Learning Forum Friday

What's New with QPP in 2018?

Questions and Answers

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Question 1:	**As a small group, how many measures have to be done to reach 50 points?** The required number of measures would remain at 6 measures to reach the data completeness for that category if you are trying to achieve the full 50 points, then you would have to submit the 6 quality measures.
Question 2:	**I submitted all my data through claims based do I need to do anything else or just wait and see how I did?** If you did claims based reporting, then you should be good to go. If you log into the attestation portal to submit your data for advancing care activities or improvement activities you will not see that quality score yet, the quality score will not be posted until after the data submission period. The score that you see within the portal may be artificially low because they are waiting for the data submission portal to close on March 31, 2018.
Question 3:	**How do you calculate whether you are exempt or not? Is it based on billing charges? Collective payments?** Eligibility status is based on your allowable charges for Medicare part B fee-for service. It's not what you bill Medicare, because you bill more for the E&M and for the codes that Medicare allows, so it is based on the allowable charges. There is nothing you need to try to calculate on your own. CMS will analyze the data to determine if you are included in MIPS reporting, so check the QPP website. It is updated annually. One of the biggest changes for this year is the increase in the exemption criteria, so some of the providers that were included in the program last year, may be exempt. However, we do recommend that you continue to participate. It gives you practice for the future.
Question 4:	**Has anyone else had issues with uploading to the QPP portal?** We have talked to several practices who have had some issues. CMS is still working out all of the bugs with the Portal. I have not heard of any specific issues uploading, but yesterday there were issues with CMS sending out the multi-factor authentication codes. A good thing to do would be to register for the CMS listserv. Go to the webpage, and at the bottom, click [Subscribe]. This will ensure that you receive notice anytime something is down in the production environment, and again when the issue is resolved. Some of the issues that you may be having with the Portal, may not be with the Portal, itself.

The issue could be with your EHR, or the data file from your EHR. Some of the EHRs, even though they say they have the capability to generate the file to upload, may not be quite ready to do so. Many of the vendors need to apply one last update to the system before you can generate the QRDA for 2017 and upload. What we're seeing is that the update has not been applied, so you're generating a file that is not ready for submission. Check with your vendor to make sure they have applied all of the necessary updates before you try to generate and upload the file.

Question 5:

Do we need to report commercial insurance information?

It depends on the data submission method you plan to use. If you are submitting your measure data via claims, then it is 60% data completeness for your Medicare Part B Fee-for-Service. If you're using any other form of data submission, like a qualified registry, the EHR, then it is 60% all patients, all payers.

Question 6:

Are practices planning on transitioning EHR in the middle of 2018? What should we take into consideration?

You should decide right now how you plan to submit your quality data. If you don't have an EHR, or you're upgrading your EHR, you can look at using claims or a registry. If you are moving to a new vendor, you may want to look at a possible data conversion. If data conversion is not practical for your practice, you may want to see if the registry can combine the data from both systems.

Quality is a full-year reporting period, whereas the Advancing Care Information and the Improvement Activities are only 90 days. You have time to get your EHR implemented or converted to a different vendor before the start of the last 90-day reporting period in 2018.

Question 7:

Is there going to be any training that is not a webinar?

You can receive one-on-one training from our QPP service desk at 844.472.4227. Our QPP specialists will ask you questions about your practice and everything you're currently doing. Then, we can help you set up a reporting plan. The service you receive when you call the service desk is very personalized and specific to your needs.

Question 8:

What is the 2018 requirement for a solo practice?

Eligibility status is based on the allowable charges for Medicare Part B Fee-for-Service patients and the number of patients. For 2018, it is over $90,000 and over 200 patients.

Question 9:

Can updated quality measures for 2018 be found on the QPP website?

Yes, go to the website, click on [About] and then, [Resource Center]. You will see an option for 2018 documents. When you click on that, you will see a list of all the measures for this year. It is different this year. Last year you had to download one huge file. This year, CMS has broken down those zip files by number. One file will have measure numbers 1–50, and then the next file will have measure 51–99.

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Question 10:	**We used our EHR for the required point for an improvement activity. Can we do more to get extra credit?** Once you reach 40 points, you have reached the maximum number of points available. The same holds true for quality. When you reach the maximum available points, you will earn the full weight of 50%.
Question 11:	**Can we use the same measures in 2018 that we used for 2017?** Yes, most of the measures remain the same. I'm not aware of any measures that have been removed. However, six measures have been marked as "topped-out." Depending on how well you did with those six measures, you may want to look at the benchmark to ensure they are not topped-out measures. Download the measures sheet to confirm what is required for each measure.
Question 12:	**What are topped out measures?** Topped out measures are measures that CMS feels that everyone is doing, and they can no longer define any adjustments that need to be made.
Question 13:	**The security risk analysis review for EHRs are needed for each one of the providers. Do you only need one?** The security risk analysis is based on your practice. You only need to do one of them.
Question 14:	**Cost for 2018, how is this data submitted?** Cost is based on claims submitted to CMS for reimbursement, so no data submission is required.
Question 15:	**Can you clarify the distinction between method one and method two as it relates to CAHs and mixed eligible clinician types and billing rights?** There are no changes this year for critical access hospitals. If you're a MIPS-eligible clinician type practicing under Method I, MIPS payment adjustments would apply to payments made for Medicare Part B items and services billed by the eligible clinicians. The payment adjustments would not apply to the facility payment of the critical access hospital. If you're a MIPS-eligible clinician practicing under Method II, meaning you assign your billing rights to the critical access hospital, the MIPS payment adjustment would apply to the Method II critical access hospital payment. However, if you're an eligible clinician practicing under Method II but have **not** assigned your rights to the critical access hospital, the payment adjustment would be applied to payments made for Medicare Part B items and services billed by the eligible clinician.

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