Hello, and thank you for joining today's Overview of MIPS for Small, Rural, and Underserved Practices webinar. Today, representatives from the Centers for Medicare & Medicaid Services will present an overview of the Quality Payment Program, including the Merit-based Incentive Payment System to discuss the flexibilities and resources of small practices. You can listen to this presentation through your computer speakers, and there will be a question-and-answer session after the presentation if time allows. A phone number will be provided later in the webinar so you can ask questions via the telephone. Roger Wells, clinical constituent chair for the National Rural Health Association, will provide an introduction for today's webinar and will then turn it over to Adam Richards, health insurance specialist at CMS, and Dr. Ashby Wolfe, chief medical officer for Region 9 of CMS. Roger, you may now begin.

Well, this is Roger Wells, and I'm your host, Clinical Constituency Group chair at the National Rural Health Association. Today I'm honored to be a co-host of this event for the Centers for Medicare & Medicaid Services, as well as the National Rural Health Association, for the webinar on MIPS for Small, Rural, and Underserved Practices. Just for your background, I am a physician assistant who has practiced in St. Paul, Nebraska, at Howard County Medical Center. We have four physicians, five physician assistants in practice here, and our community population is approximately 2,000 individuals, and our medical center staff travels to two different satellite clinics and is a real health clinic, as well as a Critical Access Hospital. I've practiced here for approximately 30 years have worked in rural health throughout my PA career. And throughout my career, I've been involved in healthcare policy at the state and national level. And recently it's been my honor and pleasure to work with CMS and the relationship with national policy at the Center of Medicare & Medicaid Services, as well as the National Rural Health Association as chair of their Constituent Group. I am a volunteer at these organizations and therefore am not associated with any payment, et cetera, but feel that with the utilization of these services and integration, we will actually be able to help out patients throughout the United States. I think you'll find this webinar is a valuable event and a review of the MIPS programs and then information to follow how strategically you can look at this in small, rural, and underserved practices, that our speakers and that representatives from CMS will be well-versed and have excellence resources to provide you with the most up-to-date information. And we're happy to assist you with other avenues at the end of the program. The National Rural Health Association, for your information, is a national organization membership volunteer program, mostly volunteers, with 21,000 members. Our mission is to devise ways of providing leadership to rural issues through advocacy, communications, education, and research. As we find, there's over 62 million people who live in rural America, which is approximately 20% of the population. We're non-partisan, non-profit, and the organization is proud to partner with CMS today to present this program, with a goal in advance just to help rural healthcare and small, underserved practices. The Clinical Services Constituency Group are members of the National Rural Health Association and are mostly interested in clinical issues that include proprietary and non-proprietary practices. And my contact information is located at the PowerPoint slide. I'm sure you can read that as well as I. Now, I'd like to introduce Mr. Adam Richards -- he's a healthcare specialist from the Center of Medicare & Medicaid Services -- to initiate the program today. I think you'll find this program informative, easy to listen to, and you'll actually get an excellent grasp of the Quality Payment Program, how it affects you as a small and rural practitioner and/or

provider. And you'll find that at the end there are excellent resources. And you'll find that they're even more valuable than some of these that you're going to...here and that people want to pay for 'cause these are actually better. Adam?

Great. Thank you so much, Roger. And thank you to the National Rural Health Association for partnering with us on today's discussion to highlight the Quality Payment Program, but more specifically the Merit-based Incentive Payment System for small and rural practices. It's an honor to have Roger here with us today, and he will be sharing some of his experience a little later on in the discussion. So, we look forward to bringing him back in just a little bit. And I do also want to thank each of you for being with us here today. It's really great to have this type of turnout, especially on a Friday. So, we're gonna jump into the next slide, just general housekeeping. So, for today, we have a pretty high-level overview of the Quality Payment Program, as well as the Merit-based Incentive Payment System. We'll talk about things such as the participation requirements for the 2017 performance year, some considerations for small and rural practices. We'll go through the performance categories, reporting, data-submission options, talk a little bit about scoring and some of the payment-adjustment material. And we'll also focus on some tips on how you can get started in the Merit-based Incentive Payment System, if you haven't done so already. Or if you are participating, we certainly thank you. And maybe you'll find some other tips on here that will help you as you move throughout the rest of this year. We'll also have some technical-assistance information to provide you with in case you do need support along your journey. And then we'll wrap it up with hopefully a question-and-answer session -- we'll have time for that at the end -- as well as a brief announcement on some user-testing opportunity that we'd like all of our clinicians and partners to have. So, if we move into the next slide, please. We're going to jump right in. The Quality Payment Program was enacted under the Medicare Access and CHIP Reauthorization Act of 2015, which we often refer to as MACRA, primarily because the law ends the sustainable growth-rate formula and it does require CMS to implement an incentive program. There we go. As you can see onscreen, the Quality Payment Program is comprised of two participation tracks. So, we have the Merit-based Incentive Payment System, which we are talking about today, where clinicians may receive a performance-based adjustment for providing evidence-based and practice-specific quality care, supported by technology and reporting on your progress. Alternatively, we have the Advanced Alternative Payment Model track. We won't focus so much on this track today, but there is a lot of really good information and valuable resources available on qpp.cms.gov. That's not the first time you'll hear me say that today. So, that is something that we definitely want you to note -- qpp.cms.gov. But really the Advanced Alternative Payment Model track -- these are innovative payment models. So, if you, as a clinician, decide to participate in one through Medicare Part B, you may earn an incentive payment for doing so. One thing that I always like to note is that this program is designed to, one, be flexible and minimize burden by letting clinicians choose how they wish to participate. And we'll talk a little bit more about that as we go through the material today. So, it's not just that we have two different participation tracks, but we also have flexibilities built in within those tracks to ensure that we are reducing burden and that we are offering the maximum flexibility to help you participate and be successful. So, if we go into the next slide, here we have the foundation, or, as we call, the bedrock of the Quality Payment Program. I will point to the prominent elements as certainly bolstering high-quality and patient-centered care -- so, in other words, taking the approaches needed to work to

