Centers for Medicare & Medicaid Services (CMS)

Merit-based Incentive Payment System (MIPS) Overview: Understanding Quality and Cost

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MODERATOR: Hello, and thank you for joining today's CMS MIPS overview presentation. Today's CMS subject matter experts, Ted Long and Sophia Autrey, will provide an overview of the Quality and Cost performance categories of MIPS. The audio portion of this webinar will be broadcast through the web. You can listen to the presentation through your computer speakers. If you cannot hear the audio through your computer speakers, or are experiencing any technical difficulties, please let us know using the Q&A box. Otherwise, phone lines will be available for the Q&A portion of the webinar. Please hold problematic questions until the end of the presentation. The speakers will get through as many questions as time allows. If your question is not answered during the webinar, please visit the Quality Payment Program website or contact the Quality Payment Program Service Center at qpp@cms.hhs.gov or 1-877-715-6222 [CORRECTION: 1-866-288-8292]. The slides, recording, and transcript from the webinar will also be posted on the Quality Payment Program website after the event. CMS will send an announcement when they are available. I would now like to introduce Ted, who will be providing the introduction to today's session. Ted, you may begin.

TED LONG: Okay, thank you, everybody, for taking the time to call in for today's session. As we get started here, I'm going to ask my CMS team to change slides for me as I go, as I'm having trouble on my screen visualizing the presentation. So now I'll go to slide number three. So, what I'm hoping we can cover today is an overview, generally, of the MIPS, or the Merit-based Incentive Payment System at a glance, and then I'm hoping that Sophia and I can help you all to drill down into the categories of Quality and Cost performance. Slide four, please. So, I'm gonna start with this overview now. Now, what I want to do in the overview is start from a very, very high level, describing what the MIPS or the Merit-based Incentive Payment System is, and then drill down into the different subcategories a little bit and talk about eligibility so you can have an overall sense of what we're trying to accomplish in the program and what it specifically means for how you can and choose to participate.

So, the Merit-based Incentive Payment System has four components. The first component is Quality. The second is Cost. The third is Improvement Activities. And the fourth is Advancing Care Information. Now, some of these components are derived from former programs which we've been using for up to several years now at CMS. So, we wanted to take these and build upon what we've learned over the last several years and make improvements but also have them be familiar to you. So, the Advancing Care Information is our improvement upon our meaningful use program. Our Cost component here is based on our value modifier program. And our Quality component here is based on the former PQRS program, which is being transitioned into this category. So, in general, with the MACRA and the MIPS program, what I emphasize as I go through these slides, that there are only four categories, or MIPS. So there's not an inset number of things that you'll be affected by or that you have to seek to fully understand. And that there's different ways based on how you want to participate that we're enabling you to fully participate in. So, next slide, please -- slide number five.

In terms of the weights of the categories -- so now, again, I'm going to start going into a little bit more detail. The Quality category has its weight at 60% for the first year. The Cost category is weighted at 0%, so the information we give you for Cost -- I'm going to go into much more detail about this later in

the presentation -- is not going to be tied to payment at all in the first year. Improvement Activities will be 15%, and Advancing Care Information will be 25%. Next slide, please. Slide number six.

So, that's the four components of what the MIPS program is. Now, how do you know if you are eligible as a clinician? Well, the overall eligibility statement we have is if you're a Medicare Part B clinician, in order to be eligible for MIPS, you must bill more than $30,000 a year and you must provide care to more than 100 Medicare beneficiaries a year, as well. So, you need to meet both of those criteria in order to participate in and be eligible for the MIPS program. Now, you'll hear me in this presentation be very careful to use the word "clinician." For us, clinician falls into five different categories. Clinicians in the first year of the MIPS program are physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists. As we go on in the presentation, in full disclosure for myself, I'm a practicing primary care physician, and that's my perspective on several of these matters. I'm going on to slide number seven now.

So, in terms of if you fall into those categories of clinicians, you can either participate as a patient facing clinician or as a non-patient clinician. Now, the general definition for a non-patient facing clinician is if you have -- or you do not have patient-facing encounters. It's on the level of that encounter. Now, first of all, and I'll give you some numbers in a moment about what defines that in terms of how many encounters, but first of all, non-patient facing clinicians are still eligible to participate in MIPS as long as they exceed the low-volume threshold, they're not newly enrolled, and they're not already participating in a qualified APM or Advanced Alternative Model.

Now in terms of the numbers that I mentioned. So, a non-patient facing MIPS eligible, so in other words, participating in the MIPS program clinician, has a threshold for individual patients in terms of less than or equal to 100 patient facing encounters in a designated period. In other words, if you have more than 100 patient facing encounters, you're considered a patient facing clinician. Now, that's if you're an individual. What about if you're in a group? So, a group of non-patient facing clinicians is defined by greater than 75% of the NPIs billing under that group's TIN, or Tax Identification Number, during a performance period. Next slide, slide number eight, please.

So, we've talked a little bit so far about the overall MIPS program. It has just four components, which we're going to go into more detail for two of them today. Talked about eligibility. We've talked about who clinicians are. So, now who is not part of the MIPS program? Three general categories here. First off, if you're newly enrolled in Medicare, you are excluded from the MIPS program, and that's if I have enrolled in Medicare for the first time during the performance period that's active. In other words, if you enroll during the current year, you wouldn't be responsible for or eligible for being in the MIPS program for that year. Second category in terms of exclusions is if you don't meet the -- if you're below the low-volume threshold, you don't meet the threshold. As I said before, the threshold is charging $30,000 a year or seeing more than 100 -- and seeing more than 100 patients a year. If you don't meet both of those criteria, you don't meet the threshold. Finally, if you're in an advanced APM, or Alternative Payment Model, then you don't go into the MIPS program because you're already having an experience with Quality measurement, Quality reporting, and things like that in the APM. So you wouldn't be in both programs at once. Now, part of the question there is, well, how much do you have to be in an APM such that you wouldn't be eligible to be in the MIPS program. If you have one patient in an APM, clearly that doesn't mean that the bulk of your care is being delivered within the context of that APM. What we did for the first year of MIPS in the MACRA program here is we defined participation in the advanced APM in terms of making you ineligible for MIPS as if you're receiving 25% of your Medicare payments or seeing 20% of your actual patients. So, again, 25% of payments or 20%

of patients. Both of those criteria are applied to the extent to which you're participating in the APM. Next slide, please. Slide number nine.

So, I'm gonna pause for a moment here 'cause this slide is really important. One of the pieces of feedback that we received in the proposed rule that we took very, very seriously is we were told by clinicians that not all of them were ready to jump in the deep end of the MIPS program. We hear that and we've tried our best to be as responsive as possible. So I'm going to try to simplify this slide, but this is our concerted effort to really take that feedback into account. And what we were told was that some clinicians want to see how it goes, participate a little bit, but they don't want to have a negative payment adjustment if they aren't willing to go all in yet. So we have a few different ways in which you can choose as a clinician to participate. The first case is what we call the test case -- minimal participation. And if you do that, we'll guarantee you that you won't have a negative payment adjustment. Or you could participate more or fully. The next three slides may go into more detail about each of these three ways to participate, but I wanted to accentuate the point of this is our best effort to respond to a lot of feedback we got. We really did listen, and we hope that this will make the MIPS program suitable for you wherever you're at. Next slide, please. Slide number 10.

