AQI REPORTING OFFICE HOURS FAQS: JUNE 13

1. **Do I need to report MIPS? I received a letter that I do not have to report MIPS, did I do something wrong?**
   Practices should have received a MIPS eligibility letter from their Medicare Administrative Contractor (MAC). You can also use the Quality Payment Program eligibility tool to determine if you meet the minimum threshold required to report MIPS, at both the individual and group practice level. CMS determines eligibility based on Medicare cases and Medicare billing data.
   The minimum threshold for MIPS reporting in 2017 is:
   - Have at least $30,000 in Medicare Part B allowed charges per year ***and*** see at least 100 Medicare patients per year
   - Not first year as Medicare Participating Provider
   - Not significantly participating in an Advanced Alternative Payment Model (APM)

   If your practice intends to report individually, and your letter indicates you are not required to report MIPS at the individual level, you are exempt from MIPS. If your practice intends to report via GPRO, and your letter indicates your group/TIN meets the minimum threshold, everyone in the group must report MIPS, even if certain clinicians were exempt at the individual level.

2. **What do I need to report for the Qualified Registry (QR) option? Qualified Clinical Data Registry (QCDR) option?**
   MIPS requirements for the Qualified Registry (QR) and Qualified Clinical Data Registry (QCDR) are similar in 2017.
   - All payer data, Medicare and Non-Medicare
   - Minimum of 50 percent of all denominator-eligible cases for all measures
   - Six measures, including one outcome or other high-priority measure as specified by CMS
   - Attest to Improvement Activities equaling 40 points

   Those electing to report via QR, can ***only*** report MIPS measures offered through AQI (31 in total). If reporting via QCDR, eligible clinicians and groups can choose to report MIPS and non-MIPS QCDR measures to meet the six-measure requirement (46 in total).

3. **How do I decide GPRO or Individual reporting and who do I notify when I have decided?**
   Every practice must consider the many variables associated with individual and the Group Practice Reporting Option (GPRO). Review the GPRO vs. Individual Reporting FAQs for more information on factors to consider when deciding which way to report in 2017.

   Please note, if you elect GPRO, you are assessed at the TIN level. For the Quality component, the group must report a minimum of 50 percent of all denominator-eligible cases for all measures ***across the TIN***. Therefore, every practice clinician, including CRNAs, must report to ensure the meeting the reporting threshold.

4. **Once we receive the measure specifications, do we have to go back and report cases from the first six months of the year?**
   CMS has provided eligible clinicians (ECs) and groups with flexible MIPS reporting options in 2017.

   Practices are eligible for a "modest" positive payment adjustment if they report for the entire year. Practices choosing the full year reporting option would have to go back and chart audit to report cases applying to the measure specifications.

   Practices also have the option to report for 90 days, and are still eligible for a "small" positive payment adjustment. Learn more about 2017 Pick-Your-Pace options.

5. **How do I know if I have non-patient facing status and what does that mean?**

Practices should receive notification of non patient-facing and hospital-based status in the coming weeks. CMS determines non patient-facing status using patient encounter codes from Medicare Part B claims data. Hospital-based status is determined using Place of Service codes only (21, 22, 23).

If electing GPRO, an entire TIN will be designated a non patient-facing group if 75% of more clinicians within the TIN are deemed non patient-facing. A TIN will be designated hospital-based group if 75% of more clinicians within the TIN are deemed hospital-based.

Individuals and groups that are non patient-facing or hospital-based are exempt from the Advancing Care Information component of MIPS, worth 25% of total MIPS score. For these individuals and groups, this 25% is reweighted to the Quality component (usually 60%) – for a total of 85%. All eligible clinicians and groups must report the Improvement Activities component, which accounts for 15% of the total MIPS score. In this category, individual activities are doubled for non patient-facing and hospital-based clinicians and groups. Medium weighted activities, usually worth 10 points, are reweighted to 20 points and High weighted activities, usually worth 20 points, are reweighted to 40 points. All MIPS participants must attest to activities equaling 40 points.

Learn more about the Improvement Activities component and ASA's recommendations for improvement activities that may apply to your practice.

6. **How do we correct provider information through ArborMetrix?**
   Please click the following link to direct you to the instructions on how to audit your provider list:
   https://www.aqihq.org/files//Monthly%20Self%20Audit%20Instructions.pdf

7. **When and how do we notify AQI of how we want to report MIPS for 2017 (Individual, GPRO, QR, QCDR, etc.)?**
   For renewals or new participants, there is an order invoice form that needs to be completed. This form captures your selections for 2017 reporting.

8. **How will the registry track NPIs when a group decides GPRO? Will practices be able to access provider-level reports?**
   For GPRO, data will be aggregated at the TIN level. AQI champions will have access to TIN and individual level reports through NACOR dashboards. For 2017, NPIs and TINs must be submitted in the data file. This information will be reflected in the provider list in the NACOR dashboard.

9. **If we report 12 measures, how does CMS choose which 6 measures to include in our quality reporting? Or does AQI only send the best 6?**
   Please see the following statement from the 2017 MACRA Final Rule:
   "There is no penalty or harm in submitting more measures than required. Rather, this can benefit the clinician because if more measures than the six required are submitted, we would score all measures and use only those that have the highest performance, which can result in a MIPS eligible clinician receiving a higher score."

10. **If an EP is exempt from MIPS due to low volume, does this provider still have to participate in Practice Improvement Activities for MACRA?**
    No, only eligible providers must participate. If a provider is not eligible, there is no need to submit data unless the practice would like to.

11. **Where can we find the new XML formatting?**

On the AQI website, there is a section that reviews the 2017 Schema updates and an XML file validator. You can access this information at the following link to test your data: https://www.aqihq.org/vendorsqcdrhelp.aspx

12. **If we are the vendor and are submitting data for a new client, how do we register them?**
Please have the new client complete an interest form and review the NACOR participation steps by clicking the following link: https://www.aqihq.org/participation-steps-details.aspx

13. **Where are the AQI Fees located on the website?**

On the ASA website, under Quality and Practice Management. The left-hand menu will include "2017 Pricing" where this information can be found. Please use the following link: https://www.asahq.org/quality-and-practice-management/quality-reporting-nacor/nacor-quality-reporting-options-and-mechanisms

14. **Will there be a way to report the improvement activity via NACOR/AQI**
AQI NACOR will support attestation of improvement activities via the NACOR dashboard. ArborMetrix is currently developing the tool. Details to follow soon.

15. **With AQI no longer merging files, does this mean if a vendor submits the data for the measures and the practice submits the billing data, that AQI will not merge the files?**
Effective July 1, AQI will no longer be merging and formatting data files. If you need assistance with these services, please email askaqi@asahq.org to schedule a conference call with ePreop to discuss service options and fees.