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HSAG HEALTH SERVICES ADVISORY GROUP

Learning Forum Friday

Summer's Here—Is Your Performance Sizzling?

Questions and Answers

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Question 1: **Do we need to submit data on 60 percent of our patients? And, if so, can we exclude patients who don't meet the measure?**

At a high level, the reporting requirement is 60 percent of your eligible patients. Any quality measure you are reporting on, you need to meet the 60 percent completeness of reporting criteria. If you are reporting by claims, registry, or QCDR, we highly recommend that you report on 100 percent of the eligible patients, so you don't have to worry if you are meeting the 60 percent. If you are following the same workflow for every patient, you will meet the 60 percent completeness of reporting.

We found in the past that providers who reported only those patients who were compliant, tended to underreport and fail the measure. Using the flu measure as an example, if you saw 100 patients during the flu season but only reported the 20 patients that had their flu shot done, you'd fail the measure because you didn't meet completeness of reporting. By only reporting the patients that complied by having the flu shot, you are underreporting the patients that did not have the flu shot done. It is important to report every patient that is eligible for a measure. There is a specific code to report that the patient did not have the measure done. If you are reporting by EHR, you don't have this to worry about because, in reality, you're reporting on 100 percent of your patients. Every patient in your EHR is included in your report.

Question 2: **What is the best kind of report to generate to track practice performance?**

If you're using a CEHRT for your reporting, you should have access to run performance reports through your MIPS, or Quality dashboard. If you're not familiar with those reports, you'll want to check with your vendor for specific instructions on how to access those reports. If you're working with a qualified registry or QCDR, they should be providing you with the means to run the reports yourself or at least providing you with performance feedback throughout the year. Again, check with your vendor.

If you are reporting via claims, there is no interim performance report that you will have access to during the year. The best strategy you can implement is to review your EOB statements for the 620 remark code, which is the confirmation code you will receive from CMS to identify that you submitted a valid quality reporting code.

Question 3: **How do I navigate through the EIDM website to find the report results?**

The feedback reports are available through the QPP portal, not the EIDM portal. You will use your EIDM credentials to login to the QPP portal. That website is www.QPP.CMS.gov. You will need to have an account and the appropriate role to access the feedback reports. If you don't have that, reach out to us. We can

provide you with guidance. The *QualityNet* helpdesk has a support line you can also reach out to in order to get access to the feedback reports. The important thing is to access your reports to see what your 2017 performance looks like.

Here in Florida, some clinicians are showing a negative four percent payment adjustment for 2019. A lot of those providers were relying on the Extreme and Uncontrollable Circumstances policy to cover them. We all know that Florida was greatly impacted by the hurricanes this last year, as were other areas. Logically we thought that CMS would give the Florida providers an automatic waiver and not place the four percent penalty on them. **The waiver is not always automatic.** It may be automatic in some cases, but to confirm whether or not your feedback report is showing that negative payment adjustment, you need to review the 2017 Final QPP Feedback report. Once you look at that report, if it shows negative four percent, you will want to submit for a targeted review. There is a specific option to select the hurricane waiver, but you do have to get your feedback report in order to submit for a targeted review. **The deadline for requesting a targeted review is October 1, 2018.** If you don't access your feedback report until after October 1, there is no appeal process. You will have no recourse. The onus is on the provider and/or his or her staff to look at the feedback reports to determine if there is a need to file for the targeted review.

Question 4: **What about the payment adjustment for those high performers that received 100 percent?**

The payment adjustment this year maxed out at 2.02 percent. Most providers thought that they were going to get four percent. The language has always been “up to four percent.” The percentage is based on budget neutrality. CMS needed the providers who did not participate to incentivize the providers who did. CMS was pleased to announce that 91 percent of eligible providers participated. So, if you received 100 points in the Program, 2.02 percent is the max payment adjustment that you can receive on your submitted claims starting January 1, 2019. That includes the exceptional performer bonus, as well. The 2.02 percent is based on your MIPS composite score and the exceptional performer bonus.

Question 5: **Please explain the dashboard shown during the presentation.**

That dashboard was an example of an EHR dashboard from a practice that we worked with. Every EHR system will have its own dashboard. Contact your EHR vendor if you do not know where to locate the dashboard. Also, if you require any updates to your system, go ahead and update or schedule those upgrades with your vendor. Don't wait until the last minute. You need to get those upgrades going, now.