So, this is for the test pace. So, this is if you're a clinician, you're practicing, and you aren't ready to fully jump in the deep end of the MIPS program, submit to all of the necessary Quality measures, Improvement Activities, et cetera. We send a minimum amount of data that you have to give back to us such that we'll say, "Okay, you've met the test case. You're not going to get a negative down -- or net downward adjustment. You may even have a small positive adjustment if you do a little bit more than this." So, what is the minimum requirement? The minimum requirement is you need to submit to us one Quality measure -- just one -- or one Improvement Activity. Again, just one. Or part of the Advancing Care Information measures. I want to really emphasize the point here. This is not an "and." You don't need to do all three of these things. You pick whichever one meets what you do clinically and you find the most meaningful to give you experience with the program, and that's it. Next slide, slide number 11, please.

So, let's say that you want to participate more in the MIPS program, but you aren't ready to participate for a full year. What you can do is you can choose to participate for 90 days. If you submit data of four 90 days of the 2017 calendar year -- we call that the performance period -- you can be eligible for a positive payment adjustment, depending on how your performance is. But that 90 days gives you adequate experience to really begin to submit to us more meaningful data so that we can help you to evaluate your performance, as well. We can give you more feedback on it. Or, next slide, please. Slide number 12.

If you wish to jump in the deep end, to go all in with the MIPS program, you can choose to submit all of your data for calendar year 2017. This maximizes your chances of getting the positive payment adjustments during that period. I do want to emphasize the takeaway here, though, that the positive payment adjustment is not based on the amount of data you submit or the length of time submitted. It really is based on your performance in terms of how you do on those Quality measures, things like that. That said, you maximize your chance of doing well in the program if you submit to us more data because, in part, you have access to more measures that you can potentially submit to us, some require more than 90 days of participation. Next slide, slide number 13.

So, we've talked now about what it means for you as an individual clinician, if you're eligible, how you can choose to interact in the MIPS program, how flexible to meet you where you are. What if you're a

group? So, you can make the choice as an individual to participate in the MIPS program, or you can choose to participate in a group that you're currently in. You could also still choose to participate as an individual if you're in a group. That choice is up to you and your group. If you do decide to participate as a group, one of the criteria is, that I want to mention, two or more clinicians defined by NPI who have reassigned their billing rights to a single TIN, or Tax Identification Number. If you do decide to participate in the group, the asterisk here is that if all clinicians participate as that said group, they're assessed across all four categories, the four different components of MIPS, as a group, as well. You can't pick and choose which components or category you want to be measured on as a group and as an individual. You have to choose one or the other. Next slide, slide number 14, please.

So, we've talked about what the MIPS program is. We've talked about if you're eligible or not. We've talked about what it concretely means for you as an individual or as a group reporting back to us about these different Quality measures and Improvement Activities, et cetera. Now, what does this actually mean concretely for what you physically have to do? So, I'm not gonna go over every point on this slide. We want to offer this slide as a bit of background information for you to think about a little bit more later. But to highlight a few of the key points here, if you're an individual or a group, there are several -- not just one, but several ways that you can participate in the program by giving us data through a few different ways. So, you can give us data through an electronic health record. You can give it to us through traditional claims, which you may be more used to. You could also, if you're part of a QCDR -- Qualified Clinical Data Registry -- give us the data that way. So, the takeaway point from this slide is that there's many different ways to give us the data. It's up to you. It's up to you how you want to participate in the program, whether you want to start with the test pace just doing one Quality measure, whether you want to do more than that, whether you want to submit the data through claims, through your electronic health records, or a QCDR. It is totally up to you, and we've included what we hope will be enough flexibility to meet you where you're at. Next slide, slide number 15, please.

This is the final slide of the introduction. So, we've talked about the MIPS program, as I said. Now, I just wanted to give a little bit of a sense of what this means in terms of a timeline. So, when does the Merit-based Incentive Payment System officially begin? Well, it has begun. You're in it now. So, 2017 calendar year is the first performance year. What we mean by performance year is this is the period of time -- again, calendar year 2017 -- where your Quality, your Costs, your Improvement Activities will be measured during that 12-month year right there, 2017. Now, you can choose to participate in a 90-day window at any point during the performance year. Up to you. Same way that if you want to use that test pace submitting that one Quality measure. You can do it whenever you want during the performance year. The performance year has its bounds, though, and that is, again, the calendar year of 2017, but you have flexibility about when you want to start participating. Or you could start now. No matter when you choose to start, based on where you're at as a clinician, the deadline for submitting to us data is March 31 of 2018. What that means is that you get through the calendar year of 2017 and you can submit to us the data right away in January, 2018, if you want, or we're gonna give you several months to put all the puzzle pieces together and get us back that data.

After that, what you can expect from us. The first thing, and I really want to accentuate this point, too, is that what you really can expect from us is a feedback report which will make sense, be easy to interpret, and actually, we hope will be really helpful for you to see how you do on these Quality measures compared to your colleagues. Maybe identify different areas that you may not have been aware of that may offer different opportunities. After you get that feedback report, you'll receive a note about what that means in terms of your payment adjustment, but that won't kick in till January 1,

2019. So everything we're doing now in the performance year 2017, you won't see any change in payment based on the MIPS program until as early as January 1, 2019. With that, I'm looking forward to answering any questions you might have. I'm going to turn it over to my colleague, Sophia Autrey, now to start with slide 16 about quality. Thank you very much.

SOPHIA AUTREY: Can everyone hear me? Okay.

MODERATOR: Sophia, you are actually breaking up. Are you able to get closer to the microphone, perhaps?

SOPHIA AUTREY: Let me try that again. Is that better?

MODERATOR: That is better, yes.

SOPHIA AUTREY: Okay, great. So, thank you, Dr. Long, for that brief overview. And so what I'm going to cover is the Quality performance category for MIPS, and as Dr. Long previously stated, an eligible clinician can pick their pace. So, I'm gonna start with the next slide, slide 17, where you see the test as well as the partial and full way that you can report for the transition year. So, if you're an eligible clinician, you can pick your pace for reporting to MIPS in 2017. So, what this means for Quality is you can, one, report a minimum amount of data just to test your system and see if you need to make adjustments prior to reporting in 2018 performance year, or you can report six measures, including your outcome measure, between 90 days and a full year. Or three, you can report six measures, including the outcome measure, for the full performance year. So, if we can go to the next slide.