improve patient outcomes through a comprehensive approach, which we discussed a little bit as I talked about the MIPS track earlier. Now, one of the key pieces of the bedrock is feedback, and the feedback that each of you have provided to help us shape the program thus far has been invaluable. And we certainly encourage you to keep helping us to continually improve the program. We are still listening. And I do want to remind everyone that 2017 is only a transition year. So, for those who have seen our proposals for year two of the Quality Payment Program, you know that we have proposed to continue to ease burden and to give clinicians more time to care for their patients, really, in the matter that they choose. So, if we move on to the next slide, this is just high-level list-out of the considerations for the Quality Payment Program. As you can see, these are seven high-level considerations. We did add ensuring operational excellence in program implementation this year. But just some of these to focus on -- we always want to improve our beneficiary outcomes. Obviously, the big one -- reducing burden on clinicians. As I mentioned earlier, as we go into year two, that's one area that we really wanted to focus on, was how we can reduce burden. Certainly increasing the adoption of advanced APMs moving into future program years. Maximizing participation, and we're going to get into that a little bit today, to just talk about some tips to help you prepare for and participate in the program. And then certainly improving data and information sharing and delivering those technology systems that really meet the needs of clinicians who are using them. So, those are the seven high-level considerations of the Quality Payment Program. So, if we move on to the next slide, we're going to jump into our overview of the Merit-based Incentive Payment System. So, one more slide, please. And one question that we hear quite often is, "What is Merit-based Incentive Payment System, or MIPS? And what are the basics of this track of the Quality Payment Program?" So, as illustrated onscreen, MIPS combines three of the programs that some of you may have some previous experience with. And that includes the Physician Quality Reporting System, the Physician Value Modifier, and the Medicare EHR Incentive Program for eligible professionals. MIPS maintains the basic elements of quality, cost, and the usage of technology, more specifically EHR technology, without having those three separate programs and the additional burden. So, I'm going to stop myself for just a moment because I want to point out that, while the Medicare EHR Incentive Program for eligible professionals is phasing out, the Medicare EHR Incentive Program for hospital and the and the Medicaid EHR Incentive Program will remain in place. So, that is one important item to note. And just so you are aware, at the bottom portion of the screen, this is just an example of how the PQRS program will phase out over the next two years. We're going to talk a little bit more about this in just a slide or two. So, if we move on from the next slide, there are four performance categories under MIPS, each of which contain a different weight to the MIPS final score for the 2017 transition year. So, for this year, quality is worth 60% of the final score. Cost is 0%, so clinicians will not necessarily be assessed on cost in 2017, but we will provide some feedback around that performance category. Improvement activities is at 15%, and this is really the only truly new performance category for clinicians included in MIPS. And this aims to encourage improvements in clinician practice. And then finally advancing care information is weighed in at 25%. So, all of these add up to 100% or 100 points to give a clinician a MIPS final score. Again, I want to emphasize flexibility, as the program allows clinicians who are included in MIPS to choose the measures and activities that are most applicable to them, their practice, and their patients. So, MIPS has quite a robust number of quality measures and improvement activities available. And Dr. Wolfe will touch on these in just a few minutes. So, moving to the next slide -- I

think this is a really great visualization. So, you may have noticed that the improvement activities performance category was the only new category. This is because when we refer to quality under MIPS, it is quite similar to the PQRS program. Cost is similar to the resource use or cost-measurement side of the Value Modifier program. And advancing care information is similar to the meaningful use program. So, of course they're not necessarily identical. So, that's an important takeaway. But for those of you who have previously participated in these programs, you may already have some experience with the requirements under MIPS. So, we'll move to the next slide. On the previous slide, I mentioned two slides ago we provided an illustration of how the legacy programs, specifically PQRS, would phase out over the coming years. However, you have asked the question of us of how those changes impact the adjustments that you may be expecting. Simply put, you will still receive your adjustments. And as you can see onscreen, we've included the timelines for those adjustments just to give you an idea of how the phase-out of the legacy program -- or the programs, really -- will occur. So, please take note of those different dates. If you don't have time to jot them down today, we will be posting these slides so that you'll have access to this information in the future. So, we'll move on to our next slide. I just have to break away from our discussion on MIPS for just a second because I want to talk about a special nuance for the Medicare EHR Incentive Program. So, eligible professionals who are first-time participants in the EHR Incentive Program have until October 1st of their first year to attest and avoid payment adjustments in the subsequent year. So, those eligible professionals who are first-time participants in 2017 have until October 1, 2017, to avoid the 2018 payment adjustment. Now, we know that 2017 is also the first year of the Merit-based Incentive Payment System, which carries similar EHR reporting requirements to those of the Medicare EHR Incentive Program. So, we define "first-time participants" as being eligible to previously attest, but never did so. So, this is the first year they are participating to try to demonstrate meaningful use. Also, eligible professionals that are brand-new to Medicare are automatically exempt from the EHR Incentive Program and do not need to follow this hardship. So, for first-time Medicare EHR Incentive Program participants in 2017, we here at CMS are offering a one-time significant hardship exception for the Medicare EHR Incentive Program 2018 payment adjustment to provide eligible professionals ample time to work with their EHR vendors and really adjust to the new reporting requirements in the advancing care information performance category under MIPS. So, our goal is really to help those first-time participants successfully participate in MIPS for the 2017 transition or program year. The reason I bring this up today is because October 1st is 24 days away and counting. And actually today is already half over, so make that 23 1/2 days. If we switch over to the next slide, a little bit more information on this nuance. So, first-time participants may apply for this one-time significant hardship from the 2018 payment adjustment if -- and I have three bullets listed onscreen here -- I won't necessarily go through them verbatim -- but if the EP is a first-time participant in EHR Incentive Program in 2017, the EP is transitioning into MIPS for the 2017 performance period, and the eligible professional intends to report on measures specified for the advancing care information performance category under MIPS in 2017. So, if the eligible professional meets these criteria for this one-time exception to the 2018 EHR Incentive Program payment adjustment, they must submit a 2017 Eligible Professionals Transitioning to MIPS Hardship application no later than October 1, 2017. So, please, if this does apply to you, make sure that you jot this date down. I also want to note that this is not the Quality Payment Program Hardship Exception application to re-weight the advancing care information performance category. This information and

link is specifically for those in the Medicare EHR Incentive Program for eligible professionals. We will talk about the Quality Payment Program Hardship Exception application process later on in this presentation. Okay, so, we are going to move on to the next slide, and this will get us back on to MIPS. So, what you see onscreen is the performance and payment cycle for the MIPS track. The first performance period is currently under way and runs from January 1, 2017, to December 31st. I would be remiss if I did not mention that there is still plenty of time to begin participating. And we have several participation options available to those who are included in the program and are ready to get started. And Dr. Wolfe will cover these very, very shortly. Some other key dates to note is the deadline for submitting data. So, clinicians must submit their data by March 31, 2018, to count for payment adjustment beginning on January 1, 2019, although I do encourage each of you to submit as soon as the submission window opens up next year. Again, it is not too late to start, and we are all here to help you participate in the program. With that, I will turn it over to my colleague Dr. Ashby Wolfe for a discussion on the MIPS program requirements.

Thank you so much, Adam. And it's a pleasure to be with you all today. Thank you for taking time out from caring for your patients to join us today. As was mentioned, I am the chief medical officer for CMS Region 9, which covers several western states. And I'm also an actively practicing family physician. I see patients in one of our local community health centers, serving the urban underserved patient population. So, I'm happy to be a part of this webinar today to provide you some more concrete details about the MIPS track. So, the overview that Adam presented -- I'm going to go into some more detail, and hopefully that will answer some questions that you may have about how you actually participate this year. We're going to really build off of the overview and provide you some practical details. So, starting on slide 22, for this performance year in MIPS, clinicians who are participating include those who are billing Medicare Part B allowed charges in the amount of more than $30,000 and they're seeing more than 100 Medicare Part B patients in this year. So, you have to meet both these requirements to be participating. And we're going to dive into that in additional slides, as well. But you also have to be a particular type of clinician, and those are shown here at the bottom of slide 22. Physicians, physician assistants, nurse practitioners, clinician nurse specialists, and certified registered nurse anesthetists are those eligible clinician types. And moving to slide 23, the definition of "physician" actually includes more than just the MD or DO. It also includes doctors of dental surgery, doctors of dental medicine, podiatrists, optometrists, and, in certain situations, chiropractors, as well. So, those are all included in our definition of "physicians," which is one of the five eligible clinician types in MIPS. Moving to slide 24, let's use an example to talk more specifically about eligibility. So, let's use Dr. A. Dr. A is an MD, so Dr. A is a clinician type that is eligible. And Dr. A billed $100,000 in Medicare Part B allowed charges and saw 110 Medicare patients in a given year. So Dr. A meets both of these volume threshold requirements and is included in the MIPS program. Now, slide 25 provides some additional information that if you are like Dr. A and you are included in MIPS this year, you should actively participate this year in order to avoid any negative payment adjustments and to possibly earn a positive payment adjustment. If you are included in MIPS this year and you decide not to participate at all, that will result in a downward payment adjustment of 4% in 2019. So, very important to understand what your options are to participate this year. And we are going to go into those details in several slides forward. Let's go ahead and move to slide 26 and talk about who is not included in the program. There are several different categories

