MIPS Quality Category for 2017
Transcript from Live Webinar

Wednesday, April 19, 2017

Laurie Fink: Good afternoon and welcome to today's Quality Insights' Quality Payment Program webinar entitled, MIPS Quality Category for 2017. This webinar will be the third in Quality Insight's new series to educate practices and organizations about the components of MIPS, which began on January 1, 2017. My name is Laurie Fink and I am the Quality Insights Communications Specialist for the MACRA/MIPS Initiative.

We will get things started in just a few moments but first, a few housekeeping items. All participants entered today's webinar in a listen-only mode. Should you have a question during the presentation, we ask that you please type it into either the chat or the Q&A box to the right of your screen.

As time permits, we will answer as many questions as we can at the end of the program. But as we have done the last two webinar sessions, we will compile a list of all the questions asked today, and will include the answers to all of them in a Q&A document that we will post on the Quality Insights' website along with a recording, the presentation slides, and the transcript for today's webinar. These resources will all be posted within the next few days on the Quality Insights' website at www.qualityinsights-qin.org, and it can be found by clicking on the Events tab and then you select the Archived Events option. I will go ahead and post a direct link to that page in the chat right now. So you can just cut and paste that link and check later this week and those resources should be there.

Presenting today will be several members of the Quality Insights MACRA/MIPS team, including Lisa Sherman, Joe Pinto, Lisa Sagwitz, and Rebecca Dase.

So to start us off this afternoon, it'll be Lisa Sherman, who's one of our quality improvement specialists in Louisiana.

Lisa. I'll now hand over the presentation to you.

Lisa Sherman: Thanks Laurie. Good afternoon everyone. You can advance the slide. As you can see from our agenda, we have a lot of information to share today. You have likely attended other webinars introducing you to the Quality Payment Program,

so after a quick review, we are going to switch our focus to the quality category, which is the biggest piece of the pie at 60 points.

Our goal is to show you how to choose your measures, understand the components of a quality measure, and the scoring of the measures you report. We will also review the reporting methods available to eligible clinicians.

Stay with us until the end because we will provide a summary, introduce our staff with their contact information, and let you know about the resources available to you and your practice. We will answer questions as time allows. Next slide please.

The Quality Payment Program is a payment system that rewards value and outcomes. We are all part of the QPP. This includes eligible clinicians, office staff, and this includes everyone, the MAs, nurses, front office, billers, and coders, patients and their families, CMS, your EHR vendor, and last but not least, you're QIN, Quality Insights.

Quality Insights is one of 14 QINs in the country. We are the Quality Innovation Network for Pennsylvania, West Virginia, New Jersey, Delaware, and Louisiana, serving practices and organizations with assistance on MACRA/MIPS.

We also have other projects such as improving cardiac health, reducing disparities in diabetes, improving immunization rates, antibiotic stewardship, as well as, home health and nursing home quality initiatives. We all share a similar goal to improve patient outcomes.

I would like now to turn it over to Joe Pinto, a practice transformation specialist from Pennsylvania.

Joe Pinto: Thank you, Lisa. Good afternoon everyone. Today I will be giving you a quick review of the Quality Payment Program and the Merit-based Incentive Payment System, which is known as MIPS. Next slide please.

So, what is MIPS? The Merit-based Incentive Payment System streamlines the three legacy programs, PQRS, Meaningful Use, and the Value-based Modifier, into one program and adds a fourth component to the mix to promote improvement and innovation in clinical activities. This will allow clinicians a bit of flexibility to choose measures and activities that are the most meaningful to their practices. The four categories are quality, advance and care information, cost, and improvement activities. Next slide.

There are two tracks that clinicians and organizations may take for the Quality Payment Program. Most eligible clinicians will follow the MIPS track in 2017. Practices in Advanced Alternative Payment Models know that they are in them. On March 17, CMS updated the comprehensive list of the APMs, which is located on the Education and Tools tab on the QPP website. Just a reminder

that everyone must report to MIPS in 2017. CMS cannot determine who is a qualifying Advanced APM participants until the reporting period ends on December 31st of this year. It is estimated that approximately 95% of clinicians will be subject to reporting to MIPS. Next slide.