Okay, on slide 18, the Quality performance category is worth 60% of your overall score. And the 60% was created to add some degree of flexibility to focus on the measures that are truly important to our beneficiaries and clinicians. Each eligible clinician will select six measures, which is a current decrease from the previous program of PQRS. Under that program, the reporting requirement was nine measures covering those three domains. If you are a clinician that reported to PQRS, you will see those differences in the reporting requirements because we no longer require the domain requirements for the new program under Quality. In fact, we encourage you to choose measures that span any of the domains as long as it's relevant to your practice. Again, of those six measures that you would report, one must be an outcome measure. If an outcome measure is not available, the clinician should select either another high-priority measure. So, as a definition, a high priority measure is defined as an outcome measure, appropriate use measure, patient experience measure, patient safety measure, efficiency measure, or a care coordination measure. So those are defined in our rule as well as under the QPP website. You can click on high priority yes, and it will give you a list of all the measures that are high priority. So clinicians can either select from approximately 271 measures -- that's the full complement of measure sets -- measures within a measure set. And that's available on our website, as well. Or a clinician can select a specialty measure set, and you can choose which specialty measures that you would like to pull from. So, there's also an additional population measure that is automatically calculated for clinicians that are reporting within a group of 15 or more, and I'll talk more about that at a later time. So, if we go to the next slide, on to slide 19, I'm gonna talk a little bit more in depth of the scoring methodology for the Quality component. Slide 20.

So, let's begin with individual clinicians. Within the Quality performance category, clinicians will need to select, again, the six measures to report, including the outcome measure, and it is a good idea for us to encourage clinicians to select those measures that are most appropriate for your practice and your

patient population. Of the six measures, you would need to select the one outcome measure or the high-priority measure if an outcome measure is not available to you. Clinicians receive a minimum of three points for reporting the range of points, depending on the performance against the benchmark for the measure. You can go to the QPP website under education and tools to look up the benchmarks for each measure. If a clinician fails to submit any Quality data at all, they will receive zero points.

So, under slide 21, for year one, participants automatically receive three points for completing and submitting a measure. So, if you were to submit any measure, either under the test category or for the full year, the minimum points you would receive would be three points. Alternatively, during the first year of the program, all clinicians can receive those three points just for completing or submitting the measures. You can receive the three points, again, if you are only submitting for the test pace, and so in order for a clinician's performance to be scored against the benchmark, they must have at a minimum 20 cases, and the measure also must have a minimum of 20 cases and meet data completeness criteria. If a measure cannot be reliably scored against the benchmarks, the clinician will receive the minimum of three points.

So, under slide 22, this goes into more information about the benchmarks for the Quality component, and the benchmarks are separated by measure and data-submission methods. So there is a difference in the benchmark if an eligible clinician is reporting a measure via EHR as opposed to reporting the measure via registry reporting data-submission methods. Additionally, it doesn't matter if you are reporting as an individual clinician or as part of a group. The benchmark will remain the same.

So, if we go slide 23, we're talking about bonus points. There are bonus points available for individual clinicians as well as if you're reporting for a group. And we should encourage you to take advantage of that opportunity to report more measures or any bonus points that you see that fit your criteria. Clinicians will receive bonus points for accomplishing either the following two requirements. One -- submitting any additional high-priority measures in addition to the one requirement of the outcome measure. So, you get two bonus points for each outcome and patient experience measure you report, and you get one bonus point for each additional high-priority measure that's not an outcome or patient experience measure. And then you also get bonus points if you use a certified EHR technology to submit measures to registries -- through registries for CMS. So, we do have a definition of what we consider certified EHR technology, and it's one bonus point for submitting measures that you have -- where you'd have end-to-end electronic submissions. So the absolute maximum number of points an individual clinician or if reporting for a group that's above 15 clinicians may earn for the Quality component is 60 points.

On slide 24, we can go more into how you would calculate or can calculate that total Quality performance category score. So, the equation for that is the total Quality category score is equal to the points that you earn from the required six quality measures that you report, plus any bonus points that you receive, and that total score is over the maximum number of points that you could gain. We want you to note that your maximum score cannot exceed 100 points. 100%, sorry. So that means that you may complete several bonus points criteria, but it will not exceed the maximum number of points for the measures that you report.

So, for the next slide, slide 25, it's important to note that the calculation of clinicians for a group is 15 or more. So, however, the maximum number of points available to groups of clinicians that are within a group and reporting of the group is 70, which is different from 60 points if you're reporting as an individual. So this change is due to the fact that groups that are reporting and the clinicians within

those groups will also be measured on the readmission measure, which is a CMS calculated measure based on claims data. So, please be aware that groups of clinicians will only be measured with the readmission measure if they have more than 200 cases. So, you may have a group that has more than 15 clinicians, but you don't have more than 200 cases in your group, so you still will not be -- that readmission measure still will not count for that group. So, for groups of 15 or more, again, the maximum Quality points for the Quality category is 70. So that would be six measures. Six submitted measures plus that one readmission measure. Also, as it relates to group reporting, there is a special scoring for those clinicians that are submitting through the CMS web interface. Groups submitting Quality data via CMS web interface must have at least 25 clinicians and must submit data on 15 measures. However, CMS will use the Medicaid Shared Savings Program benchmark and only score performance on a subset of 12 measures upon which the MSSP measures they're performing. Bonus points will be available for reporting high-priority measures and using EHR for end-to-end electronic reporting. Altogether, the total possible points for category if you're reporting via the web interface is 130, and those are the 12 measures for a performance times the 10 points each for each one of those measures. The one All-cause Hospital Readmission measure, which is 10 points. So, I'm going to turn it back over to Dr. Long, and he will go over the Cost performance category.

TED LONG: All right. Thank you very much, Sophia. So, I'm going to go start on slide number 27 now. So, what I want to do now is drill down into the Cost category. Now, the Cost category is something that we know that not all clinicians have had a great deal of, or in many cases, any experience with. So what I want to do in these slides is really demystify the Cost category for you. I'm gonna go over this at a very high level and drill down a little bit, but I'm going to assume that you're not an expert in Cost measurement or Cost measured construction, and I'm gonna take it from that perspective. What I hope you take away from these slides is I hope that you will take away having a sense of what a Cost measure is and have a sense of where we're going and how you can be involved. So, I'm still on slide number 27 now.

One thing I want to emphasize about the Cost category of MIPS is that for the first year, it is 0% of your score. In other words, we're going to look at Costs for you. We're gonna give you as comprehensive feedback as we can, depending on which measures are applicable for you. But we're not going to tie it to your reimbursement starting in 2019. It's not gonna figure into your final score at all. We're doing this because we heard consistent feedback that clinicians weren't ready to be accountable for the Cost measures that we're putting forth because they wanted to have more experience with them, understand what their baseline would be, and then understand what this would mean for their clinical practice. Also, an important note about the Cost category -- it is the only category in MIPS that requires nothing from you. We get it all from the claim data that we already are receiving from you. You don't need to do anything additional. So, in other words, the Cost category in year one, you don't need to do anything. It will not be a part of your final score. We hope it will just be helpful. So, a few other notes, and this is just generally about the Cost category. I'm gonna talk in a moment about the measures that we're using for the first year, but one note is that these measures, none of them are brand new. These are measures that we have a few years of experience with through the VM, or Value Modifier program, and reports that you may have referred to as Quality of Resource Use Reports. So, we drew from those reports and the measure that we've spent years developing to get a sense of how they work, to start giving clinicians feedback, and then to transition them into this new MIPS program in order to give you feedback. Next slide, slide number 28, please.

