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MIPS Small Practice Office Hours: Aiming for Success in 2018
June 12, 2018

Presented by Chris Becker, Lisa Gall & Mona Matthews * 44 minute Webinar * 06-12-2018

Sarah: Hello everyone, my name is Sarah Brinkman and I want to welcome you to the MIPS webinar. This event is a collaborative effort between MedStar in Wisconsin and Stratis Health in Minnesota.

The information provided in this session is based on the latest information made available by the Centers for Medicare and Medicaid services or CMS and is subject to change. CMS policies change, so we encourage you to review specific statutes and regulations that may apply to you for interpretation and update.

Know that at the end of the call you will have the opportunity to complete a brief evaluation. We would very much appreciate your feedback about this feedback and suggestions for future educational opportunities. Upon completion of evaluation you will receive a certificate of attendance for your records. As a reminder, for those of you that receive direct technical assistance related to QPP to please take time to complete the evaluation that's sent to you at the conclusion of each technical assistance encounter. Your feedback is valuable and allows us to gauge how we're doing in regards to meeting your information in a timely and courteous manner.

With that I'll turn things over to our presenters today. We have Christ Becker and Mona Matthews joining us from MediSar and Lisa Gall from Stratis Health. Christ is going to kick things off for us today.

Chris: Thanks Sarah. Welcome everybody, we're all glad you could join us today. We'll first do a high level overview of the Quality Payment Program. We're going to move through these slides fairly rapidly today. Much of it is information you've seen in the past in 2017, so let's start with this.

Quality Payment Program based on the Medicare access and chip reauthorization after 2015, which created the MIPS and advanced EPMs programs. Some considerations CMS took into place when implementing the Quality Payment Program. Some are:

- improving beneficiary outcomes,
- reducing the burden on clinicians,
- insuring operational excellence and program implementation,
- maximizing participation and
- using IT to help deliver information capabilities that meet the need of users

For 2018 there are no changes in the types of clinicians that are eligible to participate in the Quality Payment Program or MIPS. Again, those disciplines that are eligible are…

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- Physicians
- Nurse practitioners
- PAs
- Clinical nurse specialists
- CRNAs

All are eligible this year with no additions or deletions in that aspect. As far as eligibility, continuing 2017 that changed a little bit, in order to be eligible in 2017 you had to bill greater than $30k in Medicare Part B and also provide care to greater than 100 beneficiaries. Those levels were raised for a year or two in 2018 that billing threshold is left up to greater than $90k Part B allowable billings and then also you'd be providing care to greater than 200 beneficiaries and both of those conditions need to be met.

This is where one can look up their eligibility. If you navigate, I believe, there's a link in here so when you get the slides you're able to go to that link. You can enter your NPI and that'll show your eligibility for both 2017 and 2018.

Next is a result, when you enter into the CMS QPP site, you'll see a screen similar to this. It's nothing that this clinician if they were to report as an individual would be included in MIPS, also if they reported in a group. Also it identifies any special statuses at this practice for this clinician and with the next they're part of a health professional or sort or hips. They're also in a rural area in a small practice and those are special statuses based on their zip codes.

Again, no change in the basic MIPS exemption criteria. If it's your first year enrolled in Medicare you can be exempt. If you're significantly participating in an advanced APM, and those definitions of 25 and 20% are the thresholds there and then there's a low volume threshold if you have either less than $90k billed in Medicare Part B or less than 200 visits you're exempt. Again, that's determined at the 10 NPI levels.

Next is special statuses and there's some special scoring in place for improvement activities for small rural non-patient facing hospital based and then bonuses for others based on these special statuses. There's no change to non-patient facing criteria if you have individuals less than or equal to 100 patient facing encounters and then groups greater than 75% of clinicians in the group are non-patient facing. Those are still in place and then again, no zip code of the practice designated the smaller the group. More than 75% of NPIs billing under the individual MIPS, EC or groups 10.

Next is some different reporting options which remain in place same as for 2017. You can report either as an individual or group.

Lisa: This is Lisa Gall from Stratis Health, hi everyone and thanks for joining. I'm going to talk about the first path of the Quality Payment Program, which is the advanced alternative payment models and basically these are new models of healthcare payment that move away from traditional fees for service and that incentivized volume to models that provide incentives for clinicians and organizations to provide high quality, high value services.

