means you are manually entering numerators and denominators, or answering, yes, no, or whatever questions they need in there.

Kathy Wild: Then there's of course claims reporting, which next year we will go over, but it is only going to be available for individuals who work in small practices and that is defined as 15 or fewer MIPS eligible clinicians. Then there's still the CMS web interface, so groups with 25 or more clinicians can choose that option to submit their data and they do have specific quality measures that they have to report that way. So those are called submission types.

Kathy Wild: Submitter types, the options are individual group or a third party intermediary, which encompasses the vendors, the registries, billing companies, whoever may do that for you on your behalf. Another thing that CMS wanted to clarify is collection types, which they're now calling the quality measure sets. So the electronic clinical quality measures, ECQMs, those are the ones that are usually reported through your EHR. Then what they did is they renamed registry measures. They now call clinical quality measures. So if you see that word, it's basically your formal registry measures.

Kathy Wild: Then you have specific measures that are for QCDRs, certain measures for claims, the web interface, administrative claims, and then the caps for MIP survey is also considered a quality measure. Next slide please.

Kathy Wild: So this is basically just an overview of the terminology I just kind of went over showing me the options at the individual level and their terminology. And then next slide.

Kathy Wild: This is the same thing, but if data was submitted at the group level and I'll give it back to you Diana.

Diana Haniak: Thanks, Kathy. That was great. Now back to Rabecca. So what's new in the Quality category? Can you tell us a little bit about that?

Rabecca Dase: Yeah. So I will kind of dive into the quality category and what's the same and what's changed. As I had mentioned previously, the Cost category is actually the biggest component of your MIPS score and it stands at 45% for 2019, which Joe will talk about later, the reweighting. If their Promoting Interoperability category gets reweighted, Quality would become worth 70% of your total MIPS score. So that's a huge number.

Rabecca Dase: So as Kathy just mentioned, the reporting period for quality remains at a full year. Eligible clinicians are still required to report on six measures or a full measure specialty set and if less than six measures apply to the clinician, they cannot report any applicable measures. As in previous years, there is still the requirement of one outcome measure and if an outcome measure is not available the group would want to report on a high priority measure. Again, you can absolutely report on more than six measures. That's up to you, but CMS will score you on the highest performance rates that you submit and ultimately they would then be determining what your MIPS score is even if you didn't agree with it.

Rabecca Dase: They would still take different ones, but ultimately you want to make sure that you are submitting the best six measures that you have and if you want to submit more measures for feedback, you absolutely can. So for 2019 there are 257 quality measures available. CMS from last year to this 2019 they removed 26 measures. They've added eight new ones and they've also adjusted some of the other measures as well. So in 2019 you want to make sure that you are looking at the measures that are available, seeing if your measures had been removed or if any changes have been made to your measures to make sure that you are capturing it appropriately and that if there's any workflows that need to be made within your group. Next slide.

Rabecca Dase: So as Kathy mentioned as well, Quality measures can now be submitted using multiple submission methods with the exception of the CMS web interface measure, you can only use that one method. I think where we'll see this a lot too is going to be for specialists that use a registry and EHR, but ultimately anybody can use, except for the web interface measure reporters, they can use multiple submission methods. If you submit the same measure with different methods, whether it's EHR or registry, CMS will take the highest performance rate that you submitted.

Rabecca Dase: Something I think that's very important to highlight and I'll probably say it a couple of times throughout my slides, quality can no longer be reported via claims for groups that are 16 or more clinicians. So if you're in a group of 16 or more clinicians and you have in fact reported your quality category via claims previously, you're going to have to go back to the drawing board and decide what you're going to do. Are you going to use EHR, or registry, QCDR. If you're a group of 25 or more, maybe the web interface, but ultimately, if you have 16 or more clinicians, you can no longer use claims to report quality. Now, if you're a small practice of 15 or fewer clinicians, this is absolutely still an option for you. Next slide please.

Rabecca Dase: So data completeness, I think we maybe skipped one, but data completeness for the CMS web interface, they actually use a sampling and they take 248 Medicare Part B patients and then you would report on those. Then if you are doing the caps for a MIPS survey and you actually don't have enough patients within that measure, they would change your denominator up to 10 and then score you zero points for the caps for MIPS survey, so would not be penalized, and that again is new for 2019. Next slide please.