Who is the MIPS eligible clinician in 2017? Note, the MIPS definition of physician and who should participate. There are exclusions for providers newly enrolled in Medicare, such as those who bill less than $30,000 a year in Medicare Part B claims, or who see fewer than 100 patients per year, or those that are in an Advanced APM. Also, for non-patient facing clinicians, such as radiologists, pathologists, and anesthesiologists, there is some flexibility with the reporting requirements. CMS will be issuing letters later this month through mid-May, to every tax identification number, or TIN contact, advising providers of their eligibility.

There will also be a website providers can visit just by entering their NPI number and find out if they are considered MIPS-eligible. CMS determined an individual's eligibility based on Medicare Part B claims from September 1st, 2015 through August 31st of 2016. If a practice decides to do group reporting, MIPS eligibility is determined at the group level. So, everyone in the group attached to that TIN will be eligible. Next slide.

Now you may have already heard or read about a cost or resource use category. This will be coming next year in 2018, so there is nothing that you need to do in the present time in 2017 for this category. We also wanted to mention that for special situations, the assigned points may be reweighted. An example of this would be for a provider who is a non-patient facing provider, such as a radiologist or pathologist. The ACI category is optional for non-patient facing clinicians. If they do not report ACI measures, the quality category will be reweighted to 85% of the total MIPS score. Next slide.

For 2017, providers have four choices for MIPS in this, known as, the transition year. You can do nothing and get a 4% penalty, which will go up to 9% in a few years. The second option would be to report on something, which would be one piece of data and remain neutral. This could be one quality measure, one improvement activity, or the four to five based ACI measures. The third option would be to report 90 days of data or more than one measure, and be eligible for a positive payment adjustment. Or you can go and report a full year of data and all the measures, and then be eligible for a positive payment adjustment. The important thing to remember is that a positive payment adjustment is based on performance rates, which would be the best scores, not on the amount of information submitted or the length of time of the reporting period. Next slide.

Also, clinicians and groups with a MIPS score of at least 70 points are eligible to receive an additional positive payment adjustment funded from a pool of around $500,000,000. This is known as an exceptional performer bonus, for the

first six years of the program. That would be from 2019 through 2024. Next slide.

In summary, if you decide to report individually then all three MIPS categories are reported individually. If you decide to report as a group then all three MIPS categories would be recorded as a group. Note, with APM ACO scenarios, group reporting is always done. The quality category is reported by the APM or ACO and everyone in that APM ACO receives full credit for the improvement activity category in 2017. Each tax identification number in the APM ACO is responsible for submitting ACI measures using the group reporting method. Next slide.

For group reporting, if a practice is going to report as a group, data will be reviewed and scored at the TIN level, so it doesn't matter which eligible clinician reports the data. Also, although MIPS eligibility is determined by CMS at the individual clinician level based on the Medicare Part B claims from September 1st, 2015 through August 31st of 2016; non-eligible clinicians become MIPS-eligible when their practice submits data at the group level. The group will receive one MIPS score and it will be applied to all of the providers that bill under the tax identification number.

Now, I'd like to turn things over to my colleague, Lisa Sagwitz, who is a practice transformation specialist with Quality Insights in Pennsylvania, to discuss and review the quality category. Lisa.

Lisa Sagwitz: Thanks Joe. Next, we'll get into the heart of the MIPS quality category. We have many listeners on today's webinar at various stages of understanding about MIPS, so I've tried to make the presentation useful for all levels. We'll talk as if you're doing 90 days to a full year of reporting and you want to score the best you can for quality. My goal is to show you tools and resources that are available, if you'd like to use them. I encourage you to ask questions and contact us if you'd like Quality Insights' support. There is no cost for our services and our contact information will be available at the end of the slides. Next.

The quality category makes up 60% of your score. You'll have a total of 100 points for your MIPS score. It replaces PQRS or you might know the term clinical quality measures. You'll want to select or report on six quality measures with one of them being an outcome or a high priority measure. I recommend you choose more than six measures, so you have some backups in case the workflow's not quite as you expected it to be or there's an issue with your vendor.

You may be wondering what is an outcome measure or a high priority measure. Outcome measures are measures that make up the outcome measure set and they include those that apply to all patients in a practice, as well as patients with individual conditions. Examples would be, controlling high blood pressure or diabetes hemoglobin A1C poor control. Outcome measures represent the development of a care plan that most eligible clinicians may perform and is applicable to most elderly patients in various outpatient settings.

Some examples of high priority measures are documentation of current meds in the medical record, use of high-risk meds in the elderly, and falls, screening for future fall risks. There are a total of 271 quality measures and we'll talk about submission methods next.