Moving away from volume to value and advanced APMs are a subset of APMs or Alternative Payment Models. This is what the ultimate goal for CMS is, is that everyone joins at some point in advanced alternative payment model. Whether that will happen remains to be seen but that's the goal is that people join advanced APMs under CMS qualifying.

There are three statutory requirements to have a Medicare approved advanced APM.

1. First, they must meet the certified EHR technology requirement for participants, according to the contract.

2. Second, payments must be for covered service based on quality measures that are comparable to the MIPS path.

(MIPS is Merit based Incentive Payment System)

3. Third, that either this alternative payment model is a medical whole model expanded under CMS innovation center authority or requires participants to bear more than a nominal amount of financial risk.

As you see on the next slide, on the left you have MIPS and those are MIPS eligible clinicians that Chris just mentioned. On the right are those who of those clinicians, who are an advanced alternative payment model and have qualified participants and that they bill either 20% of their services or 25% of their billed services are billed through that method. In the middle are those who are in a qualifying APM or MIPS APM, who either fell below the threshold for being a qualified participant or they're in an alternative payment model that CMS says, you're doing all the things except for you don't have the bearing financial risk.

One example of that is the Medicare shared savings program track one. There's an upside risk of being in that track but no downside risk.

The next path is for the merit based incentive payment system (MIPS) and as you have heard before the four categories this year are…

Quality

Improvement activities

Promoting interoperability, which was previously the EHR incentive program and cost, which was previously the value based modifier. So cost is new this year. They're go add 10% of the score as cost and 50% of the score will be improvement activities and those are like medical model type activities of engagement with patients and coordinating care and using any good clinical resources. Of course, promoting interoperability's using your EHR and that counts for 25% of your score.

So the MIPS quality category we'll cover first. That counts for 50% of your MIPS score and you can earn up to 60 quality category points and you can earn points up to six of the 277 measures. You can report on as many as you want and the highest six will be scored for your quality category or you may pick from a specialty set and if you choose a specialty set your denominator could be affected if there aren't enough measures for your specialty.

At least one of those must be an outcome or high priority measure. You can earn 1-10 category points for measures that have benchmarks. For large practices the floor score of reporting a measure with benchmarks is one point if the data completeness is not met, but you can earn three points if the data completeness is met. Small practices can still earn three points just for reporting every measure.

There are six measures that are topped out of those 277 measures, which means they have little room for improvement. So your score may not be as high if you choose a topped out measure. The maximum points is seven and you must meet the data completeness to earn more than the floor score. Bonuses for reporting ECQM means you have no data entered manually, it must be extracted and reported end to end from your EHR to CMS. There are additional high priority measures that you report on which will earn you some bonus points.

There are some new improvement bonuses this year that are worth up to 10 points in two categories. In quality for this improvement bonus it's based on the improvements in your total category score. So, if last year you scored 40 points and this year you scored 50 points you'd have a 10% improvement in your score. Higher improvement results in more points. The MIPS reporting method for quality 14:02 that's automatic you do not need to report. It's measured exclusively claims you submit which are automatic, EHR, registry and qualified clinical data registry or QCDR are the other methods, in that you do have to submit for any other methods should be submitted through a vendor.

Each reporting method has different benchmarks, so if you have the same measure you're reporting on claims, you have a different benchmark that will be applied for EHR or registry.

The cost category is new this year in 2018 and as I mentioned it's 10% of your MIPS score. There are two measures that are scored that are averaged.

The Medicare spending per beneficiary and the total per capita cost measure. If you do not have one of those then it's just taking one of those measures. So the category score weight is meant to be increased to 30% by 2021. There is no data submission it's based on adjudicated claims for Medicare Part B and the benchmark is calculated using the current year's performance. So this year's cost score will not be known until next year until all the claims are adjudicated. In this category there's also an improvement bonus up to one percentage point.