of clinicians who are exempt from MIPS this year. That includes clinician who are newly enrolled as Medicare providers. These are folks who may be just coming out of their training program or, for whatever reason, have never enrolled in Medicare as an eligible provider in the past. So, these folks are not included in MIPS this year. They have a chance to get familiar with their practice, get familiar with the program. They would be expected to participate in the next calendar year of the MIPS program. Additionally, there are clinicians who are participating significantly in advanced alternative payment models. Adam mentioned that we're not going to be talking about that side of the Quality Payment Program in this program, but for those clinicians who are participating significantly in advanced APMs, they are also exempt from MIPS because they're doing a lot of the same work through their alternative payment model. And finally the box in the center articulates that there are clinicians that are below the volume thresholds that I was mentioning earlier. These are folks who are billing less than or equal to $30,000 a year in Medicare Part B allowed charges, or they're seeing 100 or fewer Medicare Part B patients that year. And let's move to slide 27 to try to work through that in an example. We're going to use Dr. B, who is also an eligible clinician type. But Dr. B billed $100,000 in Medicare Part B allowed charges and only saw 80 Medicare Part B patients. So, although Dr. B meets one of the volume criteria, Dr. B does not meet both. And you have to meet both volume thresholds in order to participate in MIPS. So, in this example, Dr. B is exempt from MIPS this year. Let's go ahead and move to slide 28 because if you are exempt, if you are like Dr. B, you can still choose to voluntarily participate in order to prepare for future years of the program. However, if you do voluntarily participate this year and you are exempt, you will not qualify for any payment adjustments based on your performance. But we do suggest that people consider voluntarily participating simply to get familiar with the program, which may help you in future years. Now, let's go ahead and move to slide 29. And based on the eligibility criteria that I just discussed, there are some important special considerations and flexibilities that we'll review in the next several slides. So, on the next slide, slide 30, let's talk specifically about clinicians in rural health clinics and federally qualified health centers. And that may very well apply to several of you on this call. Now, for clinicians who are billing under either the RHC or FQHC payment methodology, you are not subject to the MIPS payment adjustments. These are different ways that the rural health clinics and federally qualified health centers bill Medicare. However, if you are a clinician who is practicing in a rural health clinic or federally qualified health center and, for one reason or another, you are billing Medicare Part B, then you are likely required to participate in MIPS. So, the point of this slide really is to call out that, while there are some exemptions for those practicing in rural health clinics or FQHCs, it's very important that clinicians double-check with their practice manager, especially if you're a clinician who's seeing patients in multiple sights because you may be billing Part B and not be aware of it. So, just really important to double-check that you understand how your practice is billing Medicare. Let's move to slide 31 and talk a little bit about Critical Access Hospital, which, again, may be very pertinent to those of you on the call here. Critical Access Hospitals are reimbursed in a different way, as well, for services rendered to Medicare beneficiaries. And there are several methodologies for how Critical Access Hospitals actually receive reimbursement. Let's talk about box one here on slide 31. There are clinicians who practice in Critical Access Hospitals who bill under what's called Method I. For those clinicians who are billing in this way, they will be participating in MIPS just like anyone else, but any payment adjustments as a result of their

performance would only apply to the Medicare Part B charges that are billed by those clinicians. The payment adjustment does not apply to the facility payment, which the Critical Access Hospitals receive. Now, box two, there's another methodology, Method II payments, where clinicians are practicing in Critical Access Hospitals and they've actually signed their billing rights over to the facility. In that case, clinicians who are participating in MIPS, their payment adjustment based on performance would apply to these Method II payments that the Critical Access Hospital receives. Finally, there's a third box here on slide 31 where clinicians may be participating through Method II billing, but they haven't assigned their billing rights to the Critical Access Hospital. In that case, the MIPS payment adjustment would apply similarly to Method I payments. Now, this is pretty confusing, and not a lot of clinicians are that familiar with how this works. So, if you practice in a Critical Access Hospital, it would be a good idea to double-check with your group to understand how you're billing, and that will allow your group to better understand what to expect in terms of payment adjustments. Let's go ahead and move to slide 32 and talk more specifically about clinicians who are exclusively practicing in hospitals -- and not just Critical Access Hospitals, but hospital in general. We define a hospital-based MIPS-eligible clinician as a clinician who is one of the five eligible clinician types and provides 75% or more of his or her covered professional services in a site of service that is identified by a code as an in-patient hospital, which is place of service code 21, an on-campus outpatient hospital, which is place of service code 22, or an emergency room, which is place of service code 23. And this is based on claims for a period prior to the performance period that we've specified for this year. So, hospital-based clinicians are still participating in MIPS as long as they exceed the volume thresholds we discussed earlier. And there are some opportunities that we're gonna discuss, where hospital-based clinicians can report specific quality measures and improvement activities that are germane to their particular scope of practice. Slide 33 also discusses clinician types where you might not necessarily be seeing patients face-to-face. Of course, this includes certain types of anesthesiologists, radiologists, pathologists. These folks are exempt from MIPS. They're still expected to participate, as long as they meet the criteria. But they do have more flexibility in what they're required to do. An individual clinician is considered non-patient-facing if they have fewer than 100 patient-facing encounters in a given performance period. And clinicians who are practicing in a group are deemed non-patient-facing if, in that group, more than 75% of those clinicians who are billing under the group's tax I.D. number are meeting the definition that's laid out here on slide 33. So, let's go ahead and move to slide 34, and we've at this point reviewed who's eligible, we've reviewed what the special criteria and considerations are. Let's talk specifically about what options clinicians have to participate this year. And on slide 35, you will see several different paces of participation. Now, on the left-hand side, you will see that clinicians have the option to participate in advanced alternative payment models. Now, that's not a group we're going to be talking about today. We're really going be focused on these three options for how you can choose to pick your pace to participate in MIPS. Clinicians can choose to test this new program by submitting a minimum amount of data anytime in 2017. They can also choose to participate for part of the year by submitting 90 days of data this year to Medicare. With this option, clinicians may be able to earn a small bonus payment for their performance. Additionally, clinicians can choose to participate for the full year of MIPS and also may be able to earn a positive payment adjustment based on their performance. Again, just to hammer home that not participating at all in this program if you are included in MIPS will result