For claims, all 271 measures are available and the claims method is available for 2017, and has about a 60 to 65% success rate. This is done by adding additional codes to your Medicare Part B bill, like quality data codes, CPT IIs, and modifiers. Your biller would need to report on more than 50% of Medicare Part B, fee for service patients. You can look at your interim feedback dashboard report to see how you're doing. A limitation to claims reporting is that only one diagnosis can be linked to each item. I also wanted to mention under claims, this isn't just available for solo providers. Group practices can also use the claims method.

Next, we'll take about EHR as a submission method. There are up to 53 available measures. Now, there are variations in what EHRs offer, so it's important to know which quality measures can be collected and reported in your EHR because your vendor may not be certified in all 53 measures. You also want to know if you will abstract and submit your EHR data versus your vendor has the ability to submit data for you after your review, and is there a charge for that. You may hear terms like QRDA I or QRDA III files. Those are EHR data files that you're submitting for testing.

Registry is another submission method. Registry reporting has about a 90 to 95% success rate. Most registries have 150 to 200 different measures. Some are specific to certain specialties. There is a cost for using a registry, typically about 300 dollars a year per provider. Benefits are that guidance is provided, you can see how each provider's doing, and the registry submits your data for you. There are more than 80 registries to choose and they're available for individual reporting or group reporting. A list of those registries was just posted on the QPP website on Friday and I'll show you in a few slides how to find that.

There's also something called a qualified clinical data registry for reporting. These are registries that have the ability to take you outside of those 271 measures. They help specialties who struggle with clinical quality measure selection.

Then there's the CMS web interface as a submission method. This is for the larger groups of 25 or more providers. Administratively, this helps reduce the reporting burden. Now, if you did GPRO reporting in 2016, CMS has automatically registered you for the CMS web-based interface for this year. But, if it's new for you, you'll definitely want to declare by June 30th that this is the method that you'd like to use.

The CAHPS survey is the Consumer Assessment of Healthcare Providers Survey that can replace one of your quality measures for large groups using the web-based reporting. This is a customer satisfaction survey done by an independent party you pay to administer to your patients and report back results to you.

Again, large groups of greater than 25 would need to declare by June 30th if they want to administer the survey. Next slide please.

For quality measure selection tips, you'll want to review your quality measure specifications, check measure type to ensure that you've selected at least one outcome or one high priority measure, and I'll show you all of these on the following slide. Check the submission method for each measure; submit all your quality measures using the same method. So if your biller is adding things for claims, everything will go via claims. If you're using your EHR, all six measures will go via the EHR reporting. You'll want to review your numerators, denominators, and codes. Check to see if benchmarks are available for each measure. You have the potential to earn more quality points if a benchmark exists. Is your measure topped out? If so, it's going to be more difficult to earn quality points. Again, I'll show you that in a few slides.

You'll remember with 2016 meaningful use, you needed to choose nine clinical quality measures against three domains. For this year, for MIPS, you don't need a certain number of domains that you're reporting on. Next slide.

If you haven't been to the new Quality Payment Program website yet, you may want to mark this down or you'll get it in the slides that are sent to you. It's a great resource that you'll want to bookmark on your laptop or computer. What we'll be doing in a minute is going to that website, and I'm going to show you some filtering that you can do. What you see here is a filtering by specialty measure sets. So, give me one moment as Laurie and I switch.

Now you're seeing the home page of the Quality Payment Program. The navy blue ribbon has four categories that will navigate you throughout the site. Right now, we're going to choose Explore Measures. A second blue ribbon appears and you'll see the three MIPS categories here. We're going to choose Quality Measures. It reminds you that the Quality category accounts for 60% of your MIPS score. We're going to go to this section, which is for filtering. We can narrow down those 271 measures. If you're looking for just the high priority measures, you could use that filter, the data submission method. If you're not sure if you're going to submit via your EHR or use the registry, you could choose both of those. Then the specialty measures set is helpful because different practice types are listed here. You can choose more than one. I'm going to choose internal medicine for today's demo. That narrows it down to 37 measures.

That doesn't mean that if you're an internal medicine practice you couldn't use some of those other 271, it's just these are some that might apply to you.