So, I'm gonna now talk about what a Cost measure is, and then I'm going to briefly go over the first -- the whole set of Cost measures that are in the first year of the MIPS program. So, I'm gonna read off

partly from this slide because the wording is important. So, what is a Cost measure? Generally stated, a Cost measure represents the Medicare payments -- for example, payments under the Physician Fee Schedule, IPPS, et cetera -- for the items and services furnished to a beneficiary during an episode of care. Now, I use the word "episode" carefully here because what we're going towards is thinking about Cost measures in terms of episodes. The episode of care is the basis for identifying items and services through claims that are furnished to address a condition within a specified timeframe. Now, in the same breath where I'm talking about the definition of a Cost measure, it is equally important for me to say the third bullet point, which is that our goal is that Cost measures will be as closely aligned with Quality assessment, as Sophia has just described to us, as possible so that patient outcomes and smarter spending can be pursued simultaneously together.

Now, taking a step back. So, that's what a Cost measure is. So, what can you expect from us in the first year of the program? So, in the first year of the program where, again, you don't submit anything to us. We get all this all ready, and it's not tied to your reimbursement. It's 0%. What we're going to be giving you feedback on is there's 12 measures overall. Two of them are general measures. One is the MSPB, or the Medicare Spending Per Beneficiary measure. The other is the total Cost of care measure. So, whether you provide predominantly inpatient or hospital care, or whether you, like me, provide predominantly outpatient or primary care, in my case, you'll have a total Cost or an MSPB measure that captures sort of the breadth of what you do. Those are the general measures. The other 10 measures are first attempts to put forth a set of episode-based Cost measures in the MIPS program. Now, if you want to read more about these measures, we'd be happy to share information for you, but because there's just 10 of them, I thought I'd go ahead and read off the titles of them for the purpose of this webinar just so you can see the direction we're going and to get a little bit more of a sense of exactly everything that's included in the Cost category. So, the 10 episodes are mastectomy, aortic valve surgery, coronary artery bypass graft, or CABG, hip femur fracture or dislocation treatment, cholecystectomy and common bile duct exploration, colonoscopy and biopsy, transurethral resection of the prostate for benign prostatic hyperplasia, BPH, lens and cataracts procedures, hip replacement or repair, and knee arthroplasty or replacement. I just read off the entire list of the 10 episodes and the two general measures that we've included for Cost measurement, so you now know everything in the Cost category in the MIPS program. So, now let me try to have it make a little bit more sense for you.

So, where we're going is we have the general Cost measures and we have the episode-based measures. But we want to figure out to the best of our ability how we can have these episode-based measures, to the greatest extent possible, reflect what you do every day as a clinician and what you find the most meaningful. So now I'm gonna talk for a little bit in the next several slides here about where we want to go with this and where we want your help. So, I'm going to slide number 29 now.

So, we talked about the definition of a Cost measure. To demystify it a little bit further, I'm gonna make you an expert in measure because I'm gonna tell you the five different essential components of the Cost measure. Number one -- defining an episode group, and an episode group is things like a certain type of procedure like aortic valve replacements, surgery, mastectomy, things like that. Number two is assigning Costs to the episode group. So, that's where we get feedback, and this is going to be an ongoing project for us in terms of creating new Cost measures where we think about, well, there's the direct Cost maybe for a carpal tunnel surgery. Surgeon's fee, any materials, anesthesia. And then there's the indirect costs, which are if your patients keep getting readmitted in the hospital. That's, in a way that is defined by clinicians, as related to the trigger event or the episode itself. That would be an indirect cost. Number three -- attributing the episode group to one or more

responsible clinicians. In other words, we want to the greatest extent possible to understand what you do, what your relationship is to your patients, and to have the Cost measure fit with the type of care you're providing with the type of relationship you have. And I'd be happy to answer any questions about that later. Number four -- risk adjusting the episode group so that we can, to the best of our ability, compare like versus like, apples versus apples. And number five, as I'd said before, is we want to, moving forward, consider the alignment between Cost and Quality as an essential component so that we can truly say that we're pursuing smarter spending in the same context as we're pursuing improved patient outcomes. Then go to slide number 30 now.

Slide number 30 restates a little bit of what I was just saying. So, taking a moment here, why are Cost measures important? To put it another way, why are we doing this? So, CMS' goal for developing Cost measures is really to provide you with actionable information that you find useful and that can help to drive both lowered Costs and improve patient outcomes. And when I say that you would find useful, that's why it's extremely important to us to have you be a part of this process as we go forward. As we think about further episodes, we want you to tell us what the right episodes are and how to do this work with us. I'm gonna go to slide number 31 now.

Generally speaking, I talked for a moment about episode groups two slides ago, but where we can go with this is that we can think about different types of episodes of care, such as chronic care can be distinct, acute inpatient medical care can be distinct, and procedural care can be distinct. And because each of those different groups has differences between them, we want to think about what those differences are, take them to heart, and think about each of these different types of episode groups as distinct quantities that we want to get feedback on. Then go to slide number 32 now.

This is the last slide on Cost measurement. So, just to repeat back to you, we've talked a little bit about the Cost category itself, which is you don't have to do anything for it and it's 0% the first year, but we want to give you the feedback and information from what we calculate for you so that we hope that you'll find it helpful and you can see how that will change over time. I gave you the definition of a Cost measure, I gave you even the different components of a Cost measure. You can see exactly what goes into this and to demystify it a bit. And I told you all of the Cost measures that are in the first year of MACRA, and what I'm gonna do now is tell you a little more firmly where we want to go and how we want to get your input. So, stakeholder feedback. So, we, over the years, have received stakeholder feedback in the former value modifier program through those reports that I had mentioned, the supplemental quality and resource use reports. But moving forward, we want to think about a new Cost measure development as in line with where you as a clinician are going in the future, as well. So we've attempted to receive some feedback so far in April -- or I'm sorry. October of 2015 and April of 2016 we've had postings that we've received great feedback on. We've also convened two expert panels -- technical expert panels. And we've convened a clinical committee to help us think about these episode groups. The clinical committee so far has had 70 clinical experts from over 50 specialty societies. Now, the last bullet here is perhaps the most important bullet in the Cost section. So, what are we doing right now? So, what we're doing right now is a few weeks ago in December, we put out a posting that outlined a lot of what I just talked about, but in particular emphasizes the approach we've taken and the initial set of new episode groups that we're thinking about building out into Cost measures. And we really want your feedback on that. We really believe that we cannot do this well unless we get as much feedback from you as possible. So, the public comment period is open for it now. It's open for several more months til April 24, 2017. We would be very happy to share it with you. It's on our website, but we can certainly share offline the exact link about exactly how to do this, as well, because we're committed to getting as much feedback as possible, both again on the process and

also on what specific episode groups we should think about that are the most meaningful for you. With that, I will pause and transition to the last part of this presentation, but I wanted to say thank you very much again for all of your time. It's been great talking with you today, and I look forward to questions.