Question 6: **We were told that Florida did not have to submit MIPS for 2017 due to the hurricane policy occurring in the state. If we did, are we still eligible for the positive payment?**

	Yes, if you submitted data, you will be scored. Based on your performance, you could receive a positive payment adjustment. Download your report to see your incentives.
Question 7:	**If you report as a group, with all clinicians in the group, will all clinicians in the group have their increase at the same level even though individually they are not eligible clinicians?** That is correct. One of the advantages of reporting as a group is that even clinicians who might be excluded from reporting due to low- volume or patient count, will be eligible to receive the payment adjustment as determined by the group score. That is one of the advantages of reporting as a group and something you can strategize when you do your data submission in March of next year. Look at your scores on the individual basis and also look at them at the group level to see which method of reporting is most advantageous. Also, it does not harm you to report both as an individual and as a group. CMS will look at the most advantageous score and that is the payment adjustment that will be applied.
Question 8:	**What is the final date to submit data?** It really depends on your reporting method. When you are reporting via claims for Quality, you are submitting the quality data codes during the year, as you do with any of the claims that you are submitting. With regular processing, it is a 60-day runout to have claims submitted after the end of the year. If you are working with a registry or qualified vendor, they have until April 2, 2019, to submit the data to CMS. I caution you, however, EHR vendors and the registry companies may have their own internal deadline that you need to be aware of. Make sure you check with your vendor to see when their date is, so you can have the data available to them, so they can submit it to CMS before the April 2 deadline. While the deadline is typically 8 p.m. ET, please don't wait until the last minute to submit your data. As soon as the portal opens and you have the data available, we recommend that you submit your data and then relax until the next performance feedback.
Question 9:	**What are the categories for podiatry?** We will be happy to help you with that specific question and any other specific questions you may have if you call our support line at 1.844.472.4227.
Question 10:	**Where can we find the 2018 QM measure benchmark list?** Please go to https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Resources.html- and download the Quality Benchmark zipped file posted in December 2017.
Question 11:	**When is the incentive bonus added in 2019? Throughout the year, or in one time at the end of the year?** The incentive will be applied to each claim submitted for reimbursement.

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Question 12:

Where can I download my final QPP feedback report? I am new to the practice and no one seems to know if they received it.

You can download the reports by visiting www.qpp.cms.gov and select [sign in] on the right. You will need an EIDM account. If you do not have an EIDM account, you can call 1.866.288.8292 or use this guide: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Enterprise-Identity-Data-Management-EIDM-User-Guide.pdf.

Question 13:

What would it have taken to have the clinician/group get the 4% incentive for 2017? It appears they have 100/100 but only earned a 2.02% incentive payment.

2.02 percent is the max any practice received this year. The Program must remain budget neutral (non-participation clinicians help incentivize the ones that did participate). The adjustment was up to four percent.

Question 14:

Where do we find this MIPS dashboard?

The MIPS Dashboard shown in the presentation is from a practice's EHR. If you have an EHR, you will need to ask your vendor how to access the dashboard.

Question 15:

What if my question is, "Where do I even start?"

Great question! Call us directly after this call at 1.844.472.4227 and we'll get you started. Good news is you still have time!

Question 16:

Can we still report quality measures that are topped out?

You can still report on topped-out measures but may not receive the full 10 points available. Topped-out measures are capped.

Question 17:

I was told FL did not have to submit MIPS for 2017 due to the hurricanes occurring in the state. If we did submit, are we still eligible for the positive adjustment?

That is true. As long as you were included in MIPS (not exempt) and you submitted data, your data was scored, and you should receive your score in the portal.*

Question 18:

Florida did not have to submit for 2017?

For 2017, if a MIPS eligible Florida clinician did not report data for any categories their final score will be reweighted to 0 and the payment adjustment will remain neutral due to the Extreme and Uncontrollable Circumstances waiver. If your final report is showing a negative four percent downward adjustment, you do need to fill out the Targeted Review.*

*__Additional CMS guidance provided post-event__: For those clinicians in located in an area impacted by the ***Extreme and uncontrollable circumstances*** in 2017, there is no need to submit a Targeted Review. CMS will be addressing this outside of the Targeted Review process, so there is nothing else you need to do.

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