The next category is the improvement activities and in this category you have 40 points that can be applied. Each of the activities in this category are either worth 10 points as a medium activity or 20 points as a high activity. You must engage to get full points in up to four activities for at least 90 days. This is a little deceiving because you don't have to engage in them, but if you report on them to get the maximum points. You can report only one activity if it's a high activity and it's worth 20 points and that's all you do, you get 20 points out of 40. However, for small practices because you are a small practice you'll get double points for that one activity and 40 points (full credit) for this category.

For small practices who have a medium activity they'll get 20 points rather than the 10 points. Some of these activities are also eligible to earn a bonus in EHR or promoting interoperability category. So if you do have that activity and you add it to your EHR for it you can check yes and receive credit bonuses.

This is a yes no attestation, you do not need a vendor to report improvement activities you can go right to the CMS website and report. Special scoring is available as I mentioned for small practices and get double points or rural settings or those who are non-patient facing. Then full credit if you belong to a patient centered medical home, Medicare shared savings plan or next generation APMs get full credit for this category. If you are in other APMs you can earn half credit for this category.

The last category is promoting interoperability. The name in itself tells you what CMS is interested in. If anything, you want to be able to be interoperable with other organizations across the patient's care. This is 25% of your MIPS score in this year and there are a total of 100 points, but you can actually score up to 155 points and it maxes out when you get to the 100 point mark.

In 2018, you can use either the 2014 or 2015 certified EHR or a combination of those. There is a 10% bonus for only using 2015 certified EHR this year for the 90 days. There are two measurements, a base measure and a performance measure. The base is required for any score in the PI category and this will give you 50 points if you meet the four measures in the 2014 cert or five measures in the 2015 cert. There are some exclusions on those based on those base measures, including e-prescribing and health information exchange and sending summary of care for the 2014 cert.

Then, for receiving summary of care for the 2015 cert, so if you have less than 100 cases in each of those areas and you score zero, you can still get the base score if you are below 100 in your denominator. The performance measures are optional. You can earn up to 90 additional points. There are seven in the 2014 cert and nine in the 2015 cert. Bonus points available in NPI are using 2015 cert exclusively using cert for at least one improvement activity, reporting to one public health registry and reporting to any additional public health or clinical registry.

The reweighting is automatic for these types of providers, unless that provider reports to promoting interoperability. So, if you are an NP, clinical nurse special CRNA or PA, the score will be automatically reweighted unless they report to this category. The reweight goes to quality, so then quality instead of being 50% is then 75% of your score.

There are some special statuses that are also automatically reweighted. The non-patient facing clinicians, hospital based clinicians and groups with over 75% of their clinicians who meet one of those special statuses.

Interesting this year they are adding and even into last year the ambulatory surgical center and off-campus outpatient hospitals as being hospital-based.
Of course, you see that inpatient on campus, outpatient hospital or ED is considered hospital based. Also, to clarify a non-patient facing, if a clinician is patient facing but have less than 100 encounters, they're considered non-patient facing.

When can the PI category be reweighted to quality? These clinicians can apply for a hardship exception. Those clinicians are in small practices can apply for hardship exceptions. If your EHR was decertified. If there was a significant hardship exception in the past that five year limit was removed. If you are in a CMS designated natural disaster area, you need to apply for reweighting of that category if you so choose. What we've found is that most people do better if they have an EHR that they report to this category.

Next are the measures. On the left is the 2014 certified EHR and on the right is 2015 certified HER. It's more for your reference to look back on, I won't spend a lot of time since I just covered that. The orange ones on the right are the ones that are different from the 2014-2015. You can see the request accept summary of care can be used for both a base. You need it for base performance, but you can also use it for performance scoring.

MIPS scoring and reporting

The performance period for 2017 to 2018. In 2017 you had 90 days options and this year they moved quality to a 12 month period and cost is considered over a 12 month period. Of course, that's not a reporting that's based on claims. The improvement activities and promoting interoperability can be anywhere from 90 to 365 days. So you can use the whole year if you like, but you can bump it down to 90 days.

For the MIPS 2018 year scoring, what happens with your score now that you have all these scores added up with the four categories? If you are in the orange on the left of the bar at 0 to 3.75 points, you'll get a negative 5% payment adjustment. If you're between 3.76 to up to 15 then your payment adjusted range will be from .1 to 4.9% negative. If you're at 15 points it's neutral. If you're between 15 and 69.99 it's a positive payment adjustment that's budget neutral based on everybody's negative payment adjustment. There is no exceptional performance bonus in this.