ASHLEY SPENCE: Thank you, Ted. This is Ashley Spence, and if we could advance one more slide, please. So, as we begin to conclude this presentation today -- thank you to Sophia and to Dr. Long both for presenting this information -- and we do have a Q&A session to follow. So, a couple things that we just want to kind of reiterate – you've heard it before on many of the other presentations, but again, technical assistance, we are ready and willing right now and able to assist you if and when you're ready to begin. So, a couple of resources listed on this slide for you -- the portal, the Quality Payment Program portal. That is where you'll find all of the newly released educational materials, as well as links to the final rule, for instance, and other resources as they become available. We also have a direct link to our Transforming Clinical Practice Initiative, the QIN-QIOs, as well as the Innovation Center's learning system, and that learning system, again, that is for folks or clinicians that are in advanced APMs. So, this slide has direct links to those resources if you need technical assistance. They are ready and willing, so please feel free to contact them. Next slide, please.

The next slide is a breakdown of those resources to show you, like who is eligible for which resource, because they are -- some of the criteria varies just a bit. So, feel free to use this one, as well. There are resources specifically tailored for small and solo practices, as well as large practices, and then practices with primary care and specialist -- specialty physicians, sorry. And so those are the criteria for those listed there. Next slide, please.

And that is the end of the technical assistance slides, and then this slide, we mentioned in the beginning, but again, we are ready and willing and open now for questions. And so what you have is the number, so please dial in if you have questions, and there's a pass code there also to participate. We will answer as many as we can, and then just a reminder that in the event that we don't get to your question but you -- you know, we value your questions and we definitely want you to get an answer. We also have a service center that is -- they are expecting your calls. And so we have the phone number and a web address, so you can use either to contact the service center to get your questions answered. Just one thing as you begin dialing in, again, just to reiterate that today's calls focus is the quality and Cost performance category of MIPS, and so if your questions are related to Advancing Care Information, for example, that we don't have the SMEs readily available, and so those questions we would encourage you to send directly to the service center for responses. And with that, I will turn it back over to our moderator for Q&A. Thank you.

MODERATOR: At this time, if you would like to ask a question, please press "star" then a number 1 on your telephone keypad. Again, that's "star," the number 1 on your telephone keypad to ask a question. We'll pause for the first question.

ASHLEY SPENCE: Okay, so while we wait for everyone to dial in, just to give you a minute, we have a couple questions that we've received -- kind of commonly asked questions, and we thought this would be a good time to kind of bring those to the surface as we wait for you to dial in. So, one of the questions, obviously, around -- lots of questions around Quality and benchmarks. And we know that we have Quality benchmarks posted in the final rules, and we've been getting questions about what's posted on the Quality Payment Program portal versus what we included in the final rule. And so, Sophia, I don't know if you want to provide a little more insight.

SOPHIA AUTREY: Regarding the discrepancy that was noted between the benchmark document that's on the education and tools part of the website and what was finalized in the rule. So, what we want to clarify is that if you have questions about the measure types and which ones are appropriate, the measures lift, the measures specification, and the final rule, that's where you can get your source of truth as far as what you should go by regarding whether the measure type is intermediate outcome, outcome, or process. But regarding the criteria and information for the exact benchmarks and the data that we would use for that, that is appropriate in that measures benchmark document. So just wanted to clarify that. We do anticipate that we will correct the document as soon as possible, but I just wanted to make sure that we cover that issue as quickly on this call in case people had questions about that.

ASHLEY SPENCE: Okay, so turn it back over to our moderator. How are we doing with questions in the queue?

MODERATOR: Our first question comes from Gregory Kotlarz.

GREGORY KOTLARZ: Yes, hi. I have a question on the provider eligibility and the low volume thresholds. There was mention about the dollar amount. $30,000 -- more than $30,000 would make one as an eligible provider so long as they've also met the criterion for over 100 patients. Now, is that 100 -- or the dollar amount of charges, is that the actual charges that are submitted, or are those charges based on the par amounts in Medicare's fee schedule?

SOPHIA AUTREY: That is a very good question, and Dr. Long, do you know particular if it's different depending on what was charged or what is in the fee schedule?

TED LONG: Yeah, that's a good question. Thank you for asking. It's the allowed charges.

SOPHIA AUTREY: Okay.

GREGORY KOTLARZ: The allowed. So, that would correspond with the par amounts, correct?

TED LONG: Yes, it should.

GREGORY KOTLARZ: Yes, okay. And one other quick question. Under the Cost measures, from what I heard, it didn't appear that any of those 10 measures had any pertinence to psychiatric practice. So, how is the psychiatric practitioner's services measured in that context?

TED LONG: I appreciate you asking that. I was actually kind of hoping somebody would ask that, so thank you. I would advance your question to say what's the pertinence for many different other clinicians. I'm a primary care physician myself. There are no episodes that would be relevant -- that would be able to measure me. So I'm in the same boat as you there. The intention for us in the first year here is these Cost measures are actually really difficult to develop, and the only way to do it right is really to get as much feedback as we can, and that's what you really can expect from us moving forward. We don't have episode-based Cost measures for you in psychiatry, yet. And actually, you are a good example because there are many challenges, as I think you can imagine, in terms of what you think would really reflect what you do. But we want to meet those challenges with you, but we're not going to put anything forth unless it's really vetted by people in psychiatry like yourself. So it's no coincidence at all that you don't see anything that you can, in terms of the 10 episodes I read off, that

are directly applicable to you. I think what you can take away from this is that we want to think, in some cases, creatively about the best ways to do this for clinicians, and we'd love your help to do that.

GREGORY KOTLARZ: Okay. Okay, so we'll just wait and see how things develop, and then perhaps for 2018, there will be some advancement with regard to these matters' consideration.

TED LONG: You know, I would add to that, if you don't mind or if you wish to, I should say, we really want to hear as much feedback like that. We outline some of those issues in the posting that we put out in December, and we can share the exact link with you for that. But that's a great example of we'd love to hear your feedback via comments to that, 'cause that enables us to really take it into full account.

GREGORY KOTLARZ: Very good, thank you.

TED LONG: Thank you.

MODERATOR: Your next question comes from the line of Cheryl Kelly.

CHERYL KELLY: Hi, I have a few questions, but I'll start with if you make the choice to submit 90 days or a full 365, are you at risk for a downward adjustment by making the choice to submit more than the minimum amount of data?

TED LONG: I'm happy to take that. This is Ted from CMS. If you submit data to qualify for the 90-day window for Quality measures, et cetera, you will not have a downward adjustment in the first year of the program. That's because there's three different paces you can pick. There's the test pace, there's the 90-day pace, there's the full year. The minimum you have to submit would be the test pace, which is that one Quality measure or one improvement activity or part of the Advancing Care Information measures. If you do any one of those three things, you do not get a negative adjustment, period. So, your question is -- that directly answers your question. What I would add, though, is that the advantage of submitting for 90 days or longer is not just that you'll avoid a downward adjustment, but you'll really increase the chances that you could have a positive adjustment. But again, the degree to which you would have a positive adjustment is not based on the length of time or the amount of data. It is based on your performance.

CHERYL KELLY: Okay, great. Thank you. That answers my question. Well, actually, one more.

TED LONG: Sure.

CHERYL KELLY: It was the test, 90 days, or any other duration? So, can we do 180 days? Or is it a full 365 days?