I'm going to scroll down and stop at diabetes hemoglobin A1C poor control greater than nine. Click on that measure. We get a brief description. It's for patients 18 to 75 with an A1C greater than nine during a measurement period. The first box tells us the measure number; remember I mentioned you need either an outcome or a high priority measure for one of your six measures. This

is an outcome measure. It's also a high priority measure. For the data submission method, it's available with claims, the web interface, EHR, or registry. This might be one that you want to add for your practice.

By clicking add, it takes you to this section, so when you choose your six and some backups, they'll ultimately all be listed here and you can download on an Excel spreadsheet or worksheet for you to work with.

Back to the measures. I'm going to click next on Documentation of Current Meds in the Medical Record. Again, it gives you a description. Patients 18 or older. You know that you're capturing the data. Again, first box is your measure number. The measure type, this is a process measure. So it's not an outcome measure. High priority measure, yes. So that would be good. Then it's also available via claims, EHR, and registry. I'm going to add that. That's a popular one that many practices choose. Again, once you choose your six and some backup, you'll want to download and you'll have a worksheet to work with.

Now, before I leave the QPP website, I also want to show you under Education and Tools some great resources. We'll scroll down to this section for clinicians and if you're a cardiologist or have cardiologists in your practice, this is a very nice two-page flyer that has suggestions for what you might want to use for all three MIPS categories. The registries were just approved and posted on Friday, so if you want to look and see if the registry you used last year is here, or one that you might want to work with, this is the resource for that. A little bit later in the presentation, I'm going to talk about components of a measure and how to look for specifics. This first document under this section is where you'll find the components.

Next, we're going to talk about 2017 quality benchmarks. I'm going to flip to my MIPS benchmark results. If you want to load this to your laptop, there would be no highlighting. I've highlighted just for educational and demonstration purposes, but you could pick what might work for your practice. There's the measure name, the submission methods, and they vary. It indicates that it's an outcome measure, that there's a benchmark. You'll see the points range goes from three to 10, with 10 being the best. This indicates if the measures are topped out or not.

While most of these measures you want to score as close to 100% as possible, there are some that are called inverse measures. Diabetes hemoglobin A1C poor control is one of them. You want to score as close to zero as possible. Say your provider has a 10%. If you're reporting via claims, 10% will put you in decile 8. If you're reporting via EHR, 10% would put you in decile 7. If you're using a registry, 10% would put you in decile 10. So my point is that your score is going to be dependent on your submission method.

Influenza's a popular measure. Again, there are variations for how you're going to report. But what I wanted to mention is if you would only be attesting for 90 days and possibly thinking of the summer months, influenza would not be a

measure you'd choose because you'd end up with a zero with nobody getting a flu shot in the summer.

One of the practices that I work with has traditionally scored very well on diabetes urine protein screening. So I wanted to share with you, if you're looking for that it has a new name. It's now diabetes medical attention for nephropathy.

Next, we're going to talk a little bit about documentation of current meds in the medical record. That is a topped out measure, so it means it's harder to achieve a higher score for this. But I've nicknamed this measure, the triple play. The reason is that you can reach all three MIPS categories, quality, advancing care information, and improvement activities using it. In improvement activities, it would be under the name, manage meds to maximize efficiency. I also like this one because you have the ability to get 10 bonus points by using your certified EHR. So, this is a good thing to know. Tobacco's another popular measure but again you'll see you want to score well because it's topped out for EHR and registry reporting but not for claims.

Then the last thing I wanted to show you was another inverse measure, the use of high risk meds in the elderly, where you want to score as close to zero as possible.

So just a minute, we're going to flip back through our slides now. Make Laurie the presenter again.

Laurie Fink: Yep. We are seeing the slides now Lisa.

Lisa Sagwitz: Great. This is just a screenshot of the filtering that we just did. If you print out the slides and want to use that as a reference. Next slide please.

This is a screenshot of what we just looked at for the Excel spreadsheet for documentation of current meds. Again, if you just want a reference. Next slide please.

Okay. Now I'm going to show you the components of a measure. I had mentioned on the QPP website how to find these. You'll also find these in your EHR online manual. They might be listed under PQRS or clinical quality measures and each specific one is listed. Reading those details will help you to score the best. You'll know what's included for numerators and denominators. This one's on screening for depression and it tells you the measure number, the official name. It shows you this one is available only by registry reporting. It tells you the measure type, so this is a process one. There's the description and the instructions will tell you the frequency. This is important to know. So for the depression screening, it's a minimum of once per performance period, but you'll see once per year, once per visit, so you need to know what it is that you're monitoring. Next slide please.