You also don't get a negative payment adjustment. If you are 70 more points, not only do you get the performance payment adjustment, but you get exceptional performance bonus payment on top of that if you reach the 70 point mark or higher. Of course, as you go up to 100 you're going to get more of that bonus point, so the higher scores you have the better reimbursement you will get. There are some new bonuses in 2018. The complex patient bonus, you can earn up to 5 points for treating complex patients. This is based on two things that are rather complicated that CMS determines based on the hierarchical condition category risk score, plus percentage of dual

eligible beneficiaries. Small practices automatically get a 5 point bonus to the final score if you report any categories.

Chris: To wrap up here we wanted to list some steps to success, some things we saw and learned from program year 2017 in the Quality Payment Program and share those. Hopefully those will be helpful to you all.

The first step is to determine who your eligible clinicians are, if you have any. That's pretty easily done through the link to that lookup tool that we showed in an earlier slide.

Determine the path that best fits the needs of the clinician, either part of the advanced alternative payment methodology or in the MIPS.

Make sure you're collecting your data for promoting interoperability, formerly known as advancing care information. Collect that quality measure data and also collect that improvement activity data.

We can't stress enough this, which was the biggest bottleneck we saw last year. It's getting the enterprise identity management account set up and those are the credentials you need to log into the CMS system to report for the Quality Payment Program.
There's a link there for that. It's important that you do that as soon as possible. Sometimes when there are issues it can take a while to unravel, so be sure to do that. We've provided links to a full user guide and then also a quick start guide that was developed. So there are resources out there and if you run into issues please contact Stratis or MediStar and we can help walk you through it if it's not making sense. But do that, if anything.

Also, keep tabs of your current performance. Foster that performance for improvement. Make sure you're reporting periods for promoting interoperability. There's a full year calendar for reporting for quality but for PI and IA it's a minimum of 90 days. You can report up to 365 days, but you at least need to report 90 days. Evaluate the available reporting methods to you and then make sure you're choosing to report, knowing whether you want to report by that group or individual performance. Most of all contact us, we can help if you're not sure of any of that.

Next we've listed some resources and tools and those links are there so you can check the links when you get the slides. Stratis has developed a nice MIPS estimator tool so be sure to check that out.

Lisa is going to walk through a little bit of the scoring of the MIPS estimator for you.

Lisa: So this is just a few screenshots. The MIPS estimator is there for you. If you're a small group and you have no eligible clinicians but you have a group that's eligible to report, this might be a really good tool for you to see if it's worth for you to report, because you could get a positive payment adjustment as a group, rather than a neutral payment adjustment. And, you can compare, if you have eligible clinicians whether it's better to report them as individuals or as a group.

On the left you can see that also, besides doing individual and group reporting, you can compare reporting methods from a registry to EHR to claim space. What's your best method of reporting?

You can see how each MIPS category contributes to the score. It breaks it down by category how you scored in improvement activities, promoting interoperability, quality, cost and then it adds your small practice bonus and complex patient bonus. What we've done in the MIPS estimator, because we don't know what your complex patient bonus is and we don't know what your improvement is from last year to this year, is allowing you to potentially add that to your score. If you're not sure, put it in the middle, it won't affect your score as significantly if you self-rate at zero and your score is 10.

So, if you're not sure we recommend you put a middle score in there, it's about as close as you're going to get, but after you've completed the MIPS estimator you can print the results, download them to an Excel file and save an actual report that's real data or fill in data that's fake and then save it as a test report for yourself. That way when you go in, in the next quarter and enter data again you can save them your actual report and compare it to that one. So there's a lot of functionality behind the scenes of this estimator. We hope you use it and like it.

Chris: Again, as a reminder for the Quality Payment Program support technical assistance, there's obviously the CMS website and that's where that eligibility lookup tool is… QPP.CMS.gov. There's also the CMS help desk number and email listed. Also, what's known as the practice transformation networks or PTNs, they're out there assisting those practices that signed up with them and then in Minnesota, Lisa at StratisHealth.org and myself and Mona Matthews, my colleague here in Wisconsin at QPP@Medistar.com. We can drill down into any individual case by case items we need to in order to help you out.