in a negative-4% payment adjustment to your 2019 reimbursement. Now, this slide says a lot, and we're going to break down each of these paces, each of these options for you in the subsequent slides. So, let's go ahead and flip to slide 36. Testing the system this year is one option for clinicians who are MIPS-eligible and are included in the program this year. And that minimum amount of data that clinicians can choose to submit includes the following, laid out here on slide 36. You can choose to submit one quality measure or one improvement activity or the four or five required advancing care information measures. Doing one of these things will help you avoid any negative payment adjustments in your 2019 reimbursement. And testing the system will at least help you get familiar with the programs. Now, flipping to slide 37, clinicians can also choose to participate for part or the fully year. There really isn't any set difference in bonus amounts or in positive payment adjustments between the partial- and full-year participation. However, for some of the performance categories in MIPS and for quality measures in particular, it can be difficult to meet some of the requirements if you only submit 90 days worth of data. So, we're encouraging folks to submit as much data as they are able to over a period of time, but you can choose to send in 90 days worth of data or the full year. And of course information here on slide 37 allows you to understand that for both of these options you potentially can earn a positive payment adjustment based on your performance. Moving to slide 38, we've covered some of the expectations and flexibilities for participating in MIPS, but let's actually talk about how clinicians are sending this information to CMS. On slide 39, you'll see a diagram that outlines that clinicians who are participating in MIPS have to options. They can participate as individuals, based on their tax identification number, or TIN, combined with their National Provider Identifier. Or they can choose to participate as a group if there's more than one of you in a practice. And that means that two or more clinicians who each have a unique NPI have reassigned their billing rights over to a single tax I.D. number. It is important to note that if clinicians choose to participate as a group, they are assessed as a group across all four of the MIPS performance categories. Let's go ahead and move to slide 40 and use an example to try to flesh this out a little bit more. So, here in slide 40, you'll see that this slide reviews options for clinicians, again, to participate either as individuals or as a group. And we see on the left-hand side we've got Dr. A, Dr. B, and a nurse practitioner. They're all practicing and choosing to participate in MIPS as individuals. So, we evaluate each of them individually for their participation status. You'll see Dr. A meets the volume criteria and so is included in MIPS. Dr. B does not meet the volume threshold and so is exempt. Similarly, the nurse practitioner also does not meet the volume threshold and is exempt. Now, if this group of individual clinicians decided that they wanted to participate in MIPS as a group, then they are evaluated for their participation status as a group. Together, Dr. A, Dr. B, and the nurse practitioner billed 250,000 to Medicare Part B allowed charges and saw more than 100 patients in the given year. So, as a group, they are considered all included in MIPS. So, that's the distinction here, and certainly clinicians have the option to discuss among their groups how they'd like to participate. Slide 41 also shows that there are many different ways that clinicians, either as individuals or as a group, can send in their quality improvement and advancing care information data to CMS. And for those of you who have participated in PQRS and Medicare meaningful use in the past, you'll see some of these options for submitting your data look familiar. There are differences depending on how you're participating, but of note across all three categories, there are some submission methods that are consistent. All of these categories include an option to report via qualified clinician data

registry, qualified registry -- those are different -- or through your EHR. So, certainly worth thinking about, as well. And a few slides down the road, I'll talk a little bit about how you actually have help to make this decision. You don't have to necessarily make this decision on your own. Slide 42 provides some definitions of each of these submission methods, and I'm not going to read through the slide in its entirety, but it certainly provides some additional detail of each submission method and how it works. So, do feel free to review this. And we have some additional information also available on our website at qpp.cms.gov. So, turning to slide 43, at this point we've reviewed which clinicians are included in MIPS this year. We've talked about the various ways clinicians can participate by picking their pace of participation. And we've talked about some of the ways that the data is sent. But let's actually talk about what data we're talking about, the performance categories that Adam outlined for you earlier. Slide 44 starts off with the quality performance category. Now, the overall performance score for MIPS is on a scale from zero to 100. And this year you want to ensure that your score is at least above 3 points. That will allow you to avoid any negative payment adjustments. So, starting with the quality performance category, this is worth 60% of that final performance score. And this category was created to add clinician flexibility and help clinicians focus on measures that are truly important to their scope of practice. To participate fully in the quality performance category, clinicians will select six measures. That's a big decrease from what was previously required under PQRS. Additionally, within MIPS, there's no additional requirement that clinicians have to choose measures that cover a certain number of national quality domains. Really what we're looking for is simply to have clinicians select six measures that are germane to their scope of the practice. Of those six measures, one must be an outcome measure. And if an outcome measure is not available based on your scope of practice, then you would need to select from another high-priority measure that is designated. A high-priority measure is defined as a measure that focuses on a patient outcome or appropriate use, patient experience, patient safety, or care coordination. And clinicians can select their six measures from a list of approximately 300 measures that are available. But we also have specialty-specific measure sets so that you don't necessarily have to go through all of the 300 measures in order to choose the ones that make the most sense. Additionally, there are three population health measures that are automatically calculated for clinicians as part of quality performance. So, what does this mean in terms of picking your pace? Let's move to slide 45. If you're going to participate in MIPS this year and you're included, you can test the system, which might mean simply picking one quality measure and sending it in to CMS through one of the submission methods I mentioned earlier. Alternatively, if you'd like to participate for 90 or more days or the full year, you should pick six quality measures and send us that information. And the list of measures, as well as the shopping cart, which will allow you to search by keyword or by practice type, is available at qpp.cms.gov. Now, moving to slide 46, let's talk about the cost performance category. This year, the cost category is actually worth 0% of your final score, meaning it does not count for you or against you in terms of determining your 2019 reimbursement. But we will be providing clinicians information so that they know what their cost and utilization looks like as part of the feedback process for the Quality Payment Program. And clinicians are assessed based on administrative Medicare claims data, including specific episode measures for Medicare patients only and for those patients that are attributed to that clinician. So, there's no reporting requirement for this category. And again, it is 0% of your final score in 2017, to allow clinicians to get familiar with what their costs and utilizations look like.