Rabecca Dase: All right. I think we actually missed a slide. So going back two slides and Diana, if you don't want to go back, that's okay. But I want to talk about maximize ... Yep. This is the one. Perfect. So maximizing your quality score. For MIPS in order to maximize your quality score, you need to make sure that you're meeting the data completeness and the case minimum requirements that CMS has set to be eligible to receive those 10 points for each measure.

Rabecca Dase: So the data completeness, you want to report on at least 60% of your eligible cases and for claims, this is strictly just your Medicare Part B patients only and

then if they're using an EHR, registry, or QCDR, it'll actually be all patients across all measures. So again, that's 60% of your eligible cases and then the case minimum, you actually want to have at least 20 of your denominator per measure, which is considered your case minimum. Then when you're looking at your measures too, again, to maximize your score, you want to look at benchmarks that are going to be achievable to earning the most points.

Rabecca Dase: I'll use medication reconciliation for example. People typically do well at that and they might have a score of say 90%, which is really good. But if you look at the benchmarks for that measure, in order to earn those 10 points, you actually have to receive a score of 100% or almost 100% in order to receive those 10 points. So each measure comes with different benchmarks and different performance will earn you different points. So it's very important once you talk about your quality measures to also compare them to the benchmarks. Next slide.

Rabecca Dase: If you do not meet data completeness and are in a group of 15 or fewer clinicians, you will earn three points for each measure. If you're at a large practice of 16 or more clinicians, you will only earn one point for each measure. So again, the data completeness' report against 60% of all of your eligible cases and having at least 20 patients in your denominator. If you don't meet those, small practices would only earn three points for each measure and large practices would only earn one point for each measure. Next slide please.

Rabecca Dase: So we've kind of already talked about the web interface. I mentioned that they'll sample 248 patients per Quality measure for the web interface, and then if you don't meet the requirements for the caps for MIPS survey, CMS would reduce your denominator by 10 and you would just receive a score of zero for the caps for MIPS. Next slide please.

Rabecca Dase: All right, so another way to maximize your Quality score would be avoiding those topped-out measures. I think last year CMS identified, I believe, six or seven measures that are topped-out and you can only receive seven points. So even if you knock the measure out of the park, the most you could earn would be seven points. Obviously if everybody else can earn ten and your only selecting measures can earn seven, that's a way that your score could be lower. So you want to make sure that you're picking the best measures that aren't topped-out, that give you the most options to earn the most points.

Rabecca Dase: The reason for the topped-out measures is because they can't measure the improvement anymore. They can't see distinction improvement so there's not a lot of wiggle room, for lack of a better term, to show your improvement. Something to note, too, is that QCDR measures are excluded from the topped-out measure lifecycle and special scoring policies. Next slide.

Rabecca Dase: All right, bonus points, we all love bonus points and thinking about how we can take our scores and make them even a little bit better. In order to earn bonus points for your measures, you want to make sure, again, that you are meeting

those data completeness and case minimum requirements that I've mentioned. Your case minimum and your performance rate would have to be greater than zero. If your case minimum was 20 and then your performance rate again, would need to be more than zero in order to earn some bonus points.

Rabecca Dase: In addition to that required outcome or high priority measure that I mentioned earlier, if you submit any additional outcome or patient experience measures, you can earn two points per measure that you report on additionally. Then for any additional high priority measure that you report, you can actually receive one point. Unfortunately a change for 2019 is going to be that the CMS web interface reporters can no longer earn that high priority bonus, which is unfortunate.

Rabecca Dase: But so for these bonus points it is capped at 10% of the denominator, which means you cannot earn any more than six points for those additional high priority and outcome measures. Next slide.

Rabecca Dase: So more bonus point opportunities. It's remained the same for 2019. Each measure that you submit electronically end to end, you could earn additional points. Then for that, that's also capped at 10%. So even if you decided to report say 10 measures all electronically, you would still only be able to receive those six points because it's capped at 10% of the denominator.