The denominator section. This is important to know what's going to count for the denominator. You're going to be looking for the word "and" or "without," to know what counts. For the numerator, you're going to be looking for the word "or," so you know what patient fits into a numerator. There are also exclusions and exceptions for most measures. An example of an exclusion would be for the diabetes A1C poor control. Gestational patients would be excluded or diabetes patients with end-stage renal disease would be excluded. This particular measure, if you look on the QPP website, is actually eight pages long, but like I said, it gets into more detail. There's some suggested workflow but that's to help you to score the best you can for each of these measures if you'd like that detail. Next.

We'll talk about some scoring for the quality component. Next.

Each measure is scored with a decile range between 1 and 10. You saw that. The higher score is better. At least three points are awarded for each of the six measures that are successfully submitted. If a measure cannot be reliably scored against a benchmark, then only three points are awarded. If a measure can be reliably scored, then three to 10 points are awarded. There are separate benchmarks for the quality measures based on the data submission method. You saw that on my highlighted spreadsheet, whether you choose claims or EHR or registry, there's a variation. All measure reporters, individuals and groups, are combined into one benchmark. Next.

Reliable scoring requires the following: a benchmark should exist, a sufficient case volume, 20 cases for most measures, data completeness is met, 50% of the possible data is submitted. I get a lot of questions on what I'm going to talk about next. If you're submitting via EHR, registry, QCDR, all of your payor patients are in that mix of the data submitted. If you're using the claims method or the CMS web interface method, then only Medicare patients are included. Next.

Bonus Points. Everybody loves bonus points. Every point counts for your MIPS score. Two bonus points are awarded for each additional outcome measure in addition to the one required. One bonus point is awarded for each additional high-priority measure reported in addition to the one required. You can get a bonus point for submitting quality measures electronically end-to-end via registry, QCDR, EHR, CMS web interface. I'll show you some examples on the next slide.

Office number one submitted their six measures with one outcome and five process measures. Here's the required one. They got no bonus points. Office two submitted six measures with two outcome and four process measures. They have their one required, one extra, so they got two bonus points. Office three is an over-achiever. They submitted six measures with four outcome and two process measures. They have their one outcome measure that's required, so they have three extra. Three times two points got them six bonus points. Then office four submitted six measures with one outcome, one high priority, and

four process measures. Here was the required one, so they got one bonus point for the high priority measure.

Here's a tip that I'll give you. We've had some conversation asking would it be better to submit more than six measures? Right now we're thinking no because if you do, then CMS is going to pick what they think are the best six measures for your practice or your provider. So we feel it's better if you pick the six for your practice or provider. Next slide.

Quality score. I know I told you it's worth 60 points but there are some exceptions. The maximum number of points available for the quality score is based on the submission method and whether something called a readmission measure was calculated. CMS calculates a readmission measure for groups with more than 15 eligible clinicians that have more than 200 cases. So we have three boxes here and you can think about where does your practice fall? So the first box is for one to 15 clinicians. They're submitting via claims, EHR, or registry. There's no readmission measure, so you're getting a maximum of 60 points for your quality score.

The next box. Are you in a practice with more than 15 clinicians? Are you going to submit via claims, EHR, or registry? Do you have at least 200 cases? If so, then CMS is going to score a readmission measure. Your score for quality could be up to 70 points. Now, what's important to mention on this box is there's nothing you have to do. CMS is calculating scores based on claims that have already been submitted.

Then the last box. If you're in a large practice with 25 or more clinicians and you're going to use the CMS web interface, and you've got more than 200 cases, you could get up to 120 points for your quality score. Just a reminder on the CMS web interface, that's when the larger groups declare that they're using that method to attest and CMS assigns that practice 248 patients across 15 measures to report on. So that's why they have to say by June 30th that they're doing it for a year. Next slide.

We'll talk a little bit about exceptional performers. That would be for a total of 70 MIPS points or more. That's 70 for the combined three categories. MIPS has an additional performance threshold to reward the exceptional performers with a positive MIPS adjustment factor. There's $500,000,000 allocated for 2017. For 2017, that threshold's set at 70 points.

Think of this like a bell curve on a test. Everybody's going to be submitting their data early in 2018. We won't know until all that data's submitted, how you fall in that bell curve and how much of this $500,000,000 you'll receive this year. But again, the money's there for those who want to achieve it. Next slide.