Now let's go ahead and move to slide 47 and talk about the category that is new to most clinicians. This category -- improvement activities -- is worth 15% of a clinician's final score. And I like to think of this category as giving credit where credit is due. Many of us as clinicians are doing a lot of work to improve their clinical practice, whether it be reorganizing their appointment schedule to allow for same-day or urgent-care access for their patient population, working with a care manager to really manage and prevent issues for their most complex patients, or perhaps it may be using a pre-procedure checklist to ensure that patients are prepped for particularly procedures the same way every time to ensure patient safety. All of those things and more, like participating in a patient-centered medical home or alternative payment model -- all of those things improve clinical practice, and all of those things are options that clinicians have to choose from in this improvement activities performance category. The improvement activities category also includes incentives to help drive participation in alternative payment models. And there are over 90 activities in these 9 subcategories to choose from. Again, on our website, qpp.cms.gov, there is a shopping cart where clinicians can actually type in by keyword or check what they might already be doing in their practice that matches up with this kind of activity. On slide 48, there are some special considerations. So, for groups with 15 or fewer participants in MIPS or if clinicians are non-patient-facing or are in a designated rural or HPSA, they have fewer requirements in this category. So, they need to demonstrate to CMS that they have completed two of the activities in this category for a minimum of 90 days. For those clinicians who are participating in certified patient-centered medical homes or comparable specialty practices or are participating in certain alternative payment models, they will automatically earn full credit in this category. There's nothing additional that they need to do. Also, clinicians who are participating in certain other alternative payment models, like the Medicare ACO Shared Savings program, Track 1, or the oncology care model, they will receive points for their participation in this APMs. And then those points will be rolled up into a score for this category. So, there are definitely some benefits for participating in alternative payment models that get you credit for what you're already doing in MIPS. So, what does this mean in terms of participating this year? On slide 49, if we're thinking about picking our pace, if we want to test the system this year, we can simply attest to one improvement activity. You can go online, search for an activity that matches up with what you're doing in your practice, and attest that you have been doing that activity for 90 days. Alternatively, if you'd like to participate more fully, again, for 90 or more days and reporting along those lines for MIPS, you would attest to a certain combination of improvement activities. You could pick two high-weighted activities. You could pick one high-weighted and two medium-weighted activities. But we ask that clinicians send information about participating in at least four medium-weighted activities. And for those clinicians that I mentioned on slide 48 that have special considerations, there are fewer requirements to reporting if you are going to participate either for part of the year or for the full year. Now, let's talk about the final performance category, which is advancing care information. Here on slide 50, you will see that this is worth 25% of your final score for MIPS this year. And unlike the improvement activities category, which is a new category, clinicians may be more familiar with components of the advancing care information category, as it is similar to the EHR Incentive Program or Medicare meaningful use. As an example, similarities include the fact that measures that are found within advancing care information are based on measures adopted by Medicare meaningful use for stage three in 2015. But there are some important differences with advancing care information

compared to the old Medicare meaningful use program. For example, this category is not exclusive to physicians and, in fact, applies to all eligible clinician types who are participating in the MIPS program, either as an individual or a group. Additionally, one of the biggest challenges of Medicare meaningful use was that it had an all-or-nothing component. That is eliminated with advancing care information so that you have a greater degree of flexibility to choose measures in this category that fit your practice and your patients. There are two different measure sets to choose from for reporting in this category, and it's based on whether or not you have a 2014 or 2015 edition of Certified EHR Technology. Now, let's go ahead and move to slide 51, which lays out the difference here. Clinicians must have and must use their Certified EHR Technology in order to report measures in this category. And, again, depending on the edition you're using, there will be different objects in the required measures sets. So, what does this mean in terms of picking your pace? So, on slide 52, if you would like to test the system that's here, you need to submit either the four or five required or base score measures, depending on your EHR edition. And then that would allow you to, again, avoid any negative payment adjustment for 2019. Alternatively, if you'd like to submit information for part or the full year, you need to submit more than just the required measures for your certified edition. For example, there are performance measures and there are voluntary bonus measures that you can add into what you report in addition to the base score in this category. Now, let's move to slide 53 because there are some important flexibilities for this category that are pertinent to some clinician types. If you are hospital-based, non-patient-facing, or a non-physician clinician who is participating in MIPS, box one on slide 53 applies to you. If you are one of these clinician types, reporting essentially is optional, although if you choose to report, you'll be scored. CMS will automatically re-weight your score in advancing care information to zero. And then the 25% that would have otherwise gone to this category will be folded into quality, such that quality will be worth 85% of a clinician's score if box one applies to you. If you don't meet the category in box one, you can ask or apply for us to re-weight this performance category to zero and move the 25% to the quality category if you have one of these situations that's noted in box two -- either insufficient Internet connectivity, extreme or uncontrollable circumstances, or the lack of control over the availability of a Certified EHR Technology. And on slide 54, more details about this application, which is a hardship exception, is available. Now, you'll see here that we have a website where you can learn more about this particular opportunity. We would really encourage people to take a look at this link that's here on slide 54 so that you understand what exactly and who exactly may apply for this particular situation. But if you are applying for a hardship exception based on extreme and uncontrollable circumstances, for example, you have to select the information about what happened and provide us the information about when that circumstance occurred -- for example, a natural disaster in which the Certified EHR was damaged or destroyed, a practice or hospital closure, financial distress, or particular issues with your EHR certification or vendor. There are some really specific criteria, so I would really encourage people to take a look at this if you think that that might apply to you. And of course here, the second-to-last bullet on slide 54, notes that MIPS-eligible clinicians who are considered special status do not need to submit a Hardship Exception application. And we'll go into some details about what that means in a few slides. Moving to slide 55, let's pull all this information together and discuss how these performance categories affect a clinician's score. And on slide 56, you will see that when calculating this final score, we actually take each weight and add up the weighed scores to derive this value between zero and 100. That

number is your final score and will determine the practice's reimbursement under Medicare Part B in 2019. On slide 57, we break down the different areas of what that final score and what those points might mean for you. So, of course not participating at all means that you've got zero points for the entire MIPS performance category set. So you will get a negative payment adjustment of 4% to your 2019 Medicare Part B reimbursement. But if you chose to test the system at the very least, you will earn three points, which will help you avoid that negative payment adjustment. And of course going beyond simply testing the system, participating for either part of the year or for the full year will allow you to earn more than three points. And depending on your performance in each category, you can earn anywhere from 4 to 100 points. Depending on what your final score is, you may earn a positive adjustment, or you may be one of those exceptional performers where you have the opportunity to be eligible for an exceptional performance bonus. So, moving to slide 58, we know that was a lot of information, and if you're hearing this for the first time, you're not alone. This is a big chance for many clinician practices who were just getting used to the older programs of PQRS and Medicare meaningful use. So, as a result, I'd like to take you through a few steps that are key to getting started in the MIPS program this year. And as you can see here on slide 59, the most important thing to do to start is determining whether or not you're one of those clinicians who is included in MIPS this year. And the how is to review the clinician participation letter, which CMS sent to all practices this year in the spring. Now, slide 60 provides a snapshot of what the participation letter looks like. And as you can see, even though the print is small, the first page of this letter reviews changes that are coming to reimbursement for Medicare Part B and details the Quality Payment Program and why the practice receives this letter. Slide 61 provides a snapshot of the second part of the letter, which also details what to do if a clinician or practice is participating in an advanced alternative payment model. Now, slide 62 also provides a snapshot of attachment A, which was included with the letter. And attachment A reviews which clinicians in the practice are included in MIPS and should actively participate. It also identifies which clinicians are exempt based on what we discussed in the earlier slides around the volume thresholds. So, this attachment lists the National Provider Identifiers that are associated with each tax I.D. And it provides information about how to contact us if you need support, if you have questions, or if you have concerns about the information contained in the letter. Slide 63 provides an additional way that you can check your status and verify or confirm the information that you received in the letter. This is our participation status look-up tool. And all you need to do is go to our website, qpp.cms.gov, and enter your NPI number and click "check now." That will allow you to see your NPI, its associated tax I.D. numbers, and what your practice looks like based on your eligibly status. Now, I do want to mention on slide 64 that we recently added special status designations to this look-up tool. What does that mean? Well, CMS runs a series of calculations to determine if a clinician or a practice actually qualifies for some of the special rules and considerations I've talked about in the previous slides with the Quality Payment Program. Note that that special status does not actually determine your inclusion in the program. The look-up tool runs a series of calculations and will show you whether you are included or exempt, but it will also show you your special status. And these special rules apply to clinicians who are non-patient-facing, folks who are practicing within a Health Professional Shortage Area, or HPSA, clinicians who are practicing in rural areas, have a hospital-based practice, or are considered a small practice. And we have all of the official descriptions of these special statuses on our website at qpp.cms.gov. So, on the last slide