SOPHIA AUTREY: Yeah, so the range can be a minimum of 90 and up to the full year. So, any time within that, you can record. You know, it doesn't have to be 90 days or 365.

CHERYL KELLY: Great, thank you so much.

SOPHIA AUTREY: You're welcome.

MODERATOR: Your next question is from Sherry Reeves.

SHERRY REEVES: Yes, ma'am. My question is we are in an organization where we have physician practices who use our electronic health records, but we also, in our hospital organization, have physicians who practice in our hospital but do not use our instance of our EHR in their offices. And we've been approached by several of those organizations recently about how do we plan on providing them with Quality data as it relates to their MIPS submissions because they will be ECs from the standpoint from their office practices. And I'm just trying to understand what -- in the past, looking from an MU standpoint and the Quality metrics of MU, those Quality things that happened for those providers because they were practicing in our hospital, we didn't provide data out to them. And so we're just trying to seek some clarification on what the expectation is around that from a MIPS standpoint.

SOPHIA AUTREY: Okay, so you bring up a very good question. Again, this is Sophia Autrey, and what we are trying to do in this, and especially for the Quality component that's different from what we previously had for MU and PQRS is we are trying to look at measures that are within the hospital that's attributable to individual positions that work within that facility. We haven't gotten there yet, so for those providers that have their own private practice and they work within an ambulatory care setting or a private practice, and then they also work in those facilities, they can still report those measures within the use of their practice. They are not required to report measures within the hospital. However, if they find measures that they would like to report that they think are attributable to them, that is good, but we really don't -- we have not made any strides yet to look at those measures that are the facility-based measures for the hospital that can attribute to those individual clinicians. We are working towards that, but right now, that's not a requirement for those clinicians. Dr. Long, do you want to add anything?

TED LONG: No, no, that's great.

SOPHIA AUTREY: Okay.

SHERRY REEVES: So, let me just ask a different way. They are asking -- so, what they asked me was would I be able to provide them data based on not the facility-based Quality metrics, but the metrics that they have chosen within their organization, and if I'm understanding what you're saying correctly is that because they're still a set a facility-based measures versus a set of ambulatory, for lack of better terminology, measures, we would not be expected to report data on the ambulatory set of measures from a facility standpoint.

SOPHIA AUTREY: I wouldn't expect that those would actually qualify for those clinicians, but there are some measures that it's not based on setting, but it's just based on patient criteria. So, if I'm hearing you correctly, let's say for instance this is a clinician and they decided that they wanted to report on a measure that works for them in their private practice, but it also is a measure that they want to get credit for under your facility, and they're asking you to provide them with that data from your facility because they have worked under your facility with patients. Is that the question you're asking?

SHERRY REEVES: Pretty much. I mean, first set is a group of providers that are emergency room physicians, and they have an urgent care facility, and they have a group of providers who work across both facilities, the hospital emergency room and the physician's clinic. So, they have given me a list of

the metrics that they plan on reporting from their office and are asking how we're gonna be able to give them the same data from the ED settings where they're seeing patients.

SOPHIA AUTREY: Right. So, what we're trying to do is try to work with some facilities on how they would be able to do that. If you can work with your -- especially your performance administrator in the hospital to see how they can pull that data specifically for those ED docs so that you can provide that to them, that would be helpful for them. But yes, there are measures that are within the emergency department that they can report, and they would probably most likely look to you to provide that data for them.

SHERRY REEVES: On the facility list or on the provider --

SOPHIA AUTREY: On the individual clinician list there are measures for ED.

SHERRY REEVES: Okay. I'm just not quite sure yet how they're gonna accumulate all this data together, but okay. I hope you guys are gonna have some more guidance coming down the road.

ASHLEY SPENCE: This is Ashley, and just one thing to reiterate, it sounds like -- sometimes we get questions that are so specific that we can feel that you might need a little more assistance, so I would strongly encourage you to take advantage of one of the technical assistance options, because they can then work with you one on one and really look at the nuances for your organization. So please, please, please take advantage of that.

SHERRY REEVES: Thank you.

ASHLEY SPENCE: You're welcome.

MODERATOR: Your next question is from Kevin Dearing.

KEVIN DEARING: Yes, hi. Thank you. I have a couple questions. One is on the Quality measures, if we submit our six Quality measures to the EHR and so forth, are we able to submit additional measures on top of that that are high outcome? Let's say we submit 12 measures, six additional high-priority measures. Will those give us additional bonus points?

SOPHIA AUTREY: Hi, this is Sophia Autrey again, and if I'm hearing you correctly, you're wondering if you can submit more than the required six measures to get additional bonus points. And you can submit additional measures. However, your performance score will only look at the measures -- the performance on the measures that are most advantageous for you, and I just still want to note that the bonus points, you can get additional bonus points, but the measures you submit, plus your bonus points, cannot exceed the total of the required number of your score. So it won't exceed the 100%, but you can submit as many measures as you like, and that way, we can choose from the measures that you submit the best option for your performance so you can get the highest score possible. But it will not exceed 100%.

MODERATOR: Your next question comes from Mike Flynn.

MIKE FLYNN: Yeah, I just -- and I think you answered it earlier. It's about the billing for the $30,000. Is it billing or is it actually paid?

TED LONG: Yeah, thanks for asking. Total allowed charges.

MIKE FLYNN: Sorry, I didn't hear you. What did you say?

TED LONG: Oh, sorry. I said thank you for asking. And it's allowed charges.

MIKE FLYNN: Okay, thank you.

TED LONG: Yep.

MODERATOR: Your next question is from Kate Earl.

KATE EARL: Hi, I just had a question about the reporting method, as there's different claims, EHR, and registry. Do your measures have to be submitted via just one, or can you have some from registry and some from EHR?

SOPHIA AUTREY: For 2017, we are only looking at one data submission method for your measures.

KATE EARL: So, if you have more -- like, some of our measures fall into regis--

SOPHIA AUTREY: I think we got cut off, but if you have measures that have multiple data submission methods that you would like to report, unfortunately for the calculation of the performance score, we can only look at one data submission method to do that calculation.

KATE EARL: Okay. Thank you.

MODERATOR: Your next question is from Gordon Wright.

GORDON WRIGHT: Hi, thank you. My question is around EHRs, and I know that there are -- the Quality measure I think is what, 271 measures, and the beauty of that, obviously, is it gives specialists and others chances to record applicable Quality data. Now, many of them are using EHRs right now to track performance. Is there a push from CMS for maybe new certification guidelines for EHR vendors to release more measures? I know in EHR, I think there's 53 measures, but I would imagine many of them might be doing registry, which I think there's 200-plus. So, is there a push from CMS to I guess to push EHR vendors along to include more measures or new certification guidelines?

SOPHIA AUTREY: So, yes. What we're trying -- short answer, we are in the process of trying to add and develop more eCQMs that are related to the relevancy of MIPS and the Quality performance category. So yes, we are trying to move in that direction. As you know, there's a lot that goes into developing eCQMs, and a lot that goes into certifying registry to submit those. So, unfortunately, it's not a quick process, but where we want to go and our priority and goals are to have more accessible measures that are reportable via EHR.