Rabecca Dase: Something also that's remained the same for 2019 is actually the improvement scoring bonus and you can earn up to 10 extra points for the Quality category. What they would do is they would take your quality score from 2018 and compare it to 2019 and whatever the difference was, you could actually earn points. Now this is your Quality score without the bonus points so keep that in mind. It actually just goes back to the quality measures without any of the bonus put on there too. So that's still an option.

Rabecca Dase: That is the Quality category in a nutshell. If you guys have any questions, please reach out. Quality Insights is always here to help. And Diana, I will turn it back to you.

Diana Haniak: Thanks, Rabecca. Sorry about that little hiccup we had there. Joe, can you explain the changes that are going on in the PI category for us?

Joe Pinto: Certainly, Diana. There are some big changes that will take place for the 2019 performance year in the promoting operability category, also known as PI. Measures will be consolidated and there is a new scoring process that will be in place for 2019. CMS has eliminated the base performance and bonus scores and they've replaced them with performance based scoring at individual measure level. Also for 2019 if a measure has an exclusion available and the exclusion is claimed then the points for each excluded measure will be reallocated to the remaining PI measures in that category.

Joe Pinto: You must report all Promoting Interoperability measures or claim an exclusion in the 2019 calendar year. Also, maximum number of points will be 100 points for 2019. That's a reduction from the current total max of 155 for that performance category, and also keep in mind for 2019 you must use 2015 certified EHR technology during the entire reporting period in order to be eligible in the MIPS performance year. Next slide.

Joe Pinto: So what does stay the same? Well, the PI category is still worth 25% of the final MIPS score unless it's related. The reporting period is a minimum of 90 consecutive days and can be up to the full calendar year. Now what that means is that it is recommended that if you monitor performance rates through the year and you were only going to use the 90 day performance period, then you should select the highest PI score to maximize your final MIPS score if you're going to select 90 days or more, but not the full calendar year. Next slide.

Joe Pinto: There's also PI automatic reweighting for 2019 and CMS will automatically reweight the category for the following list of clinician types. That would be non-patient facing clinician, hospital-based clinicians, ambulatory surgical center-based clinicians, as well as MPs, PAs, CNS, and CRNAs.

Joe Pinto: New for 2019 will include physical therapists, occupational therapists, speech language pathologists, audiologists, as well as clinical psychologists and registered dietitians or nutritional professionals. Also to keep in mind that with the reweighting, the reweighting will be for if the PI data is not submitted, the category will then be reweighted to the Quality category, and that overall score for that performance category will be 70%.

Joe Pinto: However, if PI data is submitted, the PI category will be scored, so keep that in mind. If you don't intend to submit data for that category, then don't submit it. The category will be reweighted to the 70 points total under the quality category. Next slide.

Joe Pinto: Also, there is a PI hardship exception for reweighting and that would only apply to certain clinicians that are eligible to submit a PI hardship exception for 2019 and the application to get a PI category reweighted to zero. The deadline to submit the application will be December 31st of 2019 and the criteria for that would be clinicians in a practice with 15 or fewer clinicians. Also if an EHR is decertified during the performance period, as well as if there is insufficient internet activity available to that clinician.

Joe Pinto: You can also submit for the hardship exception reweighting if extreme and uncontrollable circumstances hit such as a hurricane or something or another that would disrupt your ability to submit the data. Also a lack of control over the availability of CEHRT, which is the certified EHR technology. That would be a significant hardship exception.

Joe Pinto: Now, if the hardship application is approved by CMS then the quality category will be reweighted to the 70% just as in the previous scenario with the PI. And also keep in mind, once again, if PI data is submitted, then the PI category will be scored. Next slide.

Joe Pinto: For certified EHR technology requirements in 2019, everyone must utilize 2015 edition CEHRT during the full 90-day reporting period or greater in order to be eligible for the MIPS program. An example of that would be if you are reporting on the period of March 1, 2019 through May 30, then you must have the 2015 edition fully functional beginning on March the 1st. Even if the EHR vendor did not receive the certification yet, that's very important. The vendor must then receive certification no later than the last day of the reporting period, which would then be May 30th in this example. Now, it is not possible to earn any points in the PI category in 2019 unless the EHR is 2015 edition, during the complete reporting period. Next slide.