that I'm gonna present, slide 65 -- We have heard many clinicians say, "Okay, I'm going to determine how I'm eligible, but what should I do if I find that I am included and need to participate in MIPS this year?" CMS has developed a checklist for getting started, and this slide, 65, shows briefly some of the items that are on that checklist. The checklist is really meant to serve as general guidance to every clinician to help them get started in preparing for and participating under MIPS, regardless of their level of experience in past Quality Payment Programs. You have the flexibility to determine how many of these elements in the checklist are applicable to your practice and your reporting situation. And certainly don't feel like you need to complete this checklist in the order that it is outlined here. You may want to take a look at the available quality measures first before determining what you're going to submit and how. And of course very important, as Adam mentioned earlier, the last part of this checklist denotes that it's incredibly important for clinicians to submit their performance data for their activities that they have done in 2017 by March 31st of 2018. And the window to submit your data begins on January 1st of 2018, so very important to submit as early as possible. Now, we do have a broader checklist with a lot more information available on our website. So, if this looks like something that would be helpful, I would strongly recommend you take a look at qpp.cms.gov. There are also some additional resources that we have that Adam will be discussing in a few moments, but first I'd like to hand it back to Roger Wells to describe how he plans to participate in MIPS this year and what his practice has been up to. Roger?

Well, thank you, Ashby. That was a wonderful review. I really appreciated it all. I think for most clinicians like myself, the program was an awesome, open-minded attempt of trying to identify, "Where am I at in a world, let alone how can I start doing something this fantastic to try to do value-based rather than fee-for-service?" But the first thing I looked at was, "It's a testing year. All I have to do is one, and there's no lose in this game." You will not lose. The second is, "I can be a volunteer if I find I don't want to and just volunteer, attest to any of these things if I'm not a candidate." So, approximately two years ago, we started looking at this when it first came out with our medical providers and started at a very early stage just looking at, "Do we want to become value-based?" and to look at the provider engagement first to see if we really wanted to be involved. As this worked through the providers, we decided to talk to the board of directors, that, "Yes, we are limited." A board in a community is very small, and a town of 2,000 people does not have the insight of the individuals who are speaking today and, in fact, probably don't know anything except what picture's on the wall in many institutions. So, with a board of limited knowledge, we began planning on how to develop a value-based engagement process with the providers. Then we looked at the social determinants of health and this daunting thing of, "Well, how can I change the social determinants of health when people don't have insurance? And won't that decrease my income? And how do I get all these people to come in and get these provider-based activities going?" And the more we learned, the more advantageous we found this program to be. We found that people who would come in with immunizations then could be talked about with their colonoscopies and their mammograms and their outpatient services, and numbers would actually increase. And we looked at some of the early providers that were working with ACOs, et cetera, and how they actually did a better job at healthcare. Their value became higher. And we started looking at ourselves and trying to look and see, "How many A1Cs did we really have that were appropriate?" and found that our data was really lackluster. And so we found that there's improvement activities. With

quality activities, we probably advanced our care rather than hindered it. And so we initiated the program. Defining the social determinants of health was utilized with the Critical Access Hospital population surveys, and we started looking at integrating behavior health with telemedicine. So, we started activities, even before we dove into the project, that would help us. And it's really been a tremendous improvement. Now the patients come in with their advancing care information, wanting their little paper of what they have as they walk out the door, when their next office appointment is going to be, what's their laboratory results, what was the diagnosis for today, and, "What do I have to do for my wellness checkup next time?" or, "What am I deficient in?" or, "What do I have to come back and do?" So, it slowly has evolved. And so I would encourage every listener to consider, if not being involved in the MIPS program because you're not going to make the criteria, to at least volunteer so that you do become involved in a later survey or time period that you actually have the data ready to go because it really has been an advantageous and excellent opportunity for us. Learning? Yes. A little bit scary? Yes. A wonderful experience? No. But it's the right experience if we want to take care of our populations. I'd like to turn it back to Adam to participate a little bit more with some of the questions we have. Adam?

Great. Thanks so much, Roger. And we are getting some questions, I think, for you, as well. Some of our participants are asking, how did you go about thinking about whether to participate individually or versus a group? So, while I still have you, I thought that would be kind of a great question to maybe just tackle before we move into technical assistance?

In a population of 2,000, we had no choice. We had to do it as a group, and we had to have group buy-in. So, it was a morning, breakfast, coffee at 7:00 with doughnuts, rolls, and everything that's cholesterol-forming, to discuss that particular issue. We decided that we wanted to go in as a group because we get along well, we wanted group performance, and we wanted to have that little bit of edge that all type-1 people have. We tend to want to beat the other guy, so to speak. And we found that even with ACOs, that tends to happen. We want to work together as a team and develop healthcare, not as an individual because then it becomes me versus them, and we did not want that to occur. We thought that that would be a stumbling block because we have found much improvement by working together in our past, as well as in the satellite clinics, et cetera. And if one person, as an example, wants to take call five nights a week and the other one doesn't want to take any call -- We don't try to put round pegs in square holes. We found that this was the best way that would work together, develop modifications for the people who wouldn't tolerate certain things, and became open-minded and open to the wants, needs, and preferences of the providers so no one got injured, hurt, or disenfranchised.

Fantastic. Thank you so much, Roger. And again, thank you for being here with us today. Roger will still be with us through the end of our discussion today, so if you do have any questions or just want to hear a little more insight, please stick with us up through the Q&A. I do want to jump into what Roger and Dr. Wolfe were talking about a little bit earlier about the support that's available right now, what we call the technical assistance for the Quality Payment Program. So, we realize that this program is a big change for many clinicians. So, in addition to taking it slow, we've also established a number of resources available to clinicians at absolutely no cost who are included in the program. And I can't emphasize that enough. These are no-cost support resources. All of these resources and forms of