Let's open things up for questions.

Sarah: Thanks Chris and Lisa, that's great.

There's a lot of information and you went through it in a good amount of time. We have plenty of time for questions and answers. Feel free to jump in and ask questions. We want to make this as useful as possible, but want this to be interactive.

Mona: I just wanted to add onto the EIDM account and signing up for that. If you don't have an account, if you register for that, once you can get in there, if you remember last year CMS sent out letters to give the various organizations of who is eligible at your organization for MIPS. Those letters are no longer going out this year. You can obtain the same information through your EIDM account, which is another reason to sign up for that sooner rather than later.

Linda: What if you tried to sign up for that and you got hung up and pretty much locked out?

Mona: You should contact the 800 number if you're having trouble. If you're from Wisconsin you can contact us. If you're from Minnesota then contact Lisa with Stratis. You will have to work through that 800 number.

Chris: That's a CMS controlled system, so we don't have access to the backend of that system, so their technical folks can help you get unlocked.

Linda: And now that it's not such a crunch they might be more available.

Mona: We hope so, which is another reason why you don't want to wait till it becomes crunch time.

Chris: I think during the first quarter of 2018 and the last month of reporting, I think there was a huge bottleneck there and they became overwhelmed by those requests. They handled them as fast as they could, but I don't know whether they got to everybody before the end of the reporting period.

Lisa: I'll add that I'm not the only one at Stratis, we have Reid and Candy, who are subject matter experts. So one of us if you send it to the QPP help desk, will respond to your questions. However, if it is a lockout from CMS then we would probably refer you directly to the CMS help desk. I'll put that in the chat for you.

If you don't have questions, share your experiences to make this usable for you. What are you looking for?

Linda: I have a question on the reweighting for the PI for the hospital based provider. My provider does not have EHR in his private practice, but does use the hospitals EHR in multiple different facilities. Is there any qualification there?

Lisa: Is he basically mostly in the clinic or hospital based?

Linda: Mostly hospital.

Lisa: If he's hospital based…

Linda: He's a private physician though, but he does the majority of his services are seeing patients in an in-patient setting.

Lisa: It will depend on his billing and what he's billing.

Linda: He's billing hospital visits through claims based software, through me.

Lisa: So he will not be automatically reweighted because he's a physician, but he could apply for a hardship exception because he's a small practice. However, if he meets the 75% of his encounters being billed in a hospital setting, he should be automatically reweighted. You need to look at his eligibility file to determine whether he's hospital based.

I advise you to look in his special status setting, if he's hospital based he would not need to report under the EPI category.

Linda: Can I see that in his EIDM account or where do I see that?

Mona: In the lookup tool. It's also important if you qualify for automatic reweighting don't report anything to the PI category, because if you do it'll get scored. You want to pay attention to this box below and if your provider is hospital based, it will say hospital based yes.

Linda: I will go back and look at that.

Mona: Just give us a call if you need help interpreting it.

Linda: That's fine. You all were helping us before. This is my infectious disease doctor.

Mona: Just give us a call and we'll give you a hand.

Linda: Okay, sounds good.

Chris: I'm curious in trying to see if a lot of folks are planning to use 2015 cert this year. Is anyone reporting for this year using 2015 cert or is everyone still using 2014?

Mona: If you want to put whatever cert you're using in the chat that might be helpful if you can type it in there.

Lisa: A quiet group, but I'd be interested to know what you're all looking for, for ongoing education moving forward.

Is everyone finding good quality measures this year? Has there been any problems with quality measure searching?

Sarah: As things are wrapping up and folks are getting off the call, I want to remind you we'd appreciate your feedback in the form of completing the evaluation.

If you have questions, the contact information is in the slide deck and the link to those was posted in the chat box.

If there are no more questions we'll wrap up this webinar. Thanks everybody for joining us today. Please watch for future educational opportunities through MediStar and Stratis Health or through Lake Superior Quality Innovation Network. We hope to have you on some of our future calls and to hear from you at our help desk.

Have a great day.