Joe Pinto: Here is an example of some PI submission options. Of course, the individual or group reporting option is still on the table. That includes EHR reporting, registry, or QCDR reporting as well as at a station via the QPP portal. A few of the submission types would be direct using the EHR vendor or a registry to do the submission, also logging in and uploading the data reports as well as log in at a station. The submitter type would include individual and also third party intermediary, which would be your EHR vendor, a registry, a billing company, and so forth. Next slide.

Joe Pinto: Now there are 2019 PI measured changes, you'll see on this chart some of the breakdowns. We'll use them one at a time. On the e-prescribing, there is no change from the 2018 performance period. The maximum points that would be rewarded for the E-prescribing measure under the PI category will be 10 points. However, the next one is a change, the support electronic referral loops by sending health information is formerly known as send a summary of care. That will be worth 20 points in 2019, as will support electronic referral loops for receiving and incorporating health information, which is new for 2019.

Joe Pinto: Also a 40 point maximum award will be for providing patients access, electronic access, to their health information. That is formally provide patient access as it is listed currently for the 2018's performance year. Also public health and clinical data exchange, that is 10 points and you can choose between the following, immunization registry reporting, electronic case reporting, public health registry reporting, clinical data registry reporting, or syndromic surveillance reporting if that is available in your state. Next slide please.

Joe Pinto: Now there are also two new PI bonus measures for 2019. You can earn five points for each of the following two. You can earn five points if you query the prescription drug monitoring program, that's the PDMP, and also new for 2019 if you verify opioid treatment with an agreement, you are eligible for five bonus points under the PI category. Next slide.

Joe Pinto: There's also PI measure scoring for each measure. It is scored on performance based on a numerator and denominator or a yes or a no. Now, in order to do that, you must submit a numerator of at least one or answer yes to fulfill the measurement requirement, and if there is an exclusion for a measure that will be claimed under the category, then the points for that measure will be allocated to other PI measures.

Joe Pinto: Also just a reminder that the measure specifications for the 29 PI measures are not yet available, but once they are available by CMS we will definitely get that information out to you. You can contact your representative with Quality Insights for further information on that. Next slide.

Joe Pinto: There are some steps to calculate the PI category score. One of the steps you can do is to calculate the performance rate by dividing the numerator by the denominator, and you can multiply the performance rate by the maximum number of points for that particular measure. Now, then if you add all of the individual measure scores together, add the applicable bonus points to the total number of measure points, then you multiply the total points by the PI category weight of .025. Sounds kind of complicated, so I'll explain it on the next slide.

Joe Pinto: So here's an example of how to calculate the PI score. We'll just use the E-prescribing measure as an example here. So the maximum number of points that you can earn is the 10 points. In this case, the data shows that the numerator denominator are 200 and 250, which would create a performance rate of 80. So in order to calculate the points, you would take the 10 points that are awarded as the maximum score for the measure times .08 and that would equal eight points out of a total 100 for that category.

Joe Pinto: If you look down at the bottom, I won't go through all of them, but at the bottom you'll see the final PI category score, when you calculate it this way, would equal 20.75 points or 83 overall points towards the 100 for that category. Next slide.

Joe Pinto: So finally, there's the security risk analysis and this is a big one for 2019 because although a security risk analysis is no longer a standalone PI measure, it still must be completed during the calendar year in order to earn any points toward the PI category. Now what that means is that clinicians and groups will still be prompted to answer yes to the following statements in order to report data for the PI category. Those statements on the at a station will be if you've used 2015 CEHRT for the performance period, if you attest to the prevention of information blocking, attest to ONC director review and also attest to completing a security risk assessment analysis. You must answer yes to all of those in order for you to receive the points for the PI category and that does it for the PI category. Back to you Diana.

Diana Haniak: Thanks, Joe. That was great. We're going to move on. Kathy, are there changes with Improvement Activity categories that you can let us know about?