support comprise what we call our Integrated Technical Assistance Initiative. So, I'm just going to go through this slide fairly quickly. Beginning in the bottom right, we have what is known as the technical support component of our Technical Assistance Initiative. So, this includes all of the information for the Quality Payment Program, including our website -- so, qpp.cms.gov -- the Quality Payment Program Service Center e-mail and phone number, and the APM learning systems, which service the direct support for those clinicians participating in alternative payment models and advanced alternative payment models. So, those are great starting points. However, if you need more direct technical assistance -- we'll begin moving counter-clockwise -- we have three on-the-ground branches of technical assistance available. So, these include the small, underserved, and rural support initiative, which has 11 organizations, the transforming clinical practice initiative, which is comprised of 29 practice transformation networks, and the quality innovation networks and quality improvement organizations. There are 14 of those, as well. Each one of these on-the-ground branches has shared goals in mind. And these include ensuring consistent and exceptional customer service, providing what we like to call a "no wrong door" approach, which means no matter where you are as a clinician and no matter which resource you try to connect with, we'll make sure -- and our technical assistance organizations will make sure -- that they're there to answer your questions and help you through the process. But if there's another branch of support that might be more applicable to you, they're going to make sure that you're transitioned over to that organization that's best for you based on your practice size, your patient population, and just your general needs. We've also committed to a 100% response time within one business day. So, as Roger mentioned earlier, we do like to have our technical assistance organizations reach out to clinicians within 24 hours to help them answer questions. We know that these are time-sensitive questions and we need to keep moving. And we also want to make sure that 100% of clinicians who are included in the Quality Payment Program have access to technical assistance. So, no matter where you turn, you will have the support available to you. You'll never be turned away. So, all of these branches are comprised of professional, experienced organizations who have worked with CMS on a number of quality-improvement-related programs over the last several years. They are very knowledge. These are very knowledge organizations and groups of people that are available to help you immediately and, as I mentioned earlier, for free, at absolutely no cost to you. So, I encourage you all to take advantage of the support and also help us spread the word so that -- As you're working with your peers, let them know that this technical assistance is available and that they're not on their own in this process. So, for some more information, please visit qpp.cms.gov. Take a look at our technical assistance resource guide under the "About" tab and by clicking on the "Resources" link. So, we'll move to the next slide. We often get the question, "How does technical assistance work?" So, really the available forms of assistance depend on how clinicians participate in the Quality Payment Program. As I mentioned, clinicians participating in an advanced APM and are considered a qualifying APM participant receive their support through the APM learning systems. Clinicians participating in MIPS may receive support as a part of the transforming clinical practice initiative, through one of the 29 practice transformation networks that I mentioned earlier, although I will mention that there is a time and data commitment. Clinicians do need to enroll with a practice transformation network in order to receive that support. However, alternatively, there are two other options for MIPS assistance for clinicians who choose not to enroll with a practice transformation network or not really ready for that large-scale practice transformation yet. So,

these include, like I mentioned, the quality innovation networks and quality improvement organizations. These organizations support clinicians who are in a large practice -- so, in other words, more than 15 clinicians. And then we have the small, underserved, and rural support initiative there to provide support to clinicians and small practices -- so, those with 15 or fewer clinicians. And we want to make sure that priority is given to those practices in rural locations, Health Professional Shortage Area, and/or medically underserved areas. We'll move on to the next slide, please. So, we wanted to take advantage here to really list out some of the forms of support that are available through our technical assistance organizations because, again, this is another question -- "What can these organizations help me to do?" So, we've broken this down specifically. So, these are practice-specific services that are available to clinicians, once again, at absolutely no cost. I won't read through all of these, but I just want to highlight a few. Right off the bat, they will help you to understand the general requirements of the Quality Payment Program. We know that you all have a lot of questions since this is the first year of the program. These technical assistance organizations can help you to answer those questions. They are very well-versed in this policy. They can certainly help you with your eligible determination, whether you are included in the program or not. They'll help you through the basic mechanism -- so, choosing quality measures, choosing your improvement activities, looking at the best submission options that are available to you, understanding how the score structure works, and really analyzing your performance to see where you may fall as we get into submitting the data and then ultimately the payment adjustment year in 2019. And they're also available if it comes time that you're prepared to transition into an alternative payment model or an advanced alternative payment model, they're there to help you along the way. This is not an exhaustive list of resources that the technical assistance organizations can help you with. This is just kind of a high-level idea of what is available. If we move to the next slide, these are more of the practice-specific services that these organizations can help you with -- so, really assessing your readiness for the Quality Payment Program, thinking about practice workflow and redesign, taking a look at your health information technology and making sure that you've got what you need to succeed in the practice. Beyond just kind of the technical aspect, really forming partnerships with practices and stakeholders, connecting with your medical societies and local associations. They'll also help you to participate in quality improvement initiatives if this is something that you're interested in. There's a lot of great initiatives out there, so this is something that you can certainly take advantage of. The bottom line is that these organizations are here to help you with whatever you need as it relates to the Quality Payment Program. They're professional organizations. They're available at no cost. Not only that, but they can help to magnify your voice when providing feedback to CMS. These technical assistance organizations are really our eyes and our ears out in the field right now as they're working with you. So, they bring all of your suggestions, comments, concerns back to us. And this is a way of helping us to continually improve the program. So, please reach out. Don't be afraid to reach out. Like I said, these organizations will respond to you normally within 24 hours. So, they're there. Please take advantage of them. If we move on to the next slide, please, I just want to spend a few remaining minutes -- and I'll go through these very quickly -- just talking about our small, underserved, and rural support. This is a newer initiative. It's been around for about six months now. We launched it in February. This is a five-year program that was authorized under MACRA. And like I mentioned earlier, it is designed for small practices -- so, those with 15 or fewer clinicians. It's available

immediately, and it is free to all clinicians in small practices. Basically, technical assistance is free to everyone, so it's not just small practices. But I just wanted to note that. On the next slide, this is actually a really nice image of the coverage areas for the small, underserved, and rural organizations. So, as you can see on the map, if you just locate your state and then locate your state with the organization, that is the organization that will help support you through your Quality Payment Program journey. So, I will say, as we move to the next slide, you can visit qpp.cms.gov. We also launched a brand-new page for small, underserved, and rural practices. So, this page contains the contact information for the small, underserved, and rural support organizations that you just saw on the previous screen, on the map on the previous screen. So, it has phone numbers, e-mail addresses to help get you connected. Certainly you can also go through our Quality Payment Program Service Center. They will also help get you connected to technical assistance. So, there are many options available. Also on this page, it highlights a number of the available options that are available for small practices, especially those that are in rural and underserved locations. So, a lot of the information we discussed today is available on that webpage, just in case you need to go back and just for a quick review. So, with that said, I believe we're going to enter into our Q&A portion of the Quality Payment Program, of our presentation today. So, we are going to open the phone lines. We'll certainly take questions from the chats. I do want to address just a few high-level questions. I've been monitoring the chat box as I can, trying to answer some questions. They come in a little quicker than I'm able to answer sometimes. But one question starting off -- just the difference between submitting a minimal amount of data and really testing the system for the first year, the partial versus the full -- so, really, what's the difference there? So, just to reiterate, if you opt to submit a minimum amount of data -- so, that would be the one quality measure, the one improvement activity, or the four or five required advancing care information base measures -- you would be looking at a neutral payment adjustment. If you opt to go participate at a partial or a full page -- so, either the 90-day or a full year worth of reporting -- it is very possible that you could receive a positive payment adjustment. Now, I do want to distinguish something, and Dr. Wolfe touched on this earlier, but there is really nothing built into the program that would give a MIPS-eligible clinician a lower-score payment adjustment based only on reporting on data for a 90-day period. We really are evaluating the overall performance on the data that is submitted, regardless of the timeframe -- so, 90, 200-plus days, whatever it is. Of course, full-year participation is generally a better way to earn that maximum MIPS payment adjustment. It certainly provides clinicians with more measures to select and the opportunity for bonus points. And it also helps to kind of enhance the reliability of those data that are being reported. However, a MIPS-eligible clinician could still earn a high final score at 90 days and still receive a positive payment adjustment or even maximum adjustment. So, there really isn't any distinguisher there. It really does just come down to performance. One other question that I saw kind of bubbling up in the chat box -- and this is more of a special rule for small practices that I wanted to touch on is, how does the improvement activities work? So, I just want to come back and highlight this one more time. So, there are special rules for the improvement activities under MIPS. So, again, those are practice with 15 or fewer clinicians or solo practitioners, certainly those that practice in designated rural areas or Health Professional Shortage Areas. But for the improvement activities category, what we do is we essentially double the weight. So, you have to still achieve the 40 points in the improvement activities performance category. However, since we doubled the weight, you