MODERATOR: Your next question comes from Karen Clark.

KAREN CLARK: Hi. Thanks for letting me ask a question. I really -- my question is is there any opening for participation measure development, and specifically, this is what I'm talking about. You know,

we're all pushing towards patient engagement, and we're finding that the way that we engage patients best is online on their mobile device or on their computer at home. That's where patients really engage. And so that's where we're doing our patient-reported outcomes for total hip replacements and total knee replacements. So, we think this is terrific. We're orthopedic surgeons. We're doing patient-reported outcomes with established instruments pre and post-surgery and getting outcomes. We are absolutely meeting the intent of the measure, the spirit of the measure, and what CMS wants to measure, and it's helpful for us, too, so it's great. However, we will be unable to report on these two outcome measures because the specifications require that it happen at a face-to-face encounter. It requires an ENM code. And secondly, that the post-operative survey be given greater than 60 days after the surgery. Now, we can certainly send -- we do send the surveys out more than 60 days after the surgery. We actually send them at 60, 90, and 180, but the face-to-face encounter prevents us from reporting. And so I guess my question is is there any opportunity to participate in kaizens or focus groups to help CMS understand how small tweaks in measures specifications would make it a lot more likely that orthopedic surgeons would report on that specific measure, but I imagine there are other examples for other measures.

SOPHIA AUTREY: You make a very good point, and one thing that we are trying to do for the upcoming year is have a little bit more specification because of the nuance of non-patients facing a criteria and what it means to have some of those encounters not be "face-to-face," but also be some type of modality that's telehealth. So we have done a little bit of that for 2017, and what we looked towards for more of the 2018 in years and beyond is having more of those measures with that ability. Unfortunately, you know, we are -- our hands are limited in what we can do with the measure specifications because CMS doesn't own all of the measures. So we do have to get buy in from the measure developer to make sure that even if it were not something that's done on a face-to-face process, it is something that still holds to the true intent of the measure. So, in looking forward to upcoming years, we see that we can look at those measures from that aspect and cover that with the measure on it to make sure that even though the encounter may not be what we initially thought when the measure was developed, does it still hold true if that encounter is outside of that round? So, we are looking into that. We haven't really talked about any kaizens for the upcoming year, but that is a good idea.

TED LONG: This is Ted, actually. If I can say a few more words, 'cause I really like that question. It actually makes me think of a few different things to mention that I think may help to clarify more of the context of the MIPS program. So, when we talked about the MIPS program having four different components, one thing to note is that we don't want to view these as four completely distinct sets of activities or components that aren't linked at all together, and that's one of the reasons why I try to really emphasize when I was talking about Cost the fact that Cost and Quality, we believe should be viewed in the same context. And that's another example of that which you were, I think, alluding to is as you think about different technologies for reporting data in different ways, both in terms of reporting data, but also you're using data for whatever purposes you find most clinically relevant and meaningful. There are Improvement Activities, which were not part of the presentation today, but that do capture some of that, as well. And the reason that we intentionally did that is so that if you're doing activities that you think are important to patient care, that are meeting your patients where they want to be met, then we want to make sure that we can capture any evaluations, too, through things like Improvement Activities. The final thing I'll say is related to the Quality measure development side. So, there's two pieces of development. First is tweaking existing measures, and Sophia, I think, answered perfectly what our stance philosophy and issues are with that. The other thing is thinking about if there's ever a need to create new measures, and we know that there is. And we do have other

activities about educating stakeholders about how to approach new measure creation development, things like that, and even ways to give us a little bit more of your feedback. So, if you or anybody else on this call would be interested in those activities, please e-mail the organizer of this event and I would be very happy to connect you to those.

MODERATOR: Your next question comes from April Cook.

APRIL COOK: Hello. Good afternoon. My question is concerning FQHC's community health centers and how we should report, and are we applicable to reporting through this system, because we are Medicare Part A billers, but we also found out that we are supposed to still be a part of the Quality program. Is that true?

SOPHIA AUTREY: Yeah. So, it is a little bit more specific. So, there are -- if there are providers under the FQHC that also bill Medicare Part B, they are required to report to MIPS. So, to talk more along the lines of what your question is, I want to forward you to the service center so that they can talk specifics to you, but in general, those eligible clinicians would be required to report in MIPS if they have other services that are Medicare Part B.

MODERATOR: Your next question is from Lisa Murdock.

LISA MURDOCK: Hi, can you hear me?

MODERATOR: Yeah.

LISA MURDOCK: Okay, my question was if an organization has providers with multiple specialties, can we report as a group but choose different Quality measures for different specialties?

SOPHIA AUTREY: You can report as a group, but the question is even if you report as a group, you're limited to the six Quality measures that would be attributed to your performance score. So, the question that you have to ask yourself is which measures you would want to report that will reflect on all of your participants within that group.

LISA MURDOCK: Okay, and if there aren't six that are relevant to everybody, they would have to just everybody report it as an individual, or can we divide into two groups?

SOPHIA AUTREY: Or you can look at the fact that, you know, there needs to be a minimum of 50% of your participants in the group have to report, so if you can make sure that at least the larger measures have a larger percentage of people participating, then yes, you can choose some of those measures. It's very difficult to choose measures that are across the board when you have a multi-specialty group, but it has been done, and, you know, for some of those specialty clinicians, they weren't well represented in those measures, but for others, they were. So that's a decision that you guys have to make as a group.

LISA MURDOCK: Okay, thank you.

MODERATOR: Your next question is from Barbara Mcaneny.

BARBARA MCANENY: Thank you. This is Barbara Mcaneny. We are participating in the Oncology Care Model, and we'll be submitting under that, but I was also hoping to be able to submit for the entire year and submit monthly because we don't know whether we'll be able to continue in the Oncology Care Model depending on how the risk quarters are set, so we wanted to make sure that we were in the program. So the first question is can we please be able to submit not only through the OCM program, but also directly submit starting right away, and the second question is on the QRURs, when we got those before, we're an oncology practice, and our oncologists were listed and compared to general internists, and not too surprising, our drug Costs were significantly higher than the internists. So, the question will be when you are looking at the QRURs that you're going to be giving us later this year, will you get more granular in terms of some specialty designations? Thank you.

SOPHIA AUTREY: So, let me address your first question first regarding submission to MIPS. So, for the Quality Payment Program for 2017, you cannot -- you're not able to report until Spring of 2018. So even though you only want to participate for part of the year, reporting will not begin until the beginning of 2018. I just wanted to clarify that for you. You can report even if you are part of the model if you want to submit it as a clinician. You would be able to do that, but you're not gonna be able to report and submit any of that data until early 2018. So, regarding the second question for the QRURs, are you talking about for PQRS submissions?

TED LONG: Or were you talking about the Cost part? I can answer for the Cost part.

SOPHIA AUTREY: Oh, okay. Go ahead.