Kathy Wild: Okay. Well actually no, there are not. I've got a couple of slides here, but I'm going to go through them really quickly. Everything is really the same. The points, the way you earn the points. There's a total of 118 activities available in 2019, that's basically the only change. They added six new ones, modified one and removed one. Modified five activities and removed one. One of the things I did just want to remind everybody, we get this question a lot. Can you complete the same activities that you did in a previous year or do you have to pick new ones? And the answer is yes. You can report the same improvement activities you reported in previous calendar years.

Kathy Wild: The only other thing is that they removed the designation for using a certified EHR technology for certain activities and the reason for that is that PI bonus is no longer available since they completely revamped the PI category. So that is also gone. Next slide.

Kathy Wild: Submission category, there's no changes whatsoever. We just want to remind everybody to keep all their documentation for at least seven years in case you are audited down the road. CMS is in the process of creating a 2019 MIPS data validation criteria resource which is really handy and contains all of the information that they'd be looking for and that you should keep and produce in case you are audited. So as soon as that becomes available, we will certainly let you know. Next slide.

Kathy Wild: Scoring remains the same. You want to get 40 points and the weight of, high weight or medium weight and the scoring is based on basically where the size of your practice or the location. Next slide.

Kathy Wild: Just some considerations, if you were reporting as a group or a virtual group, remember that only one MIPS eligible clinician actually has to complete that activity, but the whole 10 will get credit for that. Another thing is at least 50% of practice sites within a 10 must be recognized or certified as a patient centered medical home to receive full credit for the improvement activity category. MIPS and APMs will receive at least 20 improvement activity points and are eligible to possibly receive more based on their actual model. That's it for the IA category.

Diana Haniak: Thanks, Kathy. At least there's not too many changes there. Let's look at the changes for the Cost category. Lisa, can you let us know about that?

Lisa Sagwitz: Sure. Hi everyone. So for the cost category, the performance period remains the same with a full calendar year and that's mentioned on the next slide. There is no manual submission so you do not need to attest for the cost category and the reason for that, and again, it's on the next slide, is that CMS bases this on your administrative claims for Medicare Part A and Part B patients, which is your fee or service claims.

Lisa Sagwitz: Then just so you know, performance for cost is compared against other MIPS eligible clinicians and groups during a current calendar year. It's not compared to benchmarks like the quality measures are. Next slide.

Lisa Sagwitz: Now we'll talk about what changes for 2019. So the Cost category increases to 15%. You're probably familiar from 2018 with total per capita cost and that you need at least 20 cases to get a score and the term Medicare spending per beneficiary where you need at least 35 cases to get a score. Well in 2019, eight new episode based measures are introduced and I'll show you those on the following slide, but for the procedural episodes, it will be a case minimum of 10 for scoring and a case minimum of 20 for acute inpatient medical condition episodes. Next.

Lisa Sagwitz: These are the new episode-based cost measures, so if your practice is part of this or your patients, you'll want to pay attention to this. Patient PCI, knee arthroplasty, revascularization for lower extremity critical limb ischemia, cataracts, colonoscopy, intracranial hemorrhage, or cerebral infarct, pneumonia, ST elevation. As Rabecca mentioned, we will have another webinar probably in February or March with some more details on the Cost category to help you. Back to Diana.

Diana Haniak: Thanks, Lisa. We're going to move on. So Kathy, can you give us some insight on the new facility-based measurement?

Kathy Wild: Sure. So this is a new option in 2019 and it's available for clinicians who are basically facility-based, meaning the hospitalist, the radiologists, pathologists, people that work in the ER. And what CMS will do, they'll take the Quality and Cost category scores and base these clinicians performance on the hospitals where they work, if certain eligibility criteria are met. So the eligibility is based on claims for a period prior to the performance year.

Kathy Wild: At the individual clinician level, to be eligible they must furnish at least 75% of covered services in either an inpatient hospital setting, which has a point of service code of 21, in an on-campus outpatient hospital, which has a point of service 22, or in the emergency room, which is a point of service code 23. To be eligible at a group level would be, CMS would determine that based on at least 75% of the clinicians in that group are eligible at the individual level. One thing to note is that the eligible clinician must have at least one service billed from either an inpatient hospital or the emergency room. Next slide.