would only need either one high-weighted activity or two medium-weight activities. So, what we do is the high-weighted activities worth 40 points, and the two medium-weighted activities are worth 20. This is a special rule for those improvement activities under MIPS. So, I just wanted to address those two. One last thing that I do want to mention -- and I completely forgot to mention it when I was just discussing the difference between the partial day versus the full year -- October 2nd is coming very quickly. I just wanted to note that because that is really the last 90-day reporting period. I wanted to emphasize that again. We did touch on that earlier, but I think it's always good to have that reminder. That is the last true 90-day period left for partial reporting. So, I just wanted to make sure that that was out there, as well. So, now we're going to turn it over to the phone lines just to see if we have anyone available.

At this time, if you would like to ask a question, please press star, then the number 1 on your telephone keypad. Again, that's star, then the number 1. Our first question comes from Paula Manning.

Hi. I was calling to ask. Our address is listed incorrectly on the QPP website. So, when we go to poll to see if our physicians are rural, it's coming up with an address that we don't know. So, I submitted a case, and they told me that I had to change the information on PECOS. PECOS doesn't have what you have listed, so I don't know what I'm supposed to be changing in PECOS so that it's going to impact your system, and I don't want to start changing a lot of things and then upset the whole apple cart.

Yeah, that makes sense. Paula, can we connect -- We're going make this question. So, I'll connect with you, and we'll try to get this squared away. I'll just reach out to you or have other reach out to you so that way -- like you mentioned, we don't want to go and change too much if we don't have to. So, we'll connect and try to get this...

Right. I don't know what data field you pulled that address from, so I don't know what to change on PECOS. So, that's kind of really the information that I need. That's my first question. My second question is, how are you re-weighting the 25% for quality from advancing care? Do they add more metrics? Do they just add an extra 25% to the first original six?

I can answer that. This is Ashby. Thank you for that. There's actually been several folks who have added in those questions into the chat box. But essentially when we re-weight the advancing care information category, we make the advancing care information category weighted 0%. And we take that 25%, and we put it into quality so that the quality performance becomes 85% of a clinician's final score. So, it's not that there are new measures that one has to submit. It's that up to six measures that a clinician submits for quality becomes worth 85% of the final score. And then advancing care information is weighted at 0%.

So, if they have six qualifying metrics at -- let's say they hit the 10-point-each and they have 60 -- it's just going change to 85%.

It's 85% of the final score, would be that 60 points, correct.

Okay. All right. Those are my questions. Thank you very much.

Thank you. This is Ashby again. On the improvement activities category, someone else had had a question that, if you test the system and you submit

just one improvement activity, do you still need to do the other categories, in terms of the other performance categories? So, just to reiterate, if you are going to test the MIPS program this year, you just need to choose submitting one improvement activity or submitting one quality measure or submitting the four or five advancing care information base measures, depending on your certified edition. So, it's one or the other. But if you'd like to do more than just testing the system, meaning participating for 90 days or the full calendar year, then you do need to submit information in each performance category. So, it's not enough just to do one improvement activity. You do need to submit six quality measures and then the pertinent improvement activities based on your size of your practice and then the pertinent advancing care information measures.

Your next question is from the line of Kathleen Mendoz.

Thank you for taking my call. This question -- I have two question, actually. If we're going to bring a physician on board who's already a practicing physician in the community -- he joins our group in 2017, and he comes to us as a non-participating meaningful use provider, MIPS provider -- in 2019, when we get paid for any services that he does, will we be affected with the lesser of the reimbursement? Hello? Hello?

Hi. We have you. I'm sorry.

Okay.

No, we have you. That's a great question. And I think we are going to have to think through that one and take that back. So, we are going to note this question for you and make sure we try to get some type of response on this one.

And how will I get that response?

We will reach out to you. I believe we have your e-mail address from your registration.

Okay. All right. That would be great. The other question is, if I have some non-physician clinician, such as nurse practitioners or P.A.s, that receive the letter, that letter was specific just to the -- I just want to make sure I'm clear -- that was just specific to the PQRS portion, correct, the old PQRS portion, the quality portion?

This is Ashby. So, you're saying that nurse practitioners or physician assistants received the MIPS participation letter that I mentioned earlier in the slides?

Right, right, that they didn't qualify.

Okay, so, if a clinician -- any clinician, whether they're a nurse practitioner, physician assistant, M.D., or what have you -- if they received a MIPS participation letter that states that they, based on their NPI and their tax I.D., are exempt --

Right.

And that's something that you could confirm with our look-up tool online if you'd like to -- but if they received that information that they are exempt, then they are exempt from participating this year.

In what, just the quality portion?

In MIPS, the program in its entirety. So, that includes...

In its entirety?

...all four performance categories.

Okay. So, that's what I need clarification on because I thought I heard something else earlier that said that -- someone had said that if they had received those letters, they would still need to participate in the ACI portion so that they would not get a penalty. So, you're clarifying that if they got those letters, that exempts them in their entirety from the whole MIPS program?

For this year.

For 2017.

Yeah. An important thing to think about is that, particularly nurse practitioners and P.A.s have different rules around independent practice. And so if clinicians who are non-physician clinicians are participating in a group and the group decides to participate in MIPS, then that nurse practitioner or P.A., even if they're exempt individually, may very well be participating because they're in that group.

They were doing individualized --

Okay, doing individually, then the exempt status is correct. But for anyone else on the line who's thinking this might be a similar situation, just think critically. It's important that the group, if you are in a group, decides how to participate because it may change the status of some non-physician clinicians.

Okay. Thank you very much for your help.

Great. Thank you so much. We are over time right now, but I do want to take one opportunity -- if we could go to the next slide, please -- just to put this information out there. We would like to extend the opportunity to invite everyone -- Medicare clinicians, practice managers, administrative staff, et cetera -- to serve as a participant user tester for our Quality Payment Program websites. We want to ensure that we're meeting the needs of the clinician community. So, we're always looking for representatives from these organizations to just take a look at our websites, make some recommendations, provide us with feedback on what's working, what's not working, and what we can improve. So, if you are interested, please e-mail the box that we have on the slide right now. That's partnership@cms.hhs.gov to participate in a one-on-one feedback session, as we do have these different pieces of functionality come out onto our website over the new few months and over the next program year. Just gonna leave that on for another second or two. I do want to take this opportunity to thank each and every one of you for participating on the webinar today. I want to especially thank Roger Wells and Dr. Ashby Wolfe for being on and providing information

for us and walking us through what it means to participate in the Merit-based Incentive Payment System for the transition year for 2017. So, at this time, we are going to end the call. I hope everyone has a great weekend, and we'll talk again soon.

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