So simplistically, when you're calculating your quality score, you're looking at your six measures, any bonus points you got for additional outcomes or high

priority or electronically reporting, and that gives you your quality score. Then if you're part of a larger practice with a readmission measure, that's part of your quality score. Next.

Nice slide to show you what's available depending on how you report. If it's individual providers, these are your options: qualified clinical data registry, qualified registry, via your EHR, or claims. If you're doing group reporting, there are those four options plus the CMS web interface, that's the one you declare by June 30th and CMS assigns you the 248 patients across 15 measures, and also then that CAHPS survey. That CAHPS survey can count as one of your six measures. Next.

For registry reporting, we know that on Friday, CMS posted the list of approved registries and I showed you how to find that on the QPP website. It's under Education and Tools and that's the name. Registries on the list can report data for quality, advancing care information, and improvement activities for 2017. Next.

Reporting MIPS. You'll be doing that between January 2nd and March 31st of 2018. You don't need to make any decisions right now, exactly which measures or how you'll be reporting. The only exception is for those large groups of 25 or more who want to use the CMS web-based interface or administer the CAHPS survey. You have to make sure that you declare that by June 30th. This, I think, is very interesting. With 2017 being a transition year, you have the ability to score the best you can. If you're only going to report 90 days, your quality could be a different 90-day range than maybe your advancing care information. You can look at your numbers, see what looks the best, and pick different date ranges.

CMS is going to tell us later this year exactly how reporting will be done, so look for more information on that. Before I turn the last part of the presentation over to Rebecca Dase and we start some Q&A, I know we've covered a lot of information and I want to assure you that we'll answer your questions, if not during the presentation then afterwards in a Q&A document. I encourage you to work with Quality Insights to help you be successful with 2017 MIPS.

Now, I'm pleased to welcome Rebecca Dase, project coordinator in Pennsylvania, as our next presenter.

Rebecca Dase: Hi everyone. So now what? Remember, if you've successfully reported meaningful use or PQRS in the past, you're familiar with much of MIPS. Now you need to ask yourself, what is important to your practice and what do you want to achieve in 2017? Do you want to report one thing to avoid a penalty, or report 90 days or even a full year to potentially earn a positive payment adjustment?

As Lisa mentioned, you don't need to decide how much data you will report until early 2018. Next slide.

Now you can review your 2016 clinical quality measures, PQRS, and QRUR reports to see what you do well at. Use these things as guides as you choose your quality measures out of the 271 available measures, 71 which are outcome measures. Remember, EHRs and registries may not have all of these measures, so find out what is available to you.

Eligible clinicians will report on six quality measures and one must be an outcome or high-priority measure. Most measures you want to score as high as possible at with the exception of the inverse measures, which Lisa discussed earlier, like the diabetes hemoglobin A1c poor control or the use of high-risk meds in the elderly, where you want to score as close to zero as possible. Also keep in mind the timeframe that you will be reporting. If you use the flu vaccine but you report in the summer, it won't work. There'll be no data to submit.

When choosing your measures, pick a few extra to monitor to have as backups in case you don't do as well on the measure as you thought you would. As mentioned before by other people, you want to make sure that you have the best possible score to submit when it comes to submission time.

Practices may want to use the QPP website measure filter to see what measures apply to them. Specialists can also ask their associations if there are any resources available to help them as well.

Now for submitting your data and selecting your submission method. How do you want to get this data to CMS? Your submission method must be the same for each measure. For example, if you choose EHR submission for one measure, the other five measures have to be submitted via EHR as well. I know that's a question that comes up a lot, so the submission method has to be the same for all six measures.

You also need to look at whether or not your practice will report as a group or as an individual. This'll be applied to all the MIPS categories, so if you pick group for quality, group will also be applied to the ACI category and the improvement activity category. There are benefits to each but it's up to you and your practice to decide what will work best. Next slide.

In your office, what can you do? Look at the selected measures and figure out what is required and get the details on each measure from the QPP website and your EHR vendor. The information will show you how to accurately capture the required information and help you adjust the workflow accordingly. It is important to know what is required, as well as including everyone in your office and identify who is responsible for what. Make sure that your doctors and staff, including your billers, know what measures were chosen and discuss the

workflow to capture the data. Again, I can't stress this enough, include everyone in the process.