TED LONG: Okay. And please let us know if this answers your question. So, on the Cost side of things, I mentioned that we have a total per capita Cost measure, which again, is one of the 12 measures -- 12 Cost measures that are in the Cost category for the first year of the MIPS program. The total per capita Cost measure does have a specialty adjustment, which answers your question. I would encourage anybody, though, that is curious about some of the measure specifications to look at the measures themselves. I know it sounds a little bit tedious, but it actually can be fairly revealing to see what the risk-adjustment model looks like, things like that, so that you can fully understand what the feedback we give means to you, and we're going to try to summarize that for you on an ongoing basis, too. But I appreciate the question.

MODERATOR: Your next question is from [Inaudible].

ATTENDEE: You already answered my question. [Speaks indistinctly]

TED LONG: You're very welcome.

MODERATOR: Your next question is from Randi Terry.

RANDI TERRY: I have a question, and I want to go back to the lady that talked about the urgent care and ED. We have surgeons that work in the ambulatory office and that also come into hospital. In the ambulatory office, they have EHR. Let's just call it NextGen. And in the hospital, they have a hospital package. Let's just call it Cerner for this example. Would you take the Quality measures from the two packages, combine them together, and submit an attestation, and since you said you can only accept one model, how could you do point to point from both of those and submit if you needed to or wanted to get those extra points?

SOPHIA AUTREY: So, I'm assuming you mean if I'm an individual clinician and I'm submitting as an individual clinician, how do I combine data from both of those? So, am I using either one of those -- an intermediary third party to submit data for me?

RANDI TERRY: No, I'd like to submit directly from the EHR to get that point-to-point electronic end-to-end additional point.

SOPHIA AUTREY: Yeah, so, are one of those EHR vendors doing that, submitting to CMS for me?

RANDI TERRY: Yes.

SOPHIA AUTREY: Okay.

RANDI TERRY: Both of them could and should.

SOPHIA AUTREY: So, both of them cannot submit for you separately. You should have -- in some way, this needs to be electronically compiled prior to submission to CMS.

RANDI TERRY: So I take my data from Cerner and I take my data from NextGen, I combine them together and I kind of custom. I cannot get the advantage of that end-to-end additional bonus point even though both vendors will allow me to do that?

SOPHIA AUTREY: So, if the compilation is electronically done, then yes, but if you are manually attaching, then no. You are correct.

RANDI TERRY: How can you take two different vendors and compilate them and put them together on a point-to-point, end-to-end -- electronic end-to-end? Can't do that. That's probably 50% of all providers either work in their office and cover surgical or in an urgent care and cover ED or in pulmonology and cover in the hospital pulmonology, or cardiologist that covers the hospital. I mean, 50% of our providers are in this situation. They have two different EHR vendors.

ASHLEY SPENCE: Hi, this is Ashley. I think -- so, it would be beneficial for you, I think, if we can get your question at the service center, because as I mentioned, we don't have, like, some of our EHR SMEs readily available, and they would definitely be a little more well-versed in this question. And so we provided the service center information on that very last slide. But I think this one would definitely be a candidate to go there so that we can kind of review your question in detail and give you a better answer that's not as generic.

MODERATOR: Your next question comes from Tammy Mcneil.

TAMMY MCNEIL: Hi, thank you. I have two questions that I'm kind of combining here. So, for the group reporting option, will CMS be doing like they've done in the past for the PQRS reporting where you will register to tell CMS that you're reporting as a group, and if so, when will that registration period start? And then the second part of that is the actual reporting after the fact. Is CMS creating a new portal for the submission or reporting process to take place where you can electronically submit your Quality measure, do your attestation for your ACI and Improvement Activities, or will we be going out to the old PQRS port and to the old meaningful use attestations portal? How is that going to look?

SOPHIA AUTREY: Okay, to address your first question, yes. If you are reporting as a group, that registration is still required, and I think that registration process begins April 1. But for the second question, I am not sure about if there's going to be a different portal for attestation for ACI. So, I'm going to direct you to call the QPP help desk.

ASHLEY SPENCE: So, this is Ashley. So, the current portal that we have, the Quality Payment Program portal or website, however you choose to refer to it, but we call it a portal, that will be your starting point. So, it's very possible that there's a redirect, but that is the starting point, so any announcement we have for reporting attestation and so forth, it will definitely still be a direct link to the Quality Payment Program portal, so we promise not to send you to many separate places. That is the starting point.

MODERATOR: Your next question comes from Amanda Taylor.

AMANDA TAYLOR: Hi there. I have a question about clinicians that may not have six applicable measures in the Quality category. As I understand, if you truly don't have a complete six measures to report on, that your denominator can be lowered based on the number of measures that do apply. If, you know, after re-looking through the measures again, I can't find enough measures for some of my clinicians, is there a way to preemptively apply for a recalculation of the denominator in that category? How would I do that other than just submitting fewer measures, getting, you know, score adjusted accordingly, and then having to appeal that after the fact?

SOPHIA AUTREY: Hi, this is Sophia, and yes, you will have an adjustment to the denominator if there are not additional measures or up to six measures that you can report. There is no way to ask that that be done ahead of time. We will have a validation process once measures are reported, but no, we can't do that prior to any submissions 'cause it's all based on what has been submitted and the performance on those.

MODERATOR: At this time, we do have time for one additional question, and that question will be from Jeff Fossett.

JEFF FOSSETT: Hi, thank you for squeezing me in. I have I think two questions pretty quick. Is there a list of QCDRs for 2017 MIPS if we want to submit Quality measures through a QCDR, and if so, where can I find it? And then the second question is with respect to non-patient facing providers for Quality, what's a definition of a non-patient facing provider, and can you give me an example?

SOPHIA AUTREY: Hi, so this is Sophia again. So, to answer your first question regarding QCDRs, we are in the process of self-nomination for QCDRs, and that self-nomination period is still open. It will close January 15th. So, prior to us receiving those self-nominations from all considered QCDRs and approving those, we don't have a list. We anticipate that we will have a list available in early May, maybe sooner than that. But once that is approved, we will publish that list on the QPP website. And so for your second question regarding a definition for non-patient facing MIPS clinician, so we do have it on the website, but just for clarity, a non-patient facing MIPS eligible clinician is an individual MIPS eligible clinician that bills 100 or fewer patient facing encounters, and including Medicare telehealth services defined in section 1834M of the Social Security Act during the non-patient facing determination period, and a group provided that more than 75% of their clinicians billing under the group 10 meet the definition of non-patient facing. So I just gave you those two things where you're non-patient facing as

an individual, and if you're part of a group, if more than 75% of your clinicians meet that definition, then the group is considered non-patient facing.

MODERATOR: At this time, I'll turn it back over to management.

ASHLEY SPENCE: Hi, this Ashley. We thank you all for participating in the Quality and Cost performance category webinar today. The slides, there's a recording, and a transcript will be available shortly. It will also be posted. You can access it via the Quality Payment Program portal. Click on webinars and training. It'll take you directly to the page where you can find the whole thing. The whole thing will most likely be available early next week. Again, technical assistance is available if you are ready to get started in the program and you just need a little help. Please feel free to take advantage of those resources. If we were unable to get to your questions, we do apologize, but again, the service center is available and able to take those questions right now, so please feel free to hang up and give them a call. Thank you again for participating. Have a great day.

MODERATOR: Thank you. This concludes today's conference. You may now disconnect. Speakers, please hold the line.