Kathy Wild: As far as attribution, clinicians are attributed to the hospital where they provide services to the most patients. We all know that there are some doctors that have privileges at several different facilities. So that's where CMS would figure out this calculation based on where they see the most patients.

Kathy Wild: If this is going to be done at the group level, CMS would look to see where most of the facility based clinicians are attributed in the group to which hospital. If

CMS is unable to identify the facility within the hospital value-based purchasing program to attribute a clinician's performance, then that clinician would not be eligible for this possible facility-based measurement. Next slide.

Kathy Wild: So CMS will automatically apply this facility-based measurement to MIPS clinicians and groups who are eligible and meet that criteria. They would do that behind the scenes and know that they would only score it this way if it would benefit that clinician or group by having a higher combined Quality and Cost score. So individuals actually do not need to do anything to get this facility-based measurement applied. However, at the group level a group would need to submit data for either the improvement activity or promoting interoperability category in order for the facility based measurement to be applied to their group.

Kathy Wild: Once again, the measure set, and the benchmarks for the fiscal year hospital value-based purchasing program that begins during the applicable MIPS performance period are used. So for 2019 it will be the data based on 2019 hospital value based purchasing program. Next slide.

Kathy Wild: As far as the scoring, the Quality and Cost category scores are based on how well the hospital performs in comparison to other hospitals in the program nationally. If the hospital does not receive a total performance score in the hospital value-based purchasing program in the current year, then CMS would not be able to calculate a score and the clinician or group will have the regular quality and cost categories scored that way. And that's it for that. Back to you Diana.

Diana Haniak: Thanks, Kathy. Lisa, can you give us a little insight into any changes there might be with alternative payment models, or APMs, in 2019?

Lisa Sagwitz: Sure. In the next six slides we'll talk about alternate payment models, or ACOs, Accountable Care Organizations. So this is going to be of interest to anyone who's in an ACO or possibly if you're thinking of joining an ACO. At the beginning of the webinar we talked about there are two paths to take for the quality payment program, either the MIPS path or the APM path. So APMs are a payment approach that CMS developed that provide added incentives to clinicians who provide high quality and cost efficient care in their ACO.

Lisa Sagwitz: The large circle that represents the APMs, there are subsets within there. So in that large circle, we know that there are 561 ACOs in the shared savings program in the country. Of that 561, 460 are track one APMs. So what that means is there's no financial risk to be in a track one APM, that's the majority, and that may be changing next year.

Lisa Sagwitz: Then the two small circles, the MIPS APM and the advanced APM, they overlap because many MIPS APMs are advanced APMs, they take on two-sided financial

risk. What that means is if the ACO does well, they get the incentives. If the ACO would perform poorly, they would owe Medicare money. Next.

Lisa Sagwitz: So we're going to talk about the advanced APMs, the two-sided risk models. They need to meet three requirements, 75% of the eligible clinicians in the ACO need to be on an EHR with 2015 CEHRT. The APM needs to provide payment for covered professional services based on quality measures comparable to those used in MIPS, and there are 15 of those quality measures. Then either be a medical home model or it requires the participants to bear a nominal amount of financial risk.

Lisa Sagwitz: Then new is the APM scoring standard changed, so the eligible clinicians in a MIPS APM can report promoting interoperability data at either a group level or an individual level. Just a quick story to share. Many of the practices that I work with called earlier this year and said, "I'm in an ACO, there's nothing I need to do now," and that's not correct. Most providers who are in an ACO still need to report at least promoting interoperability and your ACO will be able to guide you on that or contact us at Quality Insights and we can help look up what your status is. Next.

Lisa Sagwitz: One of the benefits of being in an advanced APM are the extra incentives for a sufficient degree of participation. The clinicians and practices get greater rewards for taking on that risk related to patient outcome and there are financial rewards that are available for advanced APMs that do well. A 5% positive payment adjustment for Medicare.