With your measures selected, if you haven't already, start collecting the data and monitoring your performance. You can compare your performance numbers to the 2017 quality benchmarks available on the QPP website. You can see where your performance ranks and how many potential points your performance could earn you. We encourage practices to monitor each measure on a monthly basis. Why? This is so you can see your progress or lack of, and it allows you to see if you're on the right track or if there are any workflow issues that may need addressed.

With all that being said today ... Next slide please.

Quality Insights is here to help. If you have any questions or concerns or need some clarification, we're here to help. If you're not already working with somebody, please feel free to reach out for the representatives from your state, we can go ahead and offer some assistance to you. Next slide. Next slide.

Just in case you didn't get to write those down so quickly, they will be available in this slide. Laurie sent those out today about quarter after 11, so they should be in your email, or if not, they will be available here on the website. Quality Insights has a great website with resources and tools to help you with MIPS. You'll also be able to review the webinar that was done today, as well as previous webinars on the improvement activities and the ACI category and an overview of the MIPS program. Keep an eye out. We have some nice tools coming out in upcoming webinars that will help you be successful in 2017.

Again, Quality Insights is here to help, so any questions you might have, please reach out. We are here to help. With that, I will turn it back over for questions.

Laurie Fink: Thanks Rebecca. Thanks everyone for that great presentation. At this time, we will move into the Q&A portion of this session. If you have asked any questions in the Q&A and chat, we do have staff online who has been answering some of those questions. But if you have anything else that comes to mind now, please feel free to submit it. As was mentioned earlier, we are going to compile all of these questions along with the answers and make a separate Q&A document that we will get out to everybody.

At this time, I will take a look at some of the questions that have been submitted already and I'll read them out to our team and we'll get some answers for you.

First question is, with the QRUR reports, what method should be used to estimate MIPS scores?

Lisa Sagwitz: I'll take that. It's Lisa. If you're looking at your QRUR report, you'll want to get into some of the detailed reporting and see what your practice is doing well and possibly hone in in that direction to help you choose measures. There's the initial QRUR with a scatter gram and then there's the supplemental reports that get into some of the detail that would be of benefit to help you with guidance for measure selection.

Laurie Fink: Okay. Another question is, does it matter if we wait to hear if a specialty registry we report to will be accepted by CMS as a QCDR for MIPS. Have you heard of this type of situation??

Lisa Sagwitz: The registries are posted now on the QPP website, so that's great. With the, you said QRDA files? Was that part of the question?

Laurie Fink: The QCDR.

Lisa Sagwitz: QCDR. Okay. I'm not familiar with the QCDR. The QRDA category I or category III, I know, can be pulled from the EHRs. They're either one clinical quality measure with one patient or all patients or a batch of clinical quality measures that you'll be reporting on. I don't know if anybody else on our presenter panel has any details on QCDR. If not, we can look that up and answer it separately.

Lisa Sherman: That's the Qualified Clinical Data Registry she's referring to, Lisa. She’s asking if a specialized registry they're working on is trying to become a QCDR. I think that's what she's saying. I don't know if that registry report that currently is out there on the QPP website, if that encompasses QCDRs as well, or do they come out with a separate list for that? I'm sorry, I don't know the answer to that.

Lisa Sagwitz: Okay. We'll look into that and then when we produce the written Q&A, we'll have an answer for you.

Laurie Fink: Okay. Another attendee asks, I noted where to find if a benchmark is available for a measure, however, what exactly does this mean?

Lisa Sagwitz: A quality measure that has a benchmark can earn a higher score if it's not a topped out measure. I don't know if we would want to go back to maybe the MIPS benchmark Excel spreadsheet that I had and show that again, if that would be helpful. Yeah. I think we have one slide. It has documentation of current meds. There's a box at the top at the top, it says, "Measure Selection Considerations." That might be slide 17. Okay, there. Let's see. That's showing if it's topped out there, although I know that's hard to read. I would say, let's refer back to the QPP website with that more detailed benchmark and look at that. Or if there's something specifically that you want us to answer on a certain measure, submit that question and we're happy to get you the detail on it.

Kathy: This is Kathy. Can you hear me now?

Lisa Sagwitz: Yes.

Laurie Fink: Yep.

Kathy: Oh. Okay. Sorry. I'm using two laptops and I couldn't get off mute. As far as the benchmark, I think they were asking about how they are scored. CMS determined that the minimum amount of points you can earn if you submit a quality measure and meet the bare minimum of having 20 cases per quality measure and at least 50% of the cases for each measure is at least three points.

The benchmarks. What they're doing is comparing your results against other peers that reported that measure during previous years. What you'll find is that, as CMS adds new measures that are approved every year that new professional organizations, especially the specialists, they are not going to have benchmarks because there is no data to look at. What CMS will do is it will evaluate you against your peers. So if everyone is doing really well on a measure, such as documentation of current meds in the medical record, then you're going to have to have a higher score to get more MIPS points. But if it's a measure where people are not doing really well, then you will, maybe, only need a 80% to get the 10 points for that measure because none of the peers, and this is, once again, everybody that's reporting that measure nationally using the same submission method. So we're talking thousands of people. I don't know if that helps clarify it but you have the option to get between four and 10 points if there's a benchmark and you can only get three points if there's not a benchmark because that's the minimum.

Laurie Fink: Okay. Our next question asks, what is the success rate with reporting using a pull method from the EHR using a medical specialty association?

Kathy: Okay. Once again, I see a couple of questions in here about specialized registry reporting and I just want to make the clarification that in the past for meaningful use, you had to report the public health measure and besides immunization reporting was to report to a specialized registry. That was part of the public health reporting option. It does not count as a MIPS submission method. Remember it has to be through one of the registries that just got approved on the CMS list that CMS just posted on Friday.

The specialized registries, all that will get you, is five bonus points in the advancing care information category. In other words, that is no longer required. It's an option if you want to earn five bonus points for the advancing care information. You can still continue to do it, but that is not going to be a method to submit either your quality measures or your advancing care information measures. So if they're not on that list that just got posted then that will not be an option.

Laurie Fink: Does Quality Insights have the process to obtaining QRUR on the website? The CMS explanation is confusing.

Lisa Sagwitz: No. We do not have access to anyone's QRUR reports. That's confidential for each practice and needs to be set up with a designated user. However, if you choose to share them with us, we are able to review them with you.

Kathy: Once again, there's a lag between the data time, so that your reports to reflect the care you provided in 2016 will not be available to you probably until late summer or fall of this year. CMS will probably be changing the name of that report just to reflect everything that got changed with the Quality Payment Program. We will certainly keep you informed when those reports are available.

Rebecca Dase: This is Rebecca. Do we have the ability to provide 'how-to's' of how they actually access the reports if they haven't before? The question actually said it was a little difficult to navigate around through the website to get to the reports. Do we have instructions of how to access those?

Kathy: Yes. We do. We have provided them in the past and we can certainly send that out and include that with the questions and answers today.

Rebecca Dase: Thank you.

Laurie Fink: Do you know what the document name is on the QPP website under Education and Tools to search for qualified EHR companies? Do we know what the name of that document is?

Lisa Sagwitz: Yes. That would be MIPS 2017 Qualified Registries.

Laurie Fink: Okay. When looking at the 90-day versus a full-year reporting, is your MIPS score weighted differently or is your max potential different?

Lisa Sagwitz: The name of the game is to get the best score you can. The thought right now is if you report a full year, probably you'll have a higher score. But when you actually start to tally numbers after year end, if you see that your score is not where you would like it to be and you can find a 90-day range for each of the three categories that's higher than what your yearly total would be, it would probably be to your benefit to choose the best score to try to go after the high-performance money.

Again, remember, there's a bell curve. If you would have two practices, say each of them has a score of 82 and one submits for 90 days and the other practice submits for a full year, the practice who submits for the full year will get more of the high-performance money than the practice who submits for only 90 days.

Kathy: Just to add on, it doesn't have to be 90 days or the full calendar year. You have the flexibility to report for any period of time. It can be 91 days, 103, 150, so next January you can start looking at your data and find the best possible time period when you have the highest measure rates.

Laurie Fink: All right. Well, it looks like we're at the two o'clock hour, so we'll get things wrapped up here. I do want to thank our team today for the great presentation. Also, thanks to everyone who was able to join us today. If you have any additional questions about the MIPS Quality Performance category, or really anything regarding the Quality Payment Program, please know that the MACRA/MIPS team at Quality Insights is here to help you.

When you close out of today's session, you will be directed to a very brief evaluation. We ask that you please take just a moment to complete this very short, seven question evaluation.

Thanks again for joining us today. We hope you found it to be an informative and beneficial presentation. Have a great rest of the day. This session has now concluded.

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