Lisa Sagwitz: Now, with that said, I'd also like you to know that ACO administrative costs are very high, so you will want to read your contract and know what percentage to expect if the ACO does well. One other benefit is that in 2026, the physician fee schedule will be a little higher for those in an APM. Next.

Lisa Sagwitz: This is a list of the advanced APMs for 2019, the two-sided risk models. The fourth one down, the comprehensive primary care model, the CPC plus, I'm in Pennsylvania. So I know that the Philadelphia region has a lot of CPC plus models and there are 18 regions in the country with that.

Lisa Sagwitz: The next one, the Medicare Accountable Care Organization Track One Plus, that's new for 2018. We know that there are 55 of those in the country. I'm in southwestern Pennsylvania and I work with a handful of those organizations. The next generation ACO, there are 51 in the country. Track two there are eight. Track three, 38.

Lisa Sagwitz: So again, think back to those original circles when we started the slides with the plain track one, I call them the plain vanilla models. They are not in this advanced APM, which may be changing next year. And then next slide.

Lisa Sagwitz: So when you're in an advanced APM, you need to be what's called a qualifying participant, or a QP. You need to see a certain number of Medicare patients to achieve that and that's easy to do. You go to the qpp.CMS.gov website. Look under the check participation status with your NPI number and there will be different look-back periods during the year to determine that you've met that goal.

Lisa Sagwitz: New for 2019 is another model called the all Payer Combination. So what happened is some of the ACOs got approval from CMS to not only have the Medicare Part B patients, but they may be adding Medicare Advantage, Medicaid, commercial, or private payers to make that pool of patients in the ACO much bigger. But definitely the organization would have gotten approval from CMS and they should advise you if that's something that's going to be new if you're in an ACO. Next slide.

Lisa Sagwitz: The advanced APMs only require 50% of their clinicians to be on an EHR and have the 2015 CEHRT and the QP determinations under that all payer method may be requested at the ten level, the APM entity level, or the individual clinician level. If any of this is confusing or you're not sure, definitely contact us at Quality Insights. We're here to help you. Back to Diana.

Diana Haniak: Great. Thanks Lisa. Believe it or not, 2019 is almost here. Amy, can you give us an idea of where we should start?

Amy Weiser: Absolutely. Thanks Diana. Next slide please. Okay. So the point is, is to be proactive now. Contact your EHR vendor to request the 2015 edition if you do not have the upgrade yet. Create a hard copy audit binder and an electronic file for 2019 so you will be ready to file documentation throughout this year. Create or confirm that you have an active EIDM account, which is the account that you need in order to view past performance and participate in MIPS and put information into the portal. Schedule a 2019 security risk analysis so it's on your calendar. Submit an application for the 2019 virtual group reporting by 12/31/18 if you qualify and you are interested in doing that for 2019.

Amy Weiser: Review online QPP training courses available through the MLN LMs learning system and review resources available in the QPP resource library and information on the CMS and QPP website at qpp.CMS.gov. Next slide.

Amy Weiser: And again, we are here to help you. If you are in a practice with 15 or fewer eligible providers, you can email us at qpp-surs@qualityinsights.org. Our phone number is listed and our website is there as well. If you are in a practice with 16 or more eligible providers, you can email Kathy Wild at kwild@qualityinsights.org or contact her through that number. Then there's also our website at Quality Insights, its www.qualityinsights-qin.org. Next slide.

Amy Weiser: And I believe we are out of time today, so I just want to thank you all for attending and I'll hand it back over to Diana and Laurie.

Laurie Fink: All right. Well thanks Amy and thank you everybody who was able to join us today. We know that was a lot of information to absorb, but we wanted to make sure we touched on all those different things as you prepare for our 2019 Quality Payment Program. I have compiled all the questions and those that we did not have a chance to answer, we will make sure we get back to the email with answers to all of your questions.

Laurie Fink: When you close out of today's session, we do ask that you complete a very brief evaluation. It will just take a moment to complete it and we really do appreciate your feedback and your comments. So thanks again for joining us today. On behalf of the entire team here at Quality Insights I'd like to wish you all a very Merry Christmas, and a happy and healthy new year. Take care everyone and have a